**APPLICATION FOR APPROVAL UNDER THE OMNUBUS BUDGET RECONCILIATION ACT FOR NURSE AIDE TRAINING PROGRAM**

**RETURN 5 COPIES TO:**

**DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH CARE QUALITY
OFFICE OF LONG TERM CARE RESIDENTS PROTECTION
ATTN: ALEEN WILKER, RN, CRNA, APN
CNA COMPLIANCE NURSE
3 MILL ROAD SUITE # 308
WILMINGTON, DE 19806**

**<u>Notice of Non-Discriminatory Policy</u>**

The State of Delaware does not discriminate in program funding of services to participants on basis of race, color, religion, sex, national origin, age handicap, or political affiliation or belief.

Applicant Name _____

Address_____

_____

Training Sites _____Type of Training_____

    _____    _____

    _____    _____

    _____    _____

Contact Person _____ Telephone # _____

Initial Start Date Requested _____
*Please allow **at least** 90 days for processing

Was Pre-Approval Obtained By the Department of Education? Please Select
*Required by all private schools. Please attach documentation (Approval Certification)

**To Be Completed By Division:**

Approval Date: _____ Program ID #: _____ Pin #: _____

I. **BRIEF DESCRIPTION OF PROPOSED PROGRAM ACTIVITY TO BE OFFERED:**

    A. Description of course with goals and objectives

    B. Name of textbook with edition noted
       *Should not be older than five (5) years

    C. Breakdown of program hours for theory and clinical

    D. Instructor to student ratios for both clinical and classroom

    E. Proposed funding for the course


II. **TRAINING & CURRICULUM DESIGN:**

    A. Attach a training outline of your curriculum for your entire course including the amount of time (weeks, hours) devoted to both academic and /or skill development and a brief description of your teaching and evaluation methods. The curriculum content for the nurse aide training program must include material that will provide a basic level of both knowledge and demonstrable skills for each individual completing the program. The program must be a minimum of 150 hours divided equally between clinical and classroom instruction. Additional hours may be in either of there areas or both. (See Appendix page 11)

    B. Include behaviorally stated objectives for each unit of instruction. Each objective must state performance criteria which are measurable, and which serve as the basis for competency evaluations. The unit objective must be reviewed with the trainee at the beginning of each unit so that each trainee will know what is expected. (See Appendix page 12)

    C. Provide a classroom and clinical schedule showing days and hours of course, subjects and required reading. Please indicate when tests and quizzes will be administered, lunch and break times are given and when students will receive CPR certification. Please note that lunch and break times are subtracted from total program hours. Please maintain a classroom and clinical schedule for each class offered once approved. (See Appendix page 10)

D. Attach a list of Equipment and Supplies to be used during the training as required in the State of Delaware CNA Training Regulations (16, Del.C. §3220).

E. Submit a sample lesson plan for one unit of instruction that includes behavioral objectives, content and learning activities, including evaluation.

## III. PROGRAM LOCATION

A. Complete a Clinical Facility Request Form for each site used by the program providers. (See Appendix-page 7)

B. Please attach a copy of an affiliation agreement (s)/contract for clinical instruction/training if you are not a facility-based program. Please specify the terms of the agreement and the responsibilities of both parties.

C. Attach clinical objectives and rationale for the selection of the facility.

## IV. ENROLLMENT

Indicate how many students can be handled during any one training period and how often you plan to offer the training in any given year.

## V. STAFFING

A. Submit an organizational chart showing all program positions (administrative, instructional and support) and their relationship to the overall administrative structure of the agency including the names of staff under each indicated category.

B. Provide job descriptions for the Primary Instructor (Program Coordinator and other instructional staff.)

C. Complete Qualification sheets for all Nursing Instructors and other instructional staff/guest speakers. (See Appendix-pages 8 and 9)

## VI. EVALUATION AND MONITORING

Under this heading, describe how you will evaluate and monitor your training program.

A. Describe what will be done to determine how your program goals and objectives are being met

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B.  Describe what will be done to determine that the trainee goals and objectives are being met?

## VII.    PERFORMANCE STANDARDS

A.  Levels of Proficiency

1.  What are expected theory and practice competency levels?

2.  Submit two (2) skills competency checklists that each trainee will be required to receive (Lab and Clinical).  The skills checklists should provide a space to record the date of successful performance, level of proficiency (satisfactory/unsatisfactory) performance by trainee, and signature (or initials) of instructor supervising performance.  The checklists should be comprehensive and should include all manual skills noted in the State and Federal regulations.  Both copies of the completed skills checklist must be given to each trainee at the completion of the course.  (See Appendix pages 13 and 14)

3.  Submit a description of how the theory content of the curriculum is measured.

**\*Note:**   Approval may be refused, withdrawn or suspended when it is determined that the program does not comply with any of the requirements mandated by OBRA and State regulations.

# APPENDIX

# CLINICAL FACILITY REQUEST FORM

For an initial request to utilize a (licensed) long-term care facility as a clinical site, the following information is needed to determine the adequacy of the facility before approval can be given.  You must also attach a copy of your contract with the clinical facility.  Please contact Aleen.Wilker@delaware.gov for a current list of restricted facilities.

Name of Provider Initiating Request_____

Name of Facility to be used _____

Address_____ Telephone   Number_____

Facility Administrator_____ State  License  Date_____

Director of Nursing _____ Total Bed Capacity ————

Daily Patient Average or No. of Patients Served _____

Clinical Area(s) to be used:

| TYPE | NO. OF UNIT(S) | AVERAGE CENSUS PER UNIT |
|------|----------------|-------------------------|
| Long Term Care | | |
| | | |
| | | |
| Home Care | | |
| Acute Care | | |
| Psychiatric Care | | |
| Other | | |

Describe size, location and availability of offices and equipment available for the nursing instructors:

_____

_____

_____

Provisions for faculty and students:  (Describe size, location and availability)
   a.   Library_____
   b.   Conference Rooms_____
   c.   Classrooms_____
   d.   Locker Rooms and/or dressing rooms for
        faculty/students_____
   e.   Instructional aids and equipment _____

# NURSING ASSISTANT INSTRUCTOR QUALIFICATIONS

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

School/Program Name: _____

Address: _____

_____

Please circle all that apply:    Primary Instructor (Classroom)        Secondary Instructor (Classroom)
                                 Clinical Instructor Only        Full Time            Part Time

Nursing License Number: _____
*Attach copy of current license
CPR Certification Date: _____
*Attach copy of current certification

_____


Employment History   *Please attach resume. List all employers for last five (5) years

Employer                                    Dates Employed                              Position Held
1._____
2._____
3._____
4._____
5._____

_____
Have you attended a "Train the Trainer" Class: Please Select        *If YES please attach certificate of completion
Date:_____
Sponsoring Agency:_____

_____
I certify that the above information is correct.  I give permission to the Division to contact my current/past employers to verify the accuracy of this information.


Signature and Title_____        Date_____

# Nursing Assistant Course (Sample Only)
# Class and Clinical Schedule

Textbook required readings are listed on the right side of each lecture/clinical topic.  All readings are from <u>Name of Textbook.</u>
Students are encouraged to perform required reading prior to attending class in order to facilitate the material presented.

| DATE | TIME | SUBJECT | REQUIRED READING |
|---|---|---|---|
| Monday, June 4, 2007 | 0830-1030 | Orientation to the Nursing Assistant Course **Unit I:  Introduction to the Nursing Assistant Course** | |
| | 1030-1130 | The Health Care System | Chapter 1, p. 1-12 |
| | 1130-1230 | Lunch | |
| | 1230-1400 | Role of the Nursing Assistant | Chapter 2, p. 13-31 |
| Tuesday June 5, 2007 | 0830-1000 | Patients, Residents, and Clients | Chapter 4, p. 62-74 |
| | 1000-1130 | Working with People | |
| | 1130-1230 | Lunch | |
| | 1230-1330 | Understanding Basic Human Needs | |
| | 1330-1430 | Home Health Care | Chapter 11, p. 227-247 |
| | | **Unit II:  Physical Needs of the Patient** | |
| | 1430-1600 | Food and Nutrition | Chapter 21, p. 443-455 |
| Wednesday June 6, 2007 | 0830-0930 | Feeding Special Needs Patients-**Guest Speaker** | |
| | 0930-1130 | Observing Body Functions | Chapter 19, p. 382-408 |
| | 1130-1230 | Lunch | |
| | 1230-1530 | Vital Sighs Practice Lab-**Mandatory** | |
| Thursday June 7, 2007 | 0830-0930 | **Exam:  Unit 1** | |
| | 0930-1230 | Body Systems | Chapters 14, 16, 17, 18, 20 |
| | 1230-1330 | Lunch | |
| | 1330-1500 | Vital Signs Practice Lab-**Mandatory** | |

| EXAMPLE OF CONTENT | TIME FRAME | TEACHING METHOD | EVALUATION METHOD |
|---|---|---|---|
| **Unit I  Introduction to the Nursing Assistant Course** | **7. 5 hours** | | |
|   A.  **The Health Care System** | | **Lecture/Discussion/Handouts** | |
|      1.  **The Health Care Environment** | **1 hour** | | |
|        a.  **Purpose of Health care delivery system** | | | |
|        b.  **Diagnosis-related groups** | | | |
|        c.  **Manage care** | | | |
|      2.  **Health Care Delivery sites** | | | |
|        a.  **Services available** | | | |
|        b.  **Organizational structure** | | **Organization Charts** | |
|          1)  **Hospital** | | | |
|          2)  **Nursing Service** | | | |
|          3)  **Organization of the Health Care Team** | | | |
|   B.  **Role of the Nursing Assistant** | | | |
|      1.  **Job Description** | | | |
|      2.  **Roles and Responsibilities** | **1. 5 hours** | **Lecture/Discussion** | |
|      3.  **Personal Qualities** | | **Job Description for a nursing assistant** | |
|      4.  **Managing Time and Resources** | | | |
|      5.  **Ethical Behavior** | | | |
|        A.  **Confidentiality** | | | |
|        B.  **Accuracy** | | **Video-"Well Shut My Mouth"** | |
|        C.  **Dependability** | | | |
|      6.  **Legal Aspects of patient Care** | | | |
|        a.  **The Resident's Bill of Rights** | | | |
|        b.  **Standards of Care** | | | |
|        c.  **Consent** | | | |
|        d.  **Abandonment** | | | |
|      7.  **Incidents** | | | |
| | | | **Quiz # 1** |

**NURSING ASSISTANT TRAINING COURSE**

**UNIT 1:  INTRODUCTION TO THE NURSING ASSISTANT COURSE**

**EXAMPLE OF UNIT OBJECTIVES:**

**At the completion of this unit, the student will:**

1.  Describe how agencies make services available to patients and families.

2.  Explain the purposes and goals of the nursing assistant services.

3.  Discuss the roles of the nursing assistant in the hospital, long-term care facility, and in the home.

4.  Explain why nursing assistants do <u>NOT</u> administer medications.

5.  Identify ways to manage time and conserve resources.

6.  Identify resources within the family and the community.

7.  Identify ways in which people communicate with each other.

8.  Describe the difference between verbal and non-verbal communication.

9.  Describe methods for achieving therapeutic communication.

10. Describes basic human needs which nursing assistant services help to meet.

11. Identify ways in which individuals and families may differ.

12. Describe how people may feel and behave when needs are unmet.

# SAMPLE CLINICAL SKILLS CHECKLIST

**(Please note this is <u>not</u> a complete list, this may be organized in any fashion but must contain at least all the manual skills listed in the State and Federal regulations.)**

| Demonstrate appropriate techniques when performing basic clinical skills while caring for residents. | S | U | N/A | Date Observed | Date of Proficiency | Instructor's Initials |
|---|---|---|---|---|---|---|
| Complete Bed Bath | | | | | | |
| Partial Bed Bath | | | | | | |
| Perineal Care for a male resident | | | | | | |
| Perineal Care for a female resident | | | | | | |
| Mouth Care | | | | | | |
| Denture Care | | | | | | |
| Hair Care | | | | | | |
| Nail Care | | | | | | |
| Shave a resident | | | | | | |
| Tub bath | | | | | | |
| Showers | | | | | | |
| Provides total or assistive care in dressing residents | | | | | | |
| Encourages client independence | | | | | | |
| Dresses resident with an affected (weak or disabled) extremity | | | | | | |
| Applies knee high stockings appropriately | | | | | | |
| Provides privacy | | | | | | |
| Accurately documents all elements of client care | | | | | | |
| Make occupied bed | | | | | | |
| Make unoccupied bed | | | | | | |

| Accurately evaluate client's vital signs. | S | U | N/A | Date Observed | Date of Proficiency | Instructor's Initials |
|---|---|---|---|---|---|---|
| Measure oral and axillary temperatures | | | | | | |
| Use of glass thermometer | | | | | | |
| Report rate and rhythm of the pulse accurately | | | | | | |
| Accurately count client's respirations | | | | | | |
| Determines if residents breathing is labored or abnormal | | | | | | |
| Accurately check resident's blood pressure | | | | | | |
| Recognize the normal adult ranges & identify abnormalities | | | | | | |
| Properly document & report information | | | | | | |

| Performs nursing care following the principles of infection Control. | S | U | N/A | Date Observed | Date of Proficiency | Instructor's Initials |
|---|---|---|---|---|---|---|
| Proper hand washing technique | | | | | | |
| Proper handling of soiled linens | | | | | | |
| Practices Standard Precautions | | | | | | |
| Proper donning of gown and gloves | | | | | | |
| Proper use of gloves | | | | | | |

**Key: S=satisfactory; U= unsatisfactory; N/A= not applicable; if N/A is used please note in comment section reason such as done in lab setting only-not performed at the facility.**

Instructor Signature: _____    Student Signature: _____

Instructor Comments: