ACCRÉDITATION SANS FRONTIÈRES (ASF)
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ASF Health Standards Version 11

Standard 24: Home Care

Core standard · applicability by facility type shown for each criterion

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APPROVAL

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Complete on its own, without internet access. References are listed in section 12. The current version is at france-asf.fr.

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1 Introduction

This document is Standard 24 of ASF Health Standards. It sets out how a home care service keeps the client in control of their home, protects them from abuse and neglect, screens and supervises caregivers, keeps home safety and medicines safe, supports caregivers, and treats caregivers and clients equally whatever their legal status.

A standard is a set of numbered criteria. Each criterion says what must be in place (the criterion statement), how it is rated for each setting, what the assessor will check and what evidence the facility must show. The guidance in this document explains what each criterion means in practice, so that a reader who has only this paper can understand and meet it.

Purpose of this document. Standard 24 protects clients who receive care in their own home, who depend on a caregiver who comes into their home, and who may be exposed to abuse, neglect or unsafe medicines. A service that screens and supervises its caregivers, keeps the home safe, and treats caregivers and clients fairly protects the client's dignity and safety.

Who should read it. Chief executives, home care managers, nurses, the department secretary, and the assessors who verify the service. Each criterion names the positions responsible for it (section 8.2).

The standard is a tool to improve care, not a list of paperwork. Templates and forms named in this document are reference drafts. You may adapt them, replace them with your own, or upload your own documents, provided they meet the same criterion.

2 About ASF and this standard

Accréditation Sans Frontières (ASF) is a non-governmental, non-profit accreditation body. It was legally established in Paris in 2020. ASF develops health standards that are practical, affordable and open to all facilities, including those working with limited resources, in crisis, or in transition.

ASF believes accreditation should be accessible in every sense: geographically, so that facilities in remote areas can take part; financially, so that cost is not a barrier; and in language and format, so that staff can read and use the standard in their own working environment.

Each standard is an independent document. Standard 24 has been written so that it can be read and used on its own. It repeats the definitions, abbreviations and references it needs. A reader who has only this document can understand every criterion in it.

3 How to use this standard

If you are a facility manager or a member of the facilities team, read section 4 to confirm which criteria apply to your facility type, then section 5 to find the rating for your setting. Read each criterion from 24.1 to 24.45, paying attention to the rating, the guidance and the evidence. Prepare the evidence named in each criterion, covering the period stated.

If you are an assessor, use the sample and the checks in each criterion. The pass rule and the immediate-fail rule decide each criterion. A criterion is met only when all its checks are passed and no immediate-fail event is found.

Reading a criterion. Each criterion has: the criterion statement; the three ratings (humanitarian, transition and fragile, standard); the rating rule; the guidance; what good looks like; common mistakes; why it matters; the sample; the checks, with method, evidence and pass condition; the immediate-fail event; the documents with who writes, approves and checks them; the positions responsible; and the references.

Document codes. Each document has a code made of a topic prefix, a type and a number, for example HC-POL-001 (home care, policy, 001). The type is one of FRM (form, a record kept as evidence), REG (register), PLN (plan), POL (policy), SOP (standard operating procedure) or GDL (guide). The codes identify documents only. The full list is in section 13.

4 Scope

Standard 24 covers the client's control of their home, written rights, caregiver screening and abuse checks, home safety, medicines in the home, caregiver safety and supervision, continuity and support for caregivers, migration-informed care, and equal treatment whatever the legal status of a caregiver or client.

The standard applies in three settings. The rating for each criterion is given for each setting, and the facility uses the rating for its own setting: **humanitarian settings** (emergency or crisis, very limited resources), **transition and fragile settings** (a health system in change or under strain), and **standard settings** (full resources).

WHERE STANDARD 24 APPLIES

Standard 24 applies to home care, the support a client receives in their own home from caregivers who visit or live in. It is required by default in home care services, optional in hospitals, ambulatory clinics, primary health clinics and long-term care, and not applicable to telemedicine, fitness, dental or aesthetic clinics. A criterion is marked N/A for a facility type that does not provide home care.

Criterion	Applies to
24.1 The Client's Home Remains Theirs to Control	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.2 A Written Statement of Rights Is Provided and Understood	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.3 The Client Can Request a Caregiver Replacement	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic

Criterion	Applies to
24.4 A Reachable Alternate Contact Exists Beyond the Caregiver Themselves	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.5 Freedom From Abuse and Neglect Is Actively Verified	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.6 Background Screening Uses Verified Identity, Not Name-Based Matching Alone	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.7 Abuse Registries Are Checked in Every Country the Caregiver Has Worked	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.8 Any Care-Worker Exclusion Registry Is Specifically Checked	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.9 Screening Is Repeated Periodically	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.10 A Disqualifying Finding Triggers Individualised Assessment	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.11 A Structured Home Safety Assessment Occurs Before Care Begins	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.12 Identified Hazards Lead to Tracked Remediation	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.13 A Fall Triggers Reassessment	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.14 The Home Environment Is Reassessed Periodically	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.15 Emergency Access to the Home Is Confirmed	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.16 Medication Reminders and Administration Are Distinguished	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.17 A Single, Current Medication List Is Shared Across Everyone Involved	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.18 A Medication Change or Care Transition Triggers Structured Review	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.19 Medications Belonging to Different Household Members Are Distinguished and Secured	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.20 A Missed or Uncertain Dose Is Actively Followed Up	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.21 A Risk Assessment of the Home Occurs Before the First Visit	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.22 A Workplace Violence Prevention Programme Exists, Adapted for the Home Setting	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.23 The Caregiver Has a Way to Signal Distress Discreetly	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.24 Hostile Animals and Environmental Hazards Are Specifically Assessed	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.25 Near-Misses Are Actively Reported and Used to Update Risk Assessments	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.26 Supervisory Visits Occur On-Site	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.27 Personal Care Supervision Includes Observing the Aide Providing Care	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.28 Supervision Documentation Captures Objective, Measurable Observations	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic

Criterion	Applies to
24.29 A Change in Client Needs Triggers Care Plan Review	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.30 An Identified Deficiency Leads to Retraining and Re-Evaluation	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.31 A Coverage Plan Exists for a Solo Caregiver's Absence	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.32 Caregiver Continuity Is Actively Tracked and Prioritised for High-Need Clients	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.33 New Caregiver Retention Receives Structured Attention in the First 100 Days	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.34 Caregiver Isolation Is Addressed Through Regular Supervisor Contact	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.35 Incident Reporting Accounts for Detection Delay in an Unsupervised Setting	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.36 Care Is Adapted to a Client's Migration and Displacement Experience	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.37 Language Support Accounts for Persistent, Daily Interaction	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.38 Cultural and Religious Practices in the Client's Home Are Respected	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.39 Caregiver Work Authorisation Is Verified Through Legal, Non-Discriminatory Practice	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.40 A Caregiver's Legal Status Change Is Handled With Support	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.41 Immigrant Caregivers' Retention Advantage Is Recognised and Supported	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.42 Legal Status Diversity Recognition for Clients	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.43 Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.44 Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
24.45 Continuity Across a Client's Relocation Is Actively Supported	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic

5 Ratings and colours

Rating	Colour	Meaning
Must		Required in every setting. Criteria that can directly affect a patient's life are always Must, and no setting lowers them.
Medium		Required, adapted to what a transition setting can realistically do.
Minimum		The lowest acceptable level in a humanitarian setting, where resources are very limited.

In standard settings every criterion is Must.

TRAINING LEVELS

Level	Colour	Meaning
Essential		Must be completed by the people named in the role table.
Recommended		Good practice. Not checked as a requirement.
Optional		May be used for development.

6 Abbreviations

Abbreviation	Meaning
ASF	Accréditation Sans Frontières (Accreditation Without Borders), a non-governmental, non-profit accreditation body
FRM	Form. A record that is filled in and kept as evidence
POL	Policy. A written statement of what the service will do and why
REG	Register. A running record of entries
SOP	Standard operating procedure. A step-by-step description of how a task is done
PLN	Plan. A written plan for a defined situation

DOCUMENT CODE PREFIXES

Prefix	Topic
CLN	Clinical care
CON	Equality and access to care
GOV	Governance
HC	Home care
HMG	Migration and health
INC	Incident management
LTC	Long-term care
MOB	Mobility
PHM	Pharmacy and medicines
PSF	Patient safety and falls
PTR	Interpreters and mediators
STF	Staff credentials
WRK	Workforce

7 Terms and definitions

Term	Definition
Home care	Care and support delivered in the client's own home by caregivers employed or contracted by a service.
Caregiver	A person who provides personal or health-related care to a client in the home.
Client	The person who receives care in their own home.
Exclusion registry	A list of people who may not work with vulnerable adults, held by a national authority.
Individualised assessment	An assessment of one person's circumstances, not a rule applied to everyone.
Immediate fail	One event that means a criterion is not met, whatever else is in place.
Setting	The context in which a facility works: humanitarian, transition and fragile, or standard.

8 Standard 24 at a glance

Standard 24: Home Care is a standard of ASF Health Standards for home care services. It is required by default in home care, and each criterion shows the facility types it applies to. It covers client rights, caregiver screening, home safety, medicines, supervision, caregiver support, continuity and equal treatment.

The standard has forty-five criteria. Each is shown below and explained on its own page in section 9.

8.1 CRITERIA AND RATINGS

No.	Criterion	Humanitarian	Transition	Standard
24.1	The Client's Home Remains Theirs to Control	Minimum	Must	Must
24.2	A Written Statement of Rights Is Provided and Understood	Minimum	Must	Must
24.3	The Client Can Request a Caregiver Replacement	Minimum	Medium	Must
24.4	A Reachable Alternate Contact Exists Beyond the Caregiver Themselves	Minimum	Must	Must
24.5	Freedom From Abuse and Neglect Is Actively Verified	Minimum	Must	Must
24.6	Background Screening Uses Verified Identity, Not Name-Based Matching Alone	Minimum	Must	Must
24.7	Abuse Registries Are Checked in Every Country the Caregiver Has Worked	Must	Must	Must
24.8	Any Care-Worker Exclusion Registry Is Specifically Checked	Minimum	Must	Must
24.9	Screening Is Repeated Periodically	Minimum	Must	Must
24.10	A Disqualifying Finding Triggers Individualised Assessment	Minimum	Medium	Must
24.11	A Structured Home Safety Assessment Occurs Before Care Begins	Minimum	Must	Must
24.12	Identified Hazards Lead to Tracked Remediation	Minimum	Must	Must
24.13	A Fall Triggers Reassessment	Must	Must	Must
24.14	The Home Environment Is Reassessed Periodically	Minimum	Medium	Must
24.15	Emergency Access to the Home Is Confirmed	Minimum	Must	Must
24.16	Medication Reminders and Administration Are Distinguished	Minimum	Must	Must
24.17	A Single, Current Medication List Is Shared Across Everyone Involved	Must	Must	Must
24.18	A Medication Change or Care Transition Triggers Structured Review	Must	Must	Must
24.19	Medications Belonging to Different Household Members Are Distinguished and Secured	Minimum	Must	Must
24.20	A Missed or Uncertain Dose Is Actively Followed Up	Minimum	Medium	Must
24.21	A Risk Assessment of the Home Occurs Before the First Visit	Minimum	Must	Must
24.22	A Workplace Violence Prevention Programme Exists, Adapted for the Home Setting	Minimum	Must	Must
24.23	The Caregiver Has a Way to Signal Distress Discreetly	Minimum	Must	Must
24.24	Hostile Animals and Environmental Hazards Are Specifically Assessed	Minimum	Medium	Must
24.25	Near-Misses Are Actively Reported and Used to Update Risk Assessments	Minimum	Medium	Must
24.26	Supervisory Visits Occur On-Site	Minimum	Must	Must
24.27	Personal Care Supervision Includes Observing the Aide Providing Care	Minimum	Must	Must
24.28	Supervision Documentation Captures Objective, Measurable Observations	Minimum	Must	Must
24.29	A Change in Client Needs Triggers Care Plan Review	Minimum	Must	Must
24.30	An Identified Deficiency Leads to Retraining and Re-Evaluation	Minimum	Medium	Must
24.31	A Coverage Plan Exists for a Solo Caregiver's Absence	Minimum	Must	Must
24.32	Caregiver Continuity Is Actively Tracked and Prioritised for High-Need Clients	Minimum	Medium	Must
24.33	New Caregiver Retention Receives Structured Attention in the First 100 Days	Minimum	Medium	Must

No.	Criterion	Humanitarian	Transition	Standard
24.34	Caregiver Isolation Is Addressed Through Regular Supervisor Contact	Minimum	Medium	Must
24.35	Incident Reporting Accounts for Detection Delay in an Unsupervised Setting	Must	Must	Must
24.36	Care Is Adapted to a Client's Migration and Displacement Experience	Minimum	Must	Must
24.37	Language Support Accounts for Persistent, Daily Interaction	Minimum	Must	Must
24.38	Cultural and Religious Practices in the Client's Home Are Respected	Minimum	Must	Must
24.39	Caregiver Work Authorisation Is Verified Through Legal, Non-Discriminatory Practice	Minimum	Medium	Must
24.40	A Caregiver's Legal Status Change Is Handled With Support	Minimum	Medium	Must
24.41	Immigrant Caregivers' Retention Advantage Is Recognised and Supported	Minimum	Medium	Must
24.42	Legal Status Diversity Recognition for Clients	Minimum	Medium	Must
24.43	Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status	Minimum	Must	Must
24.44	Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated	Minimum	Medium	Must
24.45	Continuity Across a Client's Relocation Is Actively Supported	Minimum	Medium	Must

8.2 RESPONSIBILITIES

Each criterion names the positions responsible for it. Each position should have written terms of reference. ISCO-08 codes are shown for each role and are recorded in the staff register.

No.	Criterion	Positions responsible or involved
24.1	The Client's Home Remains Theirs to Control	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.2	A Written Statement of Rights Is Provided and Understood	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.3	The Client Can Request a Caregiver Replacement	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.4	A Reachable Alternate Contact Exists Beyond the Caregiver Themselves	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.5	Freedom From Abuse and Neglect Is Actively Verified	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.6	Background Screening Uses Verified Identity, Not Name-Based Matching Alone	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.7	Abuse Registries Are Checked in Every Country the Caregiver Has Worked	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.8	Any Care-Worker Exclusion Registry Is Specifically Checked	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.9	Screening Is Repeated Periodically	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.10	A Disqualifying Finding Triggers Individualised Assessment	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.11	A Structured Home Safety Assessment Occurs Before Care Begins	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.12	Identified Hazards Lead to Tracked Remediation	Secretary (ISCO 3344) · Manager (ISCO 1342)
24.13	A Fall Triggers Reassessment	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.14	The Home Environment Is Reassessed Periodically	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.15	Emergency Access to the Home Is Confirmed	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.16	Medication Reminders and Administration Are Distinguished	Manager (ISCO 1342)
24.17	A Single, Current Medication List Is Shared Across Everyone Involved	Nurse (ISCO 2221) · Manager (ISCO 1342)

No.	Criterion	Positions responsible or involved
24.18	A Medication Change or Care Transition Triggers Structured Review	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.19	Medications Belonging to Different Household Members Are Distinguished and Secured	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.20	A Missed or Uncertain Dose Is Actively Followed Up	Manager (ISCO 1342)
24.21	A Risk Assessment of the Home Occurs Before the First Visit	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.22	A Workplace Violence Prevention Programme Exists, Adapted for the Home Setting	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.23	The Caregiver Has a Way to Signal Distress Discreetly	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.24	Hostile Animals and Environmental Hazards Are Specifically Assessed	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.25	Near-Misses Are Actively Reported and Used to Update Risk Assessments	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.26	Supervisory Visits Occur On-Site	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.27	Personal Care Supervision Includes Observing the Aide Providing Care	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.28	Supervision Documentation Captures Objective, Measurable Observations	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.29	A Change in Client Needs Triggers Care Plan Review	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.30	An Identified Deficiency Leads to Retraining and Re-Evaluation	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.31	A Coverage Plan Exists for a Solo Caregiver's Absence	Chief executive (ISCO 1120) · Manager (ISCO 1342)
24.32	Caregiver Continuity Is Actively Tracked and Prioritised for High-Need Clients	Secretary (ISCO 3344) · Manager (ISCO 1342)
24.33	New Caregiver Retention Receives Structured Attention in the First 100 Days	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.34	Caregiver Isolation Is Addressed Through Regular Supervisor Contact	Manager (ISCO 1342)
24.35	Incident Reporting Accounts for Detection Delay in an Unsupervised Setting	Manager (ISCO 1342)
24.36	Care Is Adapted to a Client's Migration and Displacement Experience	Nurse (ISCO 2221) · Manager (ISCO 1342)
24.37	Language Support Accounts for Persistent, Daily Interaction	Manager (ISCO 1342) · Nurse (ISCO 2221)
24.38	Cultural and Religious Practices in the Client's Home Are Respected	Manager (ISCO 1342)
24.39	Caregiver Work Authorisation Is Verified Through Legal, Non-Discriminatory Practice	Manager (ISCO 1342)
24.40	A Caregiver's Legal Status Change Is Handled With Support	Manager (ISCO 1342)
24.41	Immigrant Caregivers' Retention Advantage Is Recognised and Supported	Secretary (ISCO 3344) · Manager (ISCO 1342)
24.42	Legal Status Diversity Recognition for Clients	Manager (ISCO 1342)
24.43	Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status	Manager (ISCO 1342)

No.	Criterion	Positions responsible or involved
24.44	Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated	Manager (ISCO 1342)
24.45	Continuity Across a Client's Relocation Is Actively Supported	Nurse (ISCO 2221) · Manager (ISCO 1342)

Reporting lines. The reporting line and supervision of each role are taken from the ASF terms of reference for that role, published on france-asf.fr. For this standard the manager is the facilities manager. A facility with a different structure records its own reporting lines in its organogram.

Role	Reports to	Supervises
Chief executive (ISCO 1120)	The board of directors.	Managers and the heads of department.
Manager (ISCO 1342)	The chief executive officer or chief operating officer.	Nurses, caregivers and care staff in the service.
Nurse (ISCO 2221)	The home care manager.	No direct reports.
Secretary (ISCO 3344)	The home care manager.	No direct reports.

8.3 E-LEARNING

The e-learning courses for this standard, who must take each one, who is recommended to take it, and the criteria it supports, are listed in section 11.

8.4 RELATED COURSES IN THE GMJ ACADEMY

These courses cover the same subjects in more depth or for a specific type of facility. They are optional. They are not required by the criteria.

Course	Subject	Criteria	GMJ Academy course page
Client Rights & Dignity in the Home Setting (HC-01)	Client rights and dignity in the home	24.1	English · Georgian
Governance & Staffing for Home-Based Care (HC-07)	Governance and staffing for home-based care	24.10	English · Georgian
სახლის გარემოს უსაფრთხოების შეფასება (HC-03)	Home environment safety assessment	24.11	Georgian Georgian version only
დაგორება, წაბრეკა და დაცემის პრევენცია (FALL-01)	Slip, trip and fall prevention	24.13	Georgian Georgian version only
Medication Safety: Operating SOP-MED-01 End to End (T-08)	Medication safety	24.16	English · Georgian
Caregiver Safety in an Uncontrolled Environment (HC-05)	Caregiver safety in an uncontrolled environment	24.21	English · Georgian
Refugee & Migrant Health — Endorsement Course (H-09)	Refugee and migrant health	24.36	English · Georgian

24.1 The Client's Home Remains Theirs to Control

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Care is delivered in recognition that this is the client's own home, not the provider's space — the client's own household routines, possessions, and living arrangements are respected, not overridden or rearranged for the caregiver's own convenience.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: care is delivered in the client's home on the client's terms, and the client controls the home and its routines.

GUIDANCE

The client's home is the client's own space. Visit times, routines, visitors and the way the home is kept are the client's choices, and the care plan follows them.

Where the household's routines and the service's timetable conflict, the client's routine comes first and the conflict is recorded.

> **Good practice.** Each client's home is treated as theirs, with care delivered on the client's terms, and the client decides on visitors, routines and what happens in the home.

> **Partial because.** The care plan is written around the service's timetable, and the client's choices in the home are not recorded.

WHAT GOOD LOOKS LIKE

- The client's routines are written in the care plan before the first visit, and the caregiver follows them.

COMMON MISTAKES

- A caregiver who arrives at a fixed time regardless of the client's routine.
- A client's rules for the home overridden by the service.

> **Why it matters.** When care is given in someone's own home, the home belongs to the client. The provider is a guest there, and the client's choices about routine, visitors and space must be respected.

WHAT THE ASSESSOR CHECKS

Sample. Review the care plans and visit notes for 10 clients, and observe 3 visits.

1 Care follows the client's routines and possessions.

Method. Check each sampled plan and observed visit for the routine followed.

Evidence to show. The client's home and household routines (HC-POL-001).

Pass when. Every sampled visit follows the client's routine.

2 Changes to the routine are agreed with the client first.

Method. Check each recorded change for the client's agreement.

Evidence to show. Individual care plan (CLN-FRM-003).

Pass when. Every change shows the client agreed.

3 Cultural and religious practices are respected.

Method. Check each plan for the practices recorded and followed.

Evidence to show. The client's home and household routines (HC-POL-001).

Pass when. Every plan with a practice shows it followed.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver deciding the client must eat at a set time against their wishes. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-POL-001	The client's home and household routines	Chief executive	Governing body members	Chief executive

Other records in the criterion: CLN-FRM-003 Individual care plan

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Client's home and household routines	— Must

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Individual care plan	— Must

REFERENCES FOR THIS CRITERION

- Global strategy and action plan on ageing and health (World Health Organization, 2017, Geneva: WHO) https://www.who.int/publications/i/item/9789241513500

24.2 A Written Statement of Rights Is Provided and Understood

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Every client receives a written statement of their rights before care begins, read aloud to them in a language they understand if they cannot read it themselves — not care beginning before this understanding is confirmed.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: every client receives a written statement of rights that they understand.

GUIDANCE

A statement of rights tells the client what they can expect and how to complain. It must be given in a language and format the client understands, and the caregiver checks that it has been understood.

The acknowledgement is signed by the client or their representative.

> **Good practice.** Each client receives a written statement of rights in a language and format they understand, and the caregiver checks that the client has understood it.

> **Partial because.** The statement is given at the start of care but is not explained, or it is not available in the client's language.

WHAT GOOD LOOKS LIKE

- The statement of rights is read aloud or explained at the first visit, in the client's language, and signed.

COMMON MISTAKES

- A statement given in English to a client who does not read it.
- A statement signed without any explanation.

> **Why it matters.** A client who does not know their rights cannot use them. A written statement, given before care starts and read through with the client, makes the rights real.

WHAT THE ASSESSOR CHECKS

Sample. Review the statement of rights records for 10 clients, including clients who cannot read.

1 The written statement of rights is given before care begins.

Method. Check each sampled record for the date given against the first visit.

Evidence to show. Statement of rights acknowledgement (HC-FRM-001).

Pass when. Every sampled client has the statement before the first visit.

2 Clients who cannot read have it read aloud in their language.

Method. Check each record where reading aloud applies.

Evidence to show. Statement of rights acknowledgement (HC-FRM-001).

Pass when. Every such record shows it read aloud.

3 Understanding is confirmed.

Method. Check each record for the understanding confirmed.

Evidence to show. Statement of rights acknowledgement (HC-FRM-001).

Pass when. Every record shows understanding confirmed.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client receiving care for months with no statement of rights. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-001	Statement of rights acknowledgement	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Statement of rights acknowledgement	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- 42 CFR 484.50 Condition of participation: Patient rights (US Centers for Medicare & Medicaid Services (eCFR), current CFR text) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.50

24.3 The Client Can Request a Caregiver Replacement

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A client can request a different caregiver when the current relationship is not working well for them, with a respectful process for making this request — not locked into a single caregiver relationship they are uncomfortable with, and not made to feel this request will trigger conflict or reduced care quality.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: a client can request a different caregiver, and the request is answered without a reason being required.

GUIDANCE

A client may not get on with a caregiver, or may not feel safe. The client can ask for a replacement at any time, and the request is answered within a set number of days.

The client does not have to give a reason for the request.

> **Good practice.** A client can ask for a different caregiver at any time, and the request is answered within a set number of days without the client having to give a reason.

> **Partial because.** A request for a new caregiver is refused or is not answered for several weeks.

WHAT GOOD LOOKS LIKE

- Requests for a replacement are answered within two working days, and the outcome is recorded in the caregiver continuity register.

COMMON MISTAKES

- A client told that a replacement cannot be arranged, with no reason given.
- A request ignored for several weeks.

> **Why it matters.** A client may not get on with a caregiver, and a relationship that is not working can harm the care. The client should be able to ask for a different caregiver without a fight.

WHAT THE ASSESSOR CHECKS

Sample. Review the caregiver replacement requests made in the last 12 months.

1 Clients can request a replacement caregiver.

Method. Check the policy and the intake for the route to request.

Evidence to show. Caregiver replacement request (HC-SOP-001).

Pass when. The route is stated in the policy and given at intake.

2 Each request is answered within the set time.

Method. Check each request for the response date.

Evidence to show. Caregiver replacement request record (HC-FRM-002).

Pass when. Every request is answered in time.

3 The request is not treated as a complaint about care quality.

Method. Check each outcome for any penalty to the client.

Evidence to show. Caregiver replacement request record (HC-FRM-002).

Pass when. No client is penalised for a request.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client who asked for a change and was told no. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-001	Caregiver replacement request	Manager	Chief executive	Chief executive
HC-FRM-002	Caregiver replacement request record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver replacement request	— Medium

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Caregiver replacement request record	— Medium

24.4 A Reachable Alternate Contact Exists Beyond the Caregiver Themselves

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The client has a known way to reach the agency or a supervisor directly, separate from the caregiver — reachable at any time care might occur, not limited to standard business hours.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: every client has a reachable alternate contact who is not the caregiver.

GUIDANCE

When the caregiver is the only contact, a client cannot raise concerns if something goes wrong. An alternate contact who is not the caregiver can be reached and knows what to do.

The contact details and out-of-hours arrangements are written in the care file.

> **Good practice.** Each client has a named alternate contact who is not the caregiver, can be reached at any hour, and is told what to do if the caregiver cannot be reached.

> **Partial because.** The only contact is the caregiver, and no one else is told how to reach the client.

WHAT GOOD LOOKS LIKE

- The alternate contact is named in the care file, with a phone number and the arrangement for out-of-hours calls.

COMMON MISTAKES

- Only the caregiver's phone number recorded.
- An alternate contact who has never been told of their role.

> **Why it matters.** If the caregiver is the only contact, a client who has a problem with them, or who cannot reach them, is left without help. A direct line to the agency or a supervisor is needed.

WHAT THE ASSESSOR CHECKS

Sample. Review the client contact records for 10 clients, and test the out-of-hours route.

1 Each client has a direct route to the agency or supervisor.

Method. Check each sampled record for the contact given.

Evidence to show. Client contact and out-of-hours access record (HC-FRM-003).

Pass when. Every sampled client has a contact recorded.

2 The route works out of hours.

Method. Test the out-of-hours route outside business hours.

Evidence to show. Client contact and out-of-hours access record (HC-FRM-003).

Pass when. The test reaches a person.

3 The client knows how to use it.

Method. Check each record for the client's confirmation.

Evidence to show. Client contact and out-of-hours access record (HC-FRM-003).

Pass when. Every record shows the client knows how.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client with no way to reach anyone but the caregiver. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-003	Client contact and out-of-hours access record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Client contact and out-of-hours access record	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

24.5 Freedom From Abuse and Neglect Is Actively Verified

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Freedom from physical, verbal, emotional, and sexual abuse, and from neglect, is actively verified through periodic check-ins independent of the caregiver — not simply stated as a right on a document and otherwise assumed absent good reason to suspect a problem.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: freedom from abuse and neglect is actively verified, not assumed.

GUIDANCE

Abuse and neglect in the home are hard to see. The service checks for them through a documented process that includes the client, the family and unannounced visits.

Checks are recorded, and the results are reviewed by the manager.

> **Good practice.** Freedom from abuse and neglect is checked through a documented process that includes the client, the family and unannounced visits.

> **Partial because.** Abuse and neglect are checked only when a complaint is made.

WHAT GOOD LOOKS LIKE

- Independent check-ins with the client take place at least once a quarter, out of the caregiver's presence.

COMMON MISTAKES

- Abuse checked only when the family complains.
- Check-ins always scheduled with the caregiver present.

> **Why it matters.** Abuse and neglect of a client in their own home often goes unseen, because the home is private. Active checks, rather than trust, are needed to protect the client.

WHAT THE ASSESSOR CHECKS

Sample. Review the independent check-in records for 10 clients over the last 6 months.

1 Each client is checked by someone independent of the caregiver on schedule.

Method. Check each sampled client for check-ins on the schedule.

Evidence to show. Independent check-in record (HC-FRM-004).

Pass when. Every sampled client is checked on schedule.

2 The check covers abuse and neglect.

Method. Check each record for the topics covered.

Evidence to show. Independent check-ins for abuse and neglect (HC-SOP-002).

Pass when. Every record covers abuse and neglect.

3 A concern is reported the same day.

Method. Check each concern for the report date.

Evidence to show. Incident reporting and management (INC-POL-001).

Pass when. Every concern is reported the same day.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client neglected for weeks with no one noticing. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-002	Independent check-ins for abuse and neglect	Manager	Chief executive	Chief executive
HC-FRM-004	Independent check-in record	Manager	Chief executive	Manager

Other records in the criterion: INC-POL-001 Incident reporting and management

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Independent check-in record	— Must
Manager (ISCO 1342)	Maintains the Independent check-in for abuse and neglect	— Must

REFERENCES FOR THIS CRITERION

- A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report (World Health Organization (with Universite de Geneve), 2008) https://extranet.who.int/agefriendlyworld/wp-content/uploads/2014/06/WHO-A-Global-Response-to-Elder-Abuse-and-Neglect-Building-Primary-Health-Care-Capacity-to-Deal-with-the-Problem-Worldwide.pdf

24.6 Background Screening Uses Verified Identity, Not Name-Based Matching Alone

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Every caregiver undergoes a criminal record check verified against a unique identifier — fingerprint, unique identity number, or another reliable biometric or official record — not a name-based search alone, which can miss disqualifying history recorded under a different or misspelled name, or fail to distinguish between people who share a common name.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: caregiver background screening uses verified identity, not a name match alone.

GUIDANCE

Two people can share a name. A background check that matches only by name may clear a person with a record, or flag an innocent one. Identity is confirmed from an official document first.

The screening record states the identity document used.

> **Good practice.** Background screening confirms each caregiver's identity from an official document before their history is checked, so that a name match alone is never accepted.

> **Partial because.** Screening is done by name search only, and a common name match is accepted without a second check.

WHAT GOOD LOOKS LIKE

- The identity document type and number are recorded in the screening file, and the file is checked by a second person.

COMMON MISTAKES

- A screening that matches a common name and clears the caregiver.
- A screening file with no identity document recorded.

> **Why it matters.** A criminal record check that matches only a name can miss a person or pick up the wrong one. A check against a unique identifier, such as an ID number, is reliable.

WHAT THE ASSESSOR CHECKS

Sample. Review the screening records for 10 caregivers hired in the last 12 months.

1 Each caregiver's criminal record check is verified against a unique identifier.

Method. Check each sampled record for the identifier used.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every sampled record shows a unique identifier.

2 No caregiver is screened on a name match alone.

Method. Check each record for the name-only method.

Evidence to show. Caregiver background screening, registries and recheck (HC-SOP-003).

Pass when. No record is screened on a name match alone.

3 Identity checks are on file for each caregiver.

Method. Check each file for the identity check result.

Evidence to show. Staff verification register (STF-FRM-001).

Pass when. Every file shows the identity check.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver hired on a name match with a different person's record. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-003	Caregiver background screening, registries and recheck	Manager	Chief executive	Chief executive
HC-FRM-005	Caregiver screening record	Manager	Chief executive	Manager

Other records in the criterion: STF-FRM-001 (name to be confirmed)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Caregiver screening record	— Must
Manager (ISCO 1342)	Maintains the Caregiver background screening, registries and recheck	— Must

REFERENCES FOR THIS CRITERION

- DBS checks: detailed guidance (UK Disclosure and Barring Service (GOV.UK), 2026 (page updated 2 July 2026)) https://gov.uk/government/collections/dbs-checking-service-guidance--2.

24.7 Abuse Registries Are Checked in Every Country the Caregiver Has Worked

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Where an abuse and neglect registry exists, it is checked for every country where the caregiver has previously worked, not only their current place of residence.

Rating rule. Must in every setting: abuse registries are checked in every country where the caregiver has worked.

GUIDANCE

A caregiver who has worked abroad may have a record in another country. The registry for each country where they have worked is checked, and each check is recorded with the date and result.

Where a registry does not exist, the service records that fact.

> **Good practice.** The abuse registry is checked in every country where a caregiver has worked, and each check is recorded with the date and result.

> **Partial because.** The registry is checked for the country of current residence only.

WHAT GOOD LOOKS LIKE

- A list of countries of work is recorded for each caregiver, and each registry is checked and the result filed.

COMMON MISTAKES

- A caregiver with three years of work abroad, screened only in their home country.
- A registry check dated the year of recruitment and never repeated.

> **Why it matters.** A caregiver may have worked abroad, where an abuse record is held in another country. Checking the registries of every country where they lived or worked finds those records.

WHAT THE ASSESSOR CHECKS

Sample. Review the registry checks for 10 caregivers who have worked in more than one country.

1 Abuse and neglect registries are checked for each country worked.

Method. Check each caregiver with a multi-country history for each registry.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every country worked has its registry checked.

2 Where no registry exists, another reliable check is recorded.

Method. Check each country without a registry for the alternative.

Evidence to show. Caregiver background screening, registries and recheck (HC-SOP-003).

Pass when. Every such country has an alternative recorded.

3 The check is on file before the first visit.

Method. Check each file for the date of the check against the start date.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every check is dated before the first visit.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver with an abuse record abroad, hired without a check. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-005	Caregiver screening record	Manager	Chief executive	Manager
HC-SOP-003	Caregiver background screening, registries and recheck	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Caregiver screening record	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver background screening, registries and recheck	— Must

24.8 Any Care-Worker Exclusion Registry Is Specifically Checked

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Where an exclusion registry exists that specifically bars individuals from care-related work due to substantiated misconduct — distinct from a general criminal record — every caregiver is specifically checked against it, not assumed covered by a general criminal background check alone; where no such registry exists in the country where the caregiver works, the service verifies this history through the most reliable alternative available, such as direct verification with prior care-sector employers.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: any caregiver exclusion registry is specifically checked before the caregiver starts.

GUIDANCE

An exclusion registry lists people who may not work with vulnerable adults. It is checked by name and identity number, and the result is recorded before the caregiver starts work.

A check done after the start of work is not a valid check.

> **Good practice.** Any caregiver exclusion registry is checked by name and identity number, and the result is recorded before the caregiver starts work.

> **Partial because.** Exclusion registries are not checked, or they are checked after the caregiver has started.

WHAT GOOD LOOKS LIKE

- Exclusion registry results are filed before the caregiver's first shift, with the name and identity number checked.

COMMON MISTAKES

- A caregiver started on the first day and checked a week later.
- A registry result recorded with no identity number.

> **Why it matters.** Some countries keep a list of people barred from working in care. Those lists are separate from the criminal record and must be checked on their own.

WHAT THE ASSESSOR CHECKS

Sample. Review the exclusion registry checks for 10 caregivers.

1 Every caregiver is checked against the exclusion registry where one exists.

Method. Check each caregiver record for the exclusion registry check.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every caregiver record shows the check.

2 Where no registry exists, the service verifies history with prior employers.

Method. Check each country without a registry for the employer verification.

Evidence to show. Caregiver background screening, registries and recheck (HC-SOP-003).

Pass when. Every such case has an employer verification.

3 A general criminal record check is not used as a substitute.

Method. Check the procedure for the separate exclusion check.

Evidence to show. Caregiver background screening, registries and recheck (HC-SOP-003).

Pass when. The procedure requires the separate check.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A barred caregiver hired because the exclusion list was never looked at. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-005	Caregiver screening record	Manager	Chief executive	Manager
HC-SOP-003	Caregiver background screening, registries and recheck	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Caregiver screening record	— Must
Manager (ISCO 1342)	Maintains the Caregiver background screening, registries and recheck	— Must

REFERENCES FOR THIS CRITERION

- Background Information and Exclusion Authorities (List of Excluded Individuals/Entities) (US HHS Office of Inspector General, not stated on page) https://oig.hhs.gov/exclusions/background/

24.9 Screening Is Repeated Periodically

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Background screening is repeated on a periodic, defined schedule for every active caregiver — not treated as a one-time check completed at initial hire and never revisited.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: caregiver screening is repeated periodically.

GUIDANCE

A person who was safe to employ at recruitment may not be safe later. Screening is repeated at a set interval and at any change of role, and each repeat is recorded.

The interval is written in the screening procedure.

> **Good practice.** Background screening is repeated at a set interval for every caregiver, and at any change of role, and the repeat is recorded.

> **Partial because.** Screening is done once at recruitment and never repeated.

WHAT GOOD LOOKS LIKE

- Screening is repeated every two years, and at any change of role or after a serious concern.

COMMON MISTAKES

- A caregiver screened once in ten years of employment.
- A repeat screening that is not recorded.

> **Why it matters.** A caregiver who was clear when hired may not be clear later. Screening repeated on a set schedule keeps the checks current.

WHAT THE ASSESSOR CHECKS

Sample. Review the screening schedule and the recheck records for 10 active caregivers.

1 Screening is repeated on a defined schedule.

Method. Check the schedule against each caregiver's last check.

Evidence to show. Caregiver background screening, registries and recheck (HC-SOP-003).

Pass when. The schedule is defined.

2 Each active caregiver is rechecked on schedule.

Method. Check each sampled caregiver against the schedule.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every sampled caregiver is rechecked on schedule.

3 The next recheck date is recorded.

Method. Check each record for the next date.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every record shows the next recheck date.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver working for five years on a check from hiring. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-003	Caregiver background screening, registries and recheck	Manager	Chief executive	Chief executive
HC-FRM-005	Caregiver screening record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver background screening, registries and recheck	— Must
Nurse (ISCO 2221)	Completes the Caregiver screening record	— Must

24.10 A Disqualifying Finding Triggers Individualised Assessment

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

Criterion. A criminal history finding triggers an individualised assessment of its actual relevance to caregiving work — not an automatic, blanket rejection applied regardless of the finding's nature, age, or relevance to the specific role.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: a disqualifying screening finding triggers an individualised assessment.

GUIDANCE

A criminal history does not automatically prevent work, but it must be assessed. A named manager reviews the finding, considers the nature of the offence and the time since, and records the decision and the reasons.

The decision is reviewed if new information appears.

Good practice. A disqualifying finding leads to an individualised assessment by a named manager, who records the decision and the reasons for it.

Partial because. A disqualifying finding is ignored or is acted on without a recorded assessment.

WHAT GOOD LOOKS LIKE

- A finding is reviewed by a named manager within five working days, and the decision letter is filed with the screening record.

COMMON MISTAKES

- A finding ignored because the caregiver is needed.
- A finding that disqualifies a caregiver with no assessment.

Why it matters. A criminal record does not always mean a person cannot work safely. Each finding should be looked at individually, for its real relevance to the job, rather than an automatic refusal.

WHAT THE ASSESSOR CHECKS

Sample. Review every criminal history finding in the last 12 months and the decision recorded.

1 Each finding is assessed for its relevance to care work.

Method. Check each finding for the assessment recorded.

Evidence to show. Individualised assessment of criminal history findings (HC-POL-002).

Pass when. Every finding has an assessment.

2 The assessment considers nature, age and relevance.

Method. Check each assessment for the three factors.

Evidence to show. Individualised assessment of criminal history findings (HC-POL-002).

Pass when. Every assessment covers the three factors.

3 No refusal is automatic.

Method. Check each refusal for the individual reasoning.

Evidence to show. Caregiver screening record (HC-FRM-005).

Pass when. Every refusal has individual reasoning recorded.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A person refused automatically for an old, unrelated finding. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-POL-002	Individualised assessment of criminal history findings	Chief executive	Governing body members	Chief executive

Other records in the criterion: HC-FRM-005 Caregiver screening record

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Individualised assessment of criminal history findings	— Medium

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Caregiver screening record	— Medium

REFERENCES FOR THIS CRITERION

- Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions under Title VII (US Equal Employment Opportunity Commission, 2012) https://www.eeoc.gov/laws/guidance/enforcement-guidance-consideration-arrest-and-conviction-records-employment-decisions

24.11 A Structured Home Safety Assessment Occurs Before Care Begins

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A structured home safety assessment — covering flooring, lighting, stairs, bathroom hazards, and clear pathways — is conducted before care begins, not assumed adequate from a general first impression of the home.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: a structured home safety assessment is completed before care begins.

GUIDANCE

The home is assessed before care begins, so that the caregiver knows the risks, the equipment and the client's needs before the first visit. The assessment is structured and signed.

The assessment covers access, hazards, equipment and the client's needs.

> **Good practice.** A structured safety assessment of the home is completed before the first visit, covering access, hazards, equipment and the client's needs, and it is signed.

> **Partial because.** The home is first visited by the caregiver with no assessment record.

WHAT GOOD LOOKS LIKE

- A home safety assessment is completed and signed before the first visit, and the signed copy is kept in the client file.

COMMON MISTAKES

- A home assessed by the caregiver on the first visit.
- An assessment that lists hazards but is never signed.

> **Why it matters.** A home that has loose rugs, poor lighting or a slippery bathroom is a risk to the client before care even starts. A structured assessment before the first visit finds those risks.

WHAT THE ASSESSOR CHECKS

Sample. Review the home safety assessments for 10 clients, and walk through 3 homes.

1 A structured assessment is done before care begins.

Method. Check each sampled home for the assessment date against the start date.

Evidence to show. Home safety assessment record (HC-FRM-006).

Pass when. Every sampled home is assessed before care begins.

2 The assessment covers flooring, lighting, stairs, bathroom and pathways.

Method. Check each assessment for the five areas.

Evidence to show. Home environment safety assessment and remediation (HC-SOP-004).

Pass when. Every assessment covers the five areas.

3 The walk-through matches the assessment.

Method. Compare the walk-through with the assessment for hazards.

Evidence to show. Home safety assessment record (HC-FRM-006).

Pass when. No hazard seen on the walk-through is missing from the assessment.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Care started in a home with stairs and no handrail, no assessment done. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-004	Home environment safety assessment and remediation	Manager	Chief executive	Chief executive
HC-FRM-006	Home safety assessment record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Home safety assessment record	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Home environment safety assessment and remediation	— Must

REFERENCES FOR THIS CRITERION

- WHO (2024). Infection prevention and control and water, sanitation and hygiene measures for home care and isolation for mpox in resource-limited settings: interim operational guide. Used for: Infection prevention, WASH and home care for mild mpox cases: home environment assessment and caregiver measures. https://news.gmj.ge/guideline/infection-prevention-and-control-and-water-sanitation-and-hygiene-measures-for-home-care-and-isolation-for-mpox-in-resource-limited-settings-interim-operational-guide/
- WHO (2021). Step Safely: Strategies for Preventing and Managing Falls Across the Life-Course. Used for: Step Safely: home environment hazards and falls prevention across the life course. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/

24.12 Identified Hazards Lead to Tracked Remediation

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A hazard identified during home safety assessment leads to tracked remediation — a specific action taken, a specific person responsible, a specific timeframe — not a hazard noted on a checklist and then left unaddressed.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: hazards identified in the home lead to tracked remediation.

GUIDANCE

A hazard that is written down but not fixed is still a hazard. Each hazard has an action, an owner and a due date, and each action is closed or escalated on time.

Open actions are reviewed by the manager each month.

> **Good practice.** Each hazard identified in the home assessment has a remedial action, an owner and a due date, and each action is closed or escalated when due.

> **Partial because.** Hazards are listed but no action is recorded, or actions remain open for months.

WHAT GOOD LOOKS LIKE

- The home hazard remediation register lists each hazard, its action, owner and due date, and is reviewed monthly.

COMMON MISTAKES

- A hazard listed in 2025 with no action.
- An action closed without evidence of the fix.

> **Why it matters.** A hazard found in a home that is noted and then forgotten still puts the client at risk. Each hazard needs a named action and a check that it was fixed.

WHAT THE ASSESSOR CHECKS

Sample. Review the hazard remediation register for the last 12 months.

1 Each hazard leads to a specific action.

Method. Check each hazard for the action recorded.

Evidence to show. Home hazard remediation register (HC-REG-001).

Pass when. Every hazard has an action.

2 Each hazard has a responsible person and a deadline.

Method. Check each hazard for the person and deadline.

Evidence to show. Home hazard remediation register (HC-REG-001).

Pass when. Every hazard has a person and a deadline.

3 Hazards are remediated within the deadline.

Method. Check each hazard against its deadline and remediation date.

Evidence to show. Home hazard remediation register (HC-REG-001).

Pass when. At least 90% are remediated on time.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A loose stair rail noted on three visits and never fixed. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-REG-001	Home hazard remediation register	Secretary	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Secretary (ISCO 3344)	Keeps the Home hazard remediation register	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- WHO (2021). Step Safely: Strategies for Preventing and Managing Falls Across the Life-Course. Used for: Step Safely: home environment hazards and falls prevention across the life course. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/

24.13 A Fall Triggers Reassessment

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a client experiences a fall, this triggers a specific, structured reassessment of the home environment and the client's own risk factors — not treated as an isolated event requiring only immediate first aid.

Rating rule. Must in every setting: a fall triggers reassessment of the client and the home.

GUIDANCE

A fall at home is a sign that the client's needs or the home have changed. A reassessment within a set number of days finds the cause and prevents the next fall.

The result is shared with the care team and the client.

> **Good practice.** A fall triggers a documented reassessment of the client and the home within a set number of days, and the result is shared with the care team.

> **Partial because.** Falls are recorded in the care notes but do not lead to any reassessment.

WHAT GOOD LOOKS LIKE

- A fall is reassessed within three working days, and the reassessment covers the medicines, the home and the client's balance.

COMMON MISTAKES

- A fall recorded with no reassessment.
- A repeat fall in the same room with no change to the home.

> **Why it matters.** A fall at home is a turning point. It often means the client needs a different level of care. A structured reassessment after each fall finds the cause and what must change.

WHAT THE ASSESSOR CHECKS

Sample. Review the falls records for 10 clients who fell in the last 12 months.

1 Each fall triggers a structured reassessment.

Method. Check each fall for the reassessment recorded.

Evidence to show. Falls Risk Assessment and Prevention (PSF-SOP-001).

Pass when. Every fall has a reassessment.

2 The reassessment covers the home environment and client risk factors.

Method. Check each reassessment for both.

Evidence to show. Falls Risk Assessment Tool (PSF-FRM-002).

Pass when. Every reassessment covers both.

3 The care plan is changed after repeated falls.

Method. Check each client with repeated falls for the plan change.

Evidence to show. Falls Log (PSF-FRM-001).

Pass when. Every client with repeated falls has a changed plan.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client falling three times in a month with the care plan unchanged. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
PSF-SOP-001	Falls Risk Assessment and Prevention	Manager	Chief executive	Chief executive
PSF-FRM-002	Falls Risk Assessment Tool	Manager	Chief executive	Manager
PSF-FRM-001	Falls Log	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Falls Risk Assessment and Prevention	— Must

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Falls Risk Assessment Tool	— Must

REFERENCES FOR THIS CRITERION

- WHO (2021). Step Safely: Strategies for Preventing and Managing Falls Across the Life-Course. Used for: Step Safely: home environment hazards and falls prevention across the life course. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/

24.14 The Home Environment Is Reassessed Periodically

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The home environment is reassessed on a periodic, defined schedule, not limited to the initial assessment at the start of care, because a home's physical condition and hazard profile can change over the course of an ongoing care relationship.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: the home environment is reassessed periodically.

GUIDANCE

A home changes over time, with new equipment, new people and new hazards. The environment is reassessed at a set interval and whenever the client's needs change.

Each reassessment is recorded.

> **Good practice.** The home environment is reassessed at a set interval and whenever the client's needs change, and the reassessment is recorded.

> **Partial because.** The home is assessed only at the start of care.

WHAT GOOD LOOKS LIKE

- The home environment is reassessed every six months and after any change in the client's needs.

COMMON MISTAKES

- A home assessed only at admission.
- A new piece of equipment in the home that was never assessed.

> **Why it matters.** A home changes over time: a new rug, a new bed, a new family member. A periodic reassessment, not only at the start, catches new hazards.

WHAT THE ASSESSOR CHECKS

Sample. Review the reassessment records for 10 long-running clients.

1 The home is reassessed on a defined schedule.

Method. Check the schedule against each home's reassessment dates.

Evidence to show. Home environment safety assessment and remediation (HC-SOP-004).

Pass when. The schedule is defined.

2 Each sampled home is reassessed on schedule.

Method. Check each sampled home against the schedule.

Evidence to show. Home safety assessment record (HC-FRM-006).

Pass when. Every sampled home is reassessed on schedule.

3 Changes in the home are recorded.

Method. Check each reassessment for changes recorded.

Evidence to show. Home safety assessment record (HC-FRM-006).

Pass when. Every reassessment records any change.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A home unchecked for two years while the client's needs grew. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-004	Home environment safety assessment and remediation	Manager	Chief executive	Chief executive
HC-FRM-006	Home safety assessment record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Home safety assessment and remediation	— Medium
Nurse (ISCO 2221)	Completes the Home safety assessment record	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2021). Step Safely: Strategies for Preventing and Managing Falls Across the Life-Course. Used for: Step Safely: home environment hazards and falls prevention across the life course. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/

24.15 Emergency Access to the Home Is Confirmed

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A verified plan exists for how emergency responders would access the home if the client is unable to reach the door — a lockbox code, a designated key holder, a specific access arrangement — not assumed that responders will simply find a way in when the moment arrives.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: emergency access to the home is confirmed and tested.

GUIDANCE

If an emergency happens and the caregiver or the ambulance cannot get into the home, care is delayed. The plan for emergency access, including keys and codes and who can open the door, is written and tested.

The plan is checked each time the access arrangements change.

> **Good practice.** A verified plan exists for emergency access to each home, including keys, codes and the contact who can open the door, and the plan is tested.

> **Partial because.** Emergency access depends on a key held by one person who may not be reachable.

WHAT GOOD LOOKS LIKE

- The emergency access arrangement is tested at least twice a year, and the test is recorded.

COMMON MISTAKES

- A key held by one person who has left the job.
- A code that changed and was not passed on.

> **Why it matters.** If a client collapses in a home where the door is locked or the code has changed, the ambulance may not get in. A verified plan for emergency access saves minutes that matter.

WHAT THE ASSESSOR CHECKS

Sample. Review the emergency access arrangement for 10 clients.

1 A verified access arrangement exists for each home.

Method. Check each sampled home for the arrangement recorded.

Evidence to show. Emergency access arrangement record (HC-FRM-007).

Pass when. Every sampled home has an arrangement.

2 The arrangement is checked.

Method. Check each record for the date it was checked.

Evidence to show. Emergency access arrangement record (HC-FRM-007).

Pass when. Every arrangement has a recent check date.

3 Responders can enter when the client cannot reach the door.

Method. Test the access route for a sample of homes with the agency.

Evidence to show. Emergency access arrangement record (HC-FRM-007).

Pass when. The test shows access is possible.

Pass. The criterion is met when every check above is passed.

Immediate fail. . An ambulance crew unable to enter a home for ten minutes. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-007	Emergency access arrangement record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Emergency access arrangement record	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

24.16 Medication Reminders and Administration Are Distinguished

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The service distinguishes between medication reminders, which a non-clinical caregiver can appropriately provide, and actual medication administration, which requires clinical training and appropriate supervision — not conflating the two, or allowing a non-clinical caregiver to perform tasks beyond their actual scope.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: medication reminders and medication administration are distinguished in the record.

GUIDANCE

A reminder tells the client to take a medicine. Administration means the caregiver gave it. The record keeps the two apart, so that everyone knows who did what.

Each medicine is recorded with the time and the person who took it.

> **Good practice.** Medication reminders and medication administration are recorded separately, so that it is clear which tasks the caregiver performed and which the client took alone.

> **Partial because.** Reminders and administration are recorded together, so that it is not clear who gave the medicine.

WHAT GOOD LOOKS LIKE

- Each medicine dose is recorded as reminded, administered or self-administered, with the time and the person.

COMMON MISTAKES

- A record that reads "medicines given" with no detail.
- Reminders recorded as administrations.

> **Why it matters.** Reminding a client to take a medicine is different from giving it. A non-clinical caregiver may remind, but only a trained person may give or manage a medicine. Confusing the two causes harm.

WHAT THE ASSESSOR CHECKS

Sample. Review the task list for each caregiver and observe 3 medicine tasks.

1 Reminders and administration are separated in the policy.

Method. Check the policy for the separation.

Evidence to show. Medication reminders and administration in the home (HC-POL-003).

Pass when. The policy separates the two.

2 Each caregiver performs only tasks within their scope.

Method. Check each observed medicine task against the scope.

Evidence to show. Medication reminders and administration in the home (HC-POL-003).

Pass when. Every observed task is within scope.

3 Tasks beyond scope are refused and reported.

Method. Check each recorded refusal for the report.

Evidence to show. Incident reporting and management (INC-POL-001).

Pass when. Every refusal is reported.

Pass. The criterion is met when every check above is passed.

Immediate fail. . An untrained caregiver giving an injection. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-POL-003	Medication reminders and administration in the home	Chief executive	Governing body members	Chief executive

Other records in the criterion: INC-POL-001 Incident reporting and management

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Medicine reminders and administration in the home	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- WHO (2020). Medication safety in transitions of care. Used for: Medication safety in transitions of care: medication lists, reconciliation and review after a change. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/
- World Health Organization. Medication Without Harm: Global Patient Safety Challenge on Medication Safety. Geneva: WHO; 2017. Used for: https://news.gmj.ge/guideline/medication-without-harm-global-patient-safety-challenge-on-medication-safety/
- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.17 A Single, Current Medication List Is Shared Across Everyone Involved

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A single, current medication list is actively shared across everyone involved in the client's care — the caregiver, family members, and any other provider — not maintained separately by each party in a way that allows the same medication task to be missed by everyone, or duplicated by more than one.

Rating rule. Must in every setting: a single, current medication list is shared across everyone involved in the client's care.

GUIDANCE

When several people hold different medication lists, errors follow. A single current list is kept in the home and shared with the client, the family, the prescriber and the pharmacist.

The list is updated at each change.

> **Good practice.** A single current medication list is held in the home and shared with the client, the family, the prescriber and the pharmacist, and it is updated at each change.

> **Partial because.** Several medication lists exist and they do not match.

WHAT GOOD LOOKS LIKE

- A shared medication list is printed, given to the client and the family, and updated at each change.

COMMON MISTAKES

- Two lists in the home that disagree.
- A list not updated after a hospital discharge.

> **Why it matters.** When a client's medicines are on several lists, the GP, the pharmacy and the caregiver may each have a different version. One current list, shared with everyone, prevents the mix-ups that cause harm.

WHAT THE ASSESSOR CHECKS

Sample. Review the shared medication list for 10 clients, against the medicines at home.

1 One current medication list exists for each client.

Method. Check each sampled client for one list.

Evidence to show. Shared medication list (HC-FRM-008).

Pass when. Every sampled client has one list.

2 The list is shared with everyone involved.

Method. Check each list for the people it is shared with.

Evidence to show. Shared medication list (HC-FRM-008).

Pass when. Every list shows the people it is shared with.

3 The list matches the medicines in the home.

Method. Compare each list with the medicines found in the home.

Evidence to show. Shared medication list, reconciled against the medicines found in the home.

Pass when. No mismatch is found in the sample.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Two different medicine lists in the home and the client taking the wrong dose. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-008	Shared medication list	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Shared medication list	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- WHO (2020). Medication safety in transitions of care. Used for: Medication safety in transitions of care: medication lists, reconciliation and review after a change. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/
- World Health Organization. Medication Without Harm: Global Patient Safety Challenge on Medication Safety. Geneva: WHO; 2017. Used for: https://news.gmj.ge/guideline/medication-without-harm-global-patient-safety-challenge-on-medication-safety/
- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.18 A Medication Change or Care Transition Triggers Structured Review

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A medication change or a care transition — hospital discharge, a new prescriber, a change in caregiver — triggers a structured review of the client's complete medication regimen, not treated as a routine update folded into ordinary care without specific, dedicated attention.

Rating rule. Must in every setting: a medication change or care transition triggers a structured review.

GUIDANCE

A change to medication or a move between care settings is a high-risk moment. A structured review by a clinician checks the new regimen before it takes effect.

A change made by telephone is reviewed and recorded before it is given.

> **Good practice.** Each medication change or care transition triggers a structured review by a clinician, and the review is recorded before the change takes effect.

> **Partial because.** A medication change is made by phone with no review or record.

WHAT GOOD LOOKS LIKE

- A clinician reviews each medication change within one working day, and the review is recorded before the change is given.

COMMON MISTAKES

- A medicine stopped after a telephone call with no review.
- A transition from hospital with no structured review.

> **Why it matters.** The most dangerous moments for medicines are changes: a hospital discharge, a new prescriber, a change of dose. Reconciling the list at those points catches the error.

WHAT THE ASSESSOR CHECKS

Sample. Review 10 medicine changes and care transitions in the last 12 months.

1 Each change or transition triggers a structured review.

Method. Check each change for the review recorded.

Evidence to show. Medication changes, transitions and missed doses (HC-SOP-005).

Pass when. Every change has a review recorded.

2 The review covers the complete regimen.

Method. Check each review for the full regimen.

Evidence to show. Record of each medication review after a change or transition, showing the full regimen reviewed.

Pass when. Every review covers the full regimen.

3 The shared list is updated at each change.

Method. Check the list date against each change.

Evidence to show. Shared medication list (HC-FRM-008).

Pass when. Every change is on the list on the same day.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A hospital discharge with a new drug not added to the home list. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-005	Medication changes, transitions and missed doses	Manager	Chief executive	Chief executive

Other records in the criterion: HC-FRM-008 Shared medication list

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Medicine changes, transitions and missed doses	— Must
Nurse (ISCO 2221)	Completes the Shared medication list	— Must

REFERENCES FOR THIS CRITERION

- WHO (2020). Medication safety in transitions of care. Used for: Medication safety in transitions of care: medication lists, reconciliation and review after a change. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/
- World Health Organization. Medication Without Harm: Global Patient Safety Challenge on Medication Safety. Geneva: WHO; 2017. Used for: https://news.gmj.ge/guideline/medication-without-harm-global-patient-safety-challenge-on-medication-safety/
- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.19 Medications Belonging to Different Household Members Are Distinguished and Secured

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Medications belonging to different people in the household are physically distinguished and securely stored separately — not left commingled in a way that risks a client taking another person's medication, a documented error type in home medication management.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: medications belonging to different household members are distinguished and secured.

GUIDANCE

Medicines in a household may belong to several people. Mixing them up is dangerous. Each person's medicines are stored and recorded separately, and the caregiver records only the client's medicines.

Medicines are secured where children or visitors can reach them.

> **Good practice.** Medicines belonging to each member of the household are stored separately and secured, and the caregiver records only the client's medicines.

> **Partial because.** Medicines for different household members are kept together in one box.

WHAT GOOD LOOKS LIKE

- Each household member's medicines are kept in a separate labelled container, and the caregiver records only the client's medicines.

COMMON MISTAKES

- One box holding the medicines of three people.
- A child able to reach the medicines.

> **Why it matters.** Medicines for different people in the same home can be mixed up, especially by an aide who is not familiar with the household. Storing each person's medicines separately prevents that.

WHAT THE ASSESSOR CHECKS

Sample. Review the medicine storage in 5 multi-person households.

1 Each person's medicines are stored separately.

Method. Observe the storage in each sampled home.

Evidence to show. Medicines in multi-person households (HC-SOP-006).

Pass when. Every sampled home stores them separately.

2 Medicines are labelled with the owner's name.

Method. Check each sampled label.

Evidence to show. Medicines in multi-person households (HC-SOP-006).

Pass when. Every sampled label shows the owner.

3 Controlled medicines are stored securely and recorded.

Method. Check the controlled medicines register for each home.

Evidence to show. Controlled medicines register (PHM-FRM-002).

Pass when. Every controlled medicine is recorded.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A husband's heart tablets given to his wife. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-006	Medicines in multi-person households	Manager	Chief executive	Chief executive

Other records in the criterion: PHM-FRM-002 (name to be confirmed)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Medicines in multi-person households	— Must
Nurse (ISCO 2221)	Completes the Controlled medicines register	— Must

REFERENCES FOR THIS CRITERION

- World Health Organization. Medication Without Harm: Global Patient Safety Challenge on Medication Safety. Geneva: WHO; 2017. Used for: https://news.gmj.ge/guideline/medication-without-harm-global-patient-safety-challenge-on-medication-safety/
- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.20 A Missed or Uncertain Dose Is Actively Followed Up

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a dose is missed, or it is uncertain whether it was taken, this is actively, specifically followed up — not left unresolved on the assumption that a single missed or uncertain dose does not warrant attention.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: a missed or uncertain dose is actively followed up.

GUIDANCE

A missed dose can cause serious harm, and an uncertain dose can be doubled by mistake. The missed dose is followed up on the same day, the prescriber is told and the event is recorded.

The follow-up is recorded as a clinical action.

> **Good practice.** A missed or uncertain dose is followed up on the same day, the prescriber is informed, and the event is recorded.

> **Partial because.** A missed dose is noted with no follow-up.

WHAT GOOD LOOKS LIKE

- A missed dose is reported to the prescriber on the same day, and the follow-up is recorded in the medication record.

COMMON MISTAKES

- A missed dose noted with no follow-up.
- An uncertain dose given a second time.

> **Why it matters.** A missed dose can cause serious harm, and an uncertain dose can lead to a double dose. A clear follow-up for each missed or uncertain dose protects the client.

WHAT THE ASSESSOR CHECKS

Sample. Review the missed-dose records for the last 6 months.

1 Each missed or uncertain dose is followed up.

Method. Check each missed dose for the follow-up recorded.

Evidence to show. Medication changes, transitions and missed doses (HC-SOP-005).

Pass when. Every missed dose has a follow-up.

2 The follow-up is the same day.

Method. Check each follow-up for the time against the missed dose.

Evidence to show. Medication changes, transitions and missed doses (HC-SOP-005).

Pass when. At least 95% are followed up the same day.

3 Anticoagulant and other high-risk doses are prioritised.

Method. Check each high-risk missed dose for the priority follow-up.

Evidence to show. Incident reporting and management (INC-POL-001).

Pass when. Every high-risk missed dose is followed up at once.

Pass. The criterion is met when every check above is passed.

Immediate fail. . An anticoagulant missed for a week with no one noticing. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-005	Medication changes, transitions and missed doses	Manager	Chief executive	Chief executive
INC-POL-001	Incident reporting and management	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Medicine changes, transitions and missed doses	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2020). Medication safety in transitions of care. Used for: Medication safety in transitions of care: medication lists, reconciliation and review after a change. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/
- World Health Organization. Medication Without Harm: Global Patient Safety Challenge on Medication Safety. Geneva: WHO; 2017. Used for: https://news.gmj.ge/guideline/medication-without-harm-global-patient-safety-challenge-on-medication-safety/
- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.21 A Risk Assessment of the Home Occurs Before the First Visit

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A risk assessment of the client's home and household — including household members, pets, and known environmental hazards — occurs before a caregiver's first visit, not left for the caregiver to discover in time upon arrival.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: a risk assessment of the home is completed before the first visit.

GUIDANCE

Before the first visit, the caregiver should know the risks in the home. A risk assessment done beforehand is shared with the caregiver before the visit.

A supervisor signs the assessment.

> **Good practice.** A risk assessment of the home is completed before the first visit and signed by a supervisor, and it is shared with the caregiver before the visit.

> **Partial because.** The caregiver sees the home for the first time at the first visit, with no prior risk assessment.

WHAT GOOD LOOKS LIKE

- The pre-visit home risk assessment is completed by a supervisor and sent to the caregiver at least one day before the first visit.

COMMON MISTAKES

- A first visit made with no risk information.
- A risk assessment written after the visit.

> **Why it matters.** Before a caregiver goes into a home, the risk to them and to the client must be known: who lives there, whether there is violence, and what is in the home. The assessment comes first.

WHAT THE ASSESSOR CHECKS

Sample. Review the pre-visit risk assessments for 10 new assignments.

1 Each home is risk-assessed before the first visit.

Method. Check each assignment for the assessment date against the first visit.

Evidence to show. Pre-visit home risk assessment (HC-FRM-009).

Pass when. Every assignment is assessed before the first visit.

2 The assessment covers household members and known risk.

Method. Check each assessment for household and known risk.

Evidence to show. Caregiver safety in private homes (HC-POL-004).

Pass when. Every assessment covers household and known risk.

3 No caregiver is sent to a home with a known risk and no assessment.

Method. Check each known risk for an assessment on file.

Evidence to show. Caregiver safety in private homes (HC-POL-004).

Pass when. Every known risk has an assessment.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver sent to a home with a known violent member and no assessment. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-009	Pre-visit home risk assessment	Manager	Chief executive	Manager
HC-POL-004	Caregiver safety in private homes	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Pre-visit home risk assessment	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver safety in private homes	— Must

REFERENCES FOR THIS CRITERION

- WHO (2024). Infection prevention and control and water, sanitation and hygiene measures for home care and isolation for mpox in resource-limited settings: interim operational guide. Used for: Infection prevention, WASH and home care for mild mpox cases: home environment assessment and caregiver measures. https://news.gmj.ge/guideline/infection-prevention-and-control-and-water-sanitation-and-hygiene-measures-for-home-care-and-isolation-for-mpox-in-resource-limited-settings-interim-operational-guide/

24.22 A Workplace Violence Prevention Programme Exists, Adapted for the Home Setting

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A workplace violence prevention programme exists, specifically adapted for the reality of a caregiver working alone in a private home — not a generic facility-based programme applied without adaptation, and not assumed unnecessary because violence seems unlikely in this specific client relationship.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: a workplace violence prevention programme exists, adapted for the home setting.

GUIDANCE

Caregivers working alone in homes face violence and aggression that an office-based programme may not cover. The programme covers lone working, visit times, reporting and support.

Each caregiver is trained in it.

> **Good practice.** A workplace violence prevention programme covers the home setting, including lone working, the choice of visit times and reporting, and every caregiver is trained in it.

> **Partial because.** The programme is written for the office, and caregivers working in homes have no training for that setting.

WHAT GOOD LOOKS LIKE

- The programme includes a check of each visit, a reporting route and a debriefing after any violent incident.

COMMON MISTAKES

- A programme written for the office that does not cover lone working.
- No debriefing after a threat.

> **Why it matters.** Caregivers work alone in homes they do not control, and violence is a real risk. A prevention programme that fits the home setting, not a hospital, protects them.

WHAT THE ASSESSOR CHECKS

Sample. Review the violence prevention programme and its training records.

1 A violence prevention programme exists for the home setting.

Method. Check the programme for home-based adaptation.

Evidence to show. Caregiver safety in private homes (HC-POL-004).

Pass when. The programme covers the home setting.

2 Caregivers working alone are trained.

Method. Check the training records for each caregiver.

Evidence to show. Violence and aggression prevention and response (WRK-SOP-006).

Pass when. Every caregiver has training recorded.

3 Incidents are tracked and reviewed.

Method. Check the incident log for the review.

Evidence to show. Violence and aggression incident record (WRK-FRM-003).

Pass when. Every incident is tracked and reviewed.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver attacked in a home with no programme and no training. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-POL-004	Caregiver safety in private homes	Chief executive	Governing body members	Chief executive
WRK-SOP-006	Violence and aggression prevention and response	Manager	Chief executive	Chief executive
WRK-FRM-003	Violence and aggression incident record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver safety in private homes	— Must
Nurse (ISCO 2221)	Completes the Violence and aggression incident record	— Must

REFERENCES FOR THIS CRITERION

- WHO (2022). Caring for those who care: Guide for the development and implementation of occupational health and safety programmes for health workers. Used for: Occupational health and safety for health workers, including violence prevention and staff wellbeing. https://news.gmj.ge/guideline/caring-for-those-who-care-guide-for-the-development-and-implementation-of-occupational-health-and-safety-programmes-for-health-workers/

24.23 The Caregiver Has a Way to Signal Distress Discreetly

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The caregiver has a practical way to signal distress or request help during a visit — without alerting anyone present in the home that they have done so — not left with no option beyond openly announcing they feel unsafe in the moment they most need discretion.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: the caregiver has a discreet way to signal distress during a visit.

GUIDANCE

A caregiver who is threatened in a home may not be able to leave or call for help. A discreet signal, such as a code phrase or a check-in call, brings help without alerting the aggressor.

The signal is answered at once.

> **Good practice.** Each caregiver has a discreet way to signal distress during a visit, such as a phone code or a check-in call, and the signal is answered at once.

> **Partial because.** A caregiver in distress has no way to get help without leaving the home.

WHAT GOOD LOOKS LIKE

- Each caregiver carries a phone with a discreet code, and a supervisor answers the call within a set time.

COMMON MISTAKES

- A caregiver with no way to call for help during a visit.
- A code that no one is trained to answer.

> **Why it matters.** A caregiver alone in a home who feels threatened needs a way to ask for help without the client or family knowing. A discreet signal, and a plan for it, keeps them safe.

WHAT THE ASSESSOR CHECKS

Sample. Review the distress signal arrangements for 10 caregivers.

1 Each caregiver has a discreet way to signal distress.

Method. Check each caregiver record for the signal arrangement.

Evidence to show. Caregiver safety and distress signalling (HC-POL-005).

Pass when. Every caregiver has a signal.

2 Each signal is responded to at once.

Method. Check each recorded signal for the response time.

Evidence to show. Lone-worker check-in log (MOB-FRM-004).

Pass when. Every signal is responded to at once.

3 The signal does not alert the household.

Method. Check the signal method in the policy.

Evidence to show. Caregiver safety and distress signalling (HC-POL-005).

Pass when. The method is discreet by design.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver threatened with no way to call for help. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-POL-005	Caregiver safety and distress signalling	Chief executive	Governing body members	Chief executive

Other records in the criterion: MOB-FRM-004 (name to be confirmed)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver safety and distress signalling	— Must

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Lone-worker check-in log	— Must

REFERENCES FOR THIS CRITERION

- WHO (2022). Caring for those who care: Guide for the development and implementation of occupational health and safety programmes for health workers. Used for: Occupational health and safety for health workers, including violence prevention and staff wellbeing. https://news.gmj.ge/guideline/caring-for-those-who-care-guide-for-the-development-and-implementation-of-occupational-health-and-safety-programmes-for-health-workers/

24.24 Hostile Animals and Environmental Hazards Are Specifically Assessed

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Hostile or unpredictable animals, along with other environmental hazards specific to home-based work — poor lighting, unsafe walking conditions, extreme temperature — are specifically assessed for each home, not overlooked as a lesser concern compared with interpersonal risk.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: hostile animals and environmental hazards are specifically assessed.

GUIDANCE

Animals and hazards in a home, such as dogs, unsafe wiring or unsafe neighbourhoods, are part of the risk. They are assessed before care begins, and each has a documented way to manage it.

Caregivers are told about them before they go in.

> **Good practice.** Hostile animals and environmental hazards in the home are assessed before care begins, and each one has a documented way of managing it.

> **Partial because.** Animals in the home are noted but not assessed, and caregivers are not told about them.

WHAT GOOD LOOKS LIKE

- The home risk assessment includes a section on animals and on the neighbourhood, and the caregiver is told the result.

COMMON MISTAKES

- A dog in the home not recorded.
- A dangerous neighbourhood with no risk recorded.

> **Why it matters.** A dog that bites, a broken stair or a chemical left on a shelf are hazards that a caregiver meets in homes but never in a hospital. These need to be named and managed.

WHAT THE ASSESSOR CHECKS

Sample. Review the home risk assessments for 10 homes with animals or outdoor work.

1 Hostile or unpredictable animals are assessed.

Method. Check each sampled home for the animal assessment.

Evidence to show. Pre-visit home risk assessment (HC-FRM-009).

Pass when. Every sampled home has the animal check.

2 Lighting, walking and temperature hazards are assessed.

Method. Check each sampled home for the environmental hazards.

Evidence to show. Pre-visit home risk assessment (HC-FRM-009).

Pass when. Every sampled home has the hazards checked.

3 Each caregiver is told of the hazards before the visit.

Method. Check each sampled caregiver for the briefing.

Evidence to show. Caregiver safety in private homes (HC-POL-004).

Pass when. Every caregiver is briefed before the first visit.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver bitten by a dog the agency knew about. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-009	Pre-visit home risk assessment	Manager	Chief executive	Manager
HC-POL-004	Caregiver safety in private homes	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Pre-visit home risk assessment	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver safety in private homes	— Medium

REFERENCES FOR THIS CRITERION

- Guidance on Managing the Risk of Lone Working in the Health and Social Care Sector (Health and Safety Authority, Ireland, not stated on page) https://hsa.ie/eng/publications_and_forms/publications/health_and_social_care_sector/guidance_on_managing_the_risk_of_lone_working_in_the_health_and_social_care_sector.pdf

24.25 Near-Misses Are Actively Reported and Used to Update Risk Assessments

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A near-miss — a situation that could have resulted in harm but did not — is actively reported by caregivers and used to update risk assessments and safety procedures, not dismissed as a non-event simply because no actual harm occurred this time.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: near-misses are reported and used to update risk assessments.

GUIDANCE

A near-miss is an early warning. When it is reported and used to update the risk assessment, the next event may be prevented.

Reporting is encouraged, not punished.

> **Good practice.** Near-misses are reported, reviewed and used to update the risk assessment of the home and the service's procedures.

> **Partial because.** Near-misses are not reported because staff believe they are not important.

WHAT GOOD LOOKS LIKE

- Near-misses are reported on a short form, reviewed in the monthly meeting, and each review changes the risk assessment where needed.

COMMON MISTAKES

- A near-miss that no one reported.
- A near-miss report that does not change anything.

> **Why it matters.** A near-miss is a warning. A caregiver who nearly fell, or nearly gave the wrong medicine, has shown where the risk is. Recording it and changing the risk assessment prevents the real event.

WHAT THE ASSESSOR CHECKS

Sample. Review the near-miss reports for the last 12 months and the risk assessments updated.

1 Near-misses are reported by caregivers.

Method. Check the reporting log for near-miss reports.

Evidence to show. Incident reporting and management (INC-POL-001).

Pass when. Near-misses are reported.

2 Each near-miss updates the risk assessment.

Method. Check each near-miss for the assessment update.

Evidence to show. Pre-visit home risk assessment (HC-FRM-009).

Pass when. Every near-miss updates the assessment.

3 Near-misses are reviewed at governance.

Method. Check the governance minutes for the near-miss review.

Evidence to show. Governing Body Minutes Template (GOV-FRM-003).

Pass when. Near-misses are reviewed at each governance meeting.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver who nearly fell on the same stair three times with no report. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
INC-POL-001	Incident reporting and management	Chief executive	Governing body members	Chief executive
HC-FRM-009	Pre-visit home risk assessment	Manager	Chief executive	Manager
GOV-FRM-003	Governing Body Minutes Template	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Incident reporting and management	— Medium

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Pre-visit home risk assessment	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Used for: Global Patient Safety Action Plan: incident and near-miss reporting, learning systems. https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.26 Supervisory Visits Occur On-Site

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Supervisory visits occur on-site and in person, on a defined schedule matching the actual level of care being provided — not substituted by a phone check-in, and not treated as satisfied by counting individual caregiver visits rather than calendar-based intervals.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: supervisory visits occur on-site.

GUIDANCE

Supervision in the home shows what happens there. Supervisory visits take place on-site, on a set schedule and at each change in the client's care.

Each visit is recorded.

> **Good practice.** Supervisory visits take place in the home, on a set schedule and at each change in the client's care, and the visit is recorded.

> **Partial because.** Supervision is carried out by telephone or by reviewing records only.

WHAT GOOD LOOKS LIKE

- A supervisory visit takes place at least once a month for a new client, and every six months for a stable one.

COMMON MISTAKES

- Supervision by telephone only.
- A supervisory visit that is recorded as held but did not take place.

> **Why it matters.** A supervisor who never enters the home cannot see how care is given. Supervisory visits on site, on a schedule, are the only way to check the care that is delivered.

WHAT THE ASSESSOR CHECKS

Sample. Review the supervisory visit records for 10 clients over the last 12 months.

1 Supervisory visits are on-site, in person.

Method. Check each visit record for the in-person entry.

Evidence to show. Supervisory visits in the home (HC-SOP-008).

Pass when. Every visit is in person.

2 Visits follow the schedule for the level of care.

Method. Check each client against the schedule.

Evidence to show. Supervisory visit record (HC-FRM-010).

Pass when. At least 95% of visits are on schedule.

3 Visits are not replaced by phone calls.

Method. Check each record for a phone call used as the visit.

Evidence to show. Supervisory visits in the home (HC-SOP-008).

Pass when. No visit is a phone call.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client with a care plan never visited by a supervisor in a year. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-008	Supervisory visits in the home	Manager	Chief executive	Chief executive

Other records in the criterion: HC-FRM-010 Supervisory visit record

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Supervisory visits in the home	— Must
Nurse (ISCO 2221)	Completes the Supervisory visit record	— Must

REFERENCES FOR THIS CRITERION

- 42 CFR 484.80 Condition of participation: Home health aide services (US Centers for Medicare & Medicaid Services (text via Cornell LII), current CFR text) https://www.law.cornell.edu/cfr/text/42/484.80

24.27 Personal Care Supervision Includes Observing the Aide Providing Care

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a client receives only personal care services, the required supervisory visit includes observing the caregiver providing care, with the caregiver present — not a supervisory visit conducted without the caregiver there, which fails to assess how care is being delivered.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: personal care supervision includes observing the caregiver providing care.

GUIDANCE

Reviewing paperwork does not show how care is given. For personal care, the supervisor observes the caregiver providing care at least once in each supervision cycle.

The observation is recorded.

> **Good practice.** For personal care, the supervisor observes the caregiver providing care at least once in each supervision cycle, and the observation is recorded.

> **Partial because.** Supervision of personal care is limited to a discussion, with no observation of care.

WHAT GOOD LOOKS LIKE

- The supervisor observes a complete personal care task, such as bathing or dressing, and records what was seen.

COMMON MISTAKES

- An observation that covers only the arrival and departure.
- Supervision that is a review of notes only.

> **Why it matters.** When a client receives only personal care, the aide is alone with them for every task. A supervisor must observe the aide giving that care, not only read about it.

WHAT THE ASSESSOR CHECKS

Sample. Review the supervisory visits for 10 clients who receive personal care only.

1 The visit includes observing the caregiver giving care.

Method. Check each visit for the observation recorded.

Evidence to show. Supervisory visit record (HC-FRM-010).

Pass when. Every visit records an observation.

2 The caregiver is present during the observation.

Method. Check each observation for the caregiver present.

Evidence to show. Supervisory visit record (HC-FRM-010).

Pass when. Every observation shows the caregiver present.

3 Care is assessed as delivered.

Method. Check each observation for the measured aspects.

Evidence to show. Supervisory visits in the home (HC-SOP-008).

Pass when. Every observation records the aspects assessed.

Pass. The criterion is met when every check above is passed.

Immediate fail. . An aide giving personal care for a year with no one watching. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-010	Supervisory visit record	Manager	Chief executive	Manager
HC-SOP-008	Supervisory visits in the home	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Supervisory visit record	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Supervisory visits in the home	— Must

REFERENCES FOR THIS CRITERION

- 42 CFR 484.80 Condition of participation: Home health aide services (US Centers for Medicare & Medicaid Services (text via Cornell LII), current CFR text) https://www.law.cornell.edu/cfr/text/42/484.80

24.28 Supervision Documentation Captures Objective, Measurable Observations

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Supervisory visit documentation captures objective, measurable observations — not a vague, general statement like "patient is progressing well, continue plan of care" that provides no comparable information for the next reviewer.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: supervision documentation records objective, measurable observations.

GUIDANCE

A supervision note that says the caregiver is good tells no one anything. The record states what was observed: the time taken, the steps followed and the client's response.

The observation uses measurable terms.

> **Good practice.** Supervision records state what was observed, using measurable terms, such as the time taken, the steps followed and the client's response.

> **Partial because.** Supervision records use general words such as good or fine, with no observation recorded.

WHAT GOOD LOOKS LIKE

- A supervision record names the task observed, the time taken and the steps completed, and it is signed by the supervisor and the caregiver.

COMMON MISTAKES

- A record that says "good work" and nothing more.
- A record with no date or time.

> **Why it matters.** A supervision note that says 'visit went well' tells no one anything. Objective, measurable observations allow the next supervisor to see a change over time.

WHAT THE ASSESSOR CHECKS

Sample. Review 10 supervisory visit records for the quality of observations.

1 Observations are objective and measurable.

Method. Check each record for measured observations.

Evidence to show. Supervisory visit record (HC-FRM-010).

Pass when. Every record has measured observations.

2 General statements alone are not accepted.

Method. Check each record for statements without data.

Evidence to show. Supervisory visit record (HC-FRM-010).

Pass when. No record relies on a general statement alone.

3 The record can be compared with the next visit.

Method. Check each record for comparable measures.

Evidence to show. Supervisory visit record (HC-FRM-010).

Pass when. Records use the same measures over time.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A visit recorded as 'satisfactory' with no detail. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-FRM-010	Supervisory visit record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Supervisory visit record	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

24.29 A Change in Client Needs Triggers Care Plan Review

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a client's actual needs change — a service is no longer required, a new need emerges, responsibility shifts between disciplines — this triggers review and update of the care plan, not left to continue reflecting needs that no longer accurately describe the client's current situation.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: a change in the client's needs triggers a care plan review.

GUIDANCE

When a client's needs change, the care plan no longer fits. A review within a set number of days updates it and shares the update with the caregiver.

The review is recorded.

> **Good practice.** A change in the client's needs triggers a care plan review within a set number of days, and the revised plan is shared with the caregiver.

> **Partial because.** The care plan is not reviewed when the client's needs change.

WHAT GOOD LOOKS LIKE

- A change in needs triggers a review within three working days, and the revised plan is given to the client and the caregiver.

COMMON MISTAKES

- A care plan unchanged after a hospital stay.
- A review that did not reach the caregiver.

> **Why it matters.** A client's needs change: a service is no longer needed, or a new need appears. The care plan must change with them, or the care no longer fits.

WHAT THE ASSESSOR CHECKS

Sample. Review the care plans for 10 clients with a change in need in the last 12 months.

1 A change in need triggers a care plan review.

Method. Check each recorded change for the review.

Evidence to show. Individualised care planning (CLN-SOP-002).

Pass when. Every change has a review.

2 The plan is updated after review.

Method. Check each reviewed plan for the update date.

Evidence to show. Individual care plan (CLN-FRM-003).

Pass when. Every reviewed plan is updated.

3 Responsibility shifts are recorded.

Method. Check each change for the responsibility recorded.

Evidence to show. Individual care plan (CLN-FRM-003).

Pass when. Every shift in responsibility is recorded.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client with new continence needs given the same plan for three months. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CLN-SOP-002	Individualised care planning	Manager	Chief executive	Chief executive
CLN-FRM-003	Individual care plan	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Individualised care planning	— Must
Nurse (ISCO 2221)	Completes the Individual care plan	— Must

24.30 An Identified Deficiency Leads to Retraining and Re-Evaluation

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a supervisory visit identifies a deficiency in a caregiver's performance, this leads to documented retraining and a subsequent competency evaluation before the caregiver resumes independent care — not a deficiency noted without resulting action, or the caregiver continuing independently without confirmed correction.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: an identified deficiency leads to retraining and re-evaluation.

GUIDANCE

When a deficiency is found, the caregiver needs retraining and a re-evaluation to show it has been corrected. The outcome is recorded.

An informal conversation alone does not close a deficiency.

> **Good practice.** An identified deficiency leads to retraining, a re-evaluation of the caregiver and a record of the outcome.

> **Partial because.** A deficiency is discussed informally, and no retraining or re-evaluation is recorded.

WHAT GOOD LOOKS LIKE

- A deficiency leads to retraining within two weeks and a re-evaluation within a month, and the outcome is recorded.

COMMON MISTAKES

- A deficiency closed in a conversation.
- Retraining that is never followed by a re-evaluation.

> **Why it matters.** A deficiency found in supervision is only useful if it leads to retraining and a re-check. Without that follow-through the same problem returns.

WHAT THE ASSESSOR CHECKS

Sample. Review the caregiver deficiency records and retraining records for the last 12 months.

1 Each deficiency leads to documented retraining.

Method. Check each deficiency for the retraining recorded.

Evidence to show. Annual competency assessment procedure (WRK-SOP-001).

Pass when. Every deficiency has retraining recorded.

2 A competency evaluation is done before independent care resumes.

Method. Check each retrained caregiver for the evaluation before independent work.

Evidence to show. Competency assessment form by role (WRK-FRM-001).

Pass when. Every caregiver is evaluated before independent work.

3 No caregiver works independently without confirmed correction.

Method. Check each caregiver for independent work after a deficiency.

Evidence to show. Competency assessment form by role (WRK-FRM-001).

Pass when. No caregiver works independently without confirmed correction.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver who failed a technique check three times with no retraining. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
WRK-SOP-001	Annual competency assessment procedure	Manager	Chief executive	Chief executive
WRK-FRM-001	Competency assessment form by role	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Annual competency assessment procedure	— Medium

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Competency assessment form by role	— Medium

REFERENCES FOR THIS CRITERION

- 42 CFR 484.80 Condition of participation: Home health aide services (US Centers for Medicare & Medicaid Services (text via Cornell LII), current CFR text) https://www.law.cornell.edu/cfr/text/42/484.80

24.31 A Coverage Plan Exists for a Solo Caregiver's Absence

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** For a client served by a single, independent caregiver, a defined coverage arrangement exists for when that caregiver is unavailable — illness, leave, emergency — with a named alternative for care in that gap, not an assumption that the client will simply manage without care.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: a coverage plan exists for a solo caregiver's absence.

GUIDANCE

A client who depends on one caregiver is at risk when that caregiver is absent. A written coverage plan names who will provide care, and the plan is tested.

The coverage plan is shared with the client.

> **Good practice.** For a client who relies on one caregiver, a written coverage plan states who will provide care during that caregiver's absence, and the plan is tested.

> **Partial because.** A solo caregiver's absence is covered by whoever is available on the day.

WHAT GOOD LOOKS LIKE

- The coverage plan names a back-up caregiver for each client who depends on one person, and the back-up has visited the client.

COMMON MISTAKES

- A solo caregiver with no back-up at all.
- A back-up who has never met the client.

> **Why it matters.** A client served by one caregiver who falls sick or goes on leave is left with no care. A written cover plan keeps the client safe in the absence.

WHAT THE ASSESSOR CHECKS

Sample. Review the coverage plans for 10 clients served by a single caregiver.

1 A coverage arrangement exists for each solo-caregiver client.

Method. Check each sampled client for the coverage plan.

Evidence to show. Solo caregiver coverage plan (HC-PLN-001).

Pass when. Every sampled client has a plan.

2 A named alternative is recorded.

Method. Check each plan for the named alternative.

Evidence to show. Solo caregiver coverage plan (HC-PLN-001).

Pass when. Every plan names an alternative.

3 The plan is tested.

Method. Check each plan for the test date.

Evidence to show. Coverage for a solo caregiver's absence (HC-SOP-009).

Pass when. Every plan has a test date.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client left without any care for two days when the only caregiver was sick. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-009	Coverage for a solo caregiver's absence	Manager	Chief executive	Chief executive
HC-PLN-001	Solo caregiver coverage plan	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Chief executive (ISCO 1120)	Approves the Solo caregiver coverage plan	— Must
Manager (ISCO 1342)	Maintains the Coverage for a solo caregiver's absence	— Must

24.32 Caregiver Continuity Is Actively Tracked and Prioritised for High-Need Clients

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Caregiver continuity is actively tracked, with specific priority given to clients with the highest care needs — not treated as a passive outcome of scheduling convenience.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: caregiver continuity is actively tracked and prioritised for high-need clients.

GUIDANCE

A client who keeps the same caregiver does better. Continuity is tracked, priority goes to clients with high needs, and each change is recorded with the reason.

The client is told about any change.

> **Good practice.** Caregiver continuity is tracked for each client, with priority given to clients with high needs, and changes of caregiver are recorded with the reason.

> **Partial because.** Continuity is not tracked, and changes of caregiver are not explained to the client.

WHAT GOOD LOOKS LIKE

- A continuity register shows, for each high-need client, the caregivers who have visited in the last three months.

COMMON MISTAKES

- A client who sees a different caregiver every week.
- Changes not recorded or explained.

> **Why it matters.** A client who sees a different caregiver each day is less safe and less well cared for. Tracking continuity and giving priority to clients with the greatest need keeps the same person coming.

WHAT THE ASSESSOR CHECKS

Sample. Review the continuity register for the highest-need clients over the last 6 months.

1 Caregiver continuity is tracked for each client.

Method. Check each sampled client in the register.

Evidence to show. Caregiver continuity register (HC-REG-003).

Pass when. Every sampled client is tracked.

2 Priority is given to the highest-need clients.

Method. Check the review order against need level.

Evidence to show. Caregiver continuity register (HC-REG-003).

Pass when. High-need clients are reviewed first.

3 Clients above the agreed number of caregivers are flagged and acted on.

Method. Check each flag for the action recorded.

Evidence to show. Caregiver continuity register (HC-REG-003).

Pass when. Every flag has an action recorded.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A dementia client seeing six caregivers in a week. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-REG-003	Caregiver continuity register	Secretary	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Secretary (ISCO 3344)	Keeps the Caregiver continuity register	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

24.33 New Caregiver Retention Receives Structured Attention in the First 100 Days

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** New caregiver retention receives specific, structured attention during their first 100 days of employment — onboarding support, regular check-ins, realistic scheduling — not left to general workplace culture alone.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: new caregiver retention receives structured attention in the first 100 days.

GUIDANCE

New caregivers are most likely to leave in their first months. Structured support in the first 100 days, with a mentor and regular check-ins, improves retention.

The support is reviewed at each stage.

> **Good practice.** New caregivers receive structured support in their first 100 days, including a named mentor, regular check-ins and a review of their retention.

> **Partial because.** New caregivers are left to work alone after their first induction day.

WHAT GOOD LOOKS LIKE

- A new caregiver has a named mentor, a check-in at 30, 60 and 100 days, and a review of their retention at each.

COMMON MISTAKES

- A new caregiver left alone after induction.
- A check-in that is never recorded.

> **Why it matters.** New caregivers often leave in the first months, which costs the client continuity and the agency money. Structured attention in those first weeks helps them stay.

WHAT THE ASSESSOR CHECKS

Sample. Review the first 100 days records for 10 new caregivers.

1 Each new caregiver has structured support in the first 100 days.

Method. Check each sampled caregiver for the support recorded.

Evidence to show. First 100 days check-in record (HC-FRM-011).

Pass when. Every sampled caregiver has support recorded.

2 Check-ins are held at each set point.

Method. Check each caregiver for the check-in dates.

Evidence to show. New caregiver support in the first 100 days (HC-SOP-010).

Pass when. At least 90% have all check-ins.

3 Reasons for leaving are recorded.

Method. Check each leaver for the reason recorded.

Evidence to show. First 100 days check-in record (HC-FRM-011).

Pass when. Every leaver has a reason recorded.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A new caregiver who left after a week with no contact from the agency. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-010	New caregiver support in the first 100 days	Manager	Chief executive	Chief executive
HC-FRM-011	First 100 days check-in record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the First 100 days check-in record	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the New caregiver support in the first 100 days	— Medium

24.34 Caregiver Isolation Is Addressed Through Regular Supervisor Contact

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Caregiver isolation is actively addressed through regular supervisor contact and peer connection opportunities — not left unaddressed on the assumption that working alone is simply an inherent, unavoidable feature of the role that cannot be meaningfully improved.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: caregiver isolation is addressed through regular supervisor contact.

GUIDANCE

Caregivers who work alone can feel isolated. Regular contact with a supervisor, recorded and reviewed, gives them a route to raise concerns.

Contact between visits is recorded.

> **Good practice.** Caregivers who work alone have regular contact with a supervisor, which is recorded, and a route to raise concerns about isolation.

> **Partial because.** Caregivers working alone have no contact with a supervisor between visits.

WHAT GOOD LOOKS LIKE

- A supervisor calls each lone caregiver at least once a week, and the call is recorded.

COMMON MISTAKES

- A caregiver who has not spoken to a supervisor for a month.
- A route to raise concerns that no one knows about.

> **Why it matters.** A caregiver who works alone for hours can become isolated and unsupported, which affects their health and the care they give. Regular supervisor contact and peer support counter the isolation.

WHAT THE ASSESSOR CHECKS

Sample. Review the contact records for 10 caregivers who work alone.

1 Each caregiver has regular supervisor contact.

Method. Check each caregiver for the contact log.

Evidence to show. Lone-worker check-in and response (MOB-SOP-002).

Pass when. Every caregiver has regular contact.

2 Peer connection is arranged.

Method. Check each caregiver for peer connection in the period.

Evidence to show. Lone-worker check-in and discreet distress signal (HC-SOP-007).

Pass when. Every caregiver has peer connection in the period.

3 Missed check-ins are followed up the same day.

Method. Check each missed check-in for the same-day follow-up.

Evidence to show. Lone-worker check-in and response (MOB-SOP-002).

Pass when. Every missed check-in is followed up the same day.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver alone for a year with no contact with the agency. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-007	Lone-worker check-in and discreet distress signal	Manager	Chief executive	Chief executive

Other records in the criterion: MOB-SOP-002 (name to be confirmed)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Lone-worker check-in and response	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2022). Caring for those who care: Guide for the development and implementation of occupational health and safety programmes for health workers. Used for: Occupational health and safety for health workers, including violence prevention and staff wellbeing. https://news.gmj.ge/guideline/caring-for-those-who-care-guide-for-the-development-and-implementation-of-occupational-health-and-safety-programmes-for-health-workers/

24.35 Incident Reporting Accounts for Detection Delay in an Unsupervised Setting

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Incident reporting practice accounts for the possibility that a problem in an unsupervised home setting may not be discovered immediately — building in specific mechanisms for delayed discovery, not designed only around incidents that happen to be witnessed or reported in time.

Rating rule. Must in every setting: incident reporting accounts for detection delay in an unsupervised setting.

GUIDANCE

When a caregiver works alone, an incident may go undetected for hours. Reports state the time between the event and its detection, and the service uses that delay to improve how it monitors the client.

The delay is reviewed in the incident review.

> **Good practice.** Incident reports for unsupervised care state the time between the event and its detection, and the report is used to improve how the service monitors the client.

> **Partial because.** Incidents are reported only when someone else sees them.

WHAT GOOD LOOKS LIKE

- Each incident report states the time between the event and its detection, and the delay is discussed in the monthly review.

COMMON MISTAKES

- An incident found by a relative three days later with no review.
- A report that does not state the time of the event.

> **Why it matters.** In a home where no one else is present, a problem can go unnoticed for days. Incident reporting must allow for that delay, and not assume a problem was reported at once.

WHAT THE ASSESSOR CHECKS

Sample. Review the incident records for the last 12 months, including late-discovered incidents.

1 Delayed-discovery incidents are reported on discovery.

Method. Check each late-discovered incident for the discovery date.

Evidence to show. Incident reporting for delayed discovery in the home (HC-SOP-011).

Pass when. Every late-discovered incident is reported on discovery.

2 The estimated time of the event is recorded.

Method. Check each record for the estimated time.

Evidence to show. Incident reporting for delayed discovery in the home (HC-SOP-011).

Pass when. Every record has an estimated time.

3 Delayed discovery is reviewed without blame by default.

Method. Check each review for the blame approach.

Evidence to show. Root cause analysis of serious incidents (INC-SOP-001).

Pass when. Reviews do not assign default blame.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A fall discovered the next morning recorded as the caregiver's fault for not reporting at once. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-011	Incident reporting for delayed discovery in the home	Manager	Chief executive	Chief executive

Other records in the criterion: INC-SOP-001 (name to be confirmed)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Incident reporting for delayed discovery	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- WHO (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Used for: Global Patient Safety Action Plan: incident and near-miss reporting, learning systems. https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

24.36 Care Is Adapted to a Client's Migration and Displacement Experience

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Care is adapted to a client's migration and displacement experience — including trauma-informed practice and awareness of legal-status barriers to access — not delivered identically regardless of that history, because a caregiver's daily, ongoing presence in the home makes this context relevant to nearly every aspect of the relationship.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: care is adapted to a client's migration and displacement experience.

GUIDANCE

A client who has migrated or been displaced may have experienced trauma. Care is adapted with trauma-informed communication and, where possible, the choice of caregiver.

The adaptation is written in the care plan.

> **Good practice.** Care is adapted to the client's experience of migration and displacement, including trauma-informed communication and the choice of caregiver where possible.

> **Partial because.** Care is delivered in the same way to all clients, whatever their migration history.

WHAT GOOD LOOKS LIKE

- The care plan states the trauma-informed approach used, and the caregiver is trained in it.

COMMON MISTAKES

- A client treated the same as any other, despite a documented displacement history.
- Trauma history recorded with no change to care.

> **Why it matters.** A client who has fled violence or displacement may carry trauma that changes how they respond to care in their own home. Care that is adapted to that experience is safer and more respectful.

WHAT THE ASSESSOR CHECKS

Sample. Review the care records for 10 clients with a migration or displacement history.

1 Care is adapted to the migration and displacement history.

Method. Check each sampled record for the history and the adaptation.

Evidence to show. Migration history and trauma-aware assessment record (HMG-FRM-001).

Pass when. Every sampled record shows the adaptation.

2 Trauma-informed practice is applied.

Method. Observe a sample of visits for trauma-informed practice.

Evidence to show. Migration-informed, trauma-aware care (HMG-POL-001).

Pass when. Observed visits follow trauma-informed practice.

3 Legal-status barriers to access are identified.

Method. Check each record for the barrier check.

Evidence to show. Migration history and trauma-aware assessment record (HMG-FRM-001).

Pass when. Every record shows the barrier check.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver entering the room of a traumatised client without asking. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HMG-FRM-001	Migration history and trauma-aware assessment record	Manager	Chief executive	Manager
HMG-POL-001	Migration-informed, trauma-aware care	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Migration history and trauma-aware assessment record	— Must
Manager (ISCO 1342)	Maintains the Migration-informed, trauma-aware care	— Must

REFERENCES FOR THIS CRITERION

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (US Substance Abuse and Mental Health Services Administration (summary on youth.gov), not stated on page) https://youth.gov/feature-article/samhsas-concept-trauma-and-guidance-trauma-informed-approach

24.37 Language Support Accounts for Persistent, Daily Interaction

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Language and communication support accounts for the persistent, daily nature of home care — not designed only around occasional, episodic interpreter access.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: language support accounts for persistent, daily interaction.

GUIDANCE

A caregiver may spend many hours a day with a client who does not share their language. Language support, through an interpreter or a shared language, is arranged and recorded.

A family member is not used as the default interpreter.

> **Good practice.** Language support is provided for the daily interactions between a caregiver and a client, through an interpreter or a shared language, and the arrangement is recorded.

> **Partial because.** A caregiver and a client who do not share a language communicate with a family member acting as interpreter, with no arrangement recorded.

WHAT GOOD LOOKS LIKE

- An interpreter is booked for each visit where the caregiver and client do not share a language, or a telephone interpreter is used.

COMMON MISTAKES

- A child used as the interpreter.
- No arrangement recorded for a client who speaks another language.

> **Why it matters.** A caregiver who spends every day with a client needs a way to communicate that goes beyond a few words. A plan for language support, that lasts across the whole relationship, keeps care understandable.

WHAT THE ASSESSOR CHECKS

Sample. Review language support arrangements for 10 clients with a language need.

1 Language support is planned for daily interaction.

Method. Check each sampled client for the daily language plan.

Evidence to show. Interpreter and mediator use (PTR-SOP-010).

Pass when. Every sampled client has a daily plan.

2 Interpreter access is not limited to occasional use.

Method. Check the support arrangement for daily access.

Evidence to show. Interpreter and mediator use (PTR-SOP-010).

Pass when. The arrangement provides daily access.

3 Pain and symptoms are communicated.

Method. Check each record for the communication of pain.

Evidence to show. Individual care plan (CLN-FRM-003).

Pass when. Every record shows pain is communicated.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client who could not explain pain to a caregiver for weeks. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
PTR-SOP-010	Interpreter and mediator use	Manager	Chief executive	Chief executive
CLN-FRM-003	Individual care plan	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Interpreter and mediator use	— Must

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Individual care plan	— Must

REFERENCES FOR THIS CRITERION

- National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) (US HHS Office of Minority Health, not stated on page) https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLAS_Standards.pdf

24.38 Cultural and Religious Practices in the Client's Home Are Respected

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A client's cultural and religious practices are respected within their own home — dietary requirements, prayer routines, gender-appropriate care preferences — not overridden by the caregiver's own habits or convenience.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: cultural and religious practices in the client's home are respected.

GUIDANCE

A client's faith and customs affect daily care, such as diet, prayer and dress. These are recorded and followed in the care plan, and caregivers are trained to follow them.

The client decides what matters to them.

> **Good practice.** The client's cultural and religious practices in the home are respected in the care plan, and the caregiver is trained to follow them.

> **Partial because.** Cultural and religious practices are recorded at admission but are not followed in the care plan.

WHAT GOOD LOOKS LIKE

- The care plan records the client's dietary, religious and dress needs, and the caregiver signs that they have been trained to follow them.

COMMON MISTAKES

- A client's prayer times ignored in the visit schedule.
- Dietary requirements recorded but not provided.

> **Why it matters.** A client's home is their most important space, and their cultural and religious practices belong there. Respecting them, including food, prayer and dress, is part of their dignity.

WHAT THE ASSESSOR CHECKS

Sample. Review the care plans for 10 clients with cultural or religious practices.

1 Dietary, prayer and gender preferences are recorded.

Method. Check each sampled plan for the practices.

Evidence to show. The client's home and household routines (HC-POL-001).

Pass when. Every sampled plan records the practices.

2 The practices are followed in the home.

Method. Observe a sample of visits for the practices followed.

Evidence to show. The client's home and household routines (HC-POL-001).

Pass when. Observed visits follow the practices.

3 Personal items are not removed.

Method. Check the visit notes for any removal of personal items.

Evidence to show. Non-Discrimination and Equal Access to Care (CON-POL-002).

Pass when. No visit note records removal.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver removing religious objects from the client's room. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-POL-001	The client's home and household routines	Chief executive	Governing body members	Chief executive
CON-POL-002	Non-Discrimination and Equal Access to Care	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Client's home and household routines	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) (US HHS Office of Minority Health, not stated on page) https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLAS_Standards.pdf

24.39 Caregiver Work Authorisation Is Verified Through Legal, Non-Discriminatory Practice

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Caregiver work authorisation is verified through the same legal, standard employment practice applied to every prospective employee — not subjected to excess scrutiny beyond what is required, and not applied inconsistently based on a caregiver's perceived country of origin or accent.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: caregiver work authorisation is verified through legal, non-discriminatory practice.

GUIDANCE

Work authorisation affects who can work. It is checked through a legal process that is applied the same way to every caregiver, and the check is recorded with its date.

The check does not treat any group of caregivers differently.

> **Good practice.** Each caregiver's work authorisation is verified through a legal and non-discriminatory process, and the verification is recorded with the date.

> **Partial because.** Work authorisation is checked in a way that treats some caregivers differently from others.

WHAT GOOD LOOKS LIKE

- Work authorisation is checked against the official document for each caregiver, using the same process for all staff.

COMMON MISTAKES

- A process that asks some caregivers for more documents than others.
- An authorisation that expired and was not checked.

> **Why it matters.** A caregiver who is not legally authorised to work may be exploited and may put the client at risk if they have to leave. Verifying work authorisation in the same way as for any employee protects both.

WHAT THE ASSESSOR CHECKS

Sample. Review the work authorisation checks for 10 caregivers hired in the last 12 months.

1 Each caregiver's work authorisation is verified.

Method. Check each sampled file for the verification.

Evidence to show. Staff credential verification and recheck (STF-SOP-001).

Pass when. Every sampled file shows verification.

2 The same standard check applies to all applicants.

Method. Compare the checks applied across applicants.

Evidence to show. Staff credential verification and recheck (STF-SOP-001).

Pass when. The same check is recorded for each applicant.

3 No caregiver is scrutinised on origin or accent.

Method. Check the hiring records for any origin-based scrutiny.

Evidence to show. Non-Discrimination and Equal Access to Care (CON-POL-002).

Pass when. No record shows scrutiny on origin or accent.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver working without authorisation and paid cash. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
STF-SOP-001	Staff credential verification and recheck	Manager	Chief executive	Chief executive
CON-POL-002	Non-Discrimination and Equal Access to Care	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Staff credential verification and recheck	— Medium
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- Report III (1B): Migrant Workers, International Labour Conference 87th Session (International Labour Organization, 1999) https://webapps.ilo.org/public/english/standards/relm/ilc/ilc87/r3-1b2.htm

24.40 A Caregiver's Legal Status Change Is Handled With Support

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a caregiver's own legal work authorisation status changes — a permit expiring, a visa category ending, a policy shift removing a pathway that existed when they were hired — the service provides support and transition time, not abrupt termination without any transition process.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: a caregiver's legal status change is handled with support.

GUIDANCE

A change in a caregiver's legal status can end their work or change their duties. It is handled with support, including advice and a review of duties, and the change is recorded.

The caregiver is not removed from work without a review.

> **Good practice.** A change in a caregiver's legal status is handled with support, including a review of their duties and access to advice, and the change is recorded.

> **Partial because.** A caregiver whose legal status changes is removed from work without support or a recorded review.

WHAT GOOD LOOKS LIKE

- A caregiver whose status changes is offered an advice session, and the duties are reviewed within a week.

COMMON MISTAKES

- A caregiver removed from the rota the day the status changed.
- A change in status recorded with no support.

> **Why it matters.** A caregiver whose own work permit is about to expire can lose their job suddenly, which leaves the client without care. Planning ahead for a change in status protects both.

WHAT THE ASSESSOR CHECKS

Sample. Review the authorisation changes for caregivers in the last 12 months.

1 Each authorisation change is tracked before it takes effect.

Method. Check each change for an early tracking date.

Evidence to show. Caregiver work authorisation change: transition support (HC-SOP-012).

Pass when. Every change is tracked early.

2 A transition period and client cover are in place.

Method. Check each change for the transition plan.

Evidence to show. Caregiver work authorisation change: transition support (HC-SOP-012).

Pass when. Every change has a transition plan.

3 No caregiver is stopped the same day without a plan.

Method. Check each stop for a same-day termination.

Evidence to show. Caregiver work authorisation change: transition support (HC-SOP-012).

Pass when. No same-day stop occurs without a plan.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A caregiver's permit expired and they stopped work the same day, leaving a client alone. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-012	Caregiver work authorisation change: transition support	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Caregiver work authorisation change: transition support	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

24.41 Immigrant Caregivers' Retention Advantage Is Recognised and Supported

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The service recognises and supports the documented retention advantage immigrant caregivers bring to continuity of care — not undermining this advantage through precarious employment practices that create instability regardless of a caregiver's own commitment to staying.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: the retention advantage of immigrant caregivers is recognised and supported.

GUIDANCE

Immigrant caregivers often stay longer in the work than others. The service recognises this and supports them, including through working conditions and career progression.

The support is reviewed at each annual review.

> **Good practice.** The retention of immigrant caregivers is recognised and supported, including through a review of their working conditions and a route to career progression.

> **Partial because.** Immigrant caregivers are retained only because they are the only staff available.

WHAT GOOD LOOKS LIKE

- An annual review of immigrant caregivers covers their retention, their working conditions and their career options.

COMMON MISTAKES

- Immigrant caregivers kept on only because there is no one else.
- No review of their conditions.

> **Why it matters.** Immigrant caregivers often stay longer in the job than others, which gives continuity to clients. That advantage should be recognised and supported, not overlooked.

WHAT THE ASSESSOR CHECKS

Sample. Review the workforce equity register and the turnover data for immigrant caregivers.

1 Retention among immigrant caregivers is measured.

Method. Check the register for the measure.

Evidence to show. Workforce equity register (WRK-REG-003).

Pass when. The register measures retention by group.

2 Precarious employment practices are reviewed.

Method. Check the review record for precarious terms.

Evidence to show. Workforce equity monitoring (WRK-SOP-009).

Pass when. The review covers employment terms.

3 The retention advantage is acted on.

Method. Check the action record for the advantage.

Evidence to show. Workforce equity monitoring (WRK-SOP-009).

Pass when. An action is recorded for the advantage.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A service with high turnover that never looked at who stayed. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
WRK-REG-003	Workforce equity register	Secretary	Chief executive	Manager
WRK-SOP-009	Workforce equity monitoring	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Secretary (ISCO 3344)	Keeps the Workforce equity register	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Workforce equity monitoring	— Medium

REFERENCES FOR THIS CRITERION

- WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organization, 2010, Geneva: WHO) https://www.who.int/publications/i/item/wha6316

24.42 Legal Status Diversity Recognition for Clients

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The service can name which legal status categories its clients represent — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it does not apply a single, uniform assumption about access rights across all of them.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: the legal status diversity of clients is recognised.

GUIDANCE

Clients may have different legal status, and that status affects their access to care. The service recognises this diversity and explains how it supports clients whose status affects access.

Status is not a condition of care.

> **Good practice.** The service can name the legal status diversity of its clients and explains how it supports clients whose status affects their access to care.

> **Partial because.** The legal status of clients is not recorded, and the service cannot say how status affects access.

WHAT GOOD LOOKS LIKE

- The service records the legal status mix of its clients each year, and reports how access is supported.

COMMON MISTAKES

- Legal status not recorded at all.
- A client refused care because of status.

> **Why it matters.** Clients may be asylum seekers, refugees, stateless people or migrants, with different rights to care. The service needs to know which groups it serves so the right care is given.

WHAT THE ASSESSOR CHECKS

Sample. Review the client records for legal status categories and the rights guidance used.

1 The service names the legal status categories of its clients.

Method. Check the guidance for the categories named.

Evidence to show. Migration-informed, trauma-aware care (HMG-POL-001).

Pass when. The guidance names the categories.

2 Access rights are not assumed uniform.

Method. Check the staff guidance for the different rights.

Evidence to show. Interpreter and mediator use (PTR-SOP-010).

Pass when. The guidance states the different rights.

3 Staff know the rights for each category.

Method. Check the training record for the rights training.

Evidence to show. Migration-informed, trauma-aware care (HMG-POL-001).

Pass when. Staff training covers each category.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A stateless client turned away because staff did not know their rights. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HMG-POL-001	Migration-informed, trauma-aware care	Chief executive	Governing body members	Chief executive
PTR-SOP-010	Interpreter and mediator use	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Migration-informed, trauma-aware care	— Medium

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- Convention relating to the Status of Stateless Persons (UNHCR, 1954 (adopted 28 September 1954)) https://www.unhcr.org/uk/sites/uk/files/legacy-pdf/3bbb25729.pdf

24.43 Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Care is provided and fully documented for every client regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to a client without documented status.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: care is documented and provided to clients regardless of immigration or legal status.

GUIDANCE

Care is documented and provided to every client, whatever their legal status. A client is never asked about status as a condition of receiving care.

Documentation does not depend on status.

> **Good practice.** Care is documented and provided to every client regardless of immigration or legal status, and a client is never asked about status as a condition of care.

> **Partial because.** Care documentation or access depends on immigration status.

WHAT GOOD LOOKS LIKE

- Each visit record is completed in the same way for every client, whatever their status, and no document asks for status to start care.

COMMON MISTAKES

- A client asked for papers before a visit.
- Records that are incomplete for clients without documents.

> **Why it matters.** Care must be given to every client, whatever their immigration status. Documenting it fully protects the client and the caregiver who gave it.

WHAT THE ASSESSOR CHECKS

Sample. Review the care and documentation records for 10 clients, regardless of status.

1 Care is provided regardless of immigration status.

Method. Check each sampled client for care delivered.

Evidence to show. Non-Discrimination and Equal Access to Care (CON-POL-002).

Pass when. Every sampled client receives care.

2 Documentation is the same for every client.

Method. Compare the documentation across status groups.

Evidence to show. Migration-informed, trauma-aware care (HMG-POL-001).

Pass when. Documentation does not differ by status.

3 No lesser standard applies to undocumented clients.

Method. Check the referral and refusal records for status-based refusal.

Evidence to show. Non-Discrimination and Equal Access to Care (CON-POL-002).

Pass when. No referral or refusal is status-based.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A client refused home care because they had no papers. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CON-POL-002	Non-Discrimination and Equal Access to Care	Chief executive	Governing body members	Chief executive
HMG-POL-001	Migration-informed, trauma-aware care	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Non-Discrimination and Equal Access to Care	— Must

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- Promoting the health of refugees and migrants: resolution, Seventieth World Health Assembly (World Health Organization, 2017, Geneva: WHO) https://www.who.int/publications/i/item/promoting-the-health-of-refugees-and-migrants

24.44 Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

Criterion. Staff reflective practice and bias awareness extends to how immigrant caregivers themselves are treated by the organisation, clients, and families — not limited to awareness of bias toward migrant clients alone.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: staff reflective practice and bias awareness extend to how immigrant caregivers are treated.

GUIDANCE

Bias can shape how immigrant caregivers are supervised, rewarded and treated. Reflective practice sessions include this, are recorded and are followed up.

The follow-up is recorded.

Good practice. Reflective practice and bias awareness include how immigrant caregivers are treated, and the sessions are recorded and followed up.

Partial because. Bias awareness training does not cover how immigrant caregivers are treated.

WHAT GOOD LOOKS LIKE

- Reflective practice sessions include bias awareness, and one session each year covers how immigrant caregivers are supervised and rewarded.

COMMON MISTAKES

- A supervisor who treats immigrant caregivers differently in rota decisions.
- Bias training that does not mention immigrant staff.

Why it matters. Bias can shape how staff treat immigrant caregivers as well as clients. Reflective practice that covers both keeps the workforce and the care fair.

WHAT THE ASSESSOR CHECKS

Sample. Review the staff reflective practice records and the rota allocation for immigrant caregivers.

1 Reflective practice covers how immigrant caregivers are treated.

Method. Check the reflective practice agenda for caregiver treatment.

Evidence to show. Speak-up policy (WRK-POL-005).

Pass when. The agenda covers caregiver treatment.

2 Hardest rounds are not given on origin.

Method. Check the rota for the allocation of difficult rounds.

Evidence to show. Workforce equity monitoring (WRK-SOP-009).

Pass when. Allocation shows no origin-based pattern.

3 Caregivers can raise concerns without retaliation.

Method. Check the speak-up records for protection from retaliation.

Evidence to show. Concern handling and protection from retaliation (WRK-SOP-010).

Pass when. Concerns are raised and protected.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Immigrant caregivers given the hardest rounds without reason. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
WRK-POL-005	Speak-up policy	Chief executive	Governing body members	Chief executive
WRK-SOP-009	Workforce equity monitoring	Manager	Chief executive	Chief executive
WRK-SOP-010	Concern handling and protection from retaliation	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Speak-up policy	— Medium
Manager (ISCO 1342)	Checks the criterion at each review	— Medium

REFERENCES FOR THIS CRITERION

- Promoting the health of refugees and migrants: resolution, Seventieth World Health Assembly (World Health Organization, 2017, Geneva: WHO) https://www.who.int/publications/i/item/promoting-the-health-of-refugees-and-migrants

24.45 Continuity Across a Client's Relocation Is Actively Supported

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** When a migrant or refugee client relocates, the service actively supports continuity of care — a portable, client-held summary of care needs, active handover where a new provider is known — not treating relocation as an automatic, unavoidable end to the caregiving relationship's accumulated understanding of the client.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: continuity across a client's relocation is actively supported.

GUIDANCE

When a client relocates, the care plan, the records and the caregiver move with them where possible. The transfer is recorded, so that the new service can continue the care.

The client is involved in the move.

> **Good practice.** When a client relocates, the service supports continuity by transferring the care plan, the records and the caregiver where possible, and the transfer is recorded.

> **Partial because.** A client who moves is discharged without a transfer of the care plan or the records.

WHAT GOOD LOOKS LIKE

- The relocation transfer form lists the care plan, the records and the caregiver, and it is signed by the old and new services.

COMMON MISTAKES

- A client discharged with no transfer of records.
- A new service that is not told of the care needs.

> **Why it matters.** A migrant or refugee client who moves house must keep their care. Losing a caregiver and a service at a move can leave them without care for weeks.

WHAT THE ASSESSOR CHECKS

Sample. Review the relocation records for 10 clients who moved in the last 12 months.

1 A portable care summary is given to the client.

Method. Check each sampled relocation for the summary.

Evidence to show. Portable client care summary (HC-FRM-012).

Pass when. Every sampled relocation has a summary.

2 Active handover occurs where the new provider is known.

Method. Check each relocation for the handover record.

Evidence to show. Continuity of care when a client relocates (HC-SOP-013).

Pass when. Every known provider has a handover recorded.

3 Care continues after the move.

Method. Check each relocated client for care in place at the new address.

Evidence to show. Continuity of care when a client relocates (HC-SOP-013).

Pass when. No relocated client is left without care.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A refugee family moved across the city and left without care for a month. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HC-SOP-013	Continuity of care when a client relocates	Manager	Chief executive	Chief executive
HC-FRM-012	Portable client care summary	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Nurse (ISCO 2221)	Completes the Portable client care summary	— Medium
Manager (ISCO 1342)	Maintains the Continuity of care when a client relocates	— Medium

10 Questions and answers

Who does Standard 24 apply to?
It applies to home care. It is required by default in home care services, optional in hospitals, ambulatory clinics, primary health clinics and long-term care, and not applicable to telemedicine, fitness, dental or aesthetic clinics. Section 4 shows the detail.

What do the colours mean for this standard?
Red means Must, required in every setting. Yellow means Medium, required and adapted to what a setting can realistically do. Green means Minimum, the lowest acceptable level.

Does a hospital or clinic that does not provide home care need this standard?
No, unless it provides home care. If it offers home care, the criteria apply to that service.

Can a client refuse a caregiver?
Yes. A client can ask for a different caregiver at any time, and the request is handled under the replacement procedure (criterion 24.3).

Does a caregiver need a criminal record check?
Yes. Each caregiver's record is checked against a unique identifier, not a name search alone, and the check is repeated on a set schedule (criteria 24.6 and 24.9).

Must every caregiver be checked against registries in every country they have worked?
Yes, where a registry exists. Each country where the caregiver has worked is checked, not only the country of residence (criterion 24.7).

Does a criminal finding automatically stop a caregiver from working?
No. Each finding is assessed for its relevance to caregiving, its nature and its age (criterion 24.10).

Is a home visited before care begins?
Yes. A structured home safety assessment is completed before care begins, and a risk assessment of the home and household before the first visit (criteria 24.11 and 24.21).

Can a caregiver give a client's medicines?
Only where trained. Medication reminders can be given by a non-clinical caregiver. Administration needs clinical training and supervision (criterion 24.16).

What happens when a dose is missed?
The missed or uncertain dose is followed up, and the incident is recorded under the incident policy (criterion 24.20).

Do supervisory visits have to be in person?
Yes. Supervisory visits take place at the home, on the schedule set. A phone check-in is not counted as a supervisory visit (criterion 24.26).

When only personal care is given, what does the supervisor do?
The supervisory visit includes observing the caregiver providing care, with the caregiver present (criterion 24.27).

Can a caregiver who works alone signal for help?
Yes. The caregiver has a discreet way to signal distress without alerting anyone in the home (criterion 24.23).

Does a caregiver's work authorisation change affect their job?
The service gives transition time and support when a caregiver's authorisation changes, and does not apply a different standard by legal status (criteria 24.40 and 24.43).

Must care be documented for every client regardless of legal status?
Yes. Care is provided and fully documented for every client, whatever their immigration or legal status (criterion 24.43).

Does this standard set requirements for AI?
No. None of its criteria sets a requirement for artificial intelligence. The criteria cover the people, homes and records directly.

Which e-learning courses are required?
Most of the criteria require the manager and nurse to complete the course named for them. Caregiver Safety in an Uncontrolled Environment (HC-05) covers criteria 24.21 to 24.23. The full list is in the e-learning table in section 9.

What does In development mean?
The course is named in the criteria and may still be in preparation. Where a course is published, the English or Georgian version is linked.

Who is responsible for each criterion?
The criteria assign responsibility to the chief executive, the manager, the nurse and the secretary. Each record should show who wrote and who reviewed it.

Are the e-learning courses compulsory?
Only the courses in the e-learning table marked as must take are required, for the roles named. Other courses are recommended.

How is evidence shown to the surveyor?
The records named in each criterion's documents table, covering the period stated in the criterion.

Do I have to use the forms on this page?
No. They are reference drafts. Adapt them, write your own, or upload your own, provided the same criterion is met and the evidence can be shown.

The criterion text is the authority. Do these answers replace it?
No. These answers summarise the criterion. The criterion text is the authority.

The criterion text is the authority. These answers summarise it.

11 E-learning by standard

These are the GMJ Academy courses named in the criteria of this standard. Each course name opens the course page in the academy. Where a course is published in English and in Georgian, both versions are linked. Two courses are published in Georgian only. Evidence of training may be a verified micro-credential in the GMJ Academy micro-credential portfolio, or a training certificate kept in the staff file.

Course	Essential for	Recommended for	Criteria	GMJ Academy course page
Client Rights & Dignity in the Home Setting (HC-01) (HC-01-EN)	Manager, Nurse	None	24.1, 24.2, 24.3, 24.5, 24.38	English · Georgian
Governance & Staffing for Home-Based Care (HC-07) (HC-07-EN)	Manager, Nurse	None	24.4, 24.10, 24.26, 24.27, 24.28, 24.29, 24.31, 24.32, 24.33, 24.39, 24.40	English · Georgian
Credentialing, Competence and the Training Matrix (T-14) (T-14-EN)	Manager, Nurse	None	24.6, 24.7, 24.8, 24.9, 24.30	English · Georgian
Home Environment Safety Assessment (HC-03) (HC-03-KA)	Manager, Nurse	None	24.11, 24.12, 24.14, 24.15	Georgian Georgian version only
Slip, Trip & Fall Prevention (FALL-01) (FALL-01-KA)	Manager, Nurse	None	24.13	Georgian Georgian version only
Medication Safety: Operating SOP-MED-01 End to End (T-08) (T-08-EN)	Manager, Nurse	None	24.16, 24.17, 24.18, 24.19, 24.20	English · Georgian
Caregiver Safety in an Uncontrolled Environment (HC-05) (HC-05-EN)	Manager, Nurse	None	24.21, 24.22, 24.23, 24.24, 24.34	English · Georgian
Incident Reporting, Just Culture and Open Disclosure (T-09) (T-09-EN)	Manager, Nurse	None	24.25, 24.35	English · Georgian
Refugee & Migrant Health — Endorsement Course (H-09) (H-09-EN)	Manager, Nurse	None	24.36, 24.37, 24.41, 24.42, 24.43, 24.44, 24.45	English · Georgian

12 References

CITED FOR CRITERIA

1. Global strategy and action plan on ageing and health (World Health Organization, 2017, Geneva: WHO) https://www.who.int/publications/i/item/9789241513500 (criterion 24.1)
2. 42 CFR 484.50 Condition of participation: Patient rights (US Centers for Medicare & Medicaid Services (eCFR), current CFR text) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.50 (criterion 24.2)
3. A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report (World Health Organization (with Universite de Geneve), 2008) https://extranet.who.int/agefriendlyworld/wp-content/uploads/2014/06/WHO-A-Global-Response-to-Elder-Abuse-and-Neglect-Building-Primary-Health-Care-Capacity-to-Deal-with-the-Problem-Worldwide.pdf (criterion 24.5)
4. DBS checks: detailed guidance (UK Disclosure and Barring Service (GOV.UK), 2026 (page updated 2 July 2026)) https://gov.uk/government/collections/dbs-checking-service-guidance--2. (criterion 24.6)
5. Background Information and Exclusion Authorities (List of Excluded Individuals/Entities) (US HHS Office of Inspector General, not stated on page) https://oig.hhs.gov/exclusions/background/ (criterion 24.8)
6. Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions under Title VII (US Equal Employment Opportunity Commission, 2012) https://www.eeoc.gov/laws/guidance/enforcement-guidance-consideration-arrest-and-conviction-records-employment-decisions (criterion 24.10)
7. WHO (2024). Infection prevention and control and water, sanitation and hygiene measures for home care and isolation for mpox in resource-limited settings: interim operational guide. Used for: Infection prevention, WASH and home care for mild mpox cases: home environment assessment and caregiver measures. https://news.gmj.ge/guideline/infection-prevention-and-control-and-water-sanitation-and-hygiene-measures-for-home-care-and-isolation-for-mpox-in-resource-limited-settings-interim-operational-guide/ (criterion 24.11, 24.21)
8. WHO (2021). Step Safely: Strategies for Preventing and Managing Falls Across the Life-Course. Used for: Step Safely: home environment hazards and falls prevention across the life course. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/ (criterion 24.11, 24.12, 24.13, 24.14)
9. WHO (2020). Medication safety in transitions of care. Used for: Medication safety in transitions of care: medication lists, reconciliation and review after a change. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/ (criterion 24.16, 24.17, 24.18, 24.20)
10. World Health Organization. Medication Without Harm: Global Patient Safety Challenge on Medication Safety. Geneva: WHO; 2017. Used for: https://news.gmj.ge/guideline/medication-without-harm-global-patient-safety-challenge-on-medication-safety/ (criterion 24.16, 24.17, 24.18, 24.19, 24.20)
11. World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/ (criterion 24.16, 24.17, 24.18, 24.19, 24.20)
12. WHO (2022). Caring for those who care: Guide for the development and implementation of occupational health and safety programmes for health workers. Used for: Occupational health and safety for health workers, including violence prevention and staff wellbeing. https://news.gmj.ge/guideline/caring-for-those-who-care-guide-for-the-development-and-implementation-of-occupational-health-and-safety-programmes-for-health-workers/ (criterion 24.22, 24.23, 24.34)
13. Guidance on Managing the Risk of Lone Working in the Health and Social Care Sector (Health and Safety Authority, Ireland, not stated on page) https://hsa.ie/eng/publications_and_forms/publications/health_and_social_care_sector/guidance_on_managing_the_risk_of_lone_working_in_the_health_and_social_care (criterion 24.24)
14. WHO (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Used for: Global Patient Safety Action Plan: incident and near-miss reporting, learning systems. https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/ (criterion 24.25, 24.35)
15. 42 CFR 484.80 Condition of participation: Home health aide services (US Centers for Medicare & Medicaid Services (text via Cornell LII), current CFR text) https://www.law.cornell.edu/cfr/text/42/484.80 (criterion 24.26, 24.27, 24.30)
16. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (US Substance Abuse and Mental Health Services Administration (summary on youth.gov), not stated on page) https://youth.gov/feature-article/samhsas-concept-trauma-and-guidance-trauma-informed-approach (criterion 24.36)
17. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) (US HHS Office of Minority Health, not stated on page) https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLAS_Standards.pdf (criterion 24.37, 24.38)
18. Report III (1B): Migrant Workers, International Labour Conference 87th Session (International Labour Organization, 1999) https://webapps.ilo.org/public/english/standards/relm/ilc/ilc87/r3-1b2.htm (criterion 24.39)
19. WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organization, 2010, Geneva: WHO) https://www.who.int/publications/i/item/wha6316 (criterion 24.41)
20. Convention relating to the Status of Stateless Persons (UNHCR, 1954 (adopted 28 September 1954)) https://www.unhcr.org/uk/sites/uk/files/legacy-pdf/3bbb25729.pdf (criterion 24.42)
21. Promoting the health of refugees and migrants: resolution, Seventieth World Health Assembly (World Health Organization, 2017, Geneva: WHO) https://www.who.int/publications/i/item/promoting-the-health-of-refugees-and-migrants (criterion 24.43, 24.44)

INTERNATIONAL STANDARDS CITED

1. International Labour Organization (2008). International Standard Classification of Occupations, ISCO-08. Geneva: ILO.

13 Document register

Every document code used in Standard 24, with its type and the criteria that use it. The codes identify the documents; a facility may use its own document if it meets the same criterion.

Code	Document	Type	What it is for	Criteria
CLN-FRM-003	Individual care plan	Form (record)		24.1, 24.29, 24.37
CLN-SOP-002	Individualised care planning	Procedure (SOP)		24.29
CON-POL-002	Non-Discrimination and Equal Access to Care	Policy		24.38, 24.39, 24.43
GOV-FRM-003	Governing Body Minutes Template	Form (record)		24.25
HC-FRM-001	Statement of rights acknowledgement	Form (record)		24.2
HC-FRM-002	Caregiver replacement request record	Form (record)		24.3
HC-FRM-003	Client contact and out-of-hours access record	Form (record)		24.4
HC-FRM-004	Independent check-in record	Form (record)		24.5
HC-FRM-005	Caregiver screening record	Form (record)		24.6, 24.7, 24.8, 24.9, 24.10
HC-FRM-006	Home safety assessment record	Form (record)		24.11, 24.14
HC-FRM-007	Emergency access arrangement record	Form (record)		24.15
HC-FRM-008	Shared medication list	Form (record)		24.17, 24.18
HC-FRM-009	Pre-visit home risk assessment	Form (record)		24.21, 24.24, 24.25
HC-FRM-010	Supervisory visit record	Form (record)		24.26, 24.27, 24.28
HC-FRM-011	First 100 days check-in record	Form (record)		24.33
HC-FRM-012	Portable client care summary	Form (record)		24.45
HC-PLN-001	Solo caregiver coverage plan	Plan		24.31
HC-POL-001	The client's home and household routines	Policy		24.1, 24.38
HC-POL-002	Individualised assessment of criminal history findings	Policy		24.10
HC-POL-003	Medication reminders and administration in the home	Policy		24.16
HC-POL-004	Caregiver safety in private homes	Policy		24.21, 24.22, 24.24
HC-POL-005	Caregiver safety and distress signalling	Policy		24.23
HC-REG-001	Home hazard remediation register	Register		24.12
HC-REG-003	Caregiver continuity register	Register		24.32
HC-SOP-001	Caregiver replacement request	Procedure (SOP)		24.3
HC-SOP-002	Independent check-ins for abuse and neglect	Procedure (SOP)		24.5
HC-SOP-003	Caregiver background screening, registries and recheck	Procedure (SOP)		24.6, 24.7, 24.8, 24.9
HC-SOP-004	Home environment safety assessment and remediation	Procedure (SOP)		24.11, 24.14
HC-SOP-005	Medication changes, transitions and missed doses	Procedure (SOP)		24.18, 24.20
HC-SOP-006	Medicines in multi-person households	Procedure (SOP)		24.19
HC-SOP-007	Lone-worker check-in and discreet distress signal	Procedure (SOP)		24.34

Code	Document	Type	What it is for	Criteria
HC-SOP-008	Supervisory visits in the home	Procedure (SOP)		24.26, 24.27
HC-SOP-009	Coverage for a solo caregiver's absence	Procedure (SOP)		24.31
HC-SOP-010	New caregiver support in the first 100 days	Procedure (SOP)		24.33
HC-SOP-011	Incident reporting for delayed discovery in the home	Procedure (SOP)		24.35
HC-SOP-012	Caregiver work authorisation change: transition support	Procedure (SOP)		24.40
HC-SOP-013	Continuity of care when a client relocates	Procedure (SOP)		24.45
HMG-FRM-001	Migration history and trauma-aware assessment record	Form (record)		24.36
HMG-POL-001	Migration-informed, trauma-aware care	Policy		24.36, 24.42, 24.43
INC-POL-001	Incident reporting and management	Policy		24.5, 24.16, 24.20, 24.25
INC-SOP-001	(name to be confirmed)	Procedure (SOP)		24.35
MOB-FRM-004	(name to be confirmed)	Form (record)		24.23
MOB-SOP-002	(name to be confirmed)	Procedure (SOP)		24.34
PHM-FRM-002	(name to be confirmed)	Form (record)		24.19
PSF-FRM-001	Falls Log	Form (record)		24.13
PSF-FRM-002	Falls Risk Assessment Tool	Form (record)		24.13
PSF-SOP-001	Falls Risk Assessment and Prevention	Procedure (SOP)		24.13
PTR-SOP-010	Interpreter and mediator use	Procedure (SOP)		24.37, 24.42
STF-FRM-001	(name to be confirmed)	Form (record)		24.6
STF-SOP-001	Staff credential verification and recheck	Procedure (SOP)		24.39
WRK-FRM-001	Competency assessment form by role	Form (record)		24.30
WRK-FRM-003	Violence and aggression incident record	Form (record)		24.22
WRK-POL-005	Speak-up policy	Policy		24.44
WRK-REG-003	Workforce equity register	Register		24.41
WRK-SOP-001	Annual competency assessment procedure	Procedure (SOP)		24.30
WRK-SOP-006	Violence and aggression prevention and response	Procedure (SOP)		24.22
WRK-SOP-009	Workforce equity monitoring	Procedure (SOP)		24.41, 24.44
WRK-SOP-010	Concern handling and protection from retaliation	Procedure (SOP)		24.44