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| **FOR DHSR USE ONLY:**   * Date DHSR Received Document From Training Program (mm/dd/yyyy): * Status Determination of Document (Approved or Denied): * Date Status Determination Communicated to Training Program (mm/dd/yyyy): * Review Completed By:   **INSTRUCTIONS:**   * Complete this application if you’re a community college and establishing a training program. * You may type your response in the space provided. * Submit the required supportive documentation with this application for review and approval. * Approval from the North Carolina Division of Health Service Regulation (DHSR) is required prior to the enrollment of students in the training program. * The Program Coordinator and Program Administrator must sign the application. * Email or fax completed documents to DHSR. Incomplete documents will be denied. You must submit all pages of the document.   + Email: [DHSR.EducationConsultant@dhhs.nc.gov](mailto:DHSR.EducationConsultant@dhhs.nc.gov)   + Fax: 919-733-9764 * Contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) with any questions or concerns.   **STUDENTS:**  Students must be listed in active status on the North Carolina Nurse Aide I Registry prior to enrollment in a training course.  **PROGRAM INFORMATION:**   1. **Date Submitted to DHSR (mm/dd/yyyy):** |
| 1. **Name of School:** |
| 1. **Name of Training Program:** |
| 1. **Mailing Address:** |
| * Street: |
| * City: * Zip Code: |

* County:

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| 1. **Site Address:** |
| * Street: |
| * City: * Zip Code: |

* County:

1. **Program Administrator:**

* Name:
* Title:
* Telephone (including area code):
* Email:

1. **Program Coordinator:**

* Name:
* Telephone (include area code and extension):
* Email:
* Fax (include area code):

1. **Program Type:**

Place an X beside the correct response.

* Continuing Education:
* Curriculum:
* Career and College Promise:

1. **Nurse Aide I Training Program:**

The training program must be approved by the North Carolina Division of Health Service regulation to offer Nurse Aide I training.

Provide the Nurse Aide I training program number:

*Important Notice:*

Include all Nurse Aide I training program numbers.

1. **Program Hours:**

The training program must meet the minimum total program (clock) hours below.

* Classroom Hours: 75
* Online Hours (if applicable):
* Clinical Hours: 25
* Total Program Hours: 100

*Important Notices*:

* A training program must be approved by the North Carolina Division of Health Service Regulation and be operational with students for at least 1 year prior to offering online classroom hours. Please contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) for additional information.
* The North Carolina Division of Health Service Regulation will not approve laboratory hours or clinical hours to be offered or completed online.

1. **Course Schedule and Supplemental Teaching Methodologies:**

Complete the [New Training Program – Course Schedule and Supplemental Teaching Methodology Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) and submit with the application.

*Important Notice:*

The training program must use the current curriculum approved by the North Carolina Division of Health Service Regulation.

1. **Primary Instructional Resource:**

The training program is required to use the current [curriculum](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#GA) approved by the North Carolina Division of Health Service Regulation.

Other forms of primary instruction include teaching guides, PowerPoint presentations, classroom activities, lectures, cooperative learning, individual or class projects, and group presentations.

1. **Faculty:**

Review the qualifications required for each faculty member in the [New Training Program – Faculty Approval Requirements Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP).

Upon completion of your review, submit the [New Training Program – Faculty Approval Request Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) with the application. One form must be submitted for each faculty member.

*Important Notices*:

* Students must be under the direct supervision of a Registered Nurse.
* All faculty for the training program, including the Registered Nurse providing supervision, must be approved by the North Carolina Division of Health Service Regulation prior to instruction.

1. **Instructor/Student Ratios:**

Complete the instructor/student ratios in the table below.

|  |  |  |
| --- | --- | --- |
| Classroom | 1 instructor per | students |
| Clinical | 1 instructor per | students |

*Important Notice*:

Per [21 NCAC 36.0318](http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0318.pdf), the instructor-to-student ratio for clinical cannot be greater than 1:10.

1. **Student Identification:**

Students are required to wear a nametag in the clinical setting. The nametag should include the student’s name, followed by the word “Nurse Aide I Trainee” or “Nurse Aide I Student.”

The nametag should be worn facing outward.

Refer to the [North Carolina Board of Nursing](https://www.ncbon.com/badge-lawlicense-required-exceptions) for more information.

1. **Attendance:**

Successful completion of the training program is dependent upon the student completing a minimum of       clock hours (your total program hours minus those your program allows by policy for absences) of instruction.

All missed classroom and clinical experiences must be completed in order for the student to successfully complete the training program.

*Important Notice*:

Refer to the *Monitoring/Maintenance of Student Records* section within this document for more information*.*

1. **Student Grading Policy:**

Theory Component

To successfully complete the training program, students must achieve a minimum passing grade of 75 in the theory component. Derivation of the theory grade may consist of tests, a comprehensive exam, quizzes, homework/activities, a project, etc. Each component must include a weighted percentage and when totaled, the percentage must equal 100%.

Provide the minimum passing grade in the theory component for the training program:

List each item which contributes to the theory component grade. Refer to the example below.

**Example Only:**

|  |  |
| --- | --- |
| Theory Component: 5 Quizzes (Each Quiz Equals 4%) | Weight: 20 % |

**To Be Completed By The Training Program:**

|  |  |
| --- | --- |
| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
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| Theory Component: | Weight:       % |
| Theory Component: | Weight:       % |
| **Total Weight** | **100%** |

Practical Component

To pass the practical (clinical) portion of the training program, students must be proficient in demonstrating tasks and skills.

Proficiency is defined as the ability to perform a task or skill in a competent and safe manner.

The clinical component is graded as pass/fail, based on the training program’s definition of proficiency and student performance on tasks and skills.

To pass clinical, the student must be able to successfully demonstrate enhanced skills. Enhanced skills demonstration is defined as the performance of basic nurse aide skills while delivering care to an older adult, in a variety of clinical situations. Enhanced skills included in the course shall be successfully performed prior to the completion of the training program.

Clinical Requirements:

* Students should attend/participate in clinical conference activities prior to and at the end of each clinical day.
* The following enhanced skills should be performed in a clinical setting with Instructor supervision:
  + Resident care interaction/person-centered care & stress management for nurse aides
  + Infection control/pressure ulcers/mobility/alternatives to restraints & safe restraint use
  + Hydration & nutrition
  + Challenging resident behavior
  + Pain management for nurse aides and palliative care

Provide additional criteria for demonstration of proficiency (if applicable):

*Important Notice*:

Students cannot perform any services to an older adult, in a variety of clinical situations, for which they have not been trained and found proficient by the Instructor.

1. **Monitoring/Maintenance of Student Records:**

The Program Coordinator is required to monitor (audit) student records for accuracy. A system for monitoring student records must be in place and followed consistently.

Documents to be completed and maintained in the student record include:

* Attendance records
  + Start date and end date of class
  + Training program number issued by the Division of Health Service Regulation
  + Instructor information (First and Last Name and RN Licensed Number)
* Missed instruction
* When – date of missed instruction
* How much time missed – hours/minutes
* What was missed – classroom (content), clinical (hours/minutes)
* What was assigned for makeup – worksheet, paper, hour-for-hour clinical
* When missed instruction was completed – completion date
* Test scores
* Tests and answer sheets
  + - Labeled with the version of test and the date given to students
* Student identification
  + Copies of identifications or a student ID verification statement must be kept in each student record

Describe the process for monitoring (auditing) and maintaining student records. Also, include the location of the student records:

*Important Notices:*

* Student records must be made available for review by the North Carolina Division of Health Service Regulation upon request.
* The training program is required to keep and maintain student records for a minimum of 3 years.
* Student records must be kept onsite, in a locked file cabinet, and in a locked area.

1. **Classroom:**

* Facility name:
* Room number:
* Location/Site address:
* Building:
* The classroom has tables and chairs to accommodate       students
* Must include adequate lighting
* Must provide an atmosphere conducive to learning and testing
* Must contain a dry erase board
* Must contain audiovisual equipment, computer/projector or smart technology
* Must contain an instructor area

Provide additional classroom components (if applicable):

1. **Classroom Diagram:**

Attach a diagram (may be hand drawn) for each classroom that includes the items listed below. All items in the drawing must be labeled.

* Facility name
* Room number
* Location/Site address
* Building name
* Room dimensions (length, width, square footage)
  + Note: length x width = square footage
* Physical layout (dry erase board, tables, chairs, desks, instructor desk, audio-visual equipment, smart technology, and any other furniture)

1. **Clinical:**

Complete the [New Training Program – Clinical Site Approval Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) and submit with this application.

*Important Notice*:

All clinical sites for the training program must be approved by the North Carolina Division of Health Service Regulation prior to instruction and the enrollment of students.

1. **Documentation Required with the Submission of this Application:**

* [New Training Program – Course Schedule and Supplemental Teaching Methodology Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [New Training Program – Faculty Approval Request Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [New Training Program – Clinical Site Approval Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* Classroom Diagram

1. **Registry:**

I understand the training program must notify the North Carolina Division of Health Service Regulation, within five (5) business days of course completion, the information of the students who successfully passed the training program in order for them to be listed on the appropriate registry.

1. **Statement of Understanding:**

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| * I understand the training program must meet the requirements set forth by federal and state rules, regulations, and requirements. * I understand students must be listed in active status on the Nurse Aide I Registry prior to enrolling in a course. * I understand approval of the training program must be renewed by the North Carolina Division of Health Service Regulation every two (2) years. * I understand the training program must be approved by the North Carolina Division of Health Service Regulation to offer Nurse Aide I training. * I understand the training program must use the current North Carolina State-approved curriculum and adhere to the policies and procedures approved by the North Carolina Division of Health Service Regulation. * I understand the training program policies must be made available to the North Carolina Division of Health Service Regulation upon request. * I understand the training program faculty must be approved by the North Carolina Division of Health Service Regulation prior to implementation and the enrollment of students. * I understand all classroom and clinical instruction must be under the direct supervision of a North Carolina Division of Health Service Regulation approved Registered Nurse. * I understand modifications to the training program must be approved by the North Carolina Division of Health Service Regulation prior to implementation. * I understand modifications to the training program required by the North Carolina Division of Health Service Regulation must be made in a timely manner. * I understand the training program must incorporate innovative instructional strategies that enable students to deliver quality, compassionate, and consistent basic nursing care. I further understand the training program must ensure objectives are met through instructor demonstration, student practice and demonstration of proficiency. * I understand the classroom must contain instructional equipment and supplies, seating for the approved number of students as required, and adequate space to accommodate activities. * I understand the training program must be made available to the North Carolina Division of Health Service Regulation upon request. * I understand the training program is required to maintain student records for a minimum of three (3) years. I further understand student records must be kept onsite, kept in a locked file cabinet, kept in a locked area, and made available for review by the North Carolina Division of Health Service Regulation upon request. * I understand the North Carolina Division of Health Service Regulation may withdraw approval of the training program if it determines that the training program does not meet federal or state rules, regulations, and requirements. * I understand the North Carolina Division of Health Service Regulation may withdraw approval of the training program if it determines that the training program is not adhering to program documentation approved by the North Carolina Division of Health Service Regulation. * I understand the North Carolina Division of Health Service Regulation will withdraw approval of the training program if the training program refuses to permit unannounced visits by the North Carolina Division of Health Service Regulation. * I understand the training program must notify the North Carolina Division of Health Service Regulation, within five (5) business days of course completion, the information of the students who successfully passed the training program in order for them to be listed on the appropriate registry.  1. **Attestation:**  * I have read and agree to the Statement of Understanding. * I certify the information in this application, and in the documentation required with the submission of this application, is truthful, accurate, and complete. * I certify the information in this application, and in the documentation required with the submission of this application, accurately represents the training program for which the North Carolina Division of Health Service Regulation approval is being requested. * I will implement directives, policies, forms, and checklists as mandated by federal and state regulations and the North Carolina Division of Health Service Regulation.   **Program Administrator:**  First Name:  Last Name:  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date (mm/dd/yyyy):  *Note: The North Carolina Division of Health Service Regulation will not accept an electronic signature. However, you may type your First Name, Last Name, and the Date.*  **Program Coordinator:**  First Name:  Last Name:  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date (mm/dd/yyyy):  *Note: The North Carolina Division of Health Service Regulation will not accept an electronic signature. However, you may type your First Name, Last Name, and the Date.* |