STANDARDS OF PRACTICE

Intensive Case Management Supports

ACCREDITATION PROCESS & STANDARDS MANUAL

2024 EDITION

Calgary Homeless FOUNDATION

Canadian Accreditation Council | Conseil d'accréditation canadien

STANDARDS OF PRACTICE

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PREAMBLE

The key goals of Calgary's Homeless-Serving System of Care (HSSC) are to coordinate, strengthen and integrate the systems needed to guide the fight against homelessness Calgary. The HSSC operates under the philosophy of a Recovery Oriented System of Care, which looks at a person's journey and recovery from experiences of homelessness through a holistic lens that includes housing, health, financial stability, and community connection. At its core, the HSSC serves those experiencing or vulnerable to homelessness with a person-centered lens: meeting people in need of services where they are and offering them real choices when choosing housing that is right for them. Case Management Standards have been developed to outline a standard quality of care among different organizations and Recovery Supportive Housing services to Calgarians experiencing homelessness.

The first objective of HSSC agencies, programs, and funding is to assist individuals experiencing homelessness to gain and maintain housing stability with appropriate support (Recovery Oriented Supportive Housing (ROSH)). A combination of case management and housing with supports has been found to be the most successful approach to achieving these goals and ending homelessness (National Alliance to End Homelessness, 1999; Nelson, Aubry, & Lafrance, 2007; Tull, 2006).

Case management refers to a collaborative and planned approach to ensure the individual experiencing homelessness receives timely access to the appropriate support and services they need to move forward with their lives. Originating in the mental health and addictions sector, the strategies and tools of case management can be used more broadly to support anyone who has experienced homelessness to overcome challenges. It is a comprehensive and strategic form of service provision whereby a case worker assesses the needs of the participant (and potentially their family) and, where appropriate, arranges, coordinates, and advocates for delivery and access to a range of programs and services designed to meet the individual's needs (Gaetz, S. 2014).

The purpose of Recovery Oriented Supportive Housing (ROSH) is to reduce barriers so that people are supported to retain their housing and prevent future experiences of homelessness. The purpose of this document is to provide a set of common standards of practice for case management provided by CHF funded agencies to ensure that there is coordinated service delivery for individuals accessing services.

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PROCESS MANUAL

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THE STANDARDS PROCESS

Calgary Homeless Foundation (CHF) engaged in an 18-month process to develop an initial set of standards. Interviews were conducted with the local community members, national and international experts, and people with lived or living experience of homelessness. The process also included a review of the relevant literature (including case management standards from other disciplines), to determine best and promising practices in case management, specifically in the context of homelessness. Although programs funded by CHF are contractually obligated to adhere to these standards, other case management programs working with people experiencing homelessness are also encouraged to adopt the standards of practice—as they represent a comprehensive process to determine best practices, as well as the opportunity to ensure consistent and standardized processes across the system-of care.

In 2011 CHF initiated a review process with funded case management programs to ensure the appropriateness and practical relevance of these standards. In 2011-2012, CHF worked with key stakeholders to determine a process for ongoing review and adaptation of these standards as part of its system planning work. The 2011/12 initial phase of implementation has been used to enhance standards with learnings and strengthen these for continued relevance. In 2014, these standards were revised to meet current knowledge and best practice, including community consultation with funded case management programs. Throughout 2019 these standards were reviewed and revised again to reflect Calgary's Homeless Serving System of Care (CHSSC), and the 2020 version was published that included feedback and suggestions from individuals with lived/living experience of homelessness. These standards are regularly reviewed and revised to stay current to best practices. This 2024 version includes a light-touch review to update the evaluation process in alignment with the Canadian Accreditation Council, as well as correct outdated information.

DEFINING CASE MANAGEMENT

Intensive case management supports is a collaborative, community-based intervention that places the individual at the centre of a holistic model of support necessary to secure housing and provide supports to sustain it while building independence. For case management to be successful in this context, it must be focused on the right matching of services. It must:

- *Be person-centred*
- *Be adaptive*
- *Be individualized*

- *Be culturally appropriate*
- *Be flexible*
- *Be holistic*
- *Be multi-disciplinary*
- *Be focused on establishing networks and relationships*
- *Include advocacy that leads to self-advocacy*
- *Include coordination and engagement*

—Research Report Dimensions of Promising Practices for Case Managed Supports in Ending Homelessness Calgary Homeless Foundation, 2011

Case Management is defined by the National Case Management Network of Canada (2009) as:

"collaborative, participant-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the participant's achievement of safe, realistic, and reasonable goals with complex health, social, and fiscal environment."

For case management to be successful in this context, it must consist of the following key principles.

KEY PRINCIPLES*

1. ***Cultural competence***

Case managers need to provide services that work with individuals' beliefs, values, and practices. Case managers should be competent to the differing needs of different people and gain the cultural knowledge necessary to become culturally conscious and effective in supporting individuals.

—From the National Case Management Network (2009)

Morse (1998) adapts the aforementioned principles in case management for the specific goal of ending homelessness:

- Person-centred and -focused, based on what the individual wants
- Respect for individual autonomy
- Trust and strong relationships are a must

* Key Principles from National Case Management Network of Canada 2009 adapted by CHF

2. ***Active engagement to ensure successful completion***

   Case Managers' primary responsibility is to ensure successful transitions from experiencing homelessness into a permanent experience of being housed. Actively identifying a person's strengths and capacities in the context of community life rather than relying on systems or service providers; this includes utilizing informal community supports, peer support and mentoring. Prior to any discharge, the case manager must complete a formal due diligence protocol to ensure that all efforts have been utilized to engage, stabilize, and support the individual.

3. ***Support for people's rights***

   Case managers work to strengthen the voice of the person in accounting for their history, evaluating present conditions, and defining desirable changes in their life

4. ***Specific, purposeful treatment***

   Case managers need to work with each person individually toward delivering person-centered services that result in measurable quality of life outcomes valued by service participants with specific care plans based on that individual. When working towards the individual's goals, the case manager should provide individuals and families with choice for supports and providers, which are flexible to meet changing needs.

5. ***Collaboration with others***

   Service provision is not the job of one individual, but of a community. Case managers must work to align system structures and processes to respect individual choice, respond to cultural diversity, foster community connection, promote flexibility, portability and accessibility. The case manager works to broker relationships with different service providers as appropriate for the individuals so that the person accessing services will have a group of people working together to support them and communicate effectively as a team.

6. ***Ethical and accountable work***

   Case managers need to provide effective, organized, and individualized care to meet the needs of the people they work with. They need to promote self-care and independence and keep up to date with changes in the goals or needs of the person. Case managers need to use care resources ethically and within the financial means allotted.

These key principles should be implemented within case management. According to Gaetz (2014), for case management to be successful in ending homelessness, it should also take the following key dimensions into account:

- Collaboration and cooperation – a true team approach, involving several people with different backgrounds, skills and areas of expertise;
- Right matching of services – person-centred and based on the complexity of need;
- Contextual case management – Interventions must appropriately take account of age, ability, culture, gender and sexual orientation. In addition, an understanding of broader structural factors and personal history (of violence, sexual abuse or assault, for instance) must underline strategies and mode of engagement;
- The right kind of engagement – Building a strong relationship on respectful encounters, openness, listening skills, non-judgmental attitudes and advocacy;
- Coordinated and well-managed system – Integrating the intervention into the broader system of care; and
- Evaluation for success – The ongoing and consistent assessment of case managed supports.

THE STANDARDS

The standards of practice for case management are based on the principles mentioned above, and are separated into four categories:

- Staffing
- Case Management Activities
- Privacy and Information Management
- Service Delivery

PRIVACY AND INFORMATION MANAGEMENT

The collection of information and the use of that information by programs must be in alignment with federal and provincial legislation and regulations and professional guidelines around privacy.

REVIEW PROCESS

The Canadian Accreditation Council (CAC) has a long history of supporting programs and organizations as they move towards service excellence. It is this experience that CAC has brought to the Calgary Homeless Foundation in the established review processes used and owned by CAC. It is the belief of CAC that accreditation should support the internal development of programs by building capacity through the application of the accreditation process. In order to ensure that standards have been fully implemented into practice, the review process measures programs on multiple levels. Objective measurements are performed in the review of policies, procedures, documents, and files, along with the on-site observations made by the Review Team. Subjective evaluations are performed during the interviews of staff and participants, which assess how each individual perceives their role and the current practices used in the service delivery model.

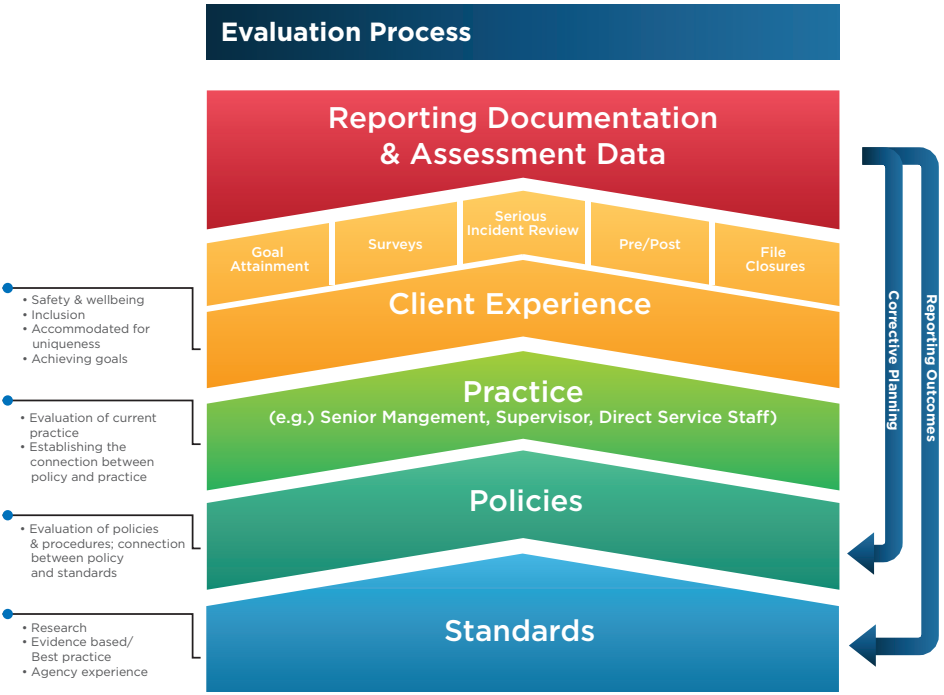
PARTICIPANT INVOLVEMENT

As the participant is the focus of service delivery, it is important that their experiences be evaluated. Adjustments are made during the survey process in order to accommodate participants who may have emotional, cognitive, or physical impairments. In general, when interviewing participants, conversations will focus on four main areas:

- **Safety and Well-Being**: Reviewers will engage with participants in conversations to determine whether the participant feels safe in the environment, both with staff and with the services that are being delivered. Reviewers will also evaluate the sense of well-being the participant feels at this particular point in their life.
- **Inclusion**: Reviewers will evaluate what level of control the participant has in making decisions about their life.
- **Accommodation for Uniqueness**: Reviewers will evaluate examples provided by the participant in regard to how the program accommodates them and responds to their specific situation and choices.
- **Achieving Goals**: Reviewers will evaluate whether participants feel they are moving toward achieving personal goals or if they feel stuck with no defined direction. Reviewers will also evaluate examples provided by the participant and examine documentation to determine the level to which the program supports, guides, advocates or facilitates opportunities for the achievement of their goals.

All information from the interviews of participants will be compared to the documentation in the files, and the program's records and policies. This is to ensure that the best interest of all participants is being considered and supported through the delivery of services.

EVALUATION PROCESS



ACCREDITATION SUPPORT COORDINATOR

Within 5 business days of CAC processing the application, organizations will be contacted by the support coordinator assigned to assist them through the process. During the self-study period, the support coordinator will provide one in-person support visit designed to orient the organization to the survey process, the standards, and their implementation. After the support visit, they will remain available for additional support during the self-study period, between the Pre-Site Survey and On-Site Survey, and during the intervening years. Please note that unlimited email, telephone, and videoconferencing support is available throughout the accreditation process. The support coordinator can also provide access to sample policies, forms, and tools.

In order for the team to provide a fair and unbiased survey, the support coordinator will not be present during the Pre-Site Survey or the On-Site Survey, nor will they have contact with the team. This allows organizations to receive both support during the accreditation process as well as the assurance of an unbiased survey provided by impartial reviewers.

REVIEW TEAM

CAC uses a peer review process to accredit organizations. Reviewers are individuals who work or have expertise in the field of the program undergoing accreditation. They evaluate documentation and policies, record on-site observations, and interview personnel and persons served. The facts they've gathered are then compiled in the On-Site Report, which measures the organization's level of compliance to the standards.

The review team generally consists of 1 team lead, 1-5 reviewers from separate organizations (if possible), and 1 contracted administrative reviewer (all positions are described in the next sections). Every effort is made to create a team that incorporates human service experience, cultural diversity, and knowledge of the program areas.

REVIEWERS

Reviewers are volunteers who work or have direct experience in the field of the organization or program undergoing accreditation and have completed the reviewer training. They must demonstrate knowledge of the On-Site Survey process and are familiar with CAC's policies, processes and CHF standards. Reviewers' main responsibilities during a survey are:

- Assessing and rating the organization's self-study materials package
- Participating in the Pre-Site Survey to share information and clarify areas of uncertainty
- Conducting the duties assigned to them by the team lead, including the On-Site Survey of documentation and interviewing of personnel and persons served
- Providing their findings to the administrative reviewer for the compilation of the On-Site Report

TEAM LEADS

Team leads are reviewers who have been selected to take on a leadership role. These individuals have undergone additional training and act as the intermediary between the organization and the team. Along with completing the tasks outlined in the reviewer description, their main responsibilities are:

- Leading the Pre-Site Survey, as well as the introduction at the On-Site Survey, and the Exit Interview
- Delegating duties and responsibilities to team members on-site
- Making the final decision when team consensus is not achieved
- Keeping the organization/program liaison informed of the progress

ADMINISTRATIVE REVIEWERS

Administrative reviewers are qualified individuals who have been contracted or employed by CAC to provide administrative support to the review team and the organization in an unbiased way. Along with completing the tasks outlined in the reviewer description, an administrative reviewer's main responsibilities are:

- Recording the findings of the Pre-Site Survey and providing that information to the organization
- Recording the on-site findings of the team
- Setting up the Organization Response document for the organization and each program.
- Finalizing the On-Site Report with the team lead and providing it to the Director of Accreditation Services, who will provide it to the organization within 10 business days

PROCESS TO VETO AND CONFLICT OF INTEREST

While it is CAC's role to select the members of the review team, the organization undergoing the survey has the right to veto team members due to perceived or real conflicts of interest within 10 business days of receiving notification of their team.

To prevent conflict of interest or bias during the survey, volunteers are prohibited from accepting a paid contract or employment from an organization they have reviewed until the conclusion of the accreditation process. Organizations undergoing a survey are also

prohibited from offering employment to any team member until the conclusion of the accreditation process.

To initiate the process to veto, the organization must contact the Director of Accreditation Services and describe the real or perceived conflict. It is at the discretion of CAC to approve or deny any claims of conflicts of interest.

ACCREDITATION PROCESS

APPLICATION

The application process is standardized for new, reaccrediting and equivalency programs. The process begins with the completion of the Application, downloaded from the CAC website by going to the Accreditation tab and selecting the How to Apply page, or provided by a CAC staff member. Once the Application has been completed, programs then sign and submit it to CAC by mail, fax, or email.

The Application remains in effect for 2 years from the date of receipt by CAC, and the programs must fully complete the process, including accreditation decision, by the expiry date. In order to accommodate these timelines, most accreditations are set to take place within 12 months of the application being submitted. A preferred On-Site Survey date is requested on the application, which CAC will take into consideration when creating the timeline. Due to the nature of scheduling individuals to conduct the survey, all efforts will be made to select a date close to the indicated preferred On-Site Survey date, though the final assignment of the date is at the discretion of CAC.

Once the application is accepted by CAC, a Timeline Workplan is created to provide the key dates that both CAC and the program must abide by and any other pertinent information. This document is sent out to the program within 5 business days of the application being processed. If the program requires any changes to be made to the dates of the timelines, they must contact CAC at least 4 months prior to the scheduled On Site date (see Timeline Adjustments section below).

Programs may choose to withdraw from the accreditation process at any time prior to the submission of the On-Site Report to the Accreditation Panel. The status of the program prior to the withdrawal will remain in effect and the program may restart the process at any time.

SELF-STUDY PERIOD

The time between application and the Pre-Site Meeting is referred to as the Self-Study period. During this time, programs will become familiar with the standards and assess their internal compliance with them. This may mean the need to create new policies or procedures, orient staff and participants to any changes made, update processes already in place or other activities identified by the program. CAC will provide programs with electronic copies of the standards.

Programs will also be provided with the following documents:

- **Self-Study Index** – A form that lists all required documents for the Pre-Site Materials package. This document must be completed by the program and be provided to the Review Team as it will be used both as a key and to track ratings and comments
- **File Review Checklists** – Checklists used by the Review Team on-site to verify that all required documents are present in staff and participant files. This checklist is provided to organizations for information only, in preparation for what will occur on-site.
- **On-Site Observations Checklist** – Checklist used by the Review Team on-site to verify compliance to standards that deal with the physical space of the program. This checklist is provided to organizations for information only, in preparation for what will occur on-site.
- **Interview Questions** – All questions that will be asked of staff and participants during the interview portion of the On-Site Review. These questions are provided to organizations for information only, in preparation for what will occur on-site.

These documents, along with the standards, provide a roadmap for programs to use to bring themselves into compliance with the standards. All programs will also be assigned a support coordinator as mentioned above in the Support Provided section, who will be available in the following ways:

- **Support Visit** – All organizations are entitled to an in-person visit by their support coordinator, who will provide them with specific information about the accreditation process, what to expect at various stages, a verification of the standards the organization will be accredited with, and other important information about the organization's accreditation and process.
- **Phone and Email Support** – Organizations are provided unlimited phone and email support by their support coordinator, who can answer ongoing questions about the process, standards, and how to come into compliance with the standards.
- **Video Conferencing Support** – Support coordinators will also be available by video conferencing to provide additional support to organizations on an ongoing basis.

TIME LINE ADJUSTMENTS

During the self-study period, organizations may find that they will not be prepared to undergo their On-Site Survey on schedule as per the Timeline Workplan.

CAC allows organizations to request timeline adjustment as long as it is at least 4 months prior to the scheduled On-Site Survey, the new dates requested are still within the contracted timeframe, and a written request for Timeline Adjustment has been submitted. This process allows CAC to provide accurate dates of survey for the review team as well as make any travel arrangements required.

Within 4 months or less prior to the On-Site Survey, after the review team has been set, no further timeline adjustments may be granted. It is at the discretion of CAC and the CHF to approve all timeline adjustments and new dates.

SELF-STUDY MATERIALS PACKAGE

Before the On-Site Survey, organizations are provided with a review of the documentation via a Pre-Site Report, compiled from the review team evaluation of policies, procedures, and other documents to reveal strengths and areas of improvement. This is to allow organizations an opportunity to correct any issues before the On-Site Survey and ensuing report. To this end, organizations are tasked with compiling a self-study materials package to be submitted to the review team.

Organizations may choose to provide their information in either a hard copy, such as an organized binder, or electronic format, unless a specific format is requested by the review team members. For organizations considering electronic formats, please contact your support coordinator for appropriate formatting.

The self-study materials package will include:

- The completed Self-Study Index
- A Policies and Procedures manual, including all pertinent policies and procedures
- Staff list as per Indicators
- All other requested documentation from the index

Prior to the documents' due date, CAC will provide organizations with further instructions regarding sending the self-study materials package, including:

- Names and addresses of all members of the review team, consisting of:
  - Team Lead
  - Administrative Reviewer
  - Reviewer(s) (Note: number of reviewers assigned to a survey is dependent on the size of the organization and is at the discretion of CAC)
- Confirmation of the date that the materials must be delivered to the team members

This package must be mailed or emailed directly to the review team and presented in an organized fashion. If the materials are disorganized or not properly identified (e.g., not in the order identified in the index, documents missing, etc.), the organization will be notified by the administrative reviewer and required to reorganize the package and resend it to all members of the team. This may lead to a postponement of the Pre-Site Survey and additional costs to the organization.

PRE-SITE SURVEY

The Pre-Site Survey allows the review team to collectively review their findings of the self-study materials package and assign ratings. The review team will meet via phone call or videoconference to discuss their findings and compile a Pre-Site Report, which will be provided to the organization within 5 business days.

The available ratings for the materials at this stage are Compliant, Partially Compliant, Non-Compliant, and Not Applicable. All documents rated as Partially Compliant or Non-Compliant will be accompanied by commentary describing why the rating was assigned. Standards that have been deemed Not Applicable will be discussed by the team, with the final decision of whether or not a standard is not applicable resting with the team. Please note that the rating of Partially Compliant is available only for the Pre-Site Report findings; any document rated as Partially Compliant on the Pre-Site Report will either be rated as Compliant or Non-Compliant during the On-Site Survey.

Table 1

Rating	Description	Actions Required
Compliant	All submitted elements of the standard have been met	No actions required
Partially Compliant	Some submitted elements of the standard have been met (Note: This rating is only available on the Pre-Site Report and will be changed to either Compliant or Non-Compliant during the On-Site Survey)	Corrections made according to the comments in the Pre-Site Report; the team will verify all corrections on-site
Non-Compliant	No submitted elements of the standard have been met	Corrections made according to the comments in the Pre-Site Report; the team will verify all corrections on-site
Not Applicable	The standard is not applicable to the organization	The team will discuss to decide if the standard does not apply to the organization and then rate accordingly

These findings, which are compiled by the administrative reviewer, will be provided to the organization, allowing the organization to make any corrections that might be necessary before the On-Site Survey. Along with providing the Pre-Site Report, the administrative reviewer will also contact the organization prior to the On-Site Survey in order to discuss the interviews that will be conducted and help the organization to set up a schedule to follow while on-site.

ON-SITE REVIEW

The On-Site Review typically lasts 1-2 days and involves interviews with staff and participants, file reviews, review of on-site documents, and observation of the practice in the program. It is the responsibility of the program to obtain consent for staff and participants who will be participating in the interview and file review process prior to the team's arrival on-site.

On-site, the team will require a private space to meet, access to telephones for any telephone interviews, as well as separate spaces to conduct interviews. The program

must also provide a designated person who can answer general questions, coordinate the interviews, provide guidance as to how the organization's files are ordered, and direct the team towards any missing pieces of documentation. Once the review team has arrived and set up, they will hold an informal introductory meeting with representatives of the program and then begin the process of conducting interviews, file reviews, and on-site observations.

Before the On-Site Survey, the review team will inform the program as to their choice of personnel to be interviewed and will request a list of available participants for the same purpose (see the next section for more on participants). It is the organization's responsibility to create an interview schedule with these individuals and provide it to the administrative reviewer ahead of their arrival on-site. The schedule will be reviewed with the program to ensure that the timelines are realistic and that it addresses all areas required for the On- Site Survey. The team will strive to work within the schedule and will remain flexible to ensure that interviewees are not kept waiting.

While conducting the survey, the team will be evaluating the Patterns of Practice (Table 2) present in the organization.

These elements are taken into consideration during the completion of the On-Site Report. Each member of the team individually records their findings from interviews, file reviews, and on-site observations and that information is compiled by the administrative reviewer. When all indicators for a standard have been measured, the final rating of Compliant or Non-Compliant will be recorded.

Table 2

Observation of Patterns of Practice	
Historical Practice	Practice with evidence to show established pattern of consistent practice since the last review date.
Established Practice	Practice with evidence to show a pattern of consistent practice for at least 6 months.
Current Practice	Practice with evidence to show a pattern of consistent practice for less than 6 months.
Demonstrated Practice	Practice with inconsistent evidence to support full implementation of practice. Able to demonstrate practice but not able to provide evidence to show consistent practice.
Incongruent Practice	Practice observed or recorded is not aligned with policies.
No Practice	Practice not observed or recorded in the delivery of service.

RISK ASSESSMENT MATRIX

All Non-Compliant findings in the On-Site Report and Organization Response will be reviewed to assess the impact on the program. Non-Compliant findings will be assigned a risk rating of low, moderate, high, or critical internally by the Accreditation Panel, which will be determined by assessing the likelihood of an event occurring (determined by the percentage found to be non-compliant onsite) versus the impact an event occurring would have on the program (which will be determined by the Accreditation Panel). The following chart demonstrates how the risk rating is determined (Table 3):

Table 3

Likelihood	High (67-100%)	Moderate Risk	High Risk	Critical Risk
	Moderate (34-66%)	Low Risk	Moderate Risk	High Risk
	Low (10-33%)	Low Risk	Low Risk	Moderate Risk
		Minor	Moderate	High
		Impact		

The goal of the risk assessment matrix is to determine the patterns of practice within a program and the impact they have on the staff, participants, and the community. Please note that the risk assessment is only based on the evidence that is presented during the On-Site Survey and as such is not a full accounting of all risks possible for a program. This is intended as a snapshot to help determine the level of compliance to the CAC standards and is not intended to replace a full assessment of risk as performed by the program itself.

SAMPLE SIZE

It is the responsibility of the program to obtain written consent for all those participating in interviews and file reviews prior to the team's arrival on-site. The review team understands that some individuals may refuse to provide consent (usually less than 5%) but if the sample size is not large enough, the team will be unable to conduct the survey. As well, it is at the discretion of the team to request additional interviews or files to determine the extent of practice. Table 4 indicates the percentage/ ratios that will be used to determine sample size.

Table 4

Number of Personnel, Persons Served, or Homes	Sample Size
3 or less	all
4 – 10	50% or up to 4
10 – 25	50% or up to 8
25 – 50	10
50 – 75	12
75 – 100	14
100 – 150	16
150 – 200	18
Over 200	20

EXIT MEETING, ON-SITE REPORT, AND PROGRAM RESPONSE

At the end of the On-Site Survey, the team lead will present the program with a verbal summary of the team's findings. Particular attention will be paid to the Excellence in Practice observed by the team, Practices to be Addressed, and findings that have been determined to be Non-Compliant. The program will be given the opportunity to ask any questions they may have before the review team leaves the site.

ON-SITE REPORT AND ORGANIZATION RESPONSE

ON-SITE REPORT

During the course of the On-Site Survey, the administrative reviewer will compile the team's findings and draft the On-Site Report. This report will provide one of the following ratings for each standard reviewed.

Table 5

Rating	Description
Compliant	Policy and practice are congruent with the intent of the standards and no response from the program is required to be forwarded to the Accreditation Panel.
Non-Compliant	Some aspect of the policy or practice has been found to be incongruent with the intent of the standards. Likelihood of the risk occurring has been assessed by the review team and the program will be required to submit a response (see next section) to the Accreditation Panel, who will assess the impact and overall risk.
Not Applicable	The standard is not applicable to the program. CAC reserves the right to refuse a request to have a standard considered Not Applicable.

The On-Site Report is finalized by the administrative reviewer, reviewed internally by the Accreditation Services Department, and provided to the program within 10 business days. As soon as the official On-Site Report has been received by the program, the program will have 5 business days to verify that all information present in the report is correct. If any inaccuracies have been found, the program can contact the Director of Accreditation Services to address the issues. Corrections of inaccuracies must be submitted in writing to the Director of Accreditation Services, who will discuss the issues with the administrative reviewer and the team lead. If the administrative reviewer and

team lead agree that corrections are required, written notification of what has been changed and an updated copy of the On-Site Report will be sent to the program within 5 business days. If no corrections are to be made, the Director of Accreditation Services will contact the program, in writing, within 5 business days with an explanation of the decision as well as the next steps in the accreditation process. No additional evidence will be considered at this time.

ORGANIZATION RESPONSE

If the review team has determined that particular findings are Non-Compliant during the survey, the program will be given the opportunity on-site to produce evidence that would change the ratings to Compliant. If the program is not able to provide the required evidence during the On- Site Survey, the findings will have to be addressed in the Organization Response.

The Organization Response is a document sent to program along with the On-Site Report. The program completes the response, setting out plans for coming into compliance with any standards that have been found to be Non-Compliant. This document must be filled out and submitted to the Director of Accreditation Services within 30 days of receiving the Organization Response. The document will be reviewed internally in the Accreditation Services department to ensure that there is no identifying information prior to being provided to the Accreditation Panel. Please note, no additional evidence will be accepted at this time. The Accreditation Panel takes the Organization Response into consideration when making decisions. If the response is not returned within the allotted timeframe, the Accreditation Panel will defer the program.

ACCREDITATION PANEL

The Accreditation Panel meets minimally every second month to review all submitted On-Site Reports and Organization Responses. If the program is seeking reaccreditation, these documents will be submitted along with the Organization Response from the last accreditation survey. All documents are presented to the Accreditation Panel with a code and with all identifiable information removed. The Accreditation Panel is not made aware of the program to which it is assigning an accreditation decision. The Accreditation Panel will review all of the documents presented, assess the impact of any non-compliances found, and make a decision based on the following criteria.

Upon first tier review of the report, the Accreditation Panel may make one of the following decisions.

To be eligible for a 4 year accreditation, organizations must:

- Have been previously accredited by CAC
- Have 5 or fewer non-compliances
- All non-compliances have no more than a moderate risk
- Comprehensive activities to meet the standard and maintain compliance with the standard are in place for all non-compliances found

It will be at the discretion of the Accreditation Panel whether the outstanding non-compliances have a plan that addresses the risks sufficiently to be eligible for a 4 year accreditation. A 4 year accreditation may only be awarded during the tier one review of the report.

To be eligible for a 3 year accreditation during the first tier review, programs must:

- Have 10 or fewer non-compliances
- No more than 3 non-compliances have a high risk and no high risk findings impact the health or safety of the person served or staff
- Any remaining non-compliances have a moderate risk
- Comprehensive activities to meet the standard and maintain compliance with the standard are in place for all non-compliances found

It will be at the discretion of the Accreditation Panel whether the outstanding non-compliances have a plan that addresses the risks sufficiently to be eligible for a 3 year accreditation.

The Accreditation Panel may determine a deferral of accreditation of 4 months pending a Follow-Up Survey (either of outstanding non-compliant standards or the entire program) be conducted if:

- There are more than 10 non-compliances or
- The risk assessments are beyond the threshold provided or
- The activities to meet the standard and maintain compliance with the standard are not sufficient to address the non-compliances found or
- The Organization Response is not provided to the Accreditation Panel

Denial can occur either before or after a follow up, and occurs when:

- There is significant immediate risk to the health and safety of stakeholders or
- There are a significant number of non-compliances found or
- The Accreditation Panel is not confident that all areas of non-compliance can be addressed or
- The organization is not willing to make changes to come into compliance with the standards or
- The organization is not willing to have a Follow-Up Survey conducted

If a deferral is the decision of the Accreditation Panel, the following second tier decisions are available after the Follow-Up has been conducted (for additional information about the Follow-Up Survey, please see the section below).

To be eligible for a 3 year accreditation after a Follow-Up Survey, programs must demonstrate:

- All non-compliant standards are addressed, either by providing evidence of new practice or a plan is in place that demonstrates good ongoing practice
- There is no risk to the ongoing health or safety of stakeholders

To be eligible for a 1 year accreditation after a Follow-Up Survey, programs must demonstrate:

- Most non-compliant standards have been addressed, either by providing evidence of new practice or a plan is in place that demonstrates good ongoing practice
- If there is any risk still outstanding, the risks have been mitigated to be reviewed over the course of the next year, prior to reaccreditation

If the Accreditation Panel has further questions about a report (e.g. needs clarification around the contents of the report) or they are unable to make a decision during the course of the meeting, the Accreditation Panel may choose to table the report until the next meeting. If a report is tabled, the Accreditation Panel will provide a description of any information that is required for a decision to be made. As tabling a report is not a decision, any of the decisions that were available for the report at the last meeting are still available when the report is reviewed again.

The Accreditation Panel seriously considers the responses submitted to all non-compliances found. Based on the response of the program, the Accreditation Panel, at its discretion, may choose to move up one decision level if sufficient mitigation processes have found to be in place. This may happen if:

- The program has no more than 2 risk ratings outside of the identified threshold, which do not have a lasting impact on the health and safety of the person served or staff and have been sufficiently mitigated in the Organization Response, or
- The program is within 2 non-compliant findings of the threshold, where all non-compliant findings do not have a lasting impact on the health and safety of the person served or staff, and they have been sufficiently mitigated in the Organization Response

Once the Accreditation Panel has made its decision, CAC will inform the program within 5 business days. The official start date of the awarded accreditation status will be the date of first presentation to the Accreditation Panel. Please note, all outstanding fees must be paid prior to CAC providing written confirmation of the awarded accreditation status or said written confirmation will be withheld until the account is settled.

Programs that have been granted a 4 -, 3-, or 1-Year Accreditation will receive a plaque and certificate of accreditation for Governance & Management and any programs on the same application. Programs may choose to have a formal presentation of their certificates at their own cost.

For more on plaques as well as the use of logos, please refer to Appendix D.

All accredited programs and programs are posted on the CAC website, at www.canadianaccreditation.ca and are accurate to the date on the document. For up to the minute accreditation information, please contact the CAC Main Office.

FOLLOW-UP SURVEY

If the Accreditation Panel requires more information from the program before they can make a final decision, the program will be awarded a Deferral of Accreditation and they will need to complete a Follow-Up Survey within a designated timeframe. The Accreditation Panel can choose to have only the Non-Compliant standards re-reviewed or order a full re-survey, depending on what has found to be non-compliant. Only 1 deferral may be granted per program per accreditation cycle.

The Director of Accreditation Services or designate will contact the program to explain the decision of the Accreditation Panel, what must be re-reviewed, and what the process will be in more detail. The 4 month deferral allows for a program to use that time to make any corrections necessary. At the end of the Follow-Up Survey, a Follow-Up Report will be created to compare the original survey findings to the findings found within the Follow-Up Survey. This report will be presented to the Accreditation Panel for a final decision.

Organizations undergoing a Follow-Up Survey may receive a 3-Year Accreditation, 1-Year Accreditation or a Denial. If receiving a 3-Year Accreditation, the official starting date of the awarded accreditation status will be the date the first accreditation panel meeting. If receiving a 1-Year Accreditation, the official starting date of the awarded accreditation status will be the date of the panel meeting at which the 1-Year Accreditation was granted. If the organization has not conducted its Follow-Up Survey within the 4 month window, their status will default to a denial of accreditation.

EQUIVALENCY ACCREDITATION

Programs currently accredited by a recognized accreditation body may request to undergo a modified accreditation process known as Equivalency of Accreditation.

This process begins by indicating on the Application that the program is requesting to be recognized as an equivalent accredited program. With the application the program will also provide a current accreditation certificate from the recognized accreditation body. The application will then be processed by CAC and the equivalency comparison document, reflective of their main accrediting body, will be sent to the program within 5 business days of receiving the application. The accreditation process will then follow this timeline:

- Support Coordinator will schedule a time to contact the program regarding the equivalency comparison document to help with any questions they may have.
- Programs will have 90 days from their initial phone call with the Support Coordinator to provide any pre-site materials as outlined in the equivalency comparison document. These can be provided in either electronic form or hard copy.
- When the Director of Accreditation Services receives the pre-site paperwork from the program, they will assign an Administrative Reviewer along with 1 peer reviewer to review the materials and set-up a 1-2-hour phone call to discuss any questions that might arise from the pre-site documents.

- Once the pre-site phone call has been completed, the Director of Accreditation Services will schedule a modified on-site for the team to review the standards that are not addressed by the recognized accrediting body, as identified in the equivalency comparison document.
- The Administrative Reviewer and 1 peer reviewer will conduct a modified on-site to review staff and participant files along with any materials that were found to be partially or fully non-compliant during the pre-site.
- At the end of the on-site, the Administrative Reviewer and the peer reviewer will meet with program staff to conduct the exit interview and present the on-site report.
- The Administrative Reviewer will provide the program with the Program Response Document, if required, to be completed and returned to CAC within 30 days from the on-site.
- The report will be presented to Accreditation Panel for their decision.
- When the Accreditation Panel meets and determines status of accreditation, the program will be notified by CAC within 5 business days of the decision being made. If accreditation is not granted, the program has the option to follow the appeals process.

APPEALS & ALLEGATIONS

GRIEVANCE OF PROCESS

CAC has a number of fail-safes in place to ensure that the accreditation process is properly followed during an On-Site Survey and that the findings are related in a clear, objective, and factual way. If, during the course of the survey, a program has concerns about the process or the team, they are encouraged to talk with the team lead or the administrative reviewer to attempt to resolve the issue. If neither the team lead nor the administrative reviewer can address and correct the situation, programs are encouraged to pursue a Grievance of Process within 10 business days of the completion of the On-Site Survey.

For more information on how to initiate a Grievance of Process, please refer to Appendix A.

APPEAL OF DECISION

CAC provides programs with verbal findings of the survey during the On-Site Survey, Exit Interview, and in writing in the On-Site Report and Organization Response documents. In the event of inaccuracies, the program should identify them to CAC for correction before the On-Site Report and Organization Response are presented to the Accreditation Panel. With these processes in place, accreditation decisions should be based on fact and reflect the state of the program. However, if a program believes that the decision reached does not fairly represent the program, they have the right to pursue an Appeal of Decision within 20 business days of receiving the Accreditation Panel's decision.

For more information on how to initiate an Appeal of Decision, please refer to Appendix B.

PROCESS TO RESPOND TO ALLEGATIONS

All allegations of misconduct laid against a program are taken seriously by CAC. Allegations from individuals who are willing to identify themselves will be considered and counsel will be given as to how to proceed. If the allegation is not within the scope of CAC, it will be redirected to the appropriate authority.

Allegations within the scope of CAC's standards will be dealt with according to the process outlined in Appendix C.

MAINTENANCE OF ACCREDITATION STATUS

ANNUAL DOCUMENTATION

In order to maintain accreditation during intervening years, programs are required to submit the following to CAC annually:

- **Annual Declaration of Compliance** – This document provides an opportunity for programs to update their information as well as declare that they are operating in compliance to the most recent set of standards and amendments.
- **Annual Plan for Compliance** – This document provides the changes that have occurred in the current Edition of Standards and requires programs to submit a plan to come into compliance with any changes made since their accreditation. This document is only required when there have been changes to the Standards which necessitate action on the part of the programs to come into compliance.

The above items will be provided once per year during the spring and will have all required timelines clearly stated. Failure to submit any of the above may result in suspension or revocation of accreditation status.

EXPANSION, TRANSFERABILITY, INTERIM, SUSPENSION & REVOCATION

PROGRAM EXPANSION

Programs currently accredited with CAC are permitted to expand those programs up to 24% of the originally reviewed services. Once expansion reaches or exceeds 25%, written notification is required to inform CAC of the type and nature of the expansion. CAC reserves the right to determine the capacity of the program to support the expansion. If it is determined that the program does not have the capacity, the program will be required to undergo a full review.

TRANSFERABILITY

CAC accreditation status is not transferable:

- From one program type to another
- From one owner to another

Accreditation status may be transferable from one location to another as long as the program has notified and discussed the change of location with CAC and the program is being operated by the same management and staff. CAC will confirm any program moves or transfers of location with CHF. CAC reserves the right to determine the significance of the move. If the move is determined to cause a shift in practice or will affect the participants, the program will be required to undergo a full review.

INTERIM ACCREDITATION

Interim accreditation status provides opportunity for organizations to expand their base of services and programs without having to undergo a complete accreditation review. Organizations with newly created programs of a similar scope, type, and nature to a program that is already accredited within an organization may request that the new program undergo an interim accreditation.

To request to have the program granted this status the organization must demonstrate the following:

- The organization operates a program which has current accreditation status with CAC under CHF standards that is similar in scope, type and nature to the program requesting to be recognized
- The new program was not in operation prior to the date of the last On-Site Review
- The new program can demonstrate that it operates under the same management structure, policy base and practices that has previously been reviewed and accredited by CAC
- The new program must be accredited at the next accreditation cycle or as determined by the Accreditation Panel

CAC reserves the right to determine capacity (the number and type of programs to be recognized under Interim Accreditation Status).

To achieve this recognition the program will commit to the following process:

1. The program completes an Interim Accreditation application for the new program
2. Administrative Reviewer with a Team Lead will conduct an on-site evaluation:
    a. Policy review required only for new or modified standards

b. Sample size will be as follows:

Number of Personnel, Persons Served, or Homes	Sample Size
10 or less	3 (or all if less than 3)
10-25	4
25-50	5
50-75	6
75-100	7
100-150	8
150-200	9
Over 200	10
Over 200	20

3. An Interim On-Site Report of the findings is compiled and submitted with no identifiable information to the Accreditation Panel for review
4. Program will complete a response to the report within 30 days to be submitted to the Accreditation Panel
5. A decision will be made by the Accreditation Panel whether the program qualifies for interim accreditation status

If a program does not qualify the program must apply and undergo the complete accreditation process within 16 months of start-up.

If the program disagrees with the decision they can submit their concerns in writing within 14 days from the date of the written notification. The CEO will forward the documents to the Appeal Committee for further review (refer to Appeal of Accreditation Panel Decisions).

PARTICIPANT SUSPENSION AND REVOCATION OF ACCREDITATION

Accreditation is granted for a period of up to 4 years and is conditional on the Agreement signed by the organization and CAC. It is the responsibility of the program to abide by the following requirements to ensure that their accreditation status is not suspended or revoked:

- The accreditation status must not lapse before a renewal
- The Application must not expire prior to the decision of the Accreditation Panel

- The Annual Declaration of Compliance and Annual Plan for Compliance (if required) must be received by CAC by the indicated due dates
- Programs undergoing a survey must not offer employment to a member of the review team prior to being notified of the final decision of the Accreditation Panel
- Programs must notify CAC within 30 calendar days of the following events:
  - Critical incidents involving the death or major injury to a person served, personnel, volunteer, or student
  - Change of senior management within the program
  - Program closure or reopening

As well, it is the responsibility of the program to report the following within 1 business day:

- When an investigation is launched
- When an investigation is concluded
- When the media is involved
- When a finding from an investigation is submitted

Failure to follow any of the above requirements may result in the suspension or revocation of accreditation status at the discretion of CAC.

Extenuating circumstances may be considered but it is the program's responsibility to provide context and arguments as to why their status should not be suspended or revoked. The final decision is at the discretion of CAC. Upon suspension or revocation of accreditation status, CAC will issue the program a written notice which will include a rationale for the decision.

STANDARDS OF PRACTICE

2024 Edition

Calgary Homeless FOUNDATION

Canadian Accreditation Council | Conseil d'accréditation canadien

Table of Contents

1 STAFFING

1.1 STAFFING AND RECRUITMENT

1.1.1 INDIGENOUS STAFF

Indigenous peoples are often overly represented in accessing programs and services. Historically and currently the number of Indigenous people providing services has been underrepresented.

Programs within Calgary's Homeless Serving System of Care (CHSSC) will have policies and procedures in place meant to target qualified Indigenous applicants. Programs will clearly define recruitment strategies used to increase number of qualified Indigenous applicants and may be built in partnership with Indigenous communities. All programs within the CHSSC are considered to be Indigenous-serving programs and staffing diversity should be reflective of this.

INDICATORS

- ❑ Narrative submitted to address:
  - Internal policies to target, recruit and hire Indigenous staff (e.g. placement of postings, practicum agreements, etc.)
- ❑ Senior Management interview
- ❑ On-site observation of recruitment materials

1.2 TRAINING AND CORE COMPETENCIES

1.2.1 ORIENTATION

The program provides all staff with an orientation, which is affirmed as understood, within 10 working days/shifts of working with participants. Orientation will minimally include:

1. Practice model utilized within the program
2. Program's code of ethics/ethical conduct
3. Introduction to the individuals being served within the CHSSC
4. Introduction/overview to strategies and techniques used to engage with participants
5. Intensive Case Management Supports Standards of Practice
6. Program's policy and procedure manual
7. FOIP Training
8. GOA privacy acts training

INDICATORS

- ❑ Orientation checklist submitted
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file

1.2.2 WORKING ALONE SAFELY

The program has policy and procedure that ensures working alone safely legislation (provincial and federal) is implemented. Staff are oriented to working alone safely processes within 10 working days/shifts of working with participants. Staff will not work alone until working alone orientation has been completed.

INDICATORS

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file

1.2.3 SAFE WORK SITE PRACTICES

The program has policy and procedure that ensures safe work practices are implemented. This includes:

1. Assessing work site and identifying potential hazards
2. Preparing a written and dated hazard assessment
3. Review hazard assessments periodically and when changes occur to the task, equipment, or work environment
4. Take measures to eliminate or control identified hazards
5. Involve staff in the hazard assessment and control process
6. Make sure staff are informed of the hazards and the methods used to eliminate or control the hazards – e.g. First Aid kits, Naloxone, etc.

https://www.alberta.ca/occupational-health-safety.aspx, OHS Act Section 2

INDICATORS

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ On-site observation

1.2.4 CRISIS INTERVENTION/DE-ESCALATION

Staff are trained in crisis intervention/de-escalation techniques (e.g. NVCI, TCI, CPI, PACE, etc.) by a qualified trainer within 6 months of hire. Certification is renewed minimally every three years.

INDICATORS

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file

1.2.5 SUICIDE INTERVENTION TRAINING

Staff are trained in suicide intervention by a qualified trainer within 6 months of hire. Certification is renewed minimally every 3 years.

INDICATORS:

- ❏ Policy and procedure
- ❏ Supervisor/direct service staff interview
- ❏ Supervisor/direct service staff file

1.2.6 FIRST AID AND CPR TRAINING

The program identifies the level of First Aid training required (Emergency, Standard, etc.).

Staff are trained by a qualified trainer within 6 months of hire. Certification is renewed minimally every 3 years unless otherwise identified by the training provider (e.g., renewal of CPR yearly).

INDICATORS:

- ❏ Policy and procedure
- ❏ Supervisor/direct service staff interview
- ❏ Supervisor/direct service staff file
- ❏ Narrative defining why program identified Emergency VS Standard as sufficient

1.2.7 DISEASE PREVENTION AND UNIVERSAL PRECAUTIONS

Staff are trained in basic disease education and prevention techniques within 6 months of hire. Training is renewed minimally every 3 years.

INDICATORS:

- ❏ Policy and procedure
- ❏ Supervisor/direct service staff interview
- ❏ Supervisor/direct service staff file

1.2.8 INDIGENOUS AWARENESS TEACHINGS*

The program will ensure that all personnel who provide or supervise those providing frontline services to Indigenous persons (First Nations, Metis or Inuit) have a minimum of 6 hours of annual learning.

For personnel who are new to the field or who are not aware of Indigenous history will have formal training within 9 months of commencement of hire. Training will minimally address following:

1. History of Indigenous people pre-contact
2. Definitions of Indigenous peoples
3. Effects of colonization and government policies (e.g., residential schools, 60's Scoop, etc.)
4. Current issues and realities of Indigenous peoples on and off reserve
5. Impact of the Indian Act
6. Impacts of systemic racism on individuals and communities
7. The Truth and Reconciliation Commission of Canada's Calls to Action

For personnel who have received prior training, have current knowledge and/or have involvement with or belong to an Indigenous community will demonstrate on-going learning of or involvement in Indigenous culture by:

- Attending cultural and educational events
- Experiential learning
- Meeting with an elder or other knowledge keeper
- Having guest speakers address staff functions, etc.
- Learning from historical interpretive centres
- Attending lectures, workshops, etc.

Documentation on file will describe the type of learning that was completed on an annual basis.

6 hours of Indigenous Awareness learning will be required annually.

INDICATORS:

- ❏ Narrative identifying the type of training required and who provides it. If personnel are exempt from training, a rational as to why.
- ❏ Supervisor, program staff, contractors, and volunteer interview
- ❏ Supervisor and program staff file review
- ❏ On-site Observations

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

1.2.9 DIVERSITY/CROSS CULTURAL TRAINING*

Diversity training is based on the population the program has served within the past year.

The program will ensure that all staff and contractors working directly with persons served receive 3 hours of training or orientation in cultural sensitivity or diversity within 9 months of hiring. Training may include:

- The effects of racism and cultural insensitivity on persons served
- The importance of culture in forming beliefs, attitudes, and behaviours
- The impact of poverty, homelessness, and other social economic issues on persons served
- The role of subcultures within a more dominant cultural group (e.g., deaf and hearing communities, etc.)

3 hours of Diversity or Cross-Cultural training will be required annually.

INDICATORS:

- ❑ Narrative identifying the type of training required and who provides it. If staff and/or contractors are exempt from training, a rationale as to why
- ❑ Supervisor/direct service staff, and contractor interview
- ❑ Supervisor/direct service staff, and contractor file review
- ❑ On-Site Observations

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

1.2.10 SPECIALIZED TRAINING*

The program will define:

1. Any specialized training requirements for staff, contractors, and volunteers (e.g., skill development, specific treatment approaches, adaptive equipment, changes in practices, changes in legislation, etc.)
2. The timelines in which the training will be completed and renewed (if applicable)

INDICATORS:

- ❑ Narrative as to what specialized training is required by the program and the rationale for it
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file
- ❑ On-Site Observations

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2 CASE MANAGEMENT ACTIVITIES

2.1 REFERRAL AND PLACEMENT

Coordinated Access and Assessment (CAA) improves coordination among agencies while reducing redundancies in services as information and data becomes centralized and standardized. CAA works to improve the participant experience within the CHSSC through improved access and support for system navigation. Furthermore, a more robust triage process allows for more effective and accurate program placements. It ensures the most vulnerable people in our community are referred to housing programs equipped to meet their needs. CAA operates based on a triage model, targeting and prioritizing individuals based on the current Terms of Reference for the Coordinated entry Placement Committees.

- *The Triage list is populated by CHF's data visualization platform (Qlik Sense) based on the following initial data points:*
    - *Active Entry to CAA and housing check-in within the past 30 days, or*
    - *Active Entry to CAA and exiting a primary system within the next 2 weeks, or*
    - *Active Entry to CAA, pregnant, and in the third trimester and,*
    - *Those who are couch surfing, sleeping unsheltered, in emergency shelter, or provisionally accommodated with an associated discharge date*
- *To identify and refer individuals to the most suitable housing or support services, the Placement process leverages data points from several sources including:*
    - *Needs and Services Questionnaire (NSQ)*
    - *Program Transfer Application*
    - *History of housing and homelessness*
    - *Bio-psycho-social vulnerabilities*
    - *Suggested program type*
    - *Engagement (housing check-ins, collateral at the table)*
- *Other data points may be used when two or more individuals meet the above criteria for a specific program that has limited space available and can include:*

- *Qualitative data that is presented as collateral during placement committee meeting or captured in the placement committee notes and housing plan*
- *People exiting primary systems*
- *Length of time on the list*
- *Last check in date*
- *Overall score on the NSQ*
- *Availability of contact information*

Reference: https://agencies.calgaryhomeless.com/wp-content/uploads/Terms-of-Reference-Coordinated-Entry.pdf

FOR PROGRAMS WHO ACCEPT REFERRALS THROUGH COORDINATED ACCESS AND ASSESSMENT (CAA)

2.1.1 NOTIFICATION OF HOUSING PLACEMENT MATCH

When a program accepts a participant from the CAA triage list, the program will, within 2 business days, attempt to contact the participant to notify them a placement has been made.

Within 7 days a minimum of two attempts will be made to contact the participant, each time using the means of contact provided by the participant. All efforts made to notify the participant will be documented in the HMIS participant notes.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant file

FOR PROGRAMS WHO DO NOT ACCEPT REFERRALS THROUGH COORDINATED ACCESS AND ASSESSMENT (CAA)

2.1.2 REFERRALS

Within 5 working days of receiving a referral, the program responds to the referred person to acknowledge whether or not the referral meets the program's eligibility criteria and provides information regarding anticipated wait times.

This information must be documented.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ On-site observation

2.2 INTAKE

2.2.1 CONSENT TO RECEIVE SERVICES

Participants are provided with clearly defined program expectations at the time of intake, which include:

1. What services the program delivers
2. What the program's expectations are of the participant, including home visits and safety checks
3. Which portion (if any) of the program is optional
4. Discharge processes (both planned and unplanned)

Expectations are written in a manner that is easily understandable by the participant. Staff are to review these expectations verbally and a written copy offered to the participant. Consent is to be provided voluntarily and can be revoked at any time. A signed and dated copy of the consent is kept on the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.2.2 PARTICIPANT ENGAGEMENT

A key focus of case management is participant engagement that occurs both in the community and in the home and varies as the level of stability of the participant changes. Participants should be made aware that home visits are a part of case management and should initially occur minimally once per week during initial relationship building.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.2.3 PARTICIPANT RIGHTS

Participants are informed of their rights at the time of intake, which include:

1. Being treated with dignity and respect
2. Choice in housing location relative to existing rental market inventory and programmatic funding capacity
3. Involvement with the program
4. Involvement in service planning
5. Establishing/setting long term goals
6. Confidentiality
7. Grievance procedures (including CHF)
8. Information sharing
9. Advocacy
10. Cultural connection
11. Spiritual connection
12. Options to connect/reconnect with any natural supports (including but not limited to family)

Rights are written in a manner that is easily understandable by the participant. Staff are to review these rights verbally and a written copy offered to the participant. Rights are accessible (e.g. posted, handbook, etc.) and known by the participants and staff.

INDICATORS:

- ❏ Policy and procedure
- ❏ Supervisor/direct service staff interview
- ❏ Participant interview
- ❏ Participant file

2.2.4.A SAFETY CHECKS – SCATTERED SITE SUPPORTIVE HOUSING

The program has written policy and procedure that minimally addresses:

1. If the program does safety checks
2. That safety checks are only conducted in accordance with the program policy
3. Under what circumstances a safety check is conducted
4. A process for re-informing the participants of their rights
5. A process for re-informing participant of the grievance process
6. Documentation must be completed for all safety checks regardless of outcome
    a. Documentation is minimally a case note but may be an incident report depending on the outcome of the safety check

INDICATORS:

- ❑ Policy and procedures
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview and files
- ❑ On-site review of Incident Reports

2.2.4.B SAFETY CHECKS – PLACE-BASED SUPPORTIVE HOUSING

The program has written policy and procedures that minimally addresses the following:

1. If the program conducts safety checks as part of individual service plans – planned safety check
    a. The process for requesting planned safety checks should be clearly outlined in a manner that is easy to understand for the participant
2. When an unplanned safety check would be conducted
3. That unplanned safety checks are only conducted in accordance with the program policy
4. A process for re-informing the participant of their rights
5. A process for re-informing the participant of the grievance process
6. Documentation must be completed for all safety checks regardless of outcome
    a. Documentation is minimally a case note but may be an incident report depending on the outcome of the safety check

INDICATORS:

- ❑ Policy and procedures
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview and files
- ❑ On-site review of Incident Reports

2.3 CONSENTS

2.3.1 RE-INFORMED OF RIGHTS*

The program will demonstrate that participants are regularly re-informed of their rights.

The rights of the participant will be:

1. Posted or are accessible to the participant (e.g., handbook, brochure, etc.)
2. Reviewed and documented as part of or within the same timeframe as regular service delivery planning meetings
3. Reviewed following any significant or critical incident that may have impacted the rights of participants (e.g., searches, restraints, restrictive procedures, etc.)

INDICATORS:

- ❑ Narrative describing the process used to re-inform participants of their rights
- ❑ Supervisor, direct service staff, and contractor interview
- ❑ Participant interview
- ❑ Participant file

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2.3.2 PARTICIPANT GRIEVANCES

The program has a written participant grievance policy that minimally addresses:

1. The process for filing a grievance regarding the program or program staff which includes relevant contact information for the appropriate staff to reach out to
2. The process of the program to follow up with participant grievances including a timeline for follow up that is no longer than 10 business days
3. The process for the participant to respond to program follow-up
4. The process for the participant to escalate the grievance through the program and to CHF when necessary
5. The program provides a clear response to the grievance, whether resolved or not
6. The program will have a process for re-informing participants of the grievance process especially after a critical incident.

INDICATORS:

- ❑ Policy and Procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.3.3 SEARCHES*

The program will have written policies and procedures for conducting searches. These policies and procedures will include:

1. Whether or not searches are permitted within the program
2. The types of searches allowed (e.g., room search, search of bags, personal search to ensure medication has been swallowed, etc.)
3. The circumstances that warrant a search, such as:
    a. To ensure the safety of persons served and others involved
    b. To recover missing or stolen property
    c. Only after consultation with the person served or program manager
4. How the program will respect the dignity of the person served and avoid undue or unnecessary force or embarrassment
5. Programs that conduct searches will notify persons serve:
    a. Through their program information, or

   b. Within the individual service delivery plan

6. Limits such as the following will be placed upon the search:
   a. Strip searches may only be conducted by the police
   b. Physically touching the person served (e.g., patting-down, frisking, etc.) is prohibited
   c. Searches that require a person served to remove their clothing are conducted in a way that allows the person served privacy to change into a provided change of clothing
   d. Whether or not persons served may be asked to empty their pockets and to open their mouth
   e. Whether or not the use of a detection system (e.g., a wand metal detector, etc.) is permitted
7. A process to deal with:
   a. Unauthorized searches (e.g., random searches by staff, volunteers, contractors, etc.)
   b. The inadvertent finding of items (e.g., during the cleaning of a bedroom, etc.)
8. The completion of an incident report for all searches
9. Documentation that demonstrates the person served was made aware of:
   a. The reason for and the findings of the search
   b. Their right to initiate the conflict resolution process

INDICATORS:

- ❑ Policy and procedures
- ❑ Senior management interview
- ❑ Supervisor, direct service staff, contractors, volunteers, and student interview
- ❑ Participant interview
- ❑ On-site review of Incident Reports

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2.3.4 DATA COLLECTION

The program has a written consent form that discusses the protection of privacy and confidentiality of participant information and must include:

1. Purpose of the information being collected
2. Reason for collection of information
3. Use of information
4. Access to information
5. Secure storage of information
6. Length of time information will be stored

Consent is written in a manner that is easily understandable by the participant. Staff are to review this consent verbally and a written copy offered to the participant. Consent is to be provided voluntarily and can be revoked at any time. A signed and dated copy of the consent is kept on the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.3.5 RELEASE OF INFORMATION*

In accordance with federal and provincial legislation, the organization will have written policies and procedures to address obtaining, sharing, and releasing confidential information. This will include:

1. Determining if the release of information is in the best interest of the participant
2. Obtaining the written acknowledgment from the participant or the legal representative, subject to legislation

The organization will also ensure that the written acknowledgement documents:

1. To whom the information will be released
2. Who will access the information
3. The purpose of sharing the information
4. The timeline, including dates, within which the release of information will be allowed. Consent is written in a manner that is easily understandable by the participant. Staff are to review this consent verbally and a written copy offered to the participant. Consent is to be provided voluntarily and can be revoked at any time. A signed and dated copy of the consent is kept on the participant file.

INDICATORS:

- ❏ Policy and procedure
- ❏ Narrative with a description of the process used in the release of information
- ❏ Senior Management, Program Managers, Service Professionals, Supervisor, and direct service staff interview
- ❏ Participant interview
- ❏ On-Site Observations (e.g. Participant file)

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2.4 SUPPORTS

2.4.1.A CRISIS SUPPORT – SCATTERED SITE SUPPORTIVE HOUSING

Participants are advised at the time of intake of how to access 24 hour, 7 day per week crisis supports. Crisis supports can be provided either by telephone or in person. If the program does not offer 24 hour crisis support, a list of crisis resources will be provided to the participant.

Participants are to be given a copy of these resources and a signed and dated copy is kept on the participant file.

2.4.1.B CRISIS SUPPORT – PLACE-BASED SUPPORTIVE HOUSING

Participants are advised at the time of intake and move in of how and where to access crisis supports, including off-site supports, that are 24-hour, 7 day per week. Crisis supports can be provided either by telephone or in person. Participants are to be given a copy of resources and a signed and dated copy is kept on the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.5 ASSESSMENT

2.5.1 ASSESSMENT TOOLS

Following the intake of a participant, programs will use an evidence-based assessment tool to inform service planning goals and priorities. Programs can determine which assessment tool they wish to use to assist in service delivery planning.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct staff interview
- ❑ Participant File
- ❑ Narrative – programs to define the validity of their chosen assessment tool

2.5.2 INITIAL ASSESSMENT

An initial assessment will be completed within 30 days of move in. A copy of the completed assessment is kept on the participant file. The participant is offered a copy of the assessment upon completion.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.5.3 ONGOING ASSESSMENT

An assessment will be completed every 90 days following the initial assessment, up to and including 30 days prior to discharge. If a participant is involved in a program for longer than 2 years, assessment may occur every six months. Copies of the completed assessment are kept on the participant file. The participant is offered a copy of the assessment upon completion.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.5.4 FINAL ASSESSMENT

If an assessment has not been completed within 30 days prior to discharge a final assessment will be completed within 10 days. If a final assessment is unable to be completed (e.g. unforeseen, unplanned discharge), documentation of the reason why is maintained on the participant file. A copy of the completed final assessment is kept on the participant file. The participant is offered a copy of the final assessment.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.6 PLANNING

2.6.1 PARTICIPANT-CENTRED SERVICE PLANNING

Service planning goals will be informed through the assessment tool but determined by the participant. Service plans should include other individuals as determined by the participant.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.6.2 SERVICE PLAN COMPONENTS*

The purpose of the individual service delivery plan is:

- *To promote the health of persons served;*
- *To maintain and support wellness (e.g., through education, prevention of illness and injury, etc.);*
- *To ensure that persons served are provided with the knowledge, resources, and tools to support their autonomy and independence; and*
- *To support and encourage communication between persons served, the family representative or guardian, staff, and service team members.*

The program will ensure that there is one integrated and complete individual service delivery plan for each person served, which includes the following components:

1. A statement that identifies the reason for involvement in the program
2. The goals to be achieved
3. Strengths of the participant that support the goals
4. The tasks, activities, and strategies required to meet the identified goals
5. The indicators or measures of success used to determine the maintenance or progress made towards goal achievement
6. The timelines for review
7. Signature of staff, participant, and any additional parties involved in service planning/delivery

Participants are to be offered a copy of the Service Plan and a signed and dated copy is kept on the participant file.

Alternately, if services are optional, attempts to engage participants in service planning are documented in circumstances where participant does not want to participate.

INDICATORS:

- ❏ Document review to provide a copy of the service plan
- ❏ Participant file review
- ❏ On-Site Observations of Practice

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2.6.3 INITIAL SERVICE PLAN – TIMELINES

The initial service plan will be completed within 45 days of intake. A signed and dated copy is kept on the participant file and a copy is offered to the participant.

Scattered-site, bridge housing, rapid-rehousing, and rent subsidy programs providing case management must also complete the following with participants within 90 days of intake:

1. A low-income subsidized housing application (e.g. Calgary Housing, Onward Homes, Norfolk Housing, etc.)
2. If applicable, an application to seniors low-income subsidized housing
3. If applicable, an application to the Advancing Futures for youth aged 18-24

Scattered-site, bridge housing, rapid-rehousing, and rent subsidy programs must keep a completed and signed application on the participant file and a copy is offered to the participant. Applications must be updated every 12 months with a copy kept on the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.6.4 SERVICE PLAN REVIEW

The service plan is reviewed with participants minimally every 3 months to ensure its continued relevance and to identify goals achieved and/or goals and timelines to be adjusted.

If a participant is in a program for a period greater than 2 years, review may occur every 6 months which allows for long term planning.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.6.5 FINAL SERVICE PLAN REVIEW

A final review of the service plan occurs 30 days before the planned discharge date.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.7 PARTICIPANT REFERRALS

2.7.1 SUPPORT TO ACCESS REFERRALS

If referral to outside services is part of the service plan, staff will offer to accompany the participant to the needed service minimally the first time to help ensure successful engagement, as staffing allows.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.8 INCIDENT REPORTING

2.8.1 REPORTABLE INCIDENTS*

The program will have a written policy to define reportable incidents. Reportable incidents will include, but are not limited to:

1. Unanticipated or unauthorized absences of the person served from the program
2. A medical or other kind of emergency, serious illness, fall or accident
3. Unintentional injuries to persons served
4. A dangerous situation (e.g., threats of violence, weapons, person served being a danger to self, etc.)
5. Thoughts of or attempts at suicide or self-harm
6. Real or suspected abuse or harassment by anyone (e.g., person served, staff, volunteer, teacher, community member, etc.)
7. Aggressive, combative or potentially harmful behaviour towards other people which has not been addressed in the service delivery plan or restrictive procedure plan
8. Risk to public safety (e.g. criminal charges related to violent/dangerous offences such as armed robbery, Form 10, etc.)
9. Issues with medication, including:
    a. Errors
    b. Any signs or symptoms of adverse drug reaction or over-sedation
    c. Missed medication
    d. Refused medication
    e. Apparent abuse of medication
10. Transfer to a hospital or medical clinic for emergency treatment
11. Outbreak of a contagious disease or condition (e.g., influenza, scabies, food-borne illness, etc.)
12. A significant weight loss
13. Substance abuse
14. Inappropriate use of strategies to alter the behaviour of person served by staff, volunteers, students or contractors
15. Searches which are not part of regular programming
16. Use of any restrictive procedures (e.g., restraint, searches, isolation, etc.) that are not identified and documented in the service delivery plan or restrictive procedure plan

17. Theft or reported theft of money or personal belongings of a person served
18. A building evacuation (e.g., in reaction to a gas leak, fire, etc.)
19. A malfunction of the safety or security systems (e.g., fire alarm, mechanical systems, etc.)
20. Death
21. Other events as identified by the program

The policy will also define and have procedures to report an incident that is considered a "near miss" (an incident that had the potential to become a reportable incident).

INDICATORS:

- ❑ Policy and Procedure
- ❑ Narrative with a description of what is addressed in the incident report or blank copy of the form
- ❑ On-Site Observations

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2.8.2 CRITICAL INCIDENTS

Specific serious incidents are considered to be critical incidents and must be reported to CHF within 24-hours of the incident occurring. The following are considered to be critical incidents:

1. Death
2. Eviction that is the result of violence and/or dangerous situation
3. Any incident that may garner media attention
4. Medical emergency, serious illness, accident requiring medical/EMS or justice intervention
5. Risk to public safety (criminal charges related to violence, dangerous offenses such as armed robbery, Form 10, etc.)
6. Searches that are not part of regular programming
7. Significant damage to property/building
8. Suspicions/allegations of abuse within/outside agency
9. Use of restrictive procedures (restraints, unlocked confinement, etc.)

INDICATORS:

- ❑ Critical incident form submitted to CHF within 24 hours of incident occurring
- ❑ Senior Staff /Staff interview
- ❑ Participant file/ On-site observation

2.8.3 DOCUMENTATION REQUIRED – SERIOUS & CRITICAL INCIDENTS*

The program will have written policies and procedures requiring reportable incidents to be documented and reviewed.

1. Documentation will include:
    a. Identification of the incident reporter (e.g., staff, volunteer, contractor, representative, person served, family member, etc.)
    b. A history of events or circumstances leading up to the incident
    c. The behaviour of the person served who required intervention, if applicable
    d. A timeline of the interventions used
    e. A description of actions taken by staff, volunteers, supervisors or others involved (e.g., police, medical personnel, etc.)
    f. Any follow-up actions or recommendations
2. Follow-up after the incident will include:
    a. A debriefing with the person served and others who may have been affected
    b. The person served being informed of their rights (e.g., to initiate a conflict resolution process, contact an advocate, etc.)
    c. A root-cause analysis for the occurrence conducted by the program
3. The policies and procedures will identify the timelines for reporting to the appropriate authorities (e.g., family representative, guardian, physician, police, etc.)
4. All incidents that receive media/potential media coverage, and/or death of any participant(s) must be reported to the funder within 24hrs.

INDICATOR:

- ❑ Policy and procedure
- ❑ Narrative with a description of the timelines for reporting of an incident
- ❑ Supervisor/direct service staff interview
- ❑ On-Site Observations

**CAC Standard used with permission from the Canadian Accreditation Council of Human Services*

2.8.4 REVIEW OF INCIDENT REPORTS*

The program will ensure that the team or supervisor reviews all incident reports on a case-by-case and program-by-program basis (e.g. identify trends in frequency, effectiveness of interventions, corrective action required, follow up, etc.) minimally semi-annually to:

1. Ensure the completeness of the information included
2. Identify trends (e.g., number of incidents with a particular participant, personnel, particular circumstances, etc.)
3. Address corrective action required (e.g., training needs identified, etc.)
4. Ensure reporting requirements are being met

INDICATORS:

- ❑ Narrative description of the process to review critical incident reports and the aggregate reports that are created annually
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ On-site observation of practice and follow up

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2.9 DISCHARGE PROCESSES

2.9.1 PLANNED DISCHARGE

Before a planned discharge from the program, staff will ensure that:

1. Participant is ready to disengage from the program
2. A review of the service plan occurs with the participant to ensure goals have been met
3. A final assessment is completed, utilizing the same evidence-based tool as at intake
4. Participant is informed of how to re-access Recovery Oriented Supportive Housing (ROSH) services in the future, if they choose to

INDICATORS

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.9.2 FORESEEN, UNPLANNED DISCHARGE

Before a foreseen, unplanned discharge from the program, staff will ensure all efforts have been made to address behavioural issues and rental arrears through mediation, conflict resolution, landlord/building operator negotiations, and options for housing transfer.

All efforts will be documented and the participant will be offered a copy. A copy is kept in the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

2.9.3 FORESEEN, UNPLANNED DISCHARGE – TRANSFER EFFORTS

In the event of foreseen, unplanned discharge, the staff will ensure all efforts have been made to facilitate transfer to another case management program. This includes:

- Following the Transfer Process outlined in the Terms of Reference: Coordinated Entry Placement Committee
- Transfer program contact information
- Acknowledgement of receipt of referral from receiving agency
- Proposed date of screening/intake
- Transfer of participant information (with consent)
- Contact information for re-engagement in the discharging program

For non-CHF funded programs that participate in Coordinated entry , a minimum of 3 appropriate referrals should be made which one may include CAA. Only when no alternative is available should emergency shelter referral be an option. If a participant is unwilling to be transferred it is important that they be supported in their right to choose. Once presented with 3 appropriate options, and they refuse all, the program may discharge the participant.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview

2.9.4 UNFORESEEN, UNPLANNED DISCHARGE – DISCHARGE SUMMARY

In the case of unforeseen, unplanned discharge, that is immediate and cannot be predicted (participant leaves without prior discussion with the case manager, violence toward a staff member/other participant, etc.), staff must complete a discharge summary that contains information related to efforts to resolve issues and keep participants engaged.

This will be documented in the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant file

2.9.5 RE-INFORMING OF GRIEVANCE PROCESS

Participants should be re-informed of the grievance process at the time of discharge. CHF grievance process requires the participant to first complete the program grievance process prior to initiating a formal grievance with CHF.

Participants are to be offered a copy and a signed and dated copy is kept on the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant file

2.9.6 RE-ACCESSING SERVICES

At discharge, the participant is advised how to formally re-access Recovery Oriented Supportive Housing (ROSH) services in the future using the CAA process. This standard does not apply to participants who access the program for strengthening sessions/support. Programs that don't accept referrals through CAA will advise participants of how to access services in the future.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant file

3 PRIVACY AND INFORMATION MANAGEMENT

3.1 DATA MANAGEMENT

3.1.1 INFORMATION MANAGEMENT SYSTEM*

The organization will possess secure systems to manage information requirements (e.g., personnel files, person served files, data collection systems, etc.), and will have written policies and procedures ensuring the completeness, accuracy, security, and use of all information.

INDICATORS:

- ❑ Policy and procedure
- ❑ Narrative description of the system used
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ On-site observation

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3.1.2 ACCESS TO FILES/DATA (STAFF)*

The program has written policies and procedures which define the processes by which it restricts and monitors access to the files/data of staff. These policies include:

1. How staff may access their own records and addresses those documents (if any) that would not be accessible
2. Positions within the program who may access files
3. Addressing the process to:
    a. Add, correct and/or delete information currently on the file
    b. Respond to requests for access by former staff

INDICATORS:

- ❑ Policy and procedure
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview

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3.1.3 ACCESS TO FILES/DATA (PARTICIPANTS)*

The program has written policies and procedures which define the processes by which it restricts and monitors access to the files/data of participants. These policies include:

1. How participants may access their own records and addresses those documents (if any) that would not be accessible
2. Positions within the program who may access files or other communication mechanisms (i.e. log books, communication books, etc.)
3. Addressing the process to:
    a. Add, correct and/or delete information currently on the file
    b. Respond to requests for access by former participants
    c. Respond to requests for the records of deceased participants

INDICATORS:

- ❑ Policy and procedure
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview

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3.1.4 MAINTENANCE OF DATA*

The program has written policy and procedures which address files and/or data for current and past staff and participants.

Procedures are congruent with legal and funder's requirements and the program's confidentiality policy. Procedures must address:

1. Transporting of information
2. Sharing and reporting of information
3. Timelines for the storage of records
4. Means of storage for open/closed files
5. Destruction of records or data

INDICATORS:

- ❏ Policy and procedure
- ❏ Senior management interview
- ❏ Supervisor/direct service staff interview
- ❏ On-Site Observations

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3.1.5 PROTECTION OF CONFIDENTIAL INFORMATION*

The organization will have written policies and procedures regarding the protection of its electronic and physical information from unauthorized access, theft, and destruction by fire, water, loss, corruption, power failure, and other damage. These policies and procedures will include, but not be limited to:

1. Locked storage for paper files containing personal information, and provisions for secure shredding
2. Best practice security measures installed on all computers, including up-to-date anti-virus protection, the use of passwords and firewalls for the electronic collection and transfer of sensitive data
3. Maintenance of regular backups for all electronic records, preferably stored off-site

INDICATORS:

- ❏ Policy and procedure
- ❏ Narrative description of the procedures and methods used to secure files and data
- ❏ On-site observation

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3.1.6 COMMUNICATION TECHNOLOGIES*

The program will have written policies and procedures addressing the use of social media and the security of electronic and wireless technologies in the program, which may include, but not be limited to:

- Who is authorized to post on the organization's social media sites on behalf of the organization
- Boundaries regarding use of personal social media in relation to the person served
- Safekeeping of any organization electronic or wireless technologies, such as cell phones.

INDICATORS:

- ❑ Policy and procedure
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ On-site observation

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4 SERVICE DELIVERY

4.1 PARTICIPANT SERVICE DELIVERY

4.1.1 PRIMARY CASE MANAGER

A team based collaborative approach with a primary case manager is essential. The primary case manager will:

1. Be identified on the participant file
2. Be responsible for service team co-ordination
3. Be responsible for arranging case conferences and reviews

Documentation of these activities is on the participant file.

INDICATORS:

- ❏ Policy and procedure
- ❏ Supervisor/direct services staff interview
- ❏ Participant interview
- ❏ Participant file

4.1.2 DIRECT CLINICAL SERVICES - QUALIFICATIONS

Agencies providing case management services that include direct clinical services such as counselling in regards to mental health and chronic health concerns will ensure that these services are provided by qualified clinicians (either via partnerships with other agencies/services or internal to the program) who are registered and/or regulated by their specific professional body. Clinical designations include: physicians, nurse practitioners, mental health therapists (RSW, Clinical Psychologist, Psychiatrist, Mental Health/Psychiatric Nurses, etc.).

INDICATORS:

- ❏ Policy and procedure
- ❏ Senior management interview
- ❏ Clinician file

4.1.3 DIRECT SERVICE PROVISION – PARTNERSHIPS

Any partnerships and/or processes to provide direct services on site via other organizations should be documented within the program's protocols along with copies of any partnership agreements or Memorandums of Understanding (MOUs).

INDICATORS:

- ❑ Policy and procedure
- ❑ Senior management interview
- ❑ On-site observation

4.1.4 MOVE IN/MOVING SUPPORT – BASIC AND NECESSITIES

Comprehensive, cost-effective move-in/moving support is planned for by the case management service or via appropriate referral. The case manager should work with participants to ensure that they have all of the basic furniture and necessities in place upon move-in or relocation (rehousing) or have a plan in place to ensure acquisition begins at the time of move in and is completed within 5 business days. Minimum necessities include:

1. Bed (bedbug protection as necessary)
2. Utility set up
3. Basic cookware and dishes
4. Telephone/cell phone
5. One week's worth of groceries and toiletries
6. Initial Cleaning Supplies

If this cannot be accommodated, documentation of the efforts made and reasons why not will be kept in the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

4.1.5 RELOCATION/REHOUSING

Prior to relocation and/or rehousing, the case manager will support the participant in accessing moving services to ensure loss is minimized. This should be documented in the participant file.

INDICATORS:

- ❑ Policy and procedure
- ❑ Supervisor/direct service staff interview
- ❑ Participant interview
- ❑ Participant file

APPENDIX A: GRIEVANCE OF PROCESS

2024 Edition

Calgary Homeless FOUNDATION

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GRIEVANCE OF PROCESS

BASIS FOR GRIEVANCE

During the course of an On-Site Survey, organizations have the right to initiate a Grievance of Process if there are concerns regarding:

- A review team member's approach, attitude or presentation
- A review team member's perceived objectivity
- The impartiality or fairness of the process

Organizations are expected to make every effort to resolve conflicts with the team prior to the conclusion of the On-Site Survey through discussions with the team lead or administrative reviewer. If the conflict is with the team lead or the administrative reviewer, the organization's representative is instead encouraged to contact CAC's Director of Accreditation Services to find a solution before proceeding to the grievance process.

ACCESSING THE GRIEVANCE PROCESS

If no solution can be reached using the above procedures, organizations may wish to file a Grievance of Process.

A Grievance of Process consists of a written outline of the problem to be submitted to CAC's CEO (deliverable to CAC's main address) within 10 business days of the completion of the On-Site Survey. The CEO has 5 business days from receipt of the concerns to respond to the organization.

The CEO may find that:

- The organization's concerns are substantiated and order a new survey with a new review team, with costs assumed by CAC
- The organization's concerns are not substantiated and have the accreditation process proceed to the Accreditation Panel

Within 5 business days of receiving the CEO's decision, if an organization believes that their concerns were not dealt with fairly, they may submit, in writing, a request for a hearing with an outline of the concerns to be addressed. The only bases upon which a Grievance of Process will be heard are listed in the above section, Basis for a Grievance. The letter requesting a grievance is deliverable to CAC's main address and will be

forwarded to the Chairperson of the Appeal Committee (the committee that deals with Grievance of Process and Appeal of Decision requests).

APPEAL COMMITTEE

PRELIMINARY DECISION

The Appeal Committee has 20 business days to respond to the organization with its decision on the validity of the grievance of process.

The Appeal Committee may preliminarily find that:

- The organization has no basis for a grievance, at which point the organization will be informed of the decision and the accreditation process will proceed to the Accreditation Panel
- The organization has grounds for a grievance of process and set a hearing date to be held within the original 20-business-days window

HEARING

The Appeal Committee will request the following documentation be presented to them at least 5 business days prior to the scheduled hearing:

- The organization's request for a grievance of process, including the reasons for the grievance
- The CEO's letter to the organization, outlining the reasons for the CEO's decision for rejecting the grievance
- The On-Site Report and Organization Response
- A brief, written chronology of events compiled in consultation with the team lead, administrative reviewer, and the Director of Accreditation Services

In addition to the written documentation, the Appeal Committee may request that the following individuals be present during the scheduled meeting:

- CAC's CEO, to provide a briefing regarding the decision to reject the grievance
- The organization's senior management, to present the reasons for the grievance
- The team lead, administrative reviewer or Director of Accreditation Services (as indicated by the Appeal Committee) to provide an overview of the chronology

The Appeal Committee will see and question each of these people individually. After deliberations, the Appeal Committee may:

- Deny the grievance of process and allow the accreditation process to proceed to the Accreditation Panel
- Request a re-survey of the organization by a different review team, to be completed within 2 months of the Appeal Committee's decision, with costs assumed by CAC

Within 10 business days of the hearing, the Appeal Committee will notify, in writing, the organization's senior management and CHF, and CAC's CEO and Director of Accreditation Services of their decision. It is the responsibility of the Director of Accreditation Services to notify the team lead and administrative reviewer of the outcome. The decision of the Appeal Committee is final.

APPENDIX B: APPEAL OF DECISION

2024 Edition

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APPEAL OF DECISION

BASIS FOR AN APPEAL

Upon receiving the Accreditation Panel's decision in writing, organizations have the right to initiate an Appeal of Decision if they believe that:

- The Accreditation Panel did not follow the established procedures
- The Accreditation Panel's conclusions are not valid based on the Organization Response

ACCESSING THE APPEAL PROCESS

Organizations have 20 business days from receipt of the Accreditation Panel's decision in which to submit a request for an Appeal of Decision. If a request for an appeal is submitted after the 20 business day deadline, it is at the discretion of the CEO of CAC if it will be accepted, depending on any extenuating circumstances present. The organization must outline their concerns in writing and forward them to the Chairperson of the Appeal Committee, deliverable to CAC's address.

Any ensuing appeal will be based solely on the information and documentation previously presented to the Accreditation Panel (i.e., no new documentation will be accepted), though organizations will have the opportunity to explain or clarify ambiguous material.

During this process, the organization will retain its previous accreditation status until the appeal process is complete.

APPEAL COMMITTEE

PRELIMINARY DECISION

The Appeal Committee has 20 business days from the receipt of the letter requesting an appeal to respond to the organization with its decision.

The Appeal Committee may preliminarily find that:

- The organization has no basis for an appeal, at which point the organization will be informed of the decision and the Accreditation Panel's decision will remain in effect
- The organization has grounds for an appeal and set a hearing date to be held within the original 20–business-day window

HEARING

The Appeal Committee will request the following documentation be presented to them at least 5 business days prior to the scheduled hearing:

- The organization's request for an appeal, including the reasons for appeal
- The Accreditation Panel's letter to the organization outlining the reasons for their decision
- The On-Site Report and Organization Response, as originally presented to the Accreditation Panel
- The minutes of the Accreditation Panel meeting in which the organization was granted a status
- A brief, written chronology of events compiled in consultation with the team lead, administrative reviewer, and the Director of Accreditation Services

In addition to the above documentation, the Appeal Committee may request that the following individuals be present during the scheduled meeting:

- The Chairperson of the Accreditation Panel, to provide a briefing regarding the previous decision (this may occur in a briefing prior to the hearing, at the discretion of the Appeal Committee)
- The organization's senior management, to present the reasons for the appeal
- The team lead, administrative reviewer, Director of Accreditation Services or CAC's CEO (as selected by the Appeal Committee) to provide an overview of the chronology of events

The Appeal Committee will see and question each of these people individually. After deliberations, the Appeal Committee may:

- Deny the appeal and uphold the decision of the Accreditation Panel
- Grant a different accreditation status to the organization, up to a maximum of 4 years
- Request a re-survey of the organization by a different review team, to be completed within 2 months of the Appeal Committee's decision, with costs assumed by CAC

Within 10 business days of the hearing, the Appeal Committee will notify, in writing, the organization's senior management and CHF, and CAC's CEO and Director of Accreditation Services of their decision. It is the responsibility of the Director of Accreditation Services to notify the CAC team lead and CAC administrative reviewer of the outcome. It is the responsibility of the CEO to notify the Chair of the Accreditation Panel of the outcome. The decision of the Appeal Committee is final.

APPENDIX C: PROCESS TO RESPOND TO COMPLAINTS

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PROCESS TO RESPOND TO COMPLAINTS

All reported allegations of misconduct are taken very seriously, though not all are within the scope of CAC's standards. Allegations are to be directed to the CEO of CAC, who will be responsible for maintaining confidentiality and directing the process of allegations. It should be noted that the CEO will try to protect the identity of the complainant, however, at some point in the process there may be a need to disclose the complainant's identity in order for the organization's leadership to be able to respond to the allegations. The complainant will be notified by the CEO of the possibility of disclosure of identity. Throughout the allegations process CAC will make every effort to meet the deadlines set forth, though timelines may be extended to accommodate any required written documentation from either the complainant or the organization. In cases where the timelines must be extended, written communication will be sent to both parties outlining the reason for timeline extension and when the next step is expected to proceed.

ACCESSING THE ALLEGATIONS PROCESS

When an allegation is brought forward against an organization that is in the process of accreditation or accredited by CAC, the complainant is directed to the CEO to provide a statement of their allegation against the organization. Details of the allegation are documented, and if the allegation is provided verbally it is recorded in a written format and sent to the complainant to verify the information provided.

Upon receiving a full account of the allegation, the CEO will determine if the allegation falls within the scope of CAC, within 5 business days. This will include a review and verification of the following:

- Was the organization's internal process utilized? – The CEO will validate the use of the internal process by the complainant (e.g. grievance, conflict resolution, ethical conflict, whistleblower, etc.)
- Were external authorities or processes utilized? – The CEO will validate the use of an external process such as professional college/ association for professional misconduct, a provincial or federal body (e.g. police, RCMP, etc.) for contravention of legislation or law, or a human resource body (e.g. Human Rights Board, Labour Standards, etc.) for contravention of the rights of the staff
- Is the issue within the scope of CAC standards? – The allegation must relate to current situations or events that present a safety concern for stakeholders or issues that have the potential to create safety

concerns for stakeholders. There must also be an assessment of the factors in play to mitigate and manage the safety concerns of the risks presented

During this time, communication will be maintained with the complainant. If the complainant chooses to proceed with the complaint, the organization will be given the opportunity to develop a written response to the allegations. The CEO will make every effort to maintain the confidentiality of the complainant, though it may be necessary to disclose the identity of the complainant to the organization in order to receive a full account of the issues brought forward. Prior to any disclosure of identity, the CEO will be in contact with the complainant to gain either verbal or written consent.

If, upon review of all documentation, the allegation is not within the scope of CAC's standards, has not utilized the organization's internal processes, or has not utilized appropriate external authorities, the CEO will direct the complainant to the appropriate authority to pursue their allegation. If the allegation does fall within the scope of CAC's standards and appropriate authorities have previously been engaged, then the allegation will move to the next step. The outcome of the first evaluation of the information will be provided to the complainant and organization leadership in writing.

PRELIMINARY DECISION

If the CEO has deemed that the allegation should move forward within the process, the President of the Board of Directors and CEO will review the information that has been provided by the complainant and the organization to determine CAC's role regarding the allegation. The outcome of the review will be decided within 10 business days of the receipt of the allegation and will be communicated in writing to all parties involved. The CEO and President of the Board of Directors may preliminarily find that:

- The allegation is currently under review by another professional body and must be completed through their processes before CAC can take action (at CAC's discretion)
- The allegation does not relate to the scope of CAC's standards and is best served through another process, in which case no further actions will be taken
- The allegation does relate to CAC's standards and warrants further review

If it is found that the allegation is to continue through the allegations process, a hearing date will be set within 20 business days of the decision.

HEARING

Once a hearing has been requested, the Allegations Committee will be convened, which is comprised of at least 3 members:

- President of the Board of Directors
- Board Member
- Community Representative

The Allegation Committee will review the following documentation:

- The full written account of the allegation
- The organization's written response to the allegation
- The most recent On-Site Report and Organization Response (if applicable) for the organization.
- The minutes of the Accreditation Panel meeting during which the organization was last granted an accreditation status
- Any additional material related to the allegation

In addition to the written documentation, the Allegation Committee may request that the complainant, a member of the organization's senior management, CAC's Director of Accreditation Services, Administrative Reviewer, and any other person whose testimony is deemed relevant, be present for the hearing, either in person or virtually. The Allegation Committee will see and question each person individually to gather a full understanding of the allegation presented.

Once the interviews have concluded and the Allegation Committee has reviewed the written documentation, the Allegation Committee may make one of the of the following decisions:

- The allegation is unfounded and the organization will maintain its current accreditation status
- A partial re-survey related to the allegation must be conducted within 2 months of the decision, at the organization's expense
- A complete re-survey of the organization must be conducted within 2 months of the decision, at the organization's expense
- Tabling of the decision to consult with a subject matter expert or request additional information and reconvene within 5 business days to make the final decision

RE-SURVEY OF THE ORGANIZATION

If a partial or complete re-survey of the organization is ordered, the new review team will be made aware that they are conducting a second survey but will not be informed of the reason, to maintain as much objectivity as possible. However, in the best interests of the persons served and personnel, the administrative reviewer will be made aware of the circumstances of the allegation. The administrative reviewer will be instructed to immediately report any pressing concerns or safety issues found during the On-Site Survey to CAC's CEO and designate(s), the organization's director, and, if appropriate, to any applicable external body (e.g. ministry, funder, etc.). If the organization fails to cooperate with the review team, the events will be reported to the Allegation Committee and the organization's accreditation status will be revoked immediately.

Within 10 business days of the completion of the On-Site Survey the Allegation Committee will reconvene, unless any pressing concerns are discovered, in which case the timeline will be moved up. After deliberations the Allegation Committee may decide:

- The allegations were unfounded and therefore maintain the organization's current accreditation status
- The allegations are founded and revoke the organization's current accreditation status

The Allegation Committee will notify, in writing, the organization's senior management, the complainant, and CAC's CEO of the decision within 5 business days of their hearing. The decision of the Allegations Committee is final.

APPENDIX D: READING THE STANDARDS

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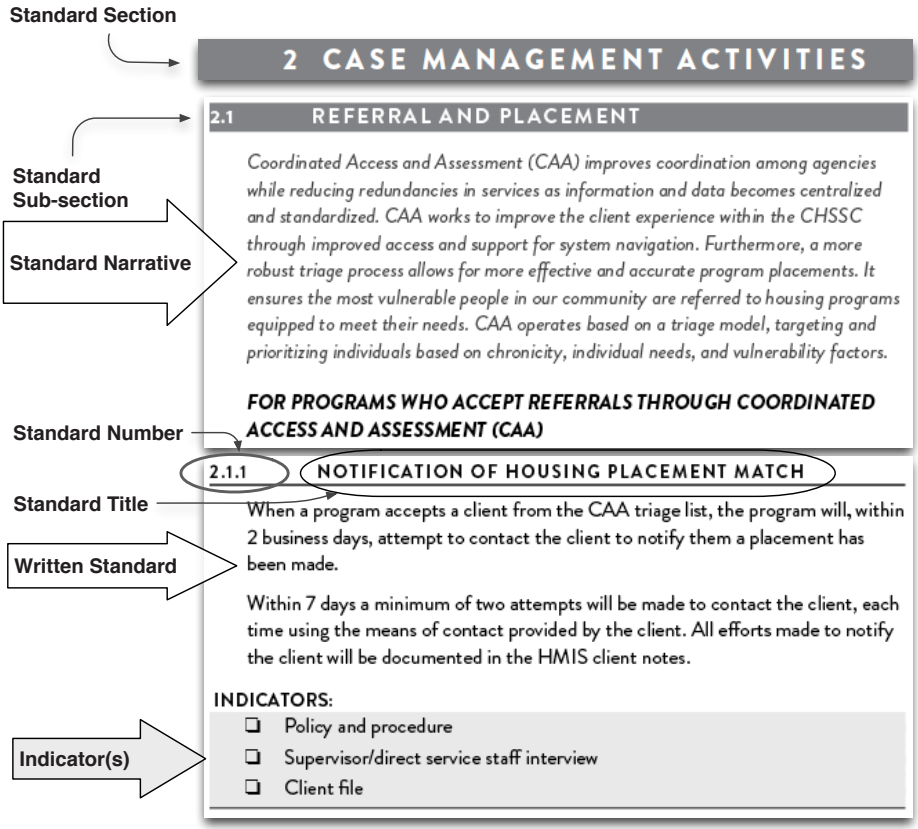
READING THE STANDARDS

HOW STANDARDS ARE WRITTEN

Standards can vary in length and may be comprised of a single statement or a number of components. Standards with lists of requirements are preceded by either:

- Numbers and Letters – These indicate that all parts of the list are required to achieve compliance. If the program is found to be not compliant on one or more parts of the list, the program is found to be not compliant to the standard as a whole
- Bullet Points – These indicate examples of ways to achieve compliance to the standards. Bullet points are found in the written standard and will indicate "some or all".



At the end of each standard there is an indicator section describing the evidence that the Review Team is required to access in order for a program to be found compliant to the standards. The indicators that could be associated with a standard are:

- **Policy** – The program policy that addresses the aspects of the standard. Policies are the written basis for operation and provide guidelines for decision-making
- **Procedure** – The directions for daily operations as conducted in the framework of the policy, which include detailed steps that outline the process to accomplish specific tasks
- **Narrative** – A descriptive statement outlining how the standard is being met in the program. Narratives are short, less than half a page in length and may be presented in point form
- **Document Review** – An indication of the specific documents to be reviewed as part of the Presite Materials Package or the On-site Review.
- **Interview** – An indication of the individuals who have been requested to be interviewed in regards to their practice (for staff) or experiences (for participants). It is expected that practice and experience are congruent with program policy and procedure
- **File Review** – The files of staff and participants reviewed on-site to assess compliance to the standards. Only the records and documents identified in the standards are required to be seen by the Review Team
- **On-site Observations** – The items that the Review Team observes and practices assessed on-site

APPENDIX E: USE OF LOGO

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CAC CERTIFICATES, PLAQUES, LOGO, AND SEAL

CAC ACCREDITATION CERTIFICATES AND PLAQUES

Any certificate or plaque provided to an organization or program to demonstrate their accreditation status remains the property of CAC. Certificates and plaques must be surrendered to CAC if requested. Reasons for requests include but are not limited to revocation or expiration of accreditation.

USE OF LOGO AND ACCREDITATION SEAL

Organizations accredited by CAC are provided with an electronic copy of the Accreditation Seal and CAC logo for use on print and electronic materials. The logo and seal remain the property of CAC and as such are subject to regulations for use set out by CAC:

- The right to use the logo or seal is granted to the specific organization that is accredited.
- When CAC has accredited only certain programs within an organization, the use of the logo or seal must specifically relate to the accredited programs and no others.
- The organization must be currently accredited by CAC. If accreditation has lapsed, use of the seal and logo must cease immediately.
- Organizations may not use the logo or seal to advertise any products or services or in connection with any commercial purpose other than the permitted uses without the prior written agreement of CAC.
- It must not be used to suggest any approval or sponsorship of the organization by CAC.
- The logo may not be altered other than to be resized or printed in either black and white or colour.

CAC reserves the right to terminate the use of the logo or seal if the organization has breached any of the above terms.

CAC reserves the right to alter the terms of use of either the logo or seal at any time, as it sees fit.

APPENDIX F: STANDARDS COMPARISON 2020 TO 2024

2024 Edition

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STANDARDS COMPARISON 2020 TO 2024

SECTION	2020 EDITION	2024 EDITION	*ADJUSTMENT NOTES*	*PAGE*
ACCREDITATION				
General Update			Language changed from "CLIENT" to "PARTICIPANT" throughout the document	
Preamble			The preamble has been updated to include a CHF definition of "RECOVERY ORIENTED SYSTEM OF CARE" and other updated language.	1
The Standards Process			Language has been updated by CHF to describe the history of updates to the manual.	5
The Review Process/ Accreditation Process			The STANDARDS PROCESS and ACCREDITATION PROCESS – CAC has updated the descriptions, language, wording, and processes from pages 9 – 29; Agencies must review before beginning a new application or accreditation renewal process.	9 – 29
Accreditation Panel			ACCREDITATION PANEL – agencies are now eligible for 4-year accreditation if they meet the outlined criteria and CAC compliance. This will go into effect for any new agency applications that are submitted after the release of the 2024 Edition of Standards.	24-27
Appeals & Allegations			GRIEVANCE OF PROCESS, APPEAL OF DECISION, and PROCESS TO RESPOND TO ALLEGATIONS - CAC has updated the descriptions, language, wording, and processes on page 31. This will go into effect for any new agency applications that are submitted after the release of the standards.	31
Maintenance of Accreditation Status			MAINTENANCE OF ACCREDITATION STATUS - CAC has updated the descriptions, language, wording, and processes from pages 33-36; Agencies must review before beginning a new application or accreditation renewal process.	33-36
Standards of Practice – Staffing	1.2.1	1.2.1	Removed review of "Aboriginal Youth and Alberta's Plan to End Homelessness" and "Homeless Charter of Rights" for orientation of new staff.	42
Standards of Practice – Staffing	1.2.8	1.2.8	INDIGENOUS AWARENESS TEACHINGS – CAC has updated the process, language, wording, and indicators.	45
Standards of Practice – Staffing	1.29	1.29	DIVERSITY/CROSS CULTURAL TRAINING - CAC has updated the process, language, wording, and indicators. Staff are now required to receive 3 hours of training or orientation in cultural sensitivity or diversity within 9 months of hiring and 3 hours of training will be required annually.	46

SECTION	2020 EDITION	2024 EDITION	ADJUSTMENT NOTES	PAGE
Standards of Practice – Staffing	1.2.10	1.2.10	SPECIALIZED TRAINING – The CAC allows programs to define what specialized training requirements are needed by staff and the timeline for completion and renewal. Indicators have been updated.	46
Standards of Practice – Case Management Activities	2.1	2.1	REFFERAL AND PLACEMENT – CHF has updated the process, wording, and language to be in alignment with the 2024 version of the "Terms of Reference: Coordinated Placement Committee"; CHF provided a link to this document.	47-48
Standards of Practice – Case Management Activities	2.2.3	2.2.3	PARTICIPANT RIGHTS – participant right #2 updated to new language. (i.e., Choice in housing location relative to existing rental market inventory and programmatic funding capacity)	51
Standards of Practice – Case Management Activities	2.3.1	2.3.1	RE-INFORMED OF RIGHTS - CAC has updated the language, wording, and indicators.	54
Standards of Practice – Case Management Activities	2.3.3	2.3.3	SEARCHES - CAC has updated the process, language, wording, and indicators.	55-56
Standards of Practice – Case Management Activities	2.3.5	2.3.5	RELEASE OF INFORMATION - CAC has updated the process, language, wording, and indicators.	58
Standards of Practice – Case Management Activities	2.6.2	2.6.2	SERVICE PLAN COMPONENTS - CAC has updated the process, language, wording, and indicators.	63
Standards of Practice – Case Management Activities	2.6.3	2.6.3	INITIAL SERVICE PLAN - TIMELINES CHF has updated the process, language, and wording	64
Standards of Practice – Case Management Activities	2.8.1	2.8.1	REPORTABLE INCIDENTS – changed from "SERIOUS INCIDENTS"; CAC has included 8 additional reportable incident categories and updated indicators.	67-68
Standards of Practice – Case Management Activities	2.8.2	2.8.2	CRITICAL INCIDENTS – CHF added 2 additional critical incident categories to be in alignment with the Government of Alberta reporting requirements; Indicators updated.	69
Standards of Practice – Case Management Activities	2.8.3	2.8.3	DOCUMENTATION REQUIRED – REPORTABLE & CRITICAL INCIDENTS – CAC has updated the required documentation and follow-up process; CHF added a process that "all incidents that receive media/potential media coverage, and/or death of any participant(s) must be reported to the funder within 24hrs", indicators updated.	70
Standards of Practice – Case Management Activities	2.8.4	2.8.4	REVIEW OF INCIDENT REPORTS - CAC has updated the process, language, wording, and indicators.	71

SECTION	2020 EDITION	2024 EDITION	*ADJUSTMENT NOTES*	*PAGE*
Standards of Practice – Case Management Activities	2.9.3	2.9.3	FORESEEN, UNPLANNED DISCHARGE – TRANSFER EFFORTS – CHF updated for programs to reference "Terms of Reference: Coordinated Entry Placement Committee" during transfer efforts; language updated to "for non-CHF funded programs that participate in Coordinated Entry".	73
Standards of Practice – Privacy and Information Management	3.1.1	3.1.1	INFORMATION MANAGEMENT SYSTEM - CAC has updated the process, language, wording, and indicators.	75
Standards of Practice – Privacy and Information Management	3.1.4	3.1.4	MAINTENANCE OF DATA – CAC updated indicators.	77
Standards of Practice – Privacy and Information Management	3.1.5	3.1.5	PROTECTION OF CONFIDENTIAL INFORMATION - CAC has updated the process, language, wording, and indicators.	77
Standards of Practice – Privacy and Information Management	3.1.6	3.1.6	COMMUNICATION TECHNOLOGIES – CAC updated language from "ELECTRONIC COMMUNICATIONS"; updated process, language, and wording.	78
Appendix A, B, C, D, E			GRIEVANCE OF PROCESS, APPEAL OF DECISION, PROCESS TO RESPOND TO COMPLAINTS, CAC CERTIFICATES, PLAQUES, LOGO, AND SEAL - CAC has updated the descriptions, language, wording, and processes from pages 83-108; Agencies must review before beginning a new application or accreditation renewal process.	83–108

GLOSSARY

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Abuse – Any pattern of behaviour, deliberate or otherwise, causing harm (physical, emotional, sexual or psychological) to another person. Abuse can occur in the home (e.g., domestic violence, spousal rape), in the community (e.g., hate crimes), in an institution (e.g., senior abuse), and anywhere else (e.g., sexual harassment, bullying). Specific examples of abusive behaviour are:

- Physical actions that are intended to inflict violence or pain on another
- Emotional or psychological coercion used to manipulate another
- Inappropriate sexual contact (e.g., sexual contact between a person served and a staff member, contact between persons served when consent is not freely given by both persons served or when one is incapable of consenting by reason of mental impairment, etc.)
- Failure to meet physical (e.g., food, medical attention, etc.) or emotional needs
- Bullying - repeated physical attacks, threats, humiliation, extortion of money and possessions, or exclusion perpetrated by individuals or a group
- Administration of medication for an inappropriate purpose
- Exploitation, taking advantage of others (e.g., using their money or belongings, persuading them to be involved in illegal actions or actions not in their best interest, etc.)

Access – Permission or the right to enter, get near, or make use of something or have contact with someone. *(Merriam-Webster Dictionary)*

Accessible – An environment free of obstacles to people with and without disabilities. Accessibility can include physical improvements to space and assistive technology such as wider hallways to accommodate wheelchairs, rails for people prone to falls, and large print for people with low visibility.

Accommodations –

1. A space (private or shared) made available for an occupant to reside in for a short-term or long-term duration.
2. Provisions made for personnel or persons served to facilitate their work or program environment.

Advocacy – The promotion and safeguarding of a person served's rights by interceding on their behalf and assisting them to intercede on their own behalf.

Agency – Is a group of people that performs some specific task, or that helps others in some way. Also refers to the organization/program that delivers those services.

All Positions – All positions that will be reviewed during the course of the accreditation, including the CEO or ED, management personnel, supervisors, direct service personnel, and volunteers.

Alone (or Working Alone) – A person is "alone" at work when:

- They are on their own
- They cannot be seen or heard by another person
- They cannot expect a visit from another worker *(Canadian Centre for Occupational Health and Safety)*

Assessment – See evidence based assessment tool.

Audit – An in-depth review of a system (not referring to a financial audit).

Authorization – The power to make decisions, or the delegation of power to a certain person or body to act on behalf of another person or body.

Authorization of Documents – Authorization may be demonstrated by the signature of a person with authority to approve policies and plans or the recorded decision of a governing body.

Awareness – Taking note of a person's behavior and the state of mind either through a formal assessment or incidental observation.

Behaviour Management – The attempt to alter a person served's behaviour through influence and other means. When engaging in behaviour management it is best to utilize positive methods, such as, a strength-based approach. A strength-based philosophy holds the core belief that all individuals have strengths and resources. The focus of the practice is on a person's skills, interests and support systems. Its simple premise is to identify what is going well, to do more of it, and to build on it The following interventions may not be utilized as a mechanism to alter behaviour:

- Corporal (physical) punishment
- Humiliation
- Degrading punishment

- Group punishment for one individual's behavior
- Medication as punishment
- Intentionally harmful or abusive practices
- Locked confinement (with the exception of Intensive Treatment Programs, Secure Programs, and Protective Safe Houses)
- Sleep deprivation
- Withholding meals
- Withholding spiritual observances
- Withholding visits with family, guardians, advocate or lawyer

Beliefs – Concepts that one holds to be true.

By-Laws – The official rules and regulations, drawn up at the time of incorporation, governing the internal affairs of an organization.

Board – Refers to a board of directors, board of trustees, board of managers or board of governors. These are the elected or appointed members who jointly oversee the activities of an organization or company.

Bring Forward System – The method used to identify the data, activities, and events required to ensure that an internal tracking system is maintained and updates are performed within predefined timelines.

Budget – An estimate of the expected income and expenses for the upcoming fiscal year.

Business days – A day when most businesses are open; a weekday that is not a holiday.

Case Management – "collaborative, participant-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the participant's achievement of safe, realistic, and reasonable goals with complex health, social, and fiscal environment." *National Case Management Network of Canada 2009*

Certification – The assertion by an external body that someone is qualified for a specific type of work after the provision of evidence of certain traits or skills.

Chief Executive Officer (CEO) – The highest-ranking executive or administrator responsible for the overall management of an organization.

Child Welfare – The catch-all term used to refer to child protection services and the organizations that provide them.

Chronicity – The length of time that an individual has experienced homelessness.

Clinician – A professional trained and registered with a professional body (e.g., College of Social Workers, College of Psychologists etc.) and maintains current licensed practitioner status with that professional body. They specialize in the psychological, emotional or psychosocial treatment of persons served, as distinct from those specializing in administration, research or academic work.

Communicable – An infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means (as by a vector). *[Merriam-Webster]*

Community – A group of people who share a common link to the services that an organization provides. Communities can be formed among professional associations, users of services, or those who are impacted by the services (e.g., shared property, use of community services, etc.). It is also understood that organizations providing services to persons served are not islands unto themselves. The work of the organization is provided within the context of the community and needs to reflect community involvement.

Conditions of Service – A set of limitations dictating how a service can be used or accessed by persons served.

Confidentiality – refers to a duty of an individual to refrain from sharing confidential information with others, except with the express consent of the other party.

Conflict Resolution – The conflict resolution process is engaged when there are conflicts between individuals or within a group of individuals. Conflict resolution is a formal process that seeks to find resolution to a dispute.

Conflict of Interest – A situation in which an individual has a current or potential interest that may influence or appear to influence how they conduct business or make decisions.

Congregate Living – A facility which combines private living quarters with centralized dining services, shared living spaces and access to recreational activities.

Consultant – A person who provides specialized or technical advice or services to a program for specific purposes on a contractual or fee-for-service basis.

Containment – The act of preventing the spread of something.

Contractor – A professional or non-professional person hired on a contractual or fee-for-service basis to provide a specific service (e.g., drivers, respite providers, supported independent living providers, and Aboriginal or Cultural resource person).

Coordinated Access and Assessment (CAA) – a system to support service integration for people experiencing homelessness. CAA coordinates engagement, assessment, triage prioritization, and program access to a range of housing and support services. Triage and referral processes are provided by CAA's Placement Committees..

CPI – Crisis Prevention and Intervention.

Crisis Intervention – Emergency services provided to a person who is in a state of crisis and requires more support and supervision than is available under other circumstances.

Critical Incident – An incident that occurs that must be reported to CHF within 24-hours of the incident occurring as outlined in Standard 2.8.2.

Cultural sensitivity – Is a set of skills that enables us to learn about and understand people who are different from ourselves, thereby becoming better able to serve them within their own communities.

Day – One calendar day unless otherwise specified.

Daytime – Refers to the program's usual awake times for persons served.

De-escalation – The act of decreasing or diminishing violent behaviours in extent, volume or scope without using physical intervention.

Decontamination – the process of removing or neutralizing a hazard from the environment, property, or life form.

Demographic Information – Statistical information about persons served within a program, such as age, gender, race, etc.

Direct Service Personnel – Individuals who have regular, direct contact with the persons served within an organization.

Disaster – Any event that:

- Causes significant suffering or loss
- Results in significant damage or destruction, requiring evacuation
- Renders a facility uninhabitable, either temporarily or permanently

Disaster/Emergency Plan – Systematic procedures that clearly detail what needs to be done, how, when, and by whom before and after the time an anticipated disastrous event occurs. The part dealing with the first and immediate response to the event is called emergency plan.

Discrimination – An act or decision that treats a person or a group of people negatively for reasons such as race, age or disability. The following 13 grounds are protected under the Canadian Human Rights Act:

- Race
- National or ethnic origin
- Colour
- Religion
- Age
- Sex
- Sexual orientation
- Gender Identity or Expression
- Marital status
- Family status
- Genetic Characteristics
- Disability
- A conviction for which a pardon has been granted or a record suspended

Donation – Anything that is given to help a person or an organization. Donations may be in the form of food, clothes, money, etc. and may or may not qualify for a tax receipt.

Duty to Accommodate – The Canadian Human Rights Act requires employers and unions, where applicable, to accommodate the needs of employees and job applicants to the point of undue hardship. Failure to accommodate short of undue hardship can have the effect of discrimination.

Duty of Care – The obligation to act conscientiously when acting toward others. If the actions of a person are not made with care, attention, caution, and prudence, their actions are considered negligent.

Duty to Warn – The obligation to provide advanced notice to others interacting with persons served who are known to have behavioural, emotional, or psychological problems which have the potential to cause harm to themselves or to those interacting with them.

Educational Program – Courses requiring the participation of persons served for a specified number of hours to gain knowledge and skills.

Emergency Evacuation – A planned, written set of actions for removing all occupants from a building or area undergoing an emergency situation such as fire or inclement weather.

Ethical – The quality of being in accordance with the rules or standards for proper conduct or practice, especially with regards to the standards of a profession.

Ethnic groups – A social group or category of the population that, in a larger society, is set apart and bound together by common ties of race, language, nationality, or culture. https://www.britannica.com/topic/ethnic-group

Ethical Conflict – A situation in which a course of action that is usually considered ethical is hindered by a context which creates a conflict. For example, persons served have the right to information about them; however, if they are under the age of consent, a parent or guardian may choose to prevent personnel from disclosing that information to the person served. In this case, the release of information to the minor would be an ethical conflict.

Ethical Fundraising – Fundraising in accordance with the ethical fundraising practices of the applicable jurisdiction (e.g., Charitable Fundraising Act, Ethical Fundraising and Financial Accountability Code, Imagine Canada, etc.).

Evaluation – A process that involves assessing the strengths and weaknesses of an individual, program, policy, personnel, or organization to improve effectiveness and promote efficiency.

Evidence-Based Assessment Tool – An assessment tool that has the following qualities:

1. Tested, valid, and appropriate
2. Reliable (provide consistent results)
3. Person-centered (focused on resolving the person's needs, instead of filling project vacancies)
4. User-friendly for both the person being assessed and the assessor
5. Strengths-based (focused on the person's barriers to and strengths for obtaining sustainable housing)
6. Recovery-Oriented (focused on rapidly housing participants without preconditions)
7. Sensitive to lived experiences (culturally and situationally sensitive, focused on reducing trauma and harm); and
8. Transparent in the relationship between the questions being asked and the potential options for housing and support services.

Reference: https://caeh.ca/wp-content/uploads/BACKGROUNDER-Information-on-common-assessment-tools.pdf

Executive Director (ED) – An executive director is the senior operating officer or manager of an organization or corporation. Executive director titles (EDs) are frequently reserved for the heads of non-profit organizations, and their duties are similar to a chief executive officer's (CEO) duties of a for-profit company.

Experiential Learning – Is the process of learning through experience, and is more specifically defined as "learning through reflection on doing"

Family Representative – A member of the family who may or may not be the person served's guardian but who, as defined by the person served, plays a significant role in the care and well-being of the person served.

File – The formal record of contact with a person served or personnel which many include both paper and electronic components.

First Nations Principles of Ownership, Control, Access, and Possession (OCAP) – The right of First Nations to control the data collection processes in their communities.

Formalized – To give proper or official form to something.

Freedom of Information and Protection of Privacy (FOIP) Training – Self-managed training for all employees of public bodies to increase basic awareness of the FOIP Act.
https://www.servicealberta.ca/foip/online_training/focusprivacy/html/frames.htm

Frontline Staff – Employees who are in direct contact with persons served on a regular basis, including shift supervisors.

Full Time Equivalent (FTE) – A paid personnel position that may be made up from a number of part-time, casual or relief positions.

Government of Alberta (GOA) Privacy Training Acts – Online training meant to deepen understanding of FOIP, Health Information Act (HIA), and the Children First Act.
http://www.humanservices.alberta.ca/elearning/informationsharing/index.html

Goal – A statement of desired performance or behavior which is specific, qualitatively and quantitatively measurable, and attainable.

Governance – The procedures associated with decision making, performance and control of organizations, including providing structures to give overall direction to the organization and satisfying the expectations of accountability to those outside of the organization.

Governing Body – The group of people, whether elected or appointed, in a non-profit organization who have the legal authority and responsibility to set policy and oversee the operation of an organization.

Grievance – A real or perceived cause for complaint brought to the attention of the organization by a person served, personnel, volunteer, student or any other person having contact with the organization or program.

Guardian – A person who has the legal responsibility for providing care and management to a person who is incapable of administering his or her own affairs due to age or other circumstances such as physical, mental or emotional impairment. See also Legal Representative.

Guardianship – A legal relationship created by a court between a guardian and their ward, either a minor child or an incapacitated adult.

Harassment – Any unwanted physical or verbal conduct, whether as a single incident or as several incidents over a period of time, that offends or humiliates *(Canadian Human Rights Commission)*. Harassment may include:

- Threats, intimidation, or verbal abuse
- Unwelcome remarks or jokes about race, gender identity or expression, sexuality, religion, disability, age
- Displaying sexist, racist or other offensive pictures or posters
- Sexually suggestive remarks or gestures
- Inappropriate physical contact such as touching, patting, pinching or punching
- Physical assault including sexual assault

Health or Adaptive Equipment – Apparatus that is used to help anyone with a disability or physical injury lead a more independent and productive life. These devices may include inhalers, wheelchairs, hearing aids, sleep apnea equipment, etc.

Healthy Living – A lifelong process of optimizing opportunities for improving and preserving health, physical, social, and mental wellness, independence, quality of life, and enhancing successful life-course transitions.

Home Visit – A home visit is when the case worker meets with the program participant in the program participant's home. Home visits are used to build rapport, are objective based (support service planning) and may help to indicate if there is anything that might signal that the program participant may need additional support to maintain housing stability (e.g. food insecurity, risks within the home, hoarding, etc.)

Homeless Serving System of Care (HSSC) – The Homeless-Serving System-of-Care (HSSC) consists of a network of agencies (both CHF-funded and non-funded) and programs working collaboratively to provide those at risk of or experiencing

homelessness with access to supportive housing and resources to meet their needs. The HSSC is grounded in evidence-based research and data analysis. Working with homeless-serving agencies and community partners, the Calgary Homeless Foundation guides the fight against homelessness in Calgary. Utilizing a three-pronged approach we:

- Allocate resources for the highest impact and outcomes to efficiently deliver and maximize benefits to people experiencing homelessness.
- Build knowledge and understanding of homelessness through our cutting-edge database and research.
- Galvanize public and political will to ensure people have the right housing at the right time

Honorarium – A payment made to recognize, without having any liability or legal obligation, a person for their services in a volunteer capacity or for services for which fees are not traditionally required.

Human Services – Programs which assist people in meeting their needs to be adequately housed, clothed, and fed, as well as their needs for social, developmental, educational, recreational, and religious opportunities for the maintenance and enhancement of physical, psychological, social, and spiritual well-being.

In Plain Sight Search – A search done that does not involve moving items or opening drawers, cupboards, etc. It is only a search of what can be viewed without making any physical contact to items in the room/area.

Inadvertent – An outcome, negative or positive, achieved accidentally and not through deliberate planning.

Incident Report –A situation or circumstance that is mandated to be documented and reported to appropriate authorities, both within and outside of the program. Refer to Critical or Serious Incident

Individual Accommodation – Any residence of a person served for which they are entirely responsible.

Indian Act – The Indian Act is the principal statute through which the federal government administers Indian status, local First Nations governments and the management of reserve land and communal monies. - *The Canadian Encyclopedia*

Indigenous – "Indigenous Peoples of Canada" includes First Nations, Inuit, and Metis peoples of Canada who may or may not reside within their cultural community (Canadian Constitution).

Informed Consent – A legal condition where a person can be said to have given consent based upon an appreciation and understanding of the facts and implications of an action. The person needs to be in possession of relevant facts, their reasoning faculties, and be without an impairment of judgment at the time of consenting. Informed consent can be given either by the person served or a guardian.

Initial Cleaning Supplies –

- ***For Place-Based Supportive Housing Programs*** – supplies for each unit or access to centralized cleaning supplies (e.g. janitor room);
- ***For Scattered Site Supportive Housing Program*** – minimally, supplies that are provided in the Calgary Food Bank's Welcome Home Package with referrals to community agencies for additional supplies (e.g. broom, mop, vacuum, etc.)

Intake – The initial gathering of information about persons served for the purpose of assessment and determination of eligibility and the need for services provided by the program or other appropriate resources in the community.

Intervening Years – The years between a full accreditation review.

Intergenerational Trauma – Intergenerational trauma is the transmission of historical oppression and its negative consequences across generations. Reference: https://www.ymcacalgary.org/sites/default/files/2022-09/Overcoming%20Intergenerational%20Trauma%20Report.pdf

Intervention – As opposed to observation, intervention requires actions to be taken to help and protect a person served in a time of crisis. Crisis and Suicide Intervention training requires a qualified trainer.

Intimate Relationship – A relationship including a personal bond (e.g., familial, emotional, romantic, sexual).

Involuntary – An action performed without will or conscious control.

Kinship Care Provider – Extended or natural family members who are contracted by an organization to care for children in their homes. Kinship care providers are not considered to be personnel of the organization but are deemed to be contracted individuals.

Legal Issues – Any situation in which personnel and volunteers may have contact with aspects of the legal system (e.g., police, investigators, bailiffs, lawyers, etc.).

Legal Representative – An individual who has the legal responsibility for a person served and can consent to services on their behalf. May include parents, family, legal guardian, etc.

Legislation – Any acts, laws or regulations enacted by Federal, Provincial, and Territorial governments.

Liability – The condition of being responsible for a possible or actual loss, penalty, expense or burden whether existing, potential or contingent.

Management Staff – Staff who are responsible for the overall operational aspects of the program and may include the Chief Executive Office, Chief Financial Officer, Program Directors, and Volunteer Coordinators, among others. Based on the size of the organization, management personnel may or may not be involved in providing direct services to persons served or their families.

Mediation – Intervention between conflicting parties to promote reconciliation, settlement, or compromise.

Mentor – An experienced person, generally a volunteer, who provides advice, support, and encouragement to a less experienced person.

Narrative – A statement describing how the standard is being met within the organization. Narratives are short, less than half a page in length, and may be presented in point form format.

Nature of Service – The type of services delivered by a program.

Near Miss –

1. An event (usually adverse) averted only at the last moment or by accident.
2. An event that would have resulted in an accident/emergency situation if not for a last minute or chance intervention; an event likely to be reproduced in the future.

Night Time – The hours in a residential program when persons served are usually asleep.

Non-identifiable – Anonymous.

NVCI – Non-violent crisis intervention.

On-Site – The state of being on the site of the facility where the program or service is conducted.

Operations Plans (or Business Plan) – A short-term, detailed, goal-oriented plan put into place to direct the operations of an organization. The Operations or Business Plan may be incorporated into other organizational plans, such as the Strategic Plan, or may be created separately.

Organization – A legal entity that manages itself in accordance to the acts, laws, policies, and regulations that direct them and may include, but are not limited to, an agency, a government-run service or a proprietorship. An organization may provide services through a single program or may offer a large range of services through many programs.

Organizational Chart – A graphic illustration that outlines the basic division of labour, span of authority, number of supervisory levels, lines of formal authority and accountability, and lines of communication.

Outcome Auditing – The practical use collected data to demonstrate how the organization is making a difference within the services they provide. The outcome may not always be positive or anticipated but should provide the organization a clear understanding of what is and is not working.

Outcomes – Changes in knowledge, behavior, feelings, thoughts, attitudes, acquisition of resources or characteristics for a person served or a community. Outcomes measure the difference the provided service makes in the short, intermediate, and long term.

PACE – Playfulness, acceptance, curiosity and empathy.

Peak Activity Period – Any time within daily routines where there is a high level of activity.

Peer Review – The process of being evaluated by members of the same or a similar professional community.

Person Served – Any person receiving services from a service provider.

Personal Directive – A legal document under provincial legislation that allows an individual to name person(s) to make decisions on their behalf should they lose mental capacity, and also lists the areas in which the person(s) listed have decision-making authority (e.g., health care, residential issues).

Personal Relationship – Refer to close connections between people, formed by emotional bonds and interactions. These bonds often grow from and are strengthened by mutual experiences.

Personnel – All paid and unpaid people working within the program either directly with persons served or in an administrative role. This includes personnel, contractors, service professionals, practicum students, and volunteers.

Place-Based Supportive Housing (PBSH) – Case management and housing supports for individuals with the goal that over time, with case management support, the participant(s) will be able to achieve housing stability and independence. Placements are designated to specific buildings and/or locations, often with agency supports on site.

Policy – A statement of practice derived from the principles and philosophies that guide organizational operations and services.

Practice Research – A general term that is applied to the techniques or methodologies used to evaluate, analyze data related to practice and is designed to identify best or leading practices that have proven to be reliable and leads to a desired result.

Practicum Student – A student enrolled in an educational facility who is completing a work placement with an organization as part of their course work.

Pre-Site Conference Call – A teleconference attended by the review team to assess an organization's self-study materials package. A member of the organization may also attend but their participation will be strictly limited to answering questions posed by the review team.

Procedure – The method and manner by which a policy is to be implemented.

Professional Boundaries – Organization-defined limits on the type and extent of conduct deemed safe and appropriate between personnel and persons served.

Professional College – A professional association, body, organization or society which seeks to further a particular profession, the interests of individuals engaged in that profession, and public interest. It may also be involved in licensing and regulating those within that profession.

Program – A Recovery-Oriented Supportive Housing (ROSH) program operated by a not-for-profit agency that provides services to individuals who have experienced homelessness. ROSH must be accredited to CHF standards, whereas the agency may/may not choose to be accredited by another accrediting body

Proprietary – Privately owned organization (also, proprietorship). Also something that is used, produced, or marketed under exclusive legal right of the inventor or maker *[Merriam-Webster]*

Public Organization – An organization established by statute, and owned and operated by any level of government.

Public Trustee – The governmental office responsible for protecting the financial interests of vulnerable people by administering the estates of represented adults, deceased persons, and minors when there is no one else to act.

Qualified Trainer –

1. An individual certified by an appropriate body to deliver a specific form of training (e.g., Suicide Intervention, First Aid, etc.).
2. For Medication Training, an individual who is certified or approved by an appropriate health professional body or uses a curriculum verified by a health professional body to provide this training.

Quality Assurance – A system using established measures which promotes and confirms consistency of performance to set measures of quality. Quality

assurance is a continuous cycle with a focus on change, directed towards purposeful and future-oriented actions including:

1. Setting of improvement goals
2. Evaluating performance of current practice
3. Changing methods to improve service delivery
4. Evaluating the impact of such changes

Quality Improvement – A continuous cycle of setting goals, measuring efficiencies and effectiveness, taking corrective actions, and evaluating the impact.

Quality Improvement Plan – A tool for gathering the necessary information to be reviewed as part of the annual performance analysis. The Quality Improvement Plan may be created as a separate plan or incorporated into the Operating Plan.

Recognized Accounting Practices – The framework of broad guidelines, conventions, rules, and procedures of accounting as set out by the relevant regulatory body.

Recovery Orientation - Recovery from homelessness is understood as improved quality of life for program participants. CHF funded programs commit to moving people who experience homelessness into housing as quickly as possible and delivering supports to achieve positive outcomes in the domains of home, health, financial wellness and community connection.

Release of Information – The sharing of protected information related to persons served, personnel, or the organization to any person, including the subject of the information, under any circumstance. The release of information is governed both by legislation and by CAC standards.

Religious Groups – A set of individuals whose identity as such is distinctive in terms of common religious creed, beliefs, doctrines, practices, or rituals. Reference: https://www.lectlaw.com/def2/q028.htm

Restraint – Any means used to restrict a person's movement, activity, or access to their body including, but not limited to, physical restraints, chemical restraints, pharmacological restraints, and mechanical restraints.

Restrictive Procedure – The placement of limits (e.g., restrictions of movement, isolation from the group, withholding privileges, etc.) on a person served in order to influence behaviour.

Rights – Entitlements assured by custom, law or property or the power or privilege to which one is justly entitled to have.

Risk Management – The process of identifying, assessing, and prioritizing risks, followed by the coordinated and economical application of resources to minimize, monitor, and control the probability and impact of unfortunate events, or to maximize the realization of opportunities.

Risk Register – A listing of all the identified risks to an organization or program and may include a rating of each risk, which is updated regularly and used to develop the Risk Management Plan.

Room and Board – An arrangement wherein money or labour is exchanged for food and lodging.

Safe Practices – Procedures which ensure the safety of personnel and persons served in any given task, from handwashing in food preparation to the safe administration of medication.

Scattered Site Supportive Housing (SSSH) – Case management and housing supports for individuals with the goal that over time, with case management support, the participant(s) will be able to achieve housing stability and independence. Placements are not designated to one specific building, rather individuals and families are housed in the community independently.

Safety Check – A safety check is when a case worker will enter a program participant's home, sometimes without prior immediate permission from the program participant, because there is indication that the safety or well-being of the program participant is at risk.

Scope of Practice – A profession's definition of the procedures, actions, and processes that are permitted for individuals in that profession. This is determined by law for legislated professions and may be defined by organizations for non-professional employees.

Search – The intentional practice of check an individual's belongings/person/room or personal space for items not permitted by program. This does not include checking a person/person's belongings for safety while responding to a crisis (e.g. overdose).

Self-Harm – Self-injury or self-poisoning which is an intentional, direct injury to the body without suicidal intent. Examples include, but are not limited to, cutting, burning, and embedding of objects in the body.

Self-Study Period – The time between the application and the Pre-Site Conference Call during which an organization prepares documentation for the review team's assessment.

Senior Management – Individuals at the highest level of an organization's management who are responsible for the day-to-day supervision of the organization.

Service Plan – A written plan identifying the goals, strategies (tasks and activities), and timelines required to address the needs and issues of the persons served. The care plan may be referred to by a number of other titles, such as the Case Plan, Healing Plan, Individual Program Plan, etc., at the discretion of the organization.

Serious Incident – Any incident that occurs that must be reported internally as outlined by the standards, the program and the agency.

Service Team – Services, contractors, service professionals, and volunteers assigned to work with or be involved with persons served.

Social Services – Services designed to assist individuals and families in coping with social and psychological problems which interfere with their regular functioning.

Specialized Medical Procedure – Procedures beyond the provision of medication that may require special attention and training. Examples include, but are not limited to, needles, enemas, g-tubes, shunts, and blood glucose monitors.

Specialized Training – Training that is unique to and mandated by the program outside of CHF Core trainings.

Staff – Persons employed by the organization for wages or salary on a full-time, part-time, casual or relief basis. Staff does not include individuals such as foster parents, service providers or service professionals hired on a contractual or fee-for-service basis.

Stakeholder – A person, group or organization that has a direct or indirect interest in an organization because it can affect or be affected by the organization's actions, objectives, and policies.

Standard Precautions – Precautions meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the workplace and in the care of the person served.

Standardized Aggregation Method – A consistent way of accumulating data for review.

Strategic Plan – A plan that documents what an organization is, where it's going and how it's going to get there. It is a long-term, flexible plan that does not regulate activities but rather outlines the means to achieve certain results, and provides the strategy to alter the course of action should the desired ends change.

Strength-Based Approach – A practice theory that emphasizes people's self-determination and strengths. It is person served led with a focus on future outcomes and strengths that people bring to resolving a problem or crisis as well as opportunity to involve the person served in self-discovery and learning. Some of the techniques used include:

- Appreciative inquiry
- Capacity building/Asset-Based Community Development
- Community Development
- Developmental Assets
- Positive Youth Development
- Resiliency
- Restorative Justice
- Social Determinants of Health
- Social Development
- Solution-Focused Therapy
- Sustainable Livelihoods
- Youth Engagement

Suicidal Ideation – Thoughts about suicide ranging from thoughts of killing one's self to having a formulated plan without having performed the suicidal act itself.

Suicide Intervention – An activity or set of activities designed to decrease risk factors or increase protective factors reference: https://www.sprc.org/about-suicide/topics-terms

Supervision – The act of overseeing and supporting the work or actions of a person who is more junior in a given context (e.g., supervisor/subordinate, mentor/mentee).

Supervisor – Staff responsible for the supervision of program personnel provide direct services to and with persons served. This definition may include clinical consultants when their responsibilities include consultative and supervisory duties.

Support Home – Accommodation and support provided to persons served, generally young adults, while they work towards independent living.

Support/Strengthening Session– Informal/unplanned connections with previous service recipients who are reaching out for referrals and/or limited supports (i.e. coaching, coffee check in, telephone check in, etc.)

Suspicions and/or Allegations of Abuse – Reported instances that allege that the program and/or program staff may be or are abusive towards the program participant

Systemic Racism – Includes the policies and practices entrenched in established institutions, which result in the exclusion or promotion of designated groups. It differs from overt discrimination in that no individual intent is necessary. *(Toronto Mayor's Committee on Community and Race Relations. Race Relations: Myths and Facts)*

Task Force – A group formed to work on a single defined task or activity.

Termination –

1. The planned or unplanned end of services in a specific program to a person served.
2. The planned or unplanned end of employment for personnel, contractors, volunteers, or students.

TCI – Therapeutic Crisis Intervention

Therapy – Activities designed to influence a change in a person served's thinking, behaviour, and relationships.

Training – Instruction given to persons seeking to learn a skill. Training may take many forms and may include classroom training, a single or many day sessions devoted to learning a particular skill, conference workshops, and distance learning opportunities (e.g., videos, on-line courses), coaching sessions, clinical case conferencing, reading materials, peer training etc.

Transportation – The act of moving a person from one location to another, usually by way of a vehicle.

Treatment – Services offered to overcome physical, behavioural, and emotional difficulties that are severe enough to be problematic in a person's physical, social, emotional, and familial functioning.

Treatment Team – A multi-disciplinary team which includes people from different disciplines and with different roles in relation to the person served and any other people involved in the life of the person served that may be able to provide input into the development and implementation of the individualized care plan.

Truth and Reconciliation Commission of Canada (TRC) Calls To Action – 94 Calls to Action made by the Truth and Reconciliation Commission of Canada in order to redress the legacy of residential schools and advance the process of Canadian reconciliation. For further information please visit: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

Undue Hardship – an accommodating action that places significant difficulty or expense on the employer.

Universal Precautions – Infection control guidelines designed to protect from exposure to diseases spread by blood and certain body fluids. This includes, but is not limited to, hand washing, use of protective barriers (Personal Protective Equipment (PPE)), cleaning of contaminated surfaces and safe handling/disposal of contaminated material.

Unplanned Safety Check – See Safety Check.

Values – Ideas that one holds to be important which in turn govern the way one behaves, communicates, and interacts with others.

Voluntary – An action done with conscious intent.

Volunteer – An unpaid person who contributes services to an organization and its persons served, and, if providing direct service to persons served, is supervised by an appointed representative of that organization.

Vulnerability Factors – The characteristics determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards. Reference: *UNISDR Terminology 2017*

Vulnerable People – Persons who belong to a group within society that is either oppressed or more susceptible to harm. Reference: http://rfmsot.apps01.yorku.ca/glossary-of-terms/vulnerable-persons/#def

Well-Being –

1. A state defined by the person served where they can indicate they are in a good or satisfactory condition of existence.
2. The goal which guides personnel's actions towards persons served.

Whistleblowers – People who act in good faith to report a criminal offence, a breach of a legal obligation, a miscarriage of justice, a danger to the health and safety of any individual, or the deliberate covering up of information tending to show any of the above. *(Public Interest Disclosure Act – UK)*

Working Alone Safely Legislation – Specific laws concerning working alone. For further information please visit: https://open.alberta/ca/dataset/757fed78-8793-40bb-a920-6f000853172b/resource/8a7a2cf9-b223-4427-80ec-2f67416d2bb6/download/4403880-part-28-working-alone.pdf

Working Groups – A group of people who investigate a particular problem and suggest ways of dealing with it.

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