Service Standards

Home Care and Support Services

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

Definition

Home Care and Support Services provide individuals with assistance and care so they can live safely at home independently or with caregivers. Individuals may need and choose from an array of care provider services and support that can include:

1. personal care aide services such as supervised, basic activities of daily living; monitoring of self-administered medication; assistance with activities and care needs required to live at home safely; routine exercise, safe lifting, and healthy movement routines to maintain ambulation; and education and interventions to prevent falls, injuries, health decline and to maintain independent functioning; and
2. homemaker services such as housekeeping, meal preparation and food safety, transportation, grocery shopping, monitoring of self-conducted household management tasks, monitoring of self-administered medications, and other instrumental activities of daily living.

Note:*For the purposes of these standards, "caregiver" refers to friends, family, and other non-professional supports. "Care provider" refers to direct-care personnel providing in-home services.*

Note:*The Home Care standards are consistent with services known in the field as professional-agency, which include a prominent client-centered philosophy and worker training and support components, as compared to services with a self-directed orientation. The latter approach is being instituted in some states to place responsibility for obtaining services and payment directly with clients and caregivers.*

Note:*Please see HCS Reference List for the research that informed the development of these standards.*

Note:*For information about changes made in the 2020 Edition, please see the HCS Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Home Care and Support Services

HCS 1: Person-Centered Logic Model

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Note: *Please see the Logic Model Template for additional guidance on this standard.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one client outcome has been identified for all of its programs; or
- All but a few staff have been trained on use of therapeutic interventions and training is scheduled for the rest; or
- With few exceptions the policy on prohibited interventions is understood by staff, or the written policy needs minor clarification.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs; or
- Several staff have not been trained on the use of therapeutic interventions; or
- There are gaps in monitoring of therapeutic interventions, as required; or
- There is no process for identifying risks associated with use of therapeutic interventions; or
- Policy on prohibited interventions does not include at least one of the required elements.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs; or
- There is no written policy or procedures for the use of therapeutic interventions; or
- Procedures are clearly inadequate or not being used; or
- Documentation on therapeutic interventions is routinely incomplete and/or missing; or
- There is evidence that clients have been harmed by inappropriate or unmonitored use of therapeutic interventions.

Table of Evidence

Self Study Evidence

*	• Program logic model that includes a list of outcomes being measured	

- See program description completed during intake

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel

HCS 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in persons served); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to:*

1. *needs assessments and periodic reassessments; and*
2. *the best available evidence of service effectiveness.*

HCS 1.02

The logic model identifies client outcomes in at least two of the following areas:

a. change in functional status;
b. health, welfare, and safety;
c. quality of life;
d. achievement of individual service goals; and
e. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Home Care and Support Services

HCS 2: Personnel

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

Program personnel have the competency and support needed to provide services and meet the needs of persons served.
Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	

*	• Procedures for providing in-home supervision	
*	• Procedures or other documentation relevant to continuity of care and case assignment	

*	• List of program personnel that includes:
	  • Title
	  • Name
	  • Employee, volunteer, or independent contractor
	  • Degree or other qualifications
	  • Time in current position
	• See organizational chart submitted during application	

*	• Health evaluation procedures	

Site Visit Evidence

*	• Sample job descriptions from across relevant job categories • Training curricula • Documentation tracking staff completion of required trainings and/or competencies • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker • Supervisor coverage schedules for the previous six months

On-Site Activities

*	• Interviews may include:
	  1. Program director
	  2. Relevant personnel
	• Review personnel files

HCS 2.01

Care providers meet state requirements, and have the competency needed to:

a. provide services to the population served;
b. read, understand, and carry out written and verbal care plan directions;
c. exercise good judgment and tact in responding to an individual's suggestions and preferences;
d. work as a member of a care team including contributing observations and recommendations at care plan conferences or to supervisors;
e. meet the training requirements for the position and services performed; and
f. work in a client-centered service delivery environment.

Examples: *State law may specify minimum age or education requirements, mandatory criminal background checks and fingerprinting, and grounds for disqualification for employment related to prior experience working with vulnerable populations. Additionally, state requirements for these positions may include passing a written examination. In some states, these occupations are open to individuals with no formal training, and on the job training is usually provided.*

HCS 2.02

Personnel who conduct screening, level of care assessments and periodic re-assessments, care management and coordination, and supervision of care providers are qualified by:

a. a bachelor's degree in a related human services field or licensure as a registered nurse;

b. a minimum of two years of experience working with the service population;?and
c. demonstrated competence providing care decisions for in-home service delivery.

HCS 2.03

Supervisors of care providers also have:

a. formal training in supervision; and/or
b. on-the-job supervisory training for the first three months of service as a supervisor.

HCS 2.04

All care providers are trained on, or demonstrate competency in:

a. maintaining a clean, safe, and healthy home environment;
b. reading and recording vital signs;
c. supporting self administration of medication in accordance with organization procedures, when applicable;
d. communicating client information, needs, and status;
e. observing and documenting client status and care or service provided;
f. following universal precautions and basic infection control procedures;
g. adapting to a range of in-home care circumstances; and
h. providing aid with activities of daily living.

Interpretation: *Elements b and f apply to personal care aides only.*

Interpretation: *Assistance with self-administered medications has a high possibility for error, representing a risk for the client and the organization. As such, personnel should have the competency needed to provide an appropriate level of assistance with self-administered medication when they will be assisting with that task.*

HCS 2.05 (FP)

Personal care aides have received first aid and age-appropriate CPR training in the previous two years that included an in-person, hands-on CPR skills assessment conducted by a certified CPR instructor.

NA: The organization provides homemaker services only.

HCS 2.06

Individuals providing personal care aide services receive a minimum of 40 hours of training instruction.
NA: The organization provides homemaker services only.

Interpretation: *Training hours do not need to be completed before the care provider begins providing services.*

HCS 2.07

Individuals providing homemaker services receive a minimum of 8 hours of training instruction.
NA: The organization provides personal care aide services only.

Interpretation: *Training hours do not need to be completed before the care provider begins providing services.*

HCS 2.08

All care providers receive continuing in-service education following completion of initial training requirements to ensure personnel are confident in their ability to provide quality support and assistance.

HCS 2.09

Employee workloads support the achievement of client outcomes and are regularly reviewed.
Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications and competencies of care providers and supervisors;*
2. *case complexity;*
3. *case status and progress toward achievement of desired outcomes;*
4. *length and strength of the worker-client relationship;*
5. *whether services are provided by multiple providers;*
6. *ability of care providers to meet the individual's or family's needs; and*
7. *relevant cultural and religious factors.*

HCS 2.10

Care providers have access to a supervisor or other professional at all times while on duty, and have the support of a supervisor who visits the individual's home.
Note: *See HCS 7.01 for timeframes for supervisory home visits.*

HCS 2.11

The organization minimizes the number of workers assigned to the individual over the course of their contact with the organization by:

a. assigning a worker at intake or early in the contact; and
b. avoiding the arbitrary or indiscriminate reassignment of care providers.

HCS 2.12 (FP)

Prior to providing personal care aide services, care providers receive a health evaluation to determine their ability to perform the essential functions of the job, with or without reasonable accommodation.
NA: The organization provides homemaker services only.

Examples: *Evaluating the ability of personnel to perform the essential functions of the job may include checking that the individual is capable of lifting 50 pounds and climbing stairs.*

Home Care and Support Services

HCS 3: Requirements for Personnel Who Provide Services to Individuals with Special Need

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

Program personnel have the competency and support needed to meet the needs of older adults and other special needs populations.
NA: The organization does not serve individuals with special needs.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	

Site Visit Evidence

*	• Sample job descriptions from across relevant job categories • Training curricula • Documentation tracking staff completion of required trainings and/or competencies

On-Site Activities

*	• Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

HCS 3.01

Personnel who provide assessment, care management, and supervision of care for individuals with serious mental health conditions and complicated medical conditions:

a. are qualified by an advanced degree in an appropriate human service field and a minimum of two years supervisory experience in direct services, or case management; or
b. have a bachelor's degree and an equivalent number of years supervisory experience and demonstrated skills providing level of care decisions for in-home service delivery.

NA: The organization does not provide services to individuals with serious mental health conditions and complicated medical conditions.

HCS 3.02

Personnel who work with individuals with special needs are trained on, or demonstrate competency in:

a. attending to the physical, mental, social, economic, and emotional needs of the service population;
b. recognizing problems and responding to impending emergencies or crises; and
c. providing preventive and supportive services to ensure maximum participation and self-determination.

Examples: *Individuals with special needs can include individuals with HIV/AIDS, Alzheimer's disease, developmental disabilities, youth and families, etc. As such, the special needs of populations will vary, and training can be tailored to address the specific needs of the identified population.*

Home Care and Support Services

HCS 4: Access to Services

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

The organization works with other providers to build community awareness of potential recipients of home care and support so services can be accessed, as needed.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*

- Tool(s) for conducting preliminary needs evaluations with prospective service recipients and their caregivers

Site Visit Evidence

*

- Sample information for caregivers distributed in the community

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

HCS 4.01

The organization increases the availability of information for caregivers by distributing information about available services and supports at locations throughout the community.
Examples: *Information about how to obtain services or a referral may be provided at local health facilities, recreation centers, community bulletin boards, town halls, and community-based social service organizations.*

HCS 4.02

Staff who serve as a gateway to services evaluate:

a. the extent and kind of services an individual needs and wants; and
b. the strengths and capabilities of caregivers, including unidentified quality of life concerns related to care giving demands.

HCS 4.03

Individuals receive timely information about institutional care when caregivers can no longer manage an unsafe, unhealthy, or stressful home situation.

Home Care and Support Services

HCS 5: Intake

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

The organization's intake practices ensure that individuals receive prompt and responsive access to appropriate services.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	

Site Visit Evidence

*	• Job descriptions for personnel responsible for critical care decision making

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

HCS 5.01

Individuals are screened, and workers use discussion and written material to promote understanding of:

a. how well their request matches the organization's services; and
b. what services will be available and when.

NA: Another organization is responsible for screening, as defined in a contract.

HCS 5.02

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. give priority to urgent needs and emergency situations;
c. clarify needs and preferences including the choice to execute an advance directive;
d. support timely initiation of services; and
e. provide for placement on a waiting list or referral to appropriate resource when individuals cannot be served or cannot be served promptly.

HCS 5.03

Critical care decision-making is carried out by, or under the direct supervision of, experienced and/or licensed personnel.

Home Care and Support Services

HCS 6: Assessment-Based Care Planning and Coordination

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

Individuals and caregivers participate in an assessment, which serves as the basis for a care plan that promotes independent functioning at home and in the community.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessment are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Assessment procedures	
*	• Copy of assessment tool(s) including caregiver assessment tool	
*	• Care planning procedures	

*	• Procedures that address health and safety issues unique to in-home care and service delivery	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Persons served
- Review case records

HCS 6.01 (FP)

Individuals and caregivers participate in individualized, culturally and linguistically responsive assessments that are:

a. completed within established timeframes;
b. focused on information pertinent for meeting service requests and objectives; and
c. supplemented with information provided by collaborating providers, when appropriate.

Examples: *Additional sources of information may enhance assessments when appropriate; for example, physical and occupational therapy services may be involved to determine how to manage or prevent further decline.*

HCS 6.02

Assessments identify:

a. the individual's view of his or her current health and functioning;
b. baseline functional, mental, emotional, and physical status information including prescription medication use and recent or progressive functioning to confirm capacity, decline, or progress; and
c. a caregiver assessment including level of caregiver burden, caregiver health, choice in serving in the caregiver role, and presence of informal support.

Interpretation:*All care providers, including those who may not have responsibility for the comprehensive assessment and determination of appropriate level of care, should obtain, at a minimum, information regarding an individual's and/or family's special needs.*

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

HCS 6.03

Professional health and/or social service personnel work with the full participation of the individual and the care team to develop an assessment-based care plan that includes:

a. specific services to be delivered by the care provider; and
b. a plan for coordinating services with other providers including nurses, physicians, rehabilitative personnel, and mental health providers, as needed.

HCS 6.04

Professional health and/or social service personnel:

a. link interventions to service recipient goals;
b. assess service appropriateness;

c. approve service plans prior to implementation; and
d. assist the care provider with plan implementation, as necessary.

HCS 6.05

Prior to beginning services, professional health and/or social service personnel meet with the individual and his or her caregivers in the home to review:

a. the role of family members in caretaking and related needs;
b. any current concerns including household and community safety;
c. specific services to be provided by the care provider;
d. limits of services provided;
e. preferences and choices of service recipients that can affect service delivery;
f. information about advanced directives and crisis planning as appropriate; and
g. guidelines for resolving differences between service recipient and care providers, including the role of supervisors.

HCS 6.06 (FP)

The organization addresses health and safety related issues unique to in-home care and service delivery.
Examples: *Health and safety issues unique to in-home services include, for example:*

1. *off-site supervision;*
2. *safety of personnel while off site; and*
3. *timely communication and record keeping practices.*

Home Care and Support Services

HCS 7: Care Monitoring

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

Routine care monitoring ensures delivery of appropriate services.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Care monitoring procedures	
*	• Documentation procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served

- Review case records

HCS 7.01

Follow-up assessments are based on the physical and cognitive needs of the individual and are conducted by a nurse or other qualified professional:

a. in person at least every 30 days for cognitively impaired clients, or clients with other special needs;
b. in person at least every 60 days for clients who are not cognitively impaired and are receiving personal care aide services;
c. in person at least every 90 days for clients receiving homemaker services only; and
d. by phone, in addition to the in-person timeframes listed above, when needed.

Interpretation: *The organization is responsible for determining the necessary qualifications for staff conducting assessments.*

HCS 7.02 (FP)

Care providers:

a. document all interventions and how the person responds;
b. monitor and document changes in physical, mental, and emotional status and gains of the individual and their caregivers;
c. respect and note the individual's choices;
d. help individuals make independent choices or assume more responsibility for making decisions;
e. recognize service gaps and alert applicable service providers to unmet needs;
f. recognize emergency situations and follow procedures to ensure the safety and well being of care recipients; and
g. report on plan implementation and progress to a supervisor or case manager at least weekly.

HCS 7.03

The care provider and the individual or legal guardian, and his or her family when appropriate:

a. review progress toward achievement of agreed upon service goals; and
b. sign revisions to service goals and care plans.

Examples: *Reviews may also include other direct care providers and caregivers when possible and appropriate.*

HCS 7.04

The worker and a supervisor, or a clinical, service, or peer team review the case quarterly, or more frequently depending on the needs of the individual, to assess:

a. care plan implementation;
b. progress toward achieving service goals and desired outcomes; and
c. the continuing appropriateness of the agreed upon service goals.

Interpretation: *When experienced managers are conducting reviews of their own cases, the manager's supervisor must review a sample of the manager's evaluations as per the requirements of the standard.*

HCS 8: Coordinated Home Management, Activities of Daily Living, and Health Services

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

Sufficient community resources are drawn upon and frequently reviewed to provide each individual or family with:

a. a comprehensive package of services; and
b. a flexible approach to service delivery that meets their changing needs.

Examples: *A service "package" refers to the number and combination of different services, and volume of care. This perspective acknowledges that users of services are a diverse group who need a variety of services with varying combinations and frequencies.*

Examples: *Services provided directly or by a cooperating provider can include:*

1. *housekeeping tasks and home management activities and education;*
2. *companionship;*
3. *chores, safe food handling and storage, and nutritious meal preparation;*
4. *assistance with personal care;*
5. *monitoring of overall health and well-being including observing, reporting, and documenting changes in bodily function;*
6. *assistance with self-administered medications;*
7. *assistance or prompting with activities of daily living;*
8. *assistance with personalizing homes and purchasing personal necessities;*
9. *assistance with ambulation and transfer; and*
10. *assistance with accessing community activities, including access to transportation.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

No Self Study Evidence

Site Visit Evidence

*

- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

Home Care and Support Services

HCS 9: Case Closing and Aftercare

Purpose

Individuals who receive Home Care and Support Services obtain a maximum level of independence, functioning, and health, and extend the time it is possible to live safely at home and in the community.

The organization works with individuals and family members when appropriate, to plan for case closing and, when possible, to develop aftercare plans.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active client participation occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Case closing procedures	
*	• Aftercare planning and follow-up procedures	

Site Visit Evidence

*	• Relevant portions of contract with public authority, as applicable	

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Review case records

HCS 9.01

Planning for case closing:

a. is a clearly defined process that includes assignment of staff responsibility;
b. begins at intake; and
c. involves the care provider, persons served, and others as appropriate to the needs and wishes of the individual.

HCS 9.02

Upon case closing, the organization notifies any collaborating service providers, including the courts, as appropriate.

HCS 9.03

If an individual has to leave the program unexpectedly, the organization makes every effort to identify other service options and link the person with appropriate services.

Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to individuals whose third-party benefits are denied or have ended and who are in critical situations.*

HCS 9.04

When appropriate, the organization works with persons served and their family to:

a. develop an aftercare plan, sufficiently in advance of case closing, that identifies short- and long-term needs and goals and facilitates the initiation or continuation of needed supports and services; or
b. conduct a formal case closing evaluation, including an assessment of unmet need, when the organization has a contract with a public authority that does not include aftercare planning or follow-up.

NA: The organization has a mission and mandate that dictate the provision of early stage services only.

HCS 9.05

The organization follows up on the aftercare plan as appropriate, when possible, and with the permission of the individual.

NA:

- The organization has a mission and mandate that dictate the provision of early stage services only.
- The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.