Company Name

Category:	Administrative	Number:	1.009.1
Subject:	Admission Criteria		
Applies:	Intake Staff	Page:	1 of 4

Purpose: To establish criteria for admission to the Agency.

Policy: The Agency will evaluate each individual for the appropriateness of admission without regard to race, age, color, creed, sex, national origin, ancestry, religion, handicap, or disability.

Procedure: The Staff determines appropriateness for admission. He/she may consult with other staff members if necessary.

1. Clients are accepted for Home Health Services based on a reasonable expectation that the client’s health care/rehabilitation needs can be met adequately in the client’s residence.
2. The agency must accept a client for home health services based on a reasonable expectation that the client's medical, nursing, and social needs can be met adequately in the client's residence. An agency has made a reasonable expectation that it can meet a client's needs if, at the time of the agency's acceptance of the client, the client and the agency have agreed as to what needs the agency would meet; for instance, the agency and the client could agree that some needs would be met but not necessarily all needs.
3. The agency must start providing licensed home health services to a client within a reasonable time after acceptance of the client and according to the agency's policy. The initiation of licensed home health services must be based on the client's health service needs.
4. Prior to initiation of services the RN will ensure that the client or their legal representative receives a written notice concerning all policies governing client conduct and responsibility, advance directives, and client rights and confidentiality. If the patient cannot read the nurse will read the statement of rights and responsibility to the patient.
5. An initial health assessment must be performed in the client's residence by the appropriate health care professional prior to or at the time that licensed home health services are initially provided to the client. The assessment must determine whether the agency has the ability to provide the necessary services.

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a. If a practitioner has not ordered skilled nursing care for a client, then the appropriate registered nurse must prepare a care plan. The care plan must be developed after consultation with the client and the client's family and must include services to be rendered, the frequency of visits or hours of service, identified problems, method of intervention, and projected date of resolution. The care plan must be reviewed and updated by all appropriate staff members involved in client care at least annually, or more often as necessary to meet the needs of the client.
b. If a practitioner orders therapy, then the appropriate PT, OT, or ST, must perform an evaluation. The plan of care must be signed and approved by a practitioner in a timely manner. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care personnel must perform services as specified in the plan of care. The plan of care must be revised as necessary, but it must be reviewed and updated at least every sixty days.

6. Considerations relevant to acceptance of a patient may include:
   a. Adequacy and suitability of Agency personnel and resources to provide the services required by the patient.
   b. Attitudes of patient and family members toward home care.
   c. Comparative benefits of home care to institutional care.
   d. Adequate physical facilities in the patient’s residence.
   e. Availability and willingness of family members or substitute family members to participate in care.
   f. Availability and cooperation of the patient’s personal physician in establishing and managing the plan of care.
   g. Conditions of coverage, including homebound status, if applicable.
   h. Safety of staff related to patient’s housing, neighborhood and attitude of members in the home.

SAMPLE

7. The decision regarding acceptance for admission to the Agency is not based solely on the physician's referral or the patient's request. It is based on the determined need for skilled intervention.

8. Upon referral, the decision regarding acceptance of and initiation of service by licensed staff will be made within 48 hours, of the referral or within 48 hours of the patients return home or knowledge of return home or on the physicians ordered start of care date.

9. No patient is admitted for services without an order from a physician. However, a visit may be made by the Agency's staff without a physician's order for the purpose of:
   a. Evaluation of patient meeting criteria of home health services.
   b. Offering guidance to the individual regarding the selection of a physician.
   c. The use of community resources.

10. If the client cannot be admitted, appropriate persons are notified and the Agency attempts to refer the individual to other community resources related to the client's needs.

11. All patients shall be under the care of a doctor of medicine, osteopathy, podiatry medicine. It is expected that the patient will be seen by the doctor when medically indicated, but at least every six months if possible.

12. The agency shall establish and maintain for each patient accepted for care a health record which shall include at least the following information
    a) Name
    b) Current address
    c) Date of birth
    d) Sex
    e) Date of admission
    f) Name, address and telephone number of the responsible party

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g) Name, address, and telephone number of the attending physician, dentist, podiatrist, or other licensed and legally authorized person whose orders or recommendations are being implemented by the home health agency.
h) Admission diagnosis or pertinent health information
i) Reason for admission
j) Notation of the conditions and diagnoses which are relevant to the plan of treatment, plan of care, or plan for personal care services.
k) Plan of treatment, plan of care, or plan for personal care services in its entirety.
l) Allergies and known untoward reactions to drugs and food. This information shall be given such prominence in the record that it is obvious to any health practitioner or agency personnel who have reasons to provide food or medication to the patient.
m) Clinical notes dictated or written at the time of service by personnel rendering the services. Clinical notes shall be signed and incorporated into the patient's health record at least every seven working days.
n) Laboratory and X-ray reports, if applicable.
o) Treatment consent or service authorization forms.
p) Documentation that a list of patient rights has been made available to each patient, patient's representative, or next of kin.
q) Clients who will receive PT, OT, and/or ST will receive a discipline specific evaluation by a therapist qualified to perform the evaluation.
r) Discharge statement. The discharge statement shall include the date of discharge, reason for termination of services, and condition upon discharge.

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