HOME HEALTH ADMISSION PROFESSIONAL TRAINING

How to correctly present, explain, complete, and document the Admission Package

Accepted for all accreditations body, State and Federal standrads.

Training based on the Agency's Admission Package / Client Information Handbook

Training Goal

Prepare admission professionals to conduct a complete, patient-centered admission visit while ensuring required education, consents, signatures, safety instructions, and documentation are addressed before the package is filed in the clinical record.

1. Learning Objectives

At the end of this training, the admission professional should be able to:

- Explain the purpose and organization of the Admission Package to the patient and/or authorized representative.
- Verify patient identity and determine who is legally able to receive information and sign admission documents.
- Explain agency services, visit frequency, charges, patient rights, complaint procedures, privacy practices, advance directives, emergency procedures, and safety information.
- Complete the Client Service Agreement and related admission consents accurately, without blank required fields.
- Provide education in a language and manner the patient can understand and arrange assistance for sensory, speech, or language needs.
- Document patient/caregiver understanding, questions, refusals, representative involvement, and copies provided.
- Perform a final admission-package quality check before leaving the home or submitting the record.

Key principle

The admission visit is not simply a signature visit. The professional must explain the information, verify understanding, answer questions, and document the patient's participation in care.

Admission Visit - Recommended Flow

1. Prepare before arrival
2. Identify patient and representative
3. Orient to agency and services
4. Review rights, privacy, complaints and advance directives
5. Review plan/services/frequency/financial information
6. Provide safety, medication, infection and emergency education
7. Complete consents and signatures
8. Perform final quality check and leave required copies

2. Know the Admission Package

The handbook combines patient education with admission forms and consents. The package table of contents identifies education on agency services, rights, safety, infection control, advance directives, privacy, OASIS privacy, AI disclosure, transfer/discharge, medication and opioid instructions, and emergency information.

YOUR AGENCY NAME HERE

CLIENT INFORMATION HANDBOOK

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(All admission forms and consents are located between the English and Spanish Patient Information Handbook sections.)

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Illustration: Client Information Handbook table of contents from the Admission Package.

Staff responsibility

Use the handbook as a teaching guide. Do not assume the patient will read all sections independently. Focus on information relevant to the patient's condition and the items that require acknowledgment or consent.

3. Before Entering the Home

- Review the referral, physician/provider information, ordered disciplines, anticipated frequency, payer information, diagnosis, known risks, allergies, language needs, and special communication needs.
- Confirm that the agency can meet the patient's identified needs and that the ordered services are within the agency's scope and staffing capacity.
- Bring the current Admission Package, required clinical assessment forms, identification badge, agency contact information, and any patient-specific educational materials.
- Know which forms require patient/representative acknowledgment and which items require additional clinical documentation.
- Plan for interpreter or communication assistance when needed.

At the Door: Verify Identity

Before providing care or discussing protected information, verify the patient's identity using agency-approved identifiers. Introduce yourself by name, title, agency, and purpose of the visit. Display your agency identification badge.

Do not proceed blindly

If identity, residence, legal representative status, or consent to the visit cannot be established, contact the agency supervisor/Clinical Manager for direction before continuing.

4. Agency Orientation and Services

Explain what home health is, which disciplines are ordered, and how the agency will coordinate care. The package describes Skilled Nursing, Home Health Aide, therapy disciplines, and Medical Social Work. The admission professional should connect these services to the patient's actual plan of care rather than reciting a generic list.

- Identify the disciplines expected to provide care.
- Explain anticipated visit frequency and that scheduling may depend on patient needs, orders, and coordination.
- Explain regular business hours and the 24-hour/on-call process.
- Clearly instruct the patient/caregiver to call 911 for a life-threatening emergency.
- Provide agency phone/contact information and explain whom to call for clinical concerns after hours.
- Explain the patient's role in participating in the plan of care and reporting changes in condition.

Teach-back question

"If you have a serious emergency tonight, what number will you call? If you have a non-life-threatening clinical concern after office hours, how will you contact the agency?"

5. Rights, Complaints, Privacy and Advance Directives

The admission professional must explain—not merely hand over—the patient rights and related notices.

Patient Rights & Responsibilities: Review participation in care, respect and dignity, confidentiality, freedom from abuse/neglect/exploitation, the right to complain without retaliation, the right to refuse treatment after consequences are explained, and the patient's responsibilities.

Complaints & Grievances: Show the patient where agency complaint contacts and state/accreditation complaint information are located. Explain that concerns may be raised without fear of reprisal.

HIPAA / Privacy: Explain the Notice of Privacy Practices and how protected health information and clinical records are handled. Document receipt of the notice.

OASIS Privacy: When OASIS applies, review the OASIS privacy notice and patient rights concerning collection and disclosure of OASIS information.

Advance Directives: Ask whether the patient has an Advance Directive, Living Will, health care proxy/advocate, DNR or related document. Record the response and follow agency procedures for obtaining a copy when applicable.

Language / Disability Assistance: Provide information in the patient's preferred language and in a manner the patient can understand. Arrange interpreter or communication assistance when needed.

Never pre-select patient choices

The admission professional should explain options and record the patient's actual decision. Do not mark "Yes/No," consent, DNR, representative, or other preference fields before discussing them with the patient/representative.

6. Completing the Client Service Agreement and Consents

The Client Service Agreement is a central admission document. The package includes sections for services/frequency/charges and acknowledgments for rights, advance directives, HIPAA/OASIS, survey home visits, AI use, and other consents.

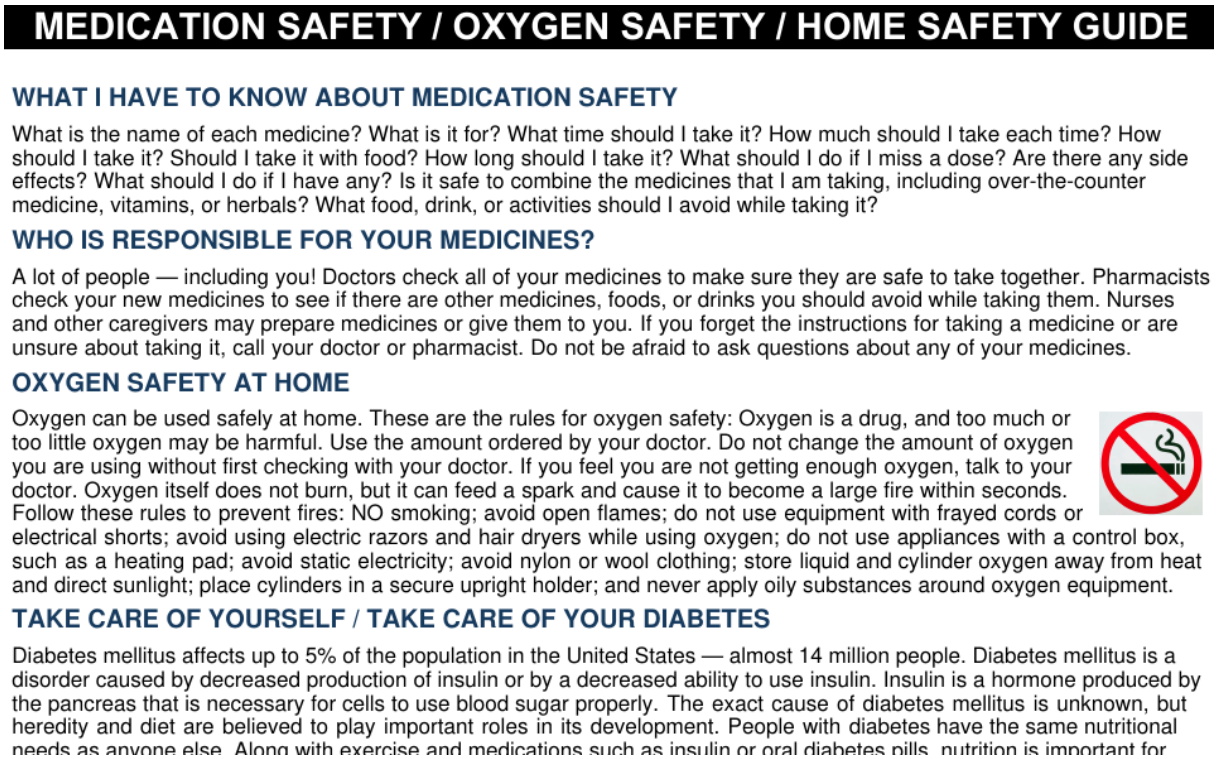
- Enter patient identifiers consistently with the clinical record.
- List each discipline to be furnished and the ordered/anticipated frequency. Do not leave applicable service/frequency fields blank.
- Explain charges, payer coverage, patient financial responsibility, and changes in coverage when applicable.
- Review the patient rights acknowledgment and complaint/abuse hotline information.
- Review Advance Directive/Living Will/Proxy/DNR questions and document the patient's answers.
- Document receipt of the Notice of Privacy Practices and Client Information/Orientation Handbook.
- Explain voluntary survey home-visit consent as presented in the package.
- Explain the Artificial Intelligence disclosure/consent when the agency uses this provision.
- If another person signs, document the authorized representative's name, relationship, and the reason the patient is unable to sign.
- Ensure patient/representative signature, agency representative name/title/signature, and dates are complete and legible.

Final signature rule

A signature does not correct an incomplete form. Before obtaining the signature, review the entire agreement for blanks, inconsistent dates, missing frequencies, unchecked choices, or information that was not explained.

7. Medication, Oxygen and Fall-Safety Education

Patient education should be individualized to the patient's condition and risks. The handbook includes medication questions, oxygen precautions, diabetes guidance, pain management, and fall-prevention measures.



MEDICATION SAFETY / OXYGEN SAFETY / HOME SAFETY GUIDE

WHAT I HAVE TO KNOW ABOUT MEDICATION SAFETY

What is the name of each medicine? What is it for? What time should I take it? How much should I take each time? How should I take it? Should I take it with food? How long should I take it? What should I do if I miss a dose? Are there any side effects? What should I do if I have any? Is it safe to combine the medicines that I am taking, including over-the-counter medicine, vitamins, or herbals? What food, drink, or activities should I avoid while taking it?

WHO IS RESPONSIBLE FOR YOUR MEDICINES?

A lot of people — including you! Doctors check all of your medicines to make sure they are safe to take together. Pharmacists check your new medicines to see if there are other medicines, foods, or drinks you should avoid while taking them. Nurses and other caregivers may prepare medicines or give them to you. If you forget the instructions for taking a medicine or are unsure about taking it, call your doctor or pharmacist. Do not be afraid to ask questions about any of your medicines.

OXYGEN SAFETY AT HOME

Oxygen can be used safely at home. These are the rules for oxygen safety: Oxygen is a drug, and too much or too little oxygen may be harmful. Use the amount ordered by your doctor. Do not change the amount of oxygen you are using without first checking with your doctor. If you feel you are not getting enough oxygen, talk to your doctor. Oxygen itself does not burn, but it can feed a spark and cause it to become a large fire within seconds. Follow these rules to prevent fires: NO smoking; avoid open flames; do not use equipment with frayed cords or electrical shorts; avoid using electric razors and hair dryers while using oxygen; do not use appliances with a control box, such as a heating pad; avoid static electricity; avoid nylon or wool clothing; store liquid and cylinder oxygen away from heat and direct sunlight; place cylinders in a secure upright holder; and never apply oily substances around oxygen equipment.

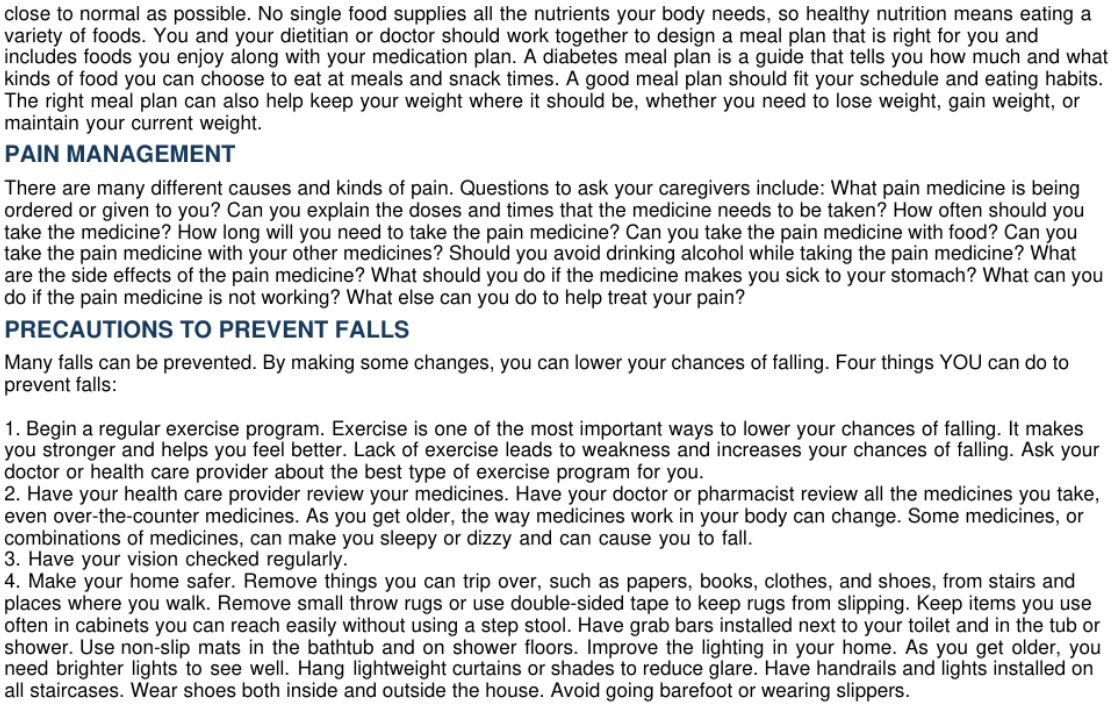
TAKE CARE OF YOURSELF / TAKE CARE OF YOUR DIABETES

Diabetes mellitus affects up to 5% of the population in the United States — almost 14 million people. Diabetes mellitus is a disorder caused by decreased production of insulin or by a decreased ability to use insulin. Insulin is a hormone produced by the pancreas that is necessary for cells to use blood sugar properly. The exact cause of diabetes mellitus is unknown, but heredity and diet are believed to play important roles in its development. People with diabetes have the same nutritional needs as anyone else. Along with exercise and medications such as insulin or oral diabetes pills, nutrition is important for

Illustration from the handbook: medication and oxygen safety education.

- Ask the patient/caregiver to show all prescription medications, over-the-counter products, vitamins, herbals, and supplements available in the home.
- Compare medication information with referral/orders and identify discrepancies for clinical follow-up.
- Reinforce that medication questions or uncertainty should be reported to the nurse, physician, or pharmacist as appropriate.
- If oxygen is present, reinforce ordered flow/use, no smoking/open flames, safe storage, and emergency precautions.
- Assess fall risks in the home and teach practical prevention measures.

8. Home Safety and Emergency Preparedness



close to normal as possible. No single food supplies all the nutrients your body needs, so healthy nutrition means eating a variety of foods. You and your dietitian or doctor should work together to design a meal plan that is right for you and includes foods you enjoy along with your medication plan. A diabetes meal plan is a guide that tells you how much and what kinds of food you can choose to eat at meals and snack times. A good meal plan should fit your schedule and eating habits. The right meal plan can also help keep your weight where it should be, whether you need to lose weight, gain weight, or maintain your current weight.

PAIN MANAGEMENT

There are many different causes and kinds of pain. Questions to ask your caregivers include: What pain medicine is being ordered or given to you? Can you explain the doses and times that the medicine needs to be taken? How often should you take the medicine? How long will you need to take the pain medicine? Can you take the pain medicine with food? Can you take the pain medicine with your other medicines? Should you avoid drinking alcohol while taking the pain medicine? What are the side effects of the pain medicine? What should you do if the medicine makes you sick to your stomach? What can you do if the pain medicine is not working? What else can you do to help treat your pain?

PRECAUTIONS TO PREVENT FALLS

Many falls can be prevented. By making some changes, you can lower your chances of falling. Four things YOU can do to prevent falls:

1. Begin a regular exercise program. Exercise is one of the most important ways to lower your chances of falling. It makes you stronger and helps you feel better. Lack of exercise leads to weakness and increases your chances of falling. Ask your doctor or health care provider about the best type of exercise program for you.
2. Have your health care provider review your medicines. Have your doctor or pharmacist review all the medicines you take, even over-the-counter medicines. As you get older, the way medicines work in your body can change. Some medicines, or combinations of medicines, can make you sleepy or dizzy and can cause you to fall.
3. Have your vision checked regularly.
4. Make your home safer. Remove things you can trip over, such as papers, books, clothes, and shoes, from stairs and places where you walk. Remove small throw rugs or use double-sided tape to keep rugs from slipping. Keep items you use often in cabinets you can reach easily without using a step stool. Have grab bars installed next to your toilet and in the tub or shower. Use non-slip mats in the bathtub and on shower floors. Improve the lighting in your home. As you get older, you need brighter lights to see well. Hang lightweight curtains or shades to reduce glare. Have handrails and lights installed on all staircases. Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.

Illustration from the handbook: fall-prevention education.

- Identify hazards such as loose rugs, cluttered pathways, poor lighting, unsafe cords, lack of grab bars, or unsafe transfer areas.
- Discuss an emergency exit plan, smoke detectors, emergency numbers, and safe access to the telephone.
- Identify whether the patient depends on electricity, oxygen, mobility devices, caregiver assistance, or other resources during emergencies.
- Review special-needs/emergency instructions in the package when applicable.
- Document safety risks and report issues requiring clinical intervention or follow-up.

Admission professional focus

Education should be practical: point out actual hazards in the home and connect handbook instructions to what you observe during the admission visit.

9. Infection Prevention Education

RESPIRATORY HYGIENE AND COUGH ETIQUETTE

To prevent the transmission of all respiratory infections in healthcare settings, including influenza, the following infection-control measures should be implemented at the first point of contact with a potentially infected person. These measures should be incorporated into infection-control practices as one component of Standard Precautions. Visual alerts, in appropriate languages, should instruct patients and accompanying persons, such as family members and friends, to inform healthcare personnel of symptoms of a respiratory infection while under our care. Symptoms may include cough, shortness of breath, breathing problems, runny nose, fatigue, and sneezing. Patients and visitors should practice respiratory hygiene/cough etiquette.

COVER YOUR COUGH: STOP THE SPREAD OF GERMS

Influenza (flu) and other serious respiratory illnesses, such as respiratory syncytial virus (RSV), whooping cough, and severe acute respiratory syndrome (SARS), are spread by coughing, sneezing, or unclean hands. To help stop the spread of germs, cover your mouth and nose with a tissue when you cough or sneeze; place used tissues in a wastebasket; and, if a tissue is not available, cough or sneeze into your upper sleeve or elbow, not your hands. You may be asked to wear a face mask to protect others. Wash your hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub. Information about Personal Protective Equipment (PPE) demonstrates the proper sequence for putting on and removing PPE.

MASKING, SEPARATION, AND DROPLET PRECAUTIONS

During periods of increased respiratory infection activity in the community, such as increased absenteeism in schools and workplaces or increased medical office visits by persons complaining of respiratory illness, we may request that coughing persons wear masks. Procedure masks with ear loops or surgical masks with ties may be used to contain respiratory secretions; respirators such as N-95 masks or higher are not necessary for this purpose. When space and seating permit in the place of residence, coughing persons are encouraged to sit at least three feet away from others in common waiting areas. Healthcare personnel should observe Droplet Precautions, including wearing a surgical or procedure mask for close contact, in addition to Standard Precautions when examining a patient with symptoms of a respiratory infection, particularly when fever is present. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent requiring Droplet Precautions.

WHAT YOU CAN DO TO PREVENT INFECTIONS

Clean your hands with soap and warm water. Rub your hands well for at least 20 seconds, including your palms, fingernails, between your fingers, and the backs of your hands. If your hands do not look dirty, clean them with an alcohol-based hand sanitizer and continue rubbing until your hands are dry. Clean your hands before touching or eating food; after using the bathroom; after taking out the trash; after changing a diaper; after visiting someone who is ill; and after playing with a pet. Make sure our staff clean their hands or wear gloves. Staff should wear clean gloves when performing care for you. Do not be afraid to ask whether they should wear gloves. Cover your mouth and nose. When you sneeze or cough germs can travel three feet or more. Cover your mouth and nose to prevent the spread of infection to others. If you are sick, avoid close contact with others, stay away from other people, or stay home. Do not shake hands or touch others. If you have any wound or skin lesion, watch for signs and symptoms of infection, such as discharge or fever.

INFECTION-CONTROL PROCEDURES IN THE HOME

To protect both clients and caregivers, infection-control procedures should be followed in the home setting. Handwashing is perhaps the easiest, most important, and most effective way to prevent transmitting infection from one person to another. The client and caregiver should wash their hands thoroughly before and after providing client care, and before and after contact with contaminated or potentially contaminated items. When in doubt about whether something may be contaminated, be safe: wash your hands. Use latex or other disposable gloves when handling or disposing of blood, urine, feces, sputum, and any body fluid or secretion. Dispose of contaminated or potentially contaminated items, such as tissues, by placing them in a sealable plastic bag. Our professional staff will instruct you on appropriate infection-control measures including proper disposal methods. If you have questions or concerns during the time services are being provided, ask your nurse, therapist, physician, or contact our office. For questions or concerns regarding infectious disease, contact your physician. Keep disposable tissues available for everyone to use, sanitize frequently touched surfaces, and use a respiratory mask if needed.

GET VACCINATED TO AVOID DISEASES AND FIGHT THE SPREAD OF INFECTIONS

Make sure your vaccinations are current, including adult vaccinations. Check with your doctor about what you may need. Vaccinations are available to help prevent chickenpox, mumps, measles, diphtheria, tetanus, hepatitis, shingles, meningitis, flu (influenza), whooping cough, German measles (rubella), pneumonia, and human papillomavirus (HPV).

STAFF UNIVERSAL AND STANDARD PRECAUTIONS PROCEDURES

Our agency guarantees that home healthcare providers will adhere to the following precautions when delivering care to all patients. By adhering to these universal precautionary measures, the risk of disease transmission is decreased when the patient's infection status is unknown. Gloves must be worn when delivering patient care, handling specimens, doing domestic cleaning, and handling items that may be soiled with blood or body fluids. Gloves or aprons must be worn during procedures or while managing patient situations when there will be exposure to body fluids, blood, draining wounds, or mucous membranes. A mask and protective eyewear or face shield must be worn during procedures that are likely to generate droplets of body fluids or blood, or when the patient is coughing excessively. Hands must be washed before putting on gloves and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood, and after all patient-care activities. Home healthcare providers who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.

RESPIRATORY HYGIENE PRACTICES

Respiratory hygiene practices are essential for preventing the spread of infectious disease in healthcare and home settings. Patients, caregivers, visitors, and healthcare personnel should consistently follow cough etiquette, hand hygiene, masking recommendations, surface disinfection practices, and proper use of personal protective equipment (PPE). Maintaining these infection prevention measures protects patients, caregivers, healthcare staff, and the community by reducing the transmission of respiratory illness and other infectious diseases.

Illustration from the handbook: infection-control and respiratory-hygiene guidance.

- Reinforce hand hygiene before/after care and contact with potentially contaminated items.
- Explain respiratory hygiene/cough etiquette and when masking may be appropriate.
- Explain safe handling/disposal of contaminated items and sharps/biohazardous waste when applicable.
- Encourage the patient/caregiver to report fever, drainage, respiratory symptoms, wound changes, or other signs of infection to the appropriate clinician.
- Demonstrate or verify understanding of infection-control instructions relevant to the patient's care.

10. Documentation Standards for the Admission Professional

The admission record should demonstrate what was explained, what the patient understood, what choices were made, and what follow-up is needed.

- Use the correct patient name, medical record number, dates, and identifiers on every applicable form.
- Use only approved abbreviations and write legibly when completing paper forms.
- Never use correction fluid, erase entries, backdate, or alter a patient's signature.
- Correct errors according to the agency's medical-record correction policy.
- Document the patient's preferred language and any interpreter/communication assistance used.
- Document the authorized representative and relationship when applicable.
- Document refusals and the education provided regarding possible consequences; notify the appropriate supervisor/clinician when required.
- Document discrepancies requiring follow-up, including medications, orders, service frequency, home safety, caregiver availability, or advance directive information.
- Ensure the patient receives the required copy of the handbook/agreement/notices as applicable.

Survey readiness

A reviewer should be able to see, from the admission record alone, that the patient was informed, involved, and provided the required notices and education.

11. Admission Package Final Quality Check

Before leaving the home or submitting the admission record, verify:

☐ Patient identity verified; agency staff identification displayed.

☐ Patient/representative contact and relationship information complete.

☐ Ordered disciplines and visit frequencies entered and explained.

☐ Financial/coverage information explained as applicable.

☐ Patient rights/responsibilities and complaint procedures explained.

☐ Abuse/neglect/exploitation reporting information reviewed.

☐ HIPAA Notice of Privacy Practices reviewed/received.

☐ OASIS privacy notice reviewed when applicable.

☐ Advance Directive/Living Will/Proxy/DNR status addressed.

☐ Emergency and 911 instructions reviewed; agency after-hours process explained.

☐ Medication, fall, home safety, infection-control and condition-specific education provided as applicable.

☐ AI disclosure/consent reviewed when applicable.

☐ All required choices/check boxes completed by or with the patient/representative.

☐ Patient/representative signature and date complete.

☐ Agency representative name, title, signature and date complete.

☐ No unexplained blanks, conflicting dates, missing frequencies, or incomplete acknowledgments.

☐ Patient received required copies and knows how to contact the agency.

12. Questions and answers discussion

1. What should you do before discussing protected health information with the person in the home?

Verify the person's identity and confirm that the patient has authorized them to receive or discuss the protected health information (PHI).

2. What is the difference between a life-threatening emergency and an after-hours clinical concern? *A life-threatening emergency requires immediate action and calling 911/EMS, while an after-hours clinical concern is a non-life-threatening patient issue that should be reported to the agency's on-call nurse or appropriate clinical staff for assessment and instructions.*

3. Name four topics that must be explained as part of patient rights/orientation.

Four topics that must be explained during patient rights/orientation are: Patient rights and responsibilities, Privacy and confidentiality/HIPAA rights, How to file a complaint or grievance without retaliation, Advance directives and the patient's right to participate in care decisions.

4. What should you do if the patient cannot sign the admission documents?

Document why the patient cannot sign and obtain the signature of the patient's legally authorized representative, when applicable, following agency policy.

5. Why is it not acceptable to obtain a signature while required frequency or choice fields remain blank? *Because the patient must know and agree to the complete information before signing. Blank frequency or choice fields could be filled in later without the patient's knowledge, making the documentation incomplete, inaccurate, and potentially invalid.*

6. What should you document if the patient refuses a recommended service or instruction?

Document the specific service or instruction refused, the education provided, the patient's reason for refusal (if given), any risks or consequences explained, and the appropriate clinician/physician notification and follow-up actions.

7. When should OASIS privacy information be reviewed?

OASIS privacy information should be reviewed with the patient at the time of the OASIS assessment, typically during the Start of Care/admission process, before OASIS information is collected or transmitted

8. What safety topics should be individualized during the home admission visit?

Safety education should be individualized to the patient's specific condition and home environment, including fall prevention, medication safety, infection prevention, emergency/911 procedures, fire and electrical safety, medical equipment/oxygen safety when applicable, and any identified home hazards or patient-specific risks.

9. What should you do when medication information in the home conflicts with referral or order information? *Perform medication reconciliation, do not guess or change the medication information yourself, document the discrepancy, and notify the appropriate nurse/physician or authorized provider for clarification and orders as needed before proceeding.*

10. What final check should be performed before the admission package is filed?

Perform a final completeness and accuracy review to ensure all required forms and fields are completed, signatures and dates are present, required choices/frequencies are documented, and any discrepancies or missing information have been resolved before filing. Call Agency DON, or qualified supervisor if help is needed.

11. What should you do if you discover a blank required field after the patient has already signed?

Follow the agency's documentation correction policy; never backdate, alter, or complete information in a way that misrepresents what the patient reviewed and agreed to.

12. What should you do if the patient does not understand a form or instruction?
Stop and explain it in understandable language, use interpreter/communication assistance when necessary, and confirm understanding before obtaining the signature.

13. What information should be verified before leaving the patient's home?
Patient demographics, emergency contacts, physician/provider information, medications, ordered services and frequencies, signatures/dates, and required admission acknowledgments.

14. What should you do when you identify an immediate safety risk in the home?
Address what can safely be corrected, educate the patient/caregiver, document the risk and interventions, and promptly notify the appropriate supervisor/clinician when follow-up is required.

15. Why should the patient receive copies of applicable admission documents?
So the patient has access to their rights, responsibilities, agency contact information, complaint procedures, emergency instructions, and other required information.

16. What is the last step before leaving the home?
Confirm that the patient/caregiver understands the plan of care, visit expectations, medications/instructions, emergency procedures, and how and when to contact the agency, and document the education provided.

Notes about **patients with cognitive impairment/dementia who reside in an ALF**. The key point is that dementia alone does not automatically mean the patient lacks decision-making capacity or that another person can sign for them. Staff should determine whether the patient can understand the admission information and identify whether there is a legally authorized representative.

What should you do if an **ALF resident has dementia and cannot understand the admission documents**?
Do not rely solely on the patient's signature. Identify and contact the patient's legally authorized representative, such as a legal guardian or other person with documented legal authority to make the applicable healthcare decisions, and follow agency policy for consent and signatures.

Can ALF staff sign home health admission documents for a resident who cannot understand them?
Not merely because they work at the ALF. Verify that the individual has documented legal authority to act for the patient before accepting a signature on the patient's behalf.

What should be verified before accepting a legal guardian/representative's signature?
Verify the representative's identity, relationship or legal capacity, and documentation establishing the authority to make the applicable decisions for the patient. Maintain required documentation in the clinical record according to agency policy.

What should you document when notifying the legal guardian/authorized representative?
Document the date and time of contact, person contacted, relationship/legal authority, information provided, decisions or consent obtained, questions or concerns, instructions given, and any required follow-up. Request the Agency send Legal Representative information copies, including Patient's Rights, authorizations, etc.

Should the patient still be involved when a legal representative is responsible for decisions?
Yes. The patient should be informed and involved to the extent they are able to understand and participate, while respecting the legal representative's established authority.

What if the legal guardian/authorized representative cannot be reached during the admission visit?
Document all contact attempts and notify the DON/Clinical Supervisor. Do not obtain an unauthorized signature from ALF personnel or another individual simply to complete the admission paperwork. Follow agency policy regarding whether admission/services may proceed and what authorization is required.

Important statement: For an ALF resident with significant cognitive impairment, staff should clearly document who participated in the admission, the patient's ability to understand the information presented, who holds legal decision-making authority, how that authority was verified, and all communications with the authorized representative.

Training Note: This training follows the content and structure of the provided Admission Package. Agency-specific policies, payer requirements, state/federal requirements, and accreditation standards should be applied when they impose additional requirements.