Procedure · HC-SOP-002 · Version 1.0 · Approved by the ASF Expert Committee

Supports: 29.5

At a glance

- Each client is checked on by someone independent of the caregiver on a set schedule (HC-FRM-004).
- The check covers physical, verbal, emotional and sexual abuse, and neglect.
- A concern is reported the same day under the incident policy (INC-POL-001).
- The client is asked privately.
- Stop and get help straight away if: a client is neglected for weeks and no one notices.

1. Purpose

To check actively that clients are free from abuse and neglect (29.5).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of the facility
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions

Term	Meaning
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background

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.

5. Responsibilities

Role	Responsibility	Competence
Home care service lead	Owns the check-in schedule	Clinician or manager
Supervisor	Carries out the check-in	Clinician

6. Materials and equipment

Item	Requirement	Condition
Records and forms named in this document	Current version	Checked before use

7. Safety

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Step 1. Schedule.

- Schedule an independent check-in for each client on the set interval.

Key point: Scheduled.

Step 2. Check privately.

- Ask the client privately about abuse, neglect and their care.

Key point: Asked.

Step 3. Report.

- Report any concern the same day, and record it on HC-FRM-004.

Key point: Reported.

10. Decision points

- No decision points in this procedure.

11. Special situations

Situation	Action
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

12. Escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Clients with an independent check-in on schedule	100%	Monthly	Home care service lead	Escalate to medical director

14. Records

Record	Kept in	Retention
Record named in this document	Patient record or the area file	the period set by the facility’s records policy years

15. Training

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

16. Related documents

ID	Title	Use
HC-FRM-004	Independent check-in record	Record
INC-POL-001	Incident reporting and management (existing, reused)	Policy

17. Evidence

Reference	Note
E-009	Based on the WHO Global strategy and action plan on ageing and health 2016-2030, WHO Integrated care for older people (ICOPE) guidelines (2017), and WHO guidance on migrant health.
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

E-learning for this document

- **Client Rights & Dignity in the Home Setting** (HC-01)

References

- Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)
- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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