*Service Standards*

# Respite Care

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

## Definition

Respite Care programs provide temporary relief to caregivers with responsibility for the care and supervision of adults or children who: have physical, emotional, developmental, cognitive, behavioral, or mental health disabilities; are at risk of abuse or neglect; or are in foster care.

Respite Care provides a supportive, enriching, and therapeutic environment in the caregiver's home, in the respite care provider's home, in a program facility, or in the community. Respite care providers can include employees, independent contractors, volunteers, and foster parents. Generally, care is provided for a few hours or days at a time. Services can be provided on a planned or as needed basis, including in response to a crisis.

Families experiencing medical emergencies and stressful home situations, such as domestic violence or homelessness, may request crisis nursery respite care. Crisis nursery and short-term residential respite services can extend to a few weeks or a month at a time. When services are provided in response to a crisis, the timeframes may be less predictable and dependent upon resolution of the crisis.

**Note:** *When an organization is completing the Family Foster Care and Kinship Care Services Standards (FKC) their respite program is covered under FKC 22: Respite Care unless they provide respite services for children and families outside of the family foster care/kinship care program. In this instance, the organization will also need to complete RC to capture all aspects of assessment, service planning, and coordination for these families.*

**Note:** *The term caregiver refers to the individual with responsibility for caring for an individual with specialized care needs as defined above, such as a parent, guardian, family member, or other responsible party. The term respite care provider refers to the paid or unpaid individual who is providing respite care either in a home or facility setting. The term care recipient refers to the individual receiving specialized care.*

**Note:** *Please see RC 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 RC Crosswalk.*

## Table of Evidence

### Self Study Evidence

*No Self Study Evidence*

Respite Care

# RC 1: Person-Centered Logic Model

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

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.,

- 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 desired outcome has been identified for all of its programs.

**3**

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

- 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.

**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.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Program logic model that includes a list of desired 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

## RC 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 individuals and families); 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 model includes, but is not limited to:*

1. *characteristics of persons served;*
2. *needs assessments and periodic reassessments;*
3. *risks assessments conducted for specific interventions; and*
4. *the best available evidence of service effectiveness.*

## RC 1.02

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

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals; and
g. 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.*

Respite Care

# RC 2: Personnel

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

Respite care providers and program personnel have the competency and support needed to provide services and meet the needs of individuals and families.

**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, 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; 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

| | | |
|---|---|---|
| * | • List of program personnel that includes:<br>  • Title<br>  • Name<br>  • Employee, volunteer, or independent contractor<br>  • Degree or other qualifications<br>  • Time in current position<br>• See organizational chart submitted during application | |
| * | • Table of contents of training curricula | |
| * | • Procedures for health evaluations | |

### Site Visit Evidence

| | |
|---|---|
| * | • Documentation tracking staff completion of required trainings and/or competencies<br>• Sample job descriptions from across relevant job categories<br>• Training curricula<br>• Caseload size requirements set by policy, regulation, or contract, when applicable<br>• Documentation of current caseload size per worker |

### On-Site Activities

| | |
|---|---|
| * | • Interviews may include:<br>  1. Program director<br>  2. Relevant personnel<br>• Review personnel files |

## RC 2.01

Supervisors are qualified by:

a. an advanced degree in social work or a comparable human service field with one year of relevant experience; or
b. a bachelor's degree in social work or a comparable human service field with two years of relevant experience.

**Interpretation:** *Demonstrated competence with appropriate experience and training can compensate for a lack of degree.*

## RC 2.02

Respite care providers are trained on or demonstrate competency in the following, as appropriate to the services provided:

a. assessing the need for additional services;
b. identification of changes in functioning;
c. identification of medical needs or problems;
d. use of adaptive equipment, such as braces and wheelchairs;
e. providing personal care, including lifting techniques;

f. promoting positive behavior and implementing appropriate behavior support techniques;
g. determining if a crisis situation is imminent and how to intervene using appropriate resources;
h. providing safe, non-discriminatory, and supportive care to an individual of a different race, ethnicity, culture, religion, sexual orientation, or gender identity; and
i. any other specialized care needs specific to persons served.

## RC 2.03

The organization provides opportunities for caregivers and care recipients, when appropriate, to participate in developing and administering training for respite care providers.

**Examples:** *Training may involve formal presentations and content development and/or individualized, in-home instruction.*

## RC 2.04 (FP)

There is at least one person on duty in each respite setting whenever care is being provided that has 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.

## RC 2.05 (FP)

Respite care providers that provide personal care or basic health services receive a health evaluation prior to providing care to determine their ability to perform the essential functions of the job, with or without reasonable accommodation.

**NA:** The program is not designed to serve individuals with personal care or health services needs.

**Interpretation:** *While a physical examination is preferred, personnel should receive a general health screening performed by a qualified medical practitioner, provided that the screening addresses communicable diseases.*

## RC 2.06

Respite care providers sign a statement agreeing to:

a. report suspected abuse and neglect;
b. employ appropriate behavior support techniques;
c. refrain from using physical and degrading punishment; and
d. ensure that others refrain from using physical and degrading punishment.

## RC 2.07 (FP)

Screening and selection procedures for respite care providers include:

a. completing a criminal record and abuse registry check for all adults living in the provider's home;
b. contacting references;
c. ensuring providers have relevant caregiving experience and specific knowledge or skills related to the persons served; and
d. allowing caregivers and care recipients to identify or select their respite care providers, when appropriate.

**Interpretation:** *When a finding of child or adult abuse, neglect, or exploitation is indicated, guidelines should be used to determine the appropriateness of provider responsibilities.*

**Interpretation:** *Background checks for other adults living in providers home only are required if respite care is delivered in the provider's home.*

## RC 2.08

Employee workloads support the achievement of positive outcomes and are regularly reviewed.

**Examples:** *Examples of factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of the worker, including the level of supervision needed;*
2. *the work and time required to accomplish assigned tasks and job responsibilities; and*
3. *service volume, accounting for assessed level of needs of persons served.*

Respite Care

# RC 3: Intake and Assessment

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

The organization ensures that caregivers and care recipients 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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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 | |
| * | • Assessment procedures | |
| * | • Copy of assessment tool(s) | |

**Site Visit Evidence**

| | |
|---|---|
| * | • Outreach strategies and informational materials<br>• Community resource and referral list |

**On-Site Activities**

| | |
|---|---|
| * | • Interviews may include:<br>1. Program director<br>2. Relevant personnel<br>3. Persons served<br><br>• Review case records |

## RC 3.01

The organization assesses the need for respite care in the community and collaborates with other providers to:

a. promote accessible and affordable respite care;
b. address and challenge any beliefs or stigmas that may discourage caregivers from seeking help; and
c. connect caregivers with respite care before they become overwhelmed with care-giving responsibilities.

**Examples:** *In regards to element (b), caregivers may believe that respite care providers are ill-equipped to care for their family members with complex care needs, or they may have feelings of guilt related to leaving their family member in the care of someone else. Discussing these concerns with caregivers can mitigate any barriers to receiving services.*

## RC 3.02

Caregivers and respite care providers are screened and informed about:

a. how the caregiver's request and the care recipient's needs match the organization's services;
b. the guidelines for eligibility and availability of services; and
c. what services will be available and when.

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

## RC 3.03 (FP)

Prompt, responsive intake practices:

a. ensure that individuals who reach out to the organization are treated equitably;
b. address any concerns and provide emotional support, as needed, regarding the use of respite care;
c. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
d. give priority to individuals with urgent needs and emergency situations;
e. support the timely initiation of services; and

f. provide placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

**Interpretation:** *When a crisis respite program is at full capacity and cannot provide services to a family, the organization should assist the family in developing a plan to provide safe care for the child or adult and refer the family to another appropriate emergency service provider.*

## RC 3.04

Caregivers and, when appropriate, care recipients and/or family members participate in an individualized, trauma-informed, culturally, and linguistically responsive assessment that is:

a. completed within established timeframes;
b. updated as needed based on the needs of persons served;
c. relationship-focused, allowing time to build rapport, answer questions, and acknowledge concerns; and
d. focused on information pertinent for meeting service requests and objectives.

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

**Examples:** *In regards to element (d), an assessment may focus on (1) understanding the caregiver's past experiences and level of satisfaction with respite care, and (2) discussing how caregivers can best utilize their respite time to meet their specific needs.*

Respite Care

# RC 4: Service Planning and Monitoring

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

Caregivers and, when appropriate, care recipients and/or family members, participate in the development and ongoing review of an individualized service plan that is the basis for delivery of appropriate services and support.

**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
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active participation of persons served 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
- Case reviews are not being done consistently; or
- Level of care for some persons served is clearly inappropriate; or
- Service planning is often done without the full participation of persons served; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

**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

| | |
|---|---|

| | | |
|---|---|---|
| * | • Service planning and monitoring 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

## RC 4.01

An individualized, family-centered, assessment-based service plan is developed in a timely manner with the full participation of the caregiver and care recipient and includes:

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. possibilities for maintaining and strengthening family relationships and other informal social networks;
d. procedures for expedited service planning when crisis or urgent need is identified;
e. guidelines for requesting additional planned or emergency respite care;
f. fees and payment arrangements, when applicable; and
g. documentation of the caregiver and care recipient's participation in service planning.

**Interpretation:** *In regards to element (b), caregiver preferences for the location, hours, activities, and other aspects of respite care delivery should be acknowledged and accommodated to the extent possible.*

**Examples:** *Assisting caregivers in setting specific goals for how they want to spend their respite time may increase caregivers' satisfaction with respite care.*

## RC 4.02

The organization works in active partnership with persons served to:

a. assume a service coordination role, as appropriate, when the need has been identified and no other organization has assumed that responsibility;
b. ensure that they receive appropriate advocacy support;
c. assist with access to the full array of services to which they are eligible; and
d. mediate barriers to services within the service delivery system, including transportation or fees.

**Examples:** *Examples of services referenced in (b) and (c) may include, but are not limited to: (1) support groups and counseling services; (2) physical and behavioral health services; (3) domestic violence services, (4) housing services; (5) financial assistance; (6) social, recreational, and day programs; and (7) mentor services.*

## RC 4.03

The worker and a supervisor, or a clinical, service, or peer team, review the case to assess:

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

**Interpretation:** *Experienced workers may conduct reviews of their own cases. In such cases, the worker's supervisor reviews a sample of the worker's evaluations as per the requirements of the standard.*

## RC 4.04

The worker, caregiver, and care recipients and/or family members when appropriate:

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

Respite Care

# RC 5: Care and Supervision

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

Care recipients receive individualized care and supervision that promote their safety and well-being.

**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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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

| | | |
|---|---|---|
| * | • Procedures for matching care recipients with respite care providers | |
| * | • Health and safety procedures | |
| * | • Care recipient/provider ratio | |
| | | |

| | | |
|---|---|---|
| * | • Procedures regarding care recipients' rights to make telephone calls | |

**Site Visit Evidence**

| | |
|---|---|
| * | • Most recent safety/risk data, if available<br>• Monthly care recipient/provider ratios and coverage schedules for the previous six months, as applicable |

**On-Site Activities**

| | |
|---|---|
| * | • Interviews may include:<br>1. Program director<br>2. Relevant personnel<br>3. Persons served<br><br>• Review case records<br>• Observe ratios and coverage at each unit or group, if applicable |

## RC 5.01 (FP)

Families are matched with respite care providers who can meet their needs or receive information to enable them to select a suitable respite provider.

**Interpretation:** *Care recipients who require therapeutic or medical treatment should be matched with a provider that has appropriate skills and qualifications.*

**Examples:** *Respite care programs can select providers that best meet the needs of caregivers and care recipients by matching families with providers who, for example: (1) speak the same primary language as the care recipients; (2) have personal or professional experience caring for individuals with similar needs as the care recipient; and (3) live in the same community as the family.*

## RC 5.02

The organization provides consistent and predictable care by:

a. assigning a respite care provider at intake or early in the contact; and
b. scheduling the same provider for each respite experience, to the extent that availability allows.

## RC 5.03 (FP)

Respite care providers are familiar with the care recipient’s daily routine, preferred foods and activities, and needed therapeutic or medical care.

**Examples:** *Organizations may use smartphone apps and other technologies to help caregivers and respite care providers: (1) share information on the care recipient's history, routines, medical needs, or other pertinent information, (2) monitor the care recipient’s health status, and (3) give feedback, share concerns, or communicate other preferences or needs.*

## RC 5.04

The program offers flexible activities with content appropriate to the interests, age, development, physical abilities, interpersonal characteristics, and special needs of the care recipient.

**Interpretation:** *When the care recipient is involved in regular therapeutic, educational, or employment activities, the respite provider should work with caregivers to plan for continued participation.*

## RC 5.05 (FP)

Crisis respite care provides needed developmentally- and age-appropriate interventions to help the care recipient cope with trauma or stress associated with the crisis.

**NA:** The organization does not provide crisis respite care.

## RC 5.06 (FP)

The program provides close supervision of care recipients to ensure safety and service quality, and provider-care recipient ratios do not exceed:

a. one to eight during waking hours;
b. one to twelve during sleeping hours; and
c. one to four during both waking and sleeping hours when children are under school age.

**Interpretation:** *Ratios should be adjusted to meet the special needs of individuals that require therapeutic or medical care, or close monitoring, and include all other children or adults being cared for in the home or facility. Ratios should demonstrate capacity for the safe evacuation of care recipients in case of an emergency.*

## RC 5.07 (FP)

When care recipients experience accidents, health problems, or changes in appearance or behavior, information is promptly recorded and reported to caregivers and administration, and follow-up occurs, as needed.

## RC 5.08

Care recipients can have private telephone conversations and any restrictions are:

a. requested by the caregiver;
b. approved in advance by the program director or an appropriate designee; and
c. documented in the case record.

**NA:** The organization only provides care for infants and young children.

## RC 5.09

Care recipients receiving overnight respite care have sufficient uninterrupted sleep and, when practical, follow their usual and familiar routines for bedtime, bathing, and meals.

**NA:** The organization does not provide overnight respite care.

## RC 5.10

Caregivers and other family members or relevant service providers have access to the care recipient while in care.

**Interpretation:** *The care recipient should be reachable by phone, text, video call, or in person visit as appropriate to the service setting and care needs.*

## RC 5.11 (FP)

Procedures for departure:

a. ensure that care recipients are returned to the caregiver or another person approved in writing by the caregiver; and
b. indicate how to respond using appropriate organization or community resources when a caregiver poses a safety risk, or an individual requires protection.

**Examples:** *Situations can include, for example, when caregivers or other individuals are intoxicated by drugs or alcohol, mentally or physically unstable, or present a safety concern.*

Respite Care

# RC 6: Service Environment

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

Respite care is provided in an environment that ensures the care recipient's health and safety.

**Note:** *Please see the Facility Observation Checklist 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.

**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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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

| | | |
|---|---|---|
| * | • Procedures for reviewing and approving respite homes | |

### Site Visit Evidence

*

- Documentation of licensing/approval
- Sample of safety plans, if applicable

**On-Site Activities**

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Respite care providers
    4. Care recipients

- Review case records
- Observe facility

## RC 6.01

The family receives respite care in a location appropriate to their needs and preferences.

**Examples:** *Respite care can be provided in the family's home, the provider's home, the community, or a facility.*

## RC 6.02 (FP)

Prior to use, all facilities and provider homes are licensed or approved as required by law or regulation, and regularly inspected to evaluate:

a. fire, health, and safety hazards;
b. cleanliness;
c. adequacy and appropriateness of space and furnishings; and
d. the safety and appropriateness of toys, materials, or equipment.

## RC 6.03

When overnight care is provided, accommodations include:

a. sleeping arrangements appropriate to the number and unique characteristics, needs, and preferences of the individuals in the home or facility;
b. adequately and attractively furnished rooms with a separate bed for each resident, including a clean, comfortable, covered mattress, pillow, sufficient linens, and blankets;
c. a non-stacking crib for each infant and toddler that is 24 months or younger that meets safety guidelines, as applicable; and
d. a safe place, such as a locker, to keep personal belongings and valuables.

**NA:** The organization does not provide overnight respite care.

**Interpretation:** *Characteristics and needs that should be considered include age, developmental level, necessary accommodations, ability to adjust to a group, gender, gender identity, and gender expression. Transgender and gender non-conforming individuals should be given access to sleeping quarters and bathroom facilities based on their preferences and in accordance with applicable federal and state laws.*

**Interpretation:** *When overnight care is not provided in a facility run by the organization, the organization should ensure these accommodations are reviewed and documented during the home licensing or approval process detailed in RC 6.02.*

**Examples:** *The Consumer Product Safety Commission (CPSC) provides standards to ensure safety for cribs.*

## RC 6.04

When respite care is provided in a facility, space and amenities are adequate to meet the needs of care recipients, and include:

a. indoor and outdoor recreation areas;
b. space for social activities, including accommodations for informal gathering;
c. dining, bathing, toileting, and personal hygiene facilities;
d. private areas for meetings with care recipients, caregivers, and other individuals as needed;
e. space for resting; and
f. rooms for providing on-site services, if applicable.

**NA:** The organization does not provide respite care in a facility.

## RC 6.05

When overnight respite care is provided in a facility, space and amenities are adequate to meet the needs of care recipients, and include:

a. supplies and equipment for food preparation, housekeeping, laundry, maintenance, storage, and administrative support functions;
b. at least one room suitably furnished for the use of on-duty personnel; and
c. private sleeping accommodations for personnel who sleep at the facility, if applicable.

**NA:** The organization does not provide overnight respite care in a facility.

## RC 6.06 (FP)

When respite care is provided in the caregiver's home, the respite care provider is familiar with the safety plan for the home.

**NA:** The organization does not provide respite care in the caregiver's home.

**Interpretation:** *The respite care provider should be familiar with the location of first aid, medical, emergency, and other supplies needed to provide care, and the ways to safely evacuate the individual receiving care.*

Respite Care

# RC 7: Short-Term Residential Respite and Crisis Nursery Services

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

Services are designed to meet the needs of care recipients who require a short-term stay in a residential respite or crisis nursery program.

**NA:** The organization does not provide residential respite or crisis nursery services.

**Note:** *Please see the Facility Observation Checklist 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.

**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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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

| | | |
|---|---|---|
| * | • Rules and behavioral expectations | |

### Site Visit Evidence

*

- Schedule of social and recreational activities

### On-Site Activities

*

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

- Review case records
- Observe facility

## RC 7.01

Respite care providers provide care recipients with predictability and structure by establishing daily routines, expectations, and scheduled programming developed with care recipients and their caregivers.

## RC 7.02

Care recipients, and their caregivers when appropriate, receive social, recreational, educational, and therapeutic activities that are:

a. matched with their needs, preferences, and goals; and
b. provided in individual, family, and/or group format.

**Interpretation:** *The organization and the caregiver should plan for the continuation of educational services for children and youth, and the organization should coordinate educational services with relevant school districts.*

**Examples:** *Crisis nursery services may provide additional services such as parenting education, case management, mentoring or peer support, and aftercare in addition to respite care.*

Respite Care

# RC 8: Case Closing

**Purpose**

Respite Care reduces caregiver stress, promotes the well-being and safety of care recipients, prevents out-of-home placements, and contributes to stable families.

The organization works with caregivers and, when appropriate, care recipients and/or family members 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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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 | |

### Site Visit Evidence

*No Site Visit Evidence*

### On-Site Activities

*

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

- Review case records

## RC 8.01

Planning for case closing:

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

## RC 8.02

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

## RC 8.03

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

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