**GERIATRIC AIDE**

**New Training Program – Initial Application for Community Colleges**

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| **Instructions:*** Complete this application if you are establishing a new Geriatric Aide training program.
* Submit the required supportive documentation with this application for review and approval.
* Sign the document. An electronic signature will not be accepted.
* Email or fax completed documents to Division of Health Service Regulation. Incomplete forms will be returned.
	+ Email: 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.

**Date (mm/dd/yyyy):**       |
| **Community College Name:**        |
| **Mailing Address:**  |
| * Street:
 |
| * City:
* Zip Code:
 |

* County:

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| **Site Address:**  |
| * Street:
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| * City:
* Zip Code:
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* County:

 **Administrative Authority:**

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

**Program Coordinator:**

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

**Program Type for Community Colleges:**

Place an X beside the correct response.

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

**Minimum Required Program Hours:**

* Classroom: 75 hours
* Clinical: 25 hours
* Total Program: 100 hours

**Proposed Program Hours:**

* Classroom Hours:
* Clinical Hours:
* Total Program Hours:

**Course Schedule and Supplemental Teaching Methodologies:**

Complete the New Training Program – Course Schedule and Supplemental Teaching Methodology Formand submit with this application.

**Primary Instructional Resource:**

The North Carolina State-approved Geriatric Aide curriculum is the primary instructional resource. Geriatric Aide training programs are required to use the most current version of the North Carolina State-approved curriculum provided by the North Carolina Division of Health Service Regulation.

**Attendance:**

Successful completion of the Geriatric Aide 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 complete the Geriatric Aide training program.

When an absence occurs, it must be documented and placed in the student record.

* Date absence occurred
* Content missed
* Date content was made-up or completed

**Student Grading Policy:**

Theory Component

To successfully complete the Geriatric Aide 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%. Include the number of tests.

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

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

Practical (Clinical) Component

Clinical shall be graded based on pass/fail. To pass clinical, the participant must be able to successfully demonstrate enhanced skills in a safe, competent, confident manner. 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:

* Participants 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, upon completion of the content in the classroom setting:
	+ 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):

**Classroom:**

* Room:
* Location:
* 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):

**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
* Site address
* Building name
* Room dimensions (length, width, square footage)
* Physical layout (dry erase board, tables, chairs, desks, instructor desk, audio-visual equipment, smart technology, and any other furniture)

**Nurse Aide I State-Approved Training Program Requirement:**

Students must be listed on the North Carolina Nurse Aide I Registry prior to attending the course.

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

1. New Training Program – Clinical Site Approval Form
2. New Training Program – Course Schedule and Supplemental Teaching Methodology Form
3. New Training Program – Faculty Approval Form (one form must be completed per faculty member)

**Statement of Understanding:**

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| I certify that the information in this application, including additional forms and attachments, accurately represents the Geriatric Aide training program for which the North Carolina Division of Health Service Regulation approval is being requested.I certify that the Geriatric Aide training program will meet the requirements set forth by State rules, regulations, and requirements. I understand that the Geriatric Aide training program approval is based on our agency using the most current version of the North Carolina State-approved curriculum and adhering to the policies approved by the North Carolina Division of Health Service Regulation. I further understand that the Geriatric Aide training program must teach, at a minimum, 75 hours of content, to include all modules as written in the curriculum, and provide 25 hours of clinical as directed. I understand that students must be listed on the North Carolina Nurse Aide I Registry prior to attending the course. I understand that modifications which are required by the North Carolina Division of Health Service Regulation will be incorporated into the Geriatric Aide training program in a timely manner. I understand that requests for Geriatric Aide training program modifications will be submitted to the North Carolina Division of Health Service Regulation for approval prior to implementation.I understand that the Geriatric Aide training program policies must be made available to the North Carolina Division of Health Service Regulation upon request.  |
| I understand that the Geriatric Aide training program must require a minimum numerical grade of 75 as the final theory grade and a clinical grade of pass/fail.  |
| I understand that changes in faculty or clinical sites must be approved the North Carolina Division of Health Service Regulation prior to implementation.  |
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| I understand that the North Carolina Division of Health Service Regulation may withdraw approval of a Geriatric Aide training program if it determines that the Geriatric Aide training program does not meet State regulations and requirements.  |
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| I certify that the Geriatric Aide training program documents and student records will be kept in a secure location and made available to the North Carolina Division of Health Service Regulation upon request. Place an X beside the correct response.I have read and agree to the Statement of Understanding.Yes:       No:        |

Name of Program Coordinator:

Signature of Program Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (mm/dd/yyyy):

Name of Administrator:

Signature of Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (mm/dd/yyyy):