Administrative Support SOP Library - Part 1

Administrative Operations, Care Coordination, Documentation, Systems Support, Quality Assurance, and Compliance Support

Prepared for Nattingham Home Care administrative support staff. This manual defines support-role expectations, documentation standards, communication practices, escalation pathways, and operational workflows. It is designed to support consistency, compliance readiness, client satisfaction, and continuity of care.

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Table of Contents

Preface

The Nattingham Home Care Administrative Support SOP Library - Part 1 provides a consistent operating framework for administrative support staff. It explains how admins support clients, caregivers, supervisors, nurses, leadership, and compliance workflows across day-to-day operations.

This library is intentionally written from a support-role perspective. Admins are vital to communication, documentation, client experience, scheduling coordination, file organization, and audit readiness. However, the administrative support role is not designed to replace supervisory authority, clinical judgment, HR authority, or leadership decision-making.

How to Use This Library

- Use this manual during onboarding, cross-training, daily workflow support, and internal quality assurance review.
- Follow the SOP sections that relate to the workflow being completed.
- Escalate uncertainty to the assigned supervisor, leadership, HR, or nursing staff as appropriate.
- Use approved Nattingham Home Care forms, CareSmartz360+, Jotform, ADP RUN, and digital file systems according to current agency workflow.
- Treat this manual as general guidance. System screens, software steps, payer expectations, and internal processes may change over time.

Purpose of Part 1

- Define the administrative support role and its boundaries.
- Promote professional communication and documentation habits.
- Support care coordination and assigned client case load management.
- Strengthen service delivery compliance and documentation retention.
- Clarify escalation responsibilities for client, staff, compliance, and safety concerns.
- Create a foundation for Part 2, which will cover the full caregiver employment lifecycle from hiring through separation.

Administrative Role Clarification

Administrative Support Staff at Nattingham Home Care function primarily as support professionals, operational coordinators, documentation specialists, communication support staff, and compliance support personnel.

Admins Are Expected To

- Support clients, caregivers, supervisors, nurses, and leadership through organized workflows.
- Coordinate communication and scheduling tasks within assigned authority.
- Document operational concerns accurately and timely.
- Maintain client and employee confidentiality.
- Escalate clinical concerns, performance concerns, misconduct concerns, and compliance concerns to the appropriate supervisor or leadership team member.
- Help maintain records, files, forms, and system updates in an audit-ready condition.

Admins Are Not Expected To Independently

- Administer formal disciplinary action to caregivers or other staff.
- Threaten termination, suspension, or corrective action.
- Provide clinical assessment, clinical direction, or nursing judgment unless separately licensed and authorized.
- Investigate allegations without direction from leadership.
- Promise payer, case management, payroll, HR, or client outcomes without approval.
- Override supervisor, nurse, HR, or leadership decisions.

Core principle: Admins support, document, coordinate, organize, communicate, and escalate. Supervisors, nursing staff, HR leadership, directors, and ownership handle formal corrective action, clinical direction, investigations, and final authority decisions.

Regulatory and Compliance Framework

Administrative staff are not expected to interpret law independently. However, admins must understand that documentation, service coordination, EVV support, incident escalation, supervisory visit coordination, background check support, and file retention are connected to Ohio Medicaid, Ohio Department of Aging, waiver, EVV, and internal policy expectations.

Rules Referenced by This Library

- Ohio Administrative Code Rule 173-39-02.11: ODA provider certification for personal care, including PCA supervision, supervisory visits, activity plan monitoring, service verification, backup planning, and PCA requirements.
- Ohio Administrative Code Rule 173-9-03: database reviews for paid direct-care positions, including ARCS and relevant exclusion/registry checks.
- Ohio Administrative Code Rule 173-9-06: disqualifying offenses for paid direct-care positions.
- Ohio Administrative Code Rule 173-9-07: situations where a disqualifying offense may not disqualify an applicant or employee.
- Ohio Administrative Code Rule 5160-44-05: incident management, reporting, health and welfare action, and documentation expectations for HCBS waiver services.
- Ohio Administrative Code Rule 5160-1-39: verification of home care service provision and EVV-related expectations.

Internal Reference Materials

- Nattingham Home Care Employee Handbook.
- Nattingham Home Care Administrative Support Specialist job description.
- Approved Jotform admin workflow forms.
- CareSmartz360+ client, caregiver, schedule, EVV, and CRM records.
- ADP RUN payroll and employee records, when access is granted.

1. Administrative Support Role Overview SOP

Purpose

This SOP defines the overall purpose, scope, and expectations of the Administrative Support role at Nattingham Home Care. Admins provide cross-trained support across client operations, scheduling, documentation, compliance, staffing, payroll support, and communication workflows.

Scope

This SOP applies to all admins, administrative support specialists, care support staff, and cross-trained office team members who perform operational support tasks for Nattingham Home Care.

Admin Support Responsibilities

- Answer calls, texts, and emails professionally and promptly.
- Support scheduling, documentation, onboarding, compliance, and client operations.
- Assist with digital files, reports, forms, and system updates.
- Coordinate with supervisors, nurses, caregivers, clients, families, and case managers as assigned.
- Participate in cross-training across client support, hiring support, compliance support, EVV support, and recruiting support.
- Maintain professional communication, reliability, organization, and problem-solving habits.

Standard Workflow

Step 1: Review assigned duties, client roster, workflow priorities, and supervisor expectations at the start of the workday.

Step 2: Complete assigned support tasks using approved systems and forms.

Step 3: Document meaningful communication, concerns, follow-up needs, and work completed in the appropriate system or form.

Step 4: Escalate operational, compliance, safety, clinical, or employee concerns to the correct supervisor or leadership team member.

Step 5: Complete the Daily Recap Form at the end of the shift when required.

Required Documentation

- Daily recap forms when required.
- Client case notes for client-related communication.
- Employee file notes for employee-related operational support concerns.
- CareSmartz360+ notes and uploads when applicable.
- PDF records of external communication when required.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Unclear authority, urgent client needs, staff performance concerns, unsafe conditions, privacy concerns, suspected falsification, repeated staffing gaps, or unresolved payer/case management issues.

Role Boundaries

- Admins do not independently discipline field staff.
- Admins do not provide clinical direction unless licensed and authorized.
- Admins do not make final HR or payroll approval decisions unless specifically authorized.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

2. Professional Communication SOP

Purpose

This SOP establishes communication expectations for administrative staff when communicating with clients, families, caregivers, case managers, nurses, supervisors, community partners, and leadership.

Scope

Applies to phone calls, text messages, emails, internal notes, CareSmartz360+ entries, Jotform submissions, ADP support communication, and any other business communication.

Admin Support Responsibilities

- Use a calm, respectful, and professional tone.
- Identify Nattingham Home Care clearly when answering business calls.
- Avoid slang, sarcasm, argument, blame, or emotional language in business communication.
- Document important communication in the proper workflow.
- Escalate complaints, threats, safety concerns, or unresolved issues promptly.
- Avoid promising outcomes outside the admin role, including pay corrections, disciplinary action, staffing guarantees, or payer decisions.

Standard Workflow

Step 1: Listen for the purpose of the communication and identify whether the matter is routine, urgent, clinical, staffing-related, payroll-related, or compliance-related.

Step 2: Provide support within the admin role and collect needed facts.

Step 3: Document the communication when it affects service delivery, staffing, client satisfaction, employee support, or compliance.

Step 4: Escalate concerns outside the admin role to the appropriate supervisor, nurse, HR/payroll lead, or leadership.

Step 5: Retain external emails as PDFs when the communication involves case management, community support, payer communication, or formal client service coordination.

Required Documentation

- Client case notes for client communication.
- Employee file notes for employee support or workflow concerns.
- PDF copy of case management or community partner emails.
- CareSmartz360+ notes when related to client service operations.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Threatening communication, safety concerns, suspected abuse or neglect, complaints, clinical concerns, payroll disputes, caregiver misconduct, service disruption, case manager escalations.

Role Boundaries

- Admins should not argue with clients or staff.
- Admins should not threaten consequences.
- Admins should not give legal, medical, or clinical advice.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

3. HIPAA and Confidentiality SOP

Purpose

This SOP protects confidential client and employee information and reinforces privacy expectations for administrative support staff.

Scope

Applies to client records, employee records, schedules, phone numbers, medical information, service details, payroll information, background check documents, Jotform submissions, CareSmartz360+ records, and ADP RUN information.

Admin Support Responsibilities

- Access only records needed to complete assigned work.
- Use client and employee information only for legitimate operational purposes.
- Avoid discussing client information with unauthorized individuals.
- Avoid photographing, recording, or sharing client information without proper authorization.
- Protect passwords, log out of systems, and secure workstations.
- Report suspected privacy incidents promptly to a supervisor or leadership.

Standard Workflow

Step 1: Before accessing a record, confirm the access is needed for assigned work.

Step 2: Use approved systems and secure storage locations only.

Step 3: When saving documents, use approved folder locations and naming conventions.

Step 4: Do not send protected information through unsecured or unauthorized channels.

Step 5: Immediately report accidental disclosure, wrong-recipient emails, missing records, or suspected unauthorized access.

Required Documentation

- Privacy concern report to supervisor.
- Case note or employee file note when operationally appropriate.
- Corrected filing/upload record if an error is fixed.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Misdirected email, lost forms, unauthorized screenshot, suspected social media disclosure, unauthorized family request, employee requesting another employee record, system access concern.

Role Boundaries

- Admins may not access records out of curiosity.
- Admins may not share credentials.
- Admins may not discuss client details with other clients, friends, or unauthorized family members.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

4. Care Coordination and Client Case Load Management SOP

Purpose

This SOP defines how admins support assigned client case loads through care coordination, client satisfaction, service delivery monitoring, caregiver coordination, CRM support, random visits, case notes, and communication retention.

Scope

Applies to admins assigned a client roster or care support roster at Nattingham Home Care.

Admin Support Responsibilities

- Serve as the client's non-clinical operational point of contact.
- Perform initial welcome calls and coordinate initial visits at start of care.
- Work with other admins, supervisors, and schedulers to assign caregivers based on skills, availability, proximity, and client needs.
- Monitor service delivery, staffing stability, client happiness, and care continuity.
- Ensure random monitoring visits/check-ins are documented at least monthly.
- Ensure an in-person monitoring visit occurs at least every other month when operationally appropriate.
- Add case notes for updates, concerns, service changes, communication, follow-up actions, and client support needs.
- Retain case management and community support emails as PDFs in the client record.

Standard Workflow

Step 1: Upon assignment, review the client profile, schedule, authorization, caregiver assignment, care plan, and recent notes.

Step 2: Complete a start-of-care welcome call and schedule the initial visit or follow-up as appropriate.

Step 3: Coordinate caregiver assignment with attention to skills, availability, proximity, transportation, and long-term consistency.

Step 4: Monitor the client's service delivery through CareSmartz360+, case notes, random visits, missed visit records, and communication history.

Step 5: Document all meaningful changes or follow-up items using the approved case notes process.

Step 6: Escalate safety, clinical, repeated staffing, or service disruption concerns promptly.

Required Documentation

- Client case notes.
- Random Visit/Monitoring Form.
- Missed Visit Form when applicable.
- CareSmartz360+ updates.
- PDF copies of case management or community support emails.
- Supervisory visit coordination notes when assigned.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Client safety concerns, caregiver mismatch, repeated call-offs, family complaint, hospitalization, change in condition, unsafe home condition, suspected abuse/neglect, case manager concern, missed visit pattern.

Retention and Audit Readiness

- All client communication with case management or community supports must be saved as PDF and retained in the client folder.
- Completed Jotform records should be pulled and filed as PDFs when required.
- CareSmartz360+ should reflect key service coordination updates.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

5. Administrative Support for Supervisory Visits SOP

Purpose

This SOP explains admin support responsibilities for supervisory visits completed by the agency nurse or contracted nurse under personal care service oversight expectations.

Scope

Applies to admins who coordinate, track, pull, review, upload, or organize supervisory visit documentation.

Admin Support Responsibilities

- Coordinate 45-60 day supervisory visits as Nattingham Home Care's internal compliance buffer.
- Contact clients to support scheduling with the nurse.
- Partner with the nurse or contracted nurse for visit scheduling and completion tracking.
- Verify supervisory visit documentation is complete before final filing and upload.
- Confirm the form includes client name and date of birth as Nattingham's internal unique identifier.
- Confirm telephone or video supervisory visits include evidence of contact, such as a nurse call log screenshot or other acceptable verification evidence.
- Pull completed Jotform submissions, save as PDF, upload to the client file and CareSmartz360+, and update CRM notes.

Standard Workflow

Step 1: Review upcoming supervisory visit due dates and prioritize visits approaching the internal 45-60 day window.

Step 2: Coordinate client availability and nurse availability.

Step 3: Confirm whether the visit will be in person, telephone, or video conference according to operational and regulatory expectations.

Step 4: After the visit, retrieve the completed Jotform and review for completeness.

Step 5: Verify client full name, client DOB, visit date, visit type, nurse name, documentation observations, satisfaction/care plan review, and call log evidence when applicable.

Step 6: Report errors or inconsistencies to the supervisor. The supervisor will communicate corrective feedback to the nurse.

Step 7: Save the finalized documentation as a PDF, upload into CareSmartz360+, and retain it in the client file.

Required Documentation

- Supervisory Visit Jotform PDF.
- Call log screenshot or verification evidence for telephone/video visits.
- CareSmartz360+ visit completion note.
- Client file upload.
- Supervisor notification of errors or missing items.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Overdue supervisory visit, missing DOB, missing call log screenshot, incomplete visit form, documentation inconsistency, client complaint, nurse unavailable, repeated scheduling barrier, safety or care plan concern identified during visit.

Role Boundaries

- Admins do not perform clinical supervisory assessments unless licensed and authorized.
- Admins do not edit nurse clinical documentation unless expressly authorized.
- Admins report errors to the supervisor instead of independently directing nurse correction.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

6. Random Visit / Monitoring SOP

Purpose

This SOP defines how admins support random monitoring visits, quality assurance check-ins, client satisfaction tracking, and safety observation.

Scope

Applies to client monitoring visits completed by admins, supervisors, or approved operational staff.

Admin Support Responsibilities

- Complete or coordinate monthly random monitoring documentation for assigned clients.
- Monitor client satisfaction, caregiver presence, punctuality, safety concerns, and environmental concerns.
- Ask financial boundary and exploitation screening questions in a respectful manner.
- Document concerns objectively and escalate promptly.
- Use approved Random Visit/Monitoring Form.

Standard Workflow

Step 1: Review client schedule, caregiver assignment, and recent case notes before contact or visit.

Step 2: Complete the monitoring visit or call using the approved form.

Step 3: Document wellness concerns, caregiver presence, timeliness, safety, smoke detectors, elevator/accessibility concerns, and financial boundary concerns.

Step 4: Document follow-up actions and notify leadership of urgent concerns.

Step 5: Save and upload the completed form according to file management workflow.

Required Documentation

- Random Visit/Monitoring Form.
- Case note for follow-up items.
- CareSmartz360+ note or upload when applicable.
- Supervisor notification for urgent issues.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Client reports not feeling safe, staff asks for money or personal items, suspected exploitation, smoke detector/elevator safety concern, caregiver absent/late, worsening client condition, complaint or service failure.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.

- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

7. Missed Visit SOP

Purpose

This SOP explains how admins support documentation and communication when a scheduled personal care shift is missed, cancelled, delayed, or cannot be staffed.

Scope

Applies to missed visits for private pay, Medicaid waiver, PASSPORT, MyCare Ohio, or other assigned clients when service delivery is disrupted.

Admin Support Responsibilities

- Attempt to partner with the client and staff to fill or reschedule the shift before marking it as missed when operationally appropriate.
- Document missed visits within 24 hours or less when service remains missed.
- Notify the client's case management team within required timeframes when applicable.
- If a shift is filled after case management notification, document the update in a case note and send follow-up communication to case management.
- Retain all case management communication as PDFs in the client folder.

Standard Workflow

Step 1: Identify the reason for service disruption: call-off, client cancellation, hospitalization, no staff available, delayed start, holiday, vacation, or reschedule request.

Step 2: Attempt coverage or rescheduling when safe and appropriate.

Step 3: Communicate with the client regarding the status of coverage or rescheduling.

Step 4: Complete the Missed Visit Form within 24 hours or less if service remains missed.

Step 5: Notify case management when required and save the email as PDF.

Step 6: If the situation changes, document the update and send follow-up to case management.

Required Documentation

- Missed Visit Form.
- Client case note.
- Case management notification PDF.
- Follow-up email PDF if shift was later filled or rescheduled.
- CareSmartz360+ schedule and notes updates.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Repeated missed visits, client safety risk, inability to staff, caregiver no call/no show, client hospitalization, client refusal of care, case manager complaint, family complaint.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

8. Incident Escalation and Operational Reporting SOP

Purpose

This SOP explains how admins support timely escalation and operational documentation of incidents or safety-related concerns.

Scope

Applies to incidents involving clients, caregivers, service delivery, safety, allegations, urgent changes in condition, and threats to health or welfare.

Admin Support Responsibilities

- Take immediate action to ensure the client's health and welfare by escalating appropriately.
- Call 911 when there is an immediate threat to life or safety, if directly involved in the communication.
- Notify the supervisor, nurse, or leadership immediately for urgent issues.
- Document the facts known to the admin without speculation.
- Support collection of operational details when directed by leadership.

Standard Workflow

Step 1: Determine whether the matter is an emergency, urgent concern, reportable incident, complaint, or operational issue.

Step 2: For immediate safety threats, ensure emergency services are contacted first when appropriate.

Step 3: Notify leadership, nursing, or the supervisor promptly.

Step 4: Document what happened, when it happened, who was involved, location, and actions taken.

Step 5: Cooperate with follow-up and provide records when requested.

Required Documentation

- Incident report or internal event documentation when directed.
- Case note or employee file note as applicable.
- Supervisor notification.
- CareSmartz360+ note or upload when applicable.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Falls, injuries, hospitalizations, suspected abuse, neglect, exploitation, missing client, medication emergency, unsafe home, threats, police/fire/EMS involvement, caregiver abandonment, client allegation.

Role Boundaries

- Admins do not conduct independent investigations unless instructed.

- Admins do not determine whether an incident is substantiated.
- Admins do not give clinical advice.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

9. Client Case Notes SOP

Purpose

This SOP explains how admins use client case notes to document service coordination, communication, concerns, observed needs, follow-up actions, and resources between random visits and supervisory visits.

Scope

Applies to all meaningful client-related communication, coordination, or follow-up activity.

Admin Support Responsibilities

- Complete a case note when meaningful client communication or service coordination occurs.
- Document reason for contact, current concern, observation, support provided, client response, barriers, and follow-up actions.
- Keep documentation factual, respectful, and concise.
- Use case notes to support continuity of care and audit readiness.

Standard Workflow

Step 1: Access the approved Client Case Notes Form from the Admin Workflow Forms page.

Step 2: Enter client identifier, date, time, admin name, and contact method.

Step 3: Document the reason for the note and the concern or update.

Step 4: Document support provided, client response, barriers, and follow-up plan.

Step 5: Submit the form and ensure the note is retained according to workflow.

Required Documentation

- Client Case Notes Form.
- CareSmartz360+ note when applicable.
- PDF communication records.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Safety concern, clinical change, recurring caregiver issue, case manager concern, client complaint, unmet need, emergency, suspected abuse/neglect/exploitation.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.

- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

10. Employee File Case Notes SOP

Purpose

This SOP explains how admins document employee-related support, observations, workflow concerns, communication trends, and supervisor partnership without independently administering discipline.

Scope

Applies to employee-related support documentation completed by admins, supervisors, or leadership.

Admin Support Responsibilities

- Document objective employee-related operational observations.
- Document employee support provided, clarification requests, attendance/communication concerns, and supervisor escalation.
- Use non-punitive language when documenting as an admin support person.
- Partner with supervisors for employee accountability concerns.

Standard Workflow

Step 1: Access the approved Employee File Case Notes Form.

Step 2: Document employee name, date, communication method, reason for note, observations, support provided, and follow-up recommendations.

Step 3: Escalate performance or accountability concerns to a supervisor.

Step 4: Submit and retain the completed note in the employee file according to workflow.

Required Documentation

- Employee File Case Notes Form.
- Supervisor notification.
- Supporting communication if authorized.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Attendance pattern, no call/no show, repeated EVV failure, documentation issue, workplace conduct concern, boundary concern, safety concern, suspected falsification.

Role Boundaries

- Admins do not independently write up, suspend, terminate, or threaten discipline.
- Only supervisors, HR leadership, directors, or ownership may administer formal corrective action unless authority is granted in writing.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

11. Documentation Standards and Audit Readiness SOP

Purpose

This SOP establishes agencywide documentation expectations for admin support workflows.

Scope

Applies to case notes, employee notes, Jotform records, CareSmartz360+ entries, ADP support records, EVV support documentation, emails, PDFs, and internal audit files.

Admin Support Responsibilities

- Document facts, direct communication, and actions taken.
- Use approved forms and systems.
- Retain PDFs of required emails and form submissions.
- Maintain files in organized, audit-ready condition.
- Identify and escalate missing or inconsistent documentation.

Standard Workflow

Step 1: Determine which system or form is appropriate for the documentation.

Step 2: Complete the documentation as soon as reasonably possible after the event or communication.

Step 3: Save the record in PDF format when required.

Step 4: Upload or file in the correct client, caregiver, payroll, compliance, or admin folder.

Step 5: Notify the supervisor of missing, inconsistent, or concerning documentation.

Required Documentation

- PDF copies of emails and forms.
- CareSmartz360+ notes/uploads.
- Jotform records.
- Audit checklists.
- Supervisor notifications.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Missing signatures, inconsistent dates, incomplete forms, missing call log screenshots, missing supervisory visits, missing EVV support documentation, suspected falsification, missing case management email records.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.

- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

12. EVV and Service Verification SOP

Purpose

This SOP explains how admins support EVV and service verification workflows while maintaining CareSmartz360+ as the primary documentation system.

Scope

Applies to clock-in/clock-out support, EVV troubleshooting, backup time sheet use, service verification follow-up, and documentation discrepancies.

Admin Support Responsibilities

- Support caregivers with EVV questions within assigned access and training.
- Monitor missed clock-ins or clock-outs when assigned.
- Help coordinate backup documentation when EVV cannot be completed.
- Escalate unsupported, inconsistent, or suspicious service verification records.
- Reinforce that documentation must reflect actual services provided.

Standard Workflow

Step 1: Review the EVV or timekeeping issue and determine whether it is a technical issue, missed clock-out, caregiver error, or service verification concern.

Step 2: Collect needed facts and supporting documentation.

Step 3: Use the backup time sheet only when appropriate.

Step 4: Notify the supervisor of discrepancies, patterns, or concerns.

Step 5: Ensure records are retained for payroll, billing, and audit support.

Required Documentation

- CareSmartz360+ EVV record.
- Backup Time Sheet when needed.
- Employee file note for support/coaching documentation.
- Supervisor notification for discrepancies.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Repeated missed clock-outs, conflicting times, client denies service occurred, unsupported manual entry, suspected falsification, missing signature, service provided outside authorization.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.

- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

13. Backup Time Sheet Documentation SOP

Purpose

This SOP explains the purpose and use of Nattingham Home Care's backup time sheet when normal EVV documentation cannot be completed.

Scope

Applies to backup documentation for time worked and tasks completed when caregivers cannot properly clock out or document through CareSmartz360+.

Admin Support Responsibilities

- Ensure caregivers use CareSmartz360+ as the primary documentation system whenever possible.
- Use the backup time sheet only for approved backup situations.
- Confirm date of service, scheduled times, actual time worked, tasks completed, employee signature, and client signature when available.
- Escalate missing, late, or inconsistent backup documentation.

Standard Workflow

Step 1: Identify why EVV documentation was not completed.

Step 2: Direct the caregiver to complete the backup time sheet when appropriate.

Step 3: Review the backup time sheet for completeness.

Step 4: Submit for supervisor, payroll, billing, or compliance review according to workflow.

Step 5: Retain the backup time sheet with the related client or payroll documentation.

Required Documentation

- Backup Time Sheet.
- CareSmartz360+ note if applicable.
- Employee file note if support or retraining is needed.
- Supervisor notification.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Missing client signature, unclear times, repeated EVV issues, unsupported services, unauthorized tasks, conflicting caregiver/client report, possible falsification.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.

- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

14. CareSmartz360+ Admin SOP

Purpose

This SOP explains how admins use CareSmartz360+ for care coordination, timekeeping support, shift management support, CRM data entry, and client/caregiver record updates.

Scope

Applies to all admins with CareSmartz360+ access.

Admin Support Responsibilities

- Maintain accurate client and caregiver CRM records.
- Support scheduling and shift management workflows.
- Support timekeeping and EVV troubleshooting within assigned access.
- Upload required documentation and PDFs as directed.
- Track communication and operational notes.
- Escalate clinical, payroll, or disciplinary concerns to the appropriate authority.

Standard Workflow

Step 1: Access only records needed for assigned work.

Step 2: Review client/caregiver profile information before making updates.

Step 3: Enter accurate, factual, and timely updates.

Step 4: Upload relevant PDFs or documentation where required.

Step 5: Notify supervisors of discrepancies or high-risk concerns.

Required Documentation

- CareSmartz360+ CRM notes.
- Schedule updates.
- Uploaded PDFs.
- EVV support notes.
- Supervisor escalation notes.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Incorrect schedule, caregiver no-show, EVV discrepancy, client complaint, missing documentation, clinical concern, repeated service disruption, access issue.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

15. ADP RUN Administrative Access SOP

Purpose

This SOP explains admin support responsibilities and limits within ADP RUN for payroll and employee administration.

Scope

Applies to admins granted limited ADP RUN access.

Admin Support Responsibilities

- Assist with adding W-2 employees when authorized.
- Enter time for payroll only if assigned and trained.
- Help employees access pay stubs, W-2 forms, W-4 forms, and election forms.
- Direct employees to update direct deposit securely through self-service when possible.
- Update direct deposit only with employee permission and only if the admin has been granted appropriate access.
- Protect payroll confidentiality.

Standard Workflow

Step 1: Verify the admin is authorized to perform the requested ADP task.

Step 2: Confirm employee identity and obtain permission when supporting sensitive changes.

Step 3: Enter or update only verified information.

Step 4: Escalate unclear payroll, tax, access, or direct deposit issues to payroll leadership.

Step 5: Maintain confidentiality and log out of ADP after use.

Required Documentation

- ADP record entries.
- Supervisor/payroll notification when needed.
- Employee support note if appropriate.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Payroll discrepancy, missing time, unauthorized access concern, direct deposit concern, tax form issue, suspected payroll fraud, employee unable to access records.

Role Boundaries

- Admins do not finalize payroll unless authorized.
- Admins do not change pay rates unless authorized.
- Admins do not modify tax elections without employee authorization and permitted access.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

16. Jotform Documentation and Workflow SOP

Purpose

This SOP explains how admins use Jotform to complete, retrieve, verify, save, and file approved Nattingham Home Care workflow forms.

Scope

Applies to all Jotform-based admin forms, including case notes, employee file notes, random visits, missed visits, supervisory visits, daily recaps, backup timesheets, and other workflow forms.

Admin Support Responsibilities

- Use approved Jotform links from the Admin Workflow Forms page.
- Complete required fields accurately.
- Review submissions for completeness when assigned.
- Save completed submissions as PDFs when required.
- Upload or file PDFs in the correct location.
- Report incomplete or inconsistent submissions to the supervisor.

Standard Workflow

Step 1: Access the approved form through the Nattingham Admin Workflow Forms page.

Step 2: Complete all required fields using professional and factual language.

Step 3: Submit the form and confirm submission.

Step 4: Pull the PDF copy when required by workflow.

Step 5: File or upload the PDF into the correct client, employee, compliance, or admin folder.

Required Documentation

- Jotform submission.
- PDF export.
- CareSmartz360+ upload if applicable.
- Supervisor notification for errors.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Missing required fields, wrong client/employee selected, missing signature, missing call log screenshot, incorrect date, duplicate submission, privacy concern.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.

- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

17. Digital File Management SOP

Purpose

This SOP establishes expectations for secure, organized, and audit-ready digital file management.

Scope

Applies to client files, employee files, payroll support files, compliance files, Jotform PDFs, case management emails, and operational records.

Admin Support Responsibilities

- Save records in the correct folder.
- Use clear naming conventions.
- Protect confidentiality and access limits.
- Keep records organized and easy to retrieve.
- Report missing, misfiled, or duplicate records.

Standard Workflow

Step 1: Identify the correct record category: client, employee, payroll, compliance, audit, or operations.

Step 2: Name the file consistently using date, client/employee name, document type, and brief description when appropriate.

Step 3: Save as PDF when required.

Step 4: Upload into CareSmartz360+ or ADP when required by workflow.

Step 5: Verify the file is readable and saved in the correct location.

Required Documentation

- Properly named PDFs.
- Upload confirmation when available.
- Supervisor notification of filing issues.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Misfiled confidential information, missing required record, unreadable PDF, wrong client folder, unauthorized access concern, audit request.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.

- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

18. Staffing Coordination SOP

Purpose

This SOP explains how admins support staffing continuity and caregiver-client matching.

Scope

Applies to open shifts, new client starts, coverage gaps, call-offs, schedule changes, and caregiver assignment support.

Admin Support Responsibilities

- Review client needs, schedule, proximity, caregiver skills, and caregiver availability.
- Communicate staffing options professionally.
- Support backup staffing efforts.
- Document staffing updates and concerns.
- Escalate patterns of instability or caregiver performance concerns.

Standard Workflow

Step 1: Identify the staffing need and urgency.

Step 2: Review caregivers based on skills, availability, proximity, and client fit.

Step 3: Coordinate with other admins, schedulers, or supervisors as needed.

Step 4: Confirm assignments and communicate updates.

Step 5: Document staffing changes and unresolved gaps.

Required Documentation

- CareSmartz360+ schedule update.
- Client case note.
- Employee file note for support/availability concerns.
- Supervisor notification.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- No staff available, repeated call-offs, caregiver mismatch, client refuses caregiver, high acuity concern, rural staffing barrier, driver-only requirement, safety concern.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.

- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

19. New Client Start-of-Care SOP

Purpose

This SOP explains how admins support a smooth start of care for new clients.

Scope

Applies to newly admitted clients, reactivated clients, and clients starting new authorized service periods.

Admin Support Responsibilities

- Complete the initial welcome call.
- Schedule the initial visit or follow-up.
- Coordinate caregiver assignment based on client needs, caregiver skills, availability, and proximity.
- Confirm key contact information and scheduling expectations.
- Ensure required records are created or updated in CareSmartz360+.
- Document the start-of-care support process.

Standard Workflow

Step 1: Review referral, authorization, schedule, care needs, and client preferences.

Step 2: Call the client/family to introduce Nattingham Home Care and confirm expectations.

Step 3: Coordinate caregiver assignment with the staffing team.

Step 4: Schedule the initial visit and communicate confirmed details.

Step 5: Document the welcome call, scheduling plan, and any barriers or follow-up needs.

Required Documentation

- Client case note.
- CareSmartz360+ profile and schedule updates.
- Uploaded referral/authorization documents if applicable.
- Email PDFs when communicating with case management.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Client cannot be reached, authorization unclear, care needs exceed staffing, unsafe home concern, urgent start date, caregiver mismatch, family conflict.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.

- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

20. Hiring Support SOP

Purpose

This SOP explains general admin support related to hiring and onboarding workflows. Detailed hiring lifecycle procedures will be included in Admin SOP Library Part 2.

Scope

Applies to admins assisting with recruiting support, onboarding coordination, background check support, document collection, ADP setup support, orientation scheduling, and employee file organization.

Admin Support Responsibilities

- Support collection of onboarding documents.
- Assist with background check coordination when assigned.
- Help maintain employee file organization.
- Support ADP setup or invitation workflows when authorized.
- Escalate missing documentation or eligibility concerns.

Standard Workflow

Step 1: Follow the employee file checklist and current hiring workflow assigned by leadership.

Step 2: Collect and file required documents using approved systems.

Step 3: Notify the supervisor or hiring lead of missing items.

Step 4: Do not independently clear an employee for work unless authorized by leadership.

Step 5: Retain documentation in the employee file according to workflow.

Required Documentation

- Employee file checklist.
- Background check records when assigned.
- ADP setup record when applicable.
- Orientation documentation.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Missing background check documentation, database hit, missing orientation test, incomplete forms, missing ID, ADP issue, applicant eligibility concern.

Role Boundaries

- Admins do not make final eligibility decisions unless authorized.
- Admins do not interpret criminal disqualification issues independently.

- Admins escalate background check or eligibility concerns to leadership.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

21. Fraud, Waste and Abuse Escalation SOP

Purpose

This SOP explains how admins identify and escalate suspected fraud, waste, abuse, theft, falsification, or unsupported documentation concerns.

Scope

Applies to EVV discrepancies, false documentation, billing concerns, time sheet concerns, client money/property concerns, payroll concerns, and service verification concerns.

Admin Support Responsibilities

- Recognize red flags and document objective facts.
- Escalate concerns promptly to supervisors or leadership.
- Avoid accusing employees, clients, or families without leadership guidance.
- Preserve relevant records, screenshots, notes, and communication when directed.

Standard Workflow

Step 1: Identify the concern and collect objective facts available to the admin.

Step 2: Notify the appropriate supervisor or leadership team member promptly.

Step 3: Do not confront the employee or client unless instructed by leadership and safe to do so.

Step 4: Document operational facts in the appropriate system or form.

Step 5: Cooperate with follow-up requests from leadership, HR, nursing, or compliance personnel.

Required Documentation

- Supervisor notification.
- Case note or employee file note when directed.
- EVV or payroll records.
- Relevant screenshots or PDF communication.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Services documented but client says caregiver was not present, forged signature concern, staff asking client for money, unsupported payroll time, falsified EVV, theft concern, misuse of client funds or benefits.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.

- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

22. Professional Boundaries SOP

Purpose

This SOP reinforces professional boundaries between staff, clients, families, and household members.

Scope

Applies to all admin support communication, caregiver support, client monitoring, random visits, case notes, and employee support documentation.

Admin Support Responsibilities

- Recognize boundary concerns and escalate them promptly.
- Document client or caregiver reports involving gifts, money, food, personal items, side work, romantic/sexual conduct, social media, or financial discomfort.
- Support clients by providing a safe space to report boundary concerns.
- Avoid giving disciplinary direction independently; escalate to supervisors or leadership.

Standard Workflow

Step 1: Listen objectively if a client, family member, or employee reports a boundary concern.

Step 2: Document the report factually using direct language when appropriate.

Step 3: Notify the supervisor or leadership immediately for financial, exploitation, harassment, or safety concerns.

Step 4: Support follow-up coordination as directed by leadership.

Required Documentation

- Random Visit/Monitoring Form if identified during monitoring.
- Client case note.
- Employee file note when directed.
- Supervisor notification.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Staff asking for money, borrowing/lending, accepting gifts, side employment, social media contact, sexual or romantic conduct, client financial discomfort, SNAP/debit card concerns, client property concerns.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.

- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

23. Internal Audit Participation SOP

Purpose

This SOP explains how admins support internal quality assurance and compliance audit readiness.

Scope

Applies to client files, employee files, supervisory visit tracking, random visits, missed visits, EVV support records, Jotform records, CareSmartz360+ uploads, and communication retention.

Admin Support Responsibilities

- Review assigned records for completeness.
- Confirm required documents are uploaded and filed.
- Identify missing or inconsistent documentation.
- Report audit findings to the supervisor.
- Support corrective follow-up as directed by leadership.

Standard Workflow

Step 1: Use the assigned audit checklist or workflow.

Step 2: Review the required records in the designated folder or system.

Step 3: Compare documentation against internal expectations and due dates.

Step 4: Document missing, incomplete, or inconsistent items.

Step 5: Notify the supervisor and support correction tracking as directed.

Required Documentation

- Audit checklist.
- Supervisor notification.
- Corrective follow-up log when used.
- Updated file upload records.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Missing supervisory visit, missing random visit, missing call log screenshot, missing EVV record, missing backup time sheet, missing employee file item, missing case management email PDF.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.

- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

24. Administrative Daily Recap SOP

Purpose

This SOP explains how admins use the Administrative Daily Recap Form to support communication, accountability, training, workflow continuity, and operational organization.

Scope

Applies to admins completing end-of-day recaps, training recaps, transition notes, or supervisor-requested daily documentation.

Admin Support Responsibilities

- Document completed tasks, urgent issues, weekly priorities, next-day priorities, accomplishments, challenges, lessons learned, improvement plans, and support needs.
- Use the recap process as a professional communication and workflow improvement tool.
- Submit before the end of the shift unless otherwise directed.

Standard Workflow

Step 1: Complete basic information including date, administrator name, and supervisor name.

Step 2: List meaningful tasks completed during the day.

Step 3: Identify tasks needing immediate attention and priorities for the following day.

Step 4: Reflect on accomplishments, mistakes, lessons learned, corrective plans, and support needs.

Step 5: Sign and submit the form according to workflow.

Required Documentation

- Administrative Daily Recap Form.
- Supervisor follow-up when needed.

Escalation Expectations

Admins escalate accountability, performance, safety, clinical, compliance, and disciplinary concerns to the appropriate supervisor or leadership team member. Admins do not independently administer discipline or final corrective action unless specifically authorized in writing.

- Unresolved operational issue, repeated workflow confusion, urgent client/staff concern, missing access, training need, supervisor support needed.

Documentation Standards

- Document only facts, direct communication, observable conditions, actions taken, and follow-up needs.
- Use professional, objective, respectful, and HIPAA-conscious language.
- Avoid gossip, emotional commentary, blame, speculation, or threats.
- Retain PDF copies of required external communication, Jotform submissions, supervisory visit records, and compliance documentation in the proper client or employee file.

Final Administrative Support Principles

Nattingham Home Care Administrative Support Staff are essential to safe, organized, consistent, and compliant operations. The admin role supports clients, caregivers, supervisors, nurses, leadership, and community partners by keeping workflows moving and records organized.

The Admin Support Standard

- Be professional.
- Be organized.
- Be accurate.
- Be calm under pressure.
- Document clearly.
- Protect confidentiality.
- Escalate early.
- Support the team.
- Do not operate outside assigned authority.

Leadership Authority Reminder

- Supervisors and leadership handle formal performance feedback and corrective action.
- Nurses handle clinical supervision and clinical assessment within their scope.
- HR/payroll leadership handle final payroll, employment, and personnel decisions.
- Admins support documentation, communication, workflow, and escalation.

References

This SOP Library was prepared using Nattingham Home Care internal documents and publicly available Ohio Administrative Code materials.

- Nattingham Home Care Employee Handbook, Complete Orientation and Employment Policies.
- Nattingham Home Care Administrative Support Specialist Job Description.
- Nattingham Home Care internal SOPs and workflow forms prepared for Admin SOP Library Part 1.
- Ohio Administrative Code Rule 173-39-02.11, ODA provider certification: personal care. Available at codes.ohio.gov.
- Ohio Administrative Code Rule 173-9-03, Background checks for paid direct-care positions: reviewing databases. Available at codes.ohio.gov.
- Ohio Administrative Code Rule 173-9-06, Background checks for paid direct-care positions: disqualifying offenses. Available at codes.ohio.gov.
- Ohio Administrative Code Rule 173-9-07, Background checks for paid direct-care positions: occasions when a disqualifying offense does not disqualify. Available at codes.ohio.gov.
- Ohio Administrative Code Rule 5160-44-05, Incident management and related waiver service requirements. Available at codes.ohio.gov.
- Ohio Administrative Code Rule 5160-1-39, Verification of home care service provision. Available at codes.ohio.gov.