

# **APPLICATION**

**Combination of  
Home Care & Long Term Care  
Nurse Aide Training  
AND  
Competency Evaluation Programs**

**Oklahoma State Department of Health  
Protective Health Services  
Nurse Aide Registry  
1000 NE 10th  
Oklahoma City, OK 73117-1299**

## General Information

The Oklahoma State Department of Health is responsible for implementing rules and approving programs that meet Federal and/or State requirements for a nurse aide training and competency evaluation program.

The application and necessary forms are enclosed. Please **retain a copy of the original application and forms in your files** and prepare additional copies for use as needed.

The completed application and **application fee of fifty dollars (\$50.00)** must be returned to:

**Oklahoma State Department of Health  
Protective Health Services-0702 Nurse Aide  
Registry 1000 NE 10th  
Oklahoma City, OK 73117-1299**

An approved program shall notify the Department when there are substantive changes made to the program.

Please call the Nurse Aide Registry staff at (405) 271-4085 or 1-800-695-2157 if you have questions about this information. We appreciate your participation and look forward to working with you.

Sincerely,

Lisa McAlister, BSN, RN  
Director, Nurse Aide Registry  
Protective Health Services

# Application

The application for a state approved nurse aide training and competency evaluation program determines if the program meets the federal and/or state requirements for such programs. All information shall be a public record. The Department shall notify an applicant within ninety (90) days of its decision.

## Instructions:

1. Read the instructions carefully and complete the appropriate forms as indicated. Additional pages may be inserted if the allotted space is not sufficient.
2. Label the appropriate forms for the specific section; i.e., Section #Page # .
3. Indicate NA (not applicable) on forms as necessary.
4. Submit the complete application and application fee of fifty dollars (\$50.00) to:

**Oklahoma State Department of Health  
Protective Health Services-0702 Nurse Aide  
Registry 1000 NE 10th  
Oklahoma City, OK 73117-1299**

**Entity Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_  
**City State Zip**

**Contact Person:** \_\_\_\_\_

<b>Telephone:</b> ____ (____) _____ _____ Area <b>Code/Telephone Number</b>
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**Program Category:**

Please check one:

- In-Facility Program
- Agency Program
- Accredited Higher Education Institution
- State Vocational and Technical Education School
- Private Vocational School
- Other

<b>A private Vocational School shall submit a copy of the license issued by _____ the Oklahoma Board of Private Vocational Schools. Attachment # _____</b>
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**Program Eligibility:**

A home health aide training program may be offered by any organization except a home health agency that, within the previous two (2) years:

1. Has been found out of compliance with requirements at 42 CFR, eg., content and duration of training, competency evaluation and in-service requirements.
2. Has permitted an individual that does not meet the definition of "home health aide" to furnish home health aide services.
3. Has been subject to an extended, or partial extended, survey as a result of having furnished substandard care (or for other reasons as determined by the Health Care Financing Administration or the Department).
4. Has been assessed a civil money penalty of five thousand dollars (\$5,000) or more as an intermediate sanction.
5. Has had deficiencies that endangered the health and safety of the patients and had temporary management appointed to oversee the management of the home health agency.
6. Has had all or part of its Medicare payments suspended.

- or
7. Under any Federal or State law within the two (2) year period beginning October 1, 1988:
    - a. Had its participation in the Medicare program terminated.
    - b. Was subject to a suspension of Medicare payments to which it otherwise would have been entitled.
    - c. Had operated under temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients.
    - d. Was closed or had its residents transferred, by the Department.

I, \_\_\_\_\_  
 Name of Administrative Official

1. Agree that the Department may not approve or shall withdraw approval for a nurse aide training and competency evaluation program on finding that any of the reasons for such action occur.
2. Verify that the facility is eligible to provide a nurse aide training and competency evaluation program.

Signature of

Administrative Official

Date

**Program Eligibility:**

The State may not approve or shall withdraw approval of a nurse aide training and competency evaluation program offered by, or in, a facility which in the previous two (2) years:

1. In the case of a skilled nursing facility, has operated under a waiver of the federal minimum nurse staffing requirements.
2. In the case of a nursing facility, has operated under a waiver of the federal minimum nurse staffing requirements for a period in excess of forty eight hours per week.
3. Has had an extended or partial extended survey by the State agency.
4. Has been assessed a civil money penalty of five thousand dollars (\$5,000) or more.
5. Has been subject to other remedies provided in federal law.
6. Has had license suspended or revoked or had a conditional license.

A State may not approve a nurse aide training and competency evaluation program, until two years since the assessment of the penalty has elapsed, for any facility that has:

1. Had its participation terminated under Title XVIII or Title XIX of the Social Security Act.
2. Been subject to a denial of payment under Title XVIII or Title XIX.
3. Been assessed a civil money penalty of more than five thousand dollars (\$5,000).
4. Operated under temporary management to ensure the health and safety of the residents.
5. Been closed or had its residents transferred by State action.

I, \_\_\_\_\_ Name  
of Administrative Official

1. Agree that the Department may not approve or shall withdraw approval for a nurse aide training and competency evaluation program on finding that any of the reasons for such action occur.
2. Verify that the facility is eligible to provide a nurse aide training and competency evaluation program.

Signature of Administrative Official

Date

## **Section I. Records and Evaluation**

A nurse aide training and competency evaluation program shall use a Trainee Performance Record approved by the Department that indicates the major duties and skills taught.

The Trainee Performance Record shall include, but not be limited to:

1. A listing of the duties and skills expected to be learned in the program.
2. A record of when the trainee performs the duties and skills and the determination of satisfactory or unsatisfactory performance.
3. The name of the instructor or evaluator supervising the performance.

**Submit a copy of the Trainee Performance Record form. Attachment #** \_\_\_\_\_

A program shall retain the following records for at least three (3) years:

1. Application for the nurse aide training and competency evaluation program.
2. Trainee performance record and individual training records.
3. Trainee's performance on the competency evaluation program, i.e., successful or unsuccessful.

**Describe the method used for retaining the required records safely for at least three (3) years. Attachment #** \_\_\_\_\_

### **Training Program Information**

An approved program shall provide current written information to applicants about: 1.

1. Policies for admission and satisfactory completion of the program.
2. Purpose and objectives of the program.
3. Trainee rights and responsibilities.
4. Successful completion of a nurse aide training and competency evaluation program results in the individual being listed in the Departments' nurse aide registry.
5. State law requiring employers to secure an Oklahoma State Bureau of Investigation (OSBI) criminal arrest report.
6. Requirements for renewal of the registry listing.

**Provide a copy of the written information, (items 1 through 6 listed above), that is provided to applicants. Attachment #** \_\_\_\_\_

### **Charges for Home Care Aides**

#### **Section II.**

**A non-agency program shall submit an itemized list of charges made to trainees. Attachment #** \_\_\_\_\_

### **Charges for Long Term Care Aides**

No nurse aide who is employed by, or who has received an offer of employment from a Facility on the date on which the person begins a nurse aide training and competency evaluation program may be charged for any portion of the training or competency evaluation program including any fees for textbooks or other required course materials.

**A Facility Program shall provide a statement signed by the administrative official that the program shall not charge any nurse aide who is employed by, or who has received an offer of employment from, a Facility on the date on which the person begins a nurse aide training and competency evaluation program for any portion of the program including any fees for textbooks or other required course materials. Attachment # \_\_\_\_\_**

**A Non-Facility Program shall submit an itemized list of charges made to trainees who are not employed by, or do not have an offer of employment from, a nursing facility. Attachment # \_\_\_\_\_**

### **Section III. Trainees**

The trainee shall be appropriately identified as a trainee whenever the individual is performing the required clinical skills training.

**Describe the method used to identify trainees.**

A home care aide must show competency prior to unsupervised client contact.

A long term care trainee shall not perform any services for which the trainee has not been trained and found proficient by the instructor.

**A program shall provide a copy of the policy that specifies that home care aide trainees shall show competency prior to any unsupervised client contact. Attachment # \_\_\_\_\_**

\_\_\_\_\_

**A program shall provide a copy of the policy that specifies that long term care trainees shall not perform any services for which they have not been trained and found proficient by the instructor. Attachment # \_\_\_\_\_**

#### **Section IV. Clinical Facilities**

**An educational based program shall submit a list of clinical facilities and a copy of letters of agreement for use of the clinical facilities signed by the nursing clinical site administrator and the program administrative official. Attachment # \_\_\_\_\_**

#### **Section V. Instructors for Home Care Aides**

**General Information:** You must notify the nurse aide registry for approval any time a change occurs in the following positions: Administrator, RN supervising the program, or program instructors.

**Registered Nurse:** The training of home care aides and the supervision during the supervised practical portion of the training shall be performed by, or under the general supervision of, a registered nurse who possesses at least two years nursing experience with at least one year in the provision of home care.

**Supplemental Instructors** may be used to provide instruction under the supervision of the qualified registered nurse.

Complete the attached Instructor Qualification Record for each person serving as an instructor. Additional copies of the Instructor Qualification Record form can be made and attached.

#### **Instructors for Long Term Care**

**General Information:** You must notify the nurse aide registry for approval any time a change occurs in the following positions:  
Administrator;

RN Supervising the Program; or  
Program Instructors.

**Registered Nurse:** The training of nurse aides shall be done by, or under the general supervision of, a registered nurse who has:

1. At least two (2) years nursing experience, at least one (1) year which has been in a long term care facility; **and**
2. Completed a course in teaching adults **or** experience in teaching adults or supervising nurse aides.
3. If the RN is the director of nurses, he/she is prohibited from performing the actual training while on duty as the director, but may supervise the program.

**Program Instructors:** Licensed Practical Nurses may act as instructors when a Registered nurse maintains the responsibility for the program; Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides.

**Supplemental Instructors:** Supplemental instructors must have at least one (1) year of experience in their fields.

**Complete the attached Instructor Qualification Record for each person serving as an instructor. Additional copies of the Instructor Qualification Record form can be made and attached.**



For a training and competency evaluation program to be approved it shall include:

- a. At least seventy-five (75) hours of training;
- b. An approved curriculum;
- c. At least sixteen (16) hours of classroom training before beginning any supervised practical training;
- d. At least sixteen (16) hours of supervised practical training;
- e. Include at least a total of sixteen (16) hours of training in the following areas prior to any direct contact with a resident:
  - a. Communication and interpersonal skills;
  - b. Infection control;
  - c. Safety/emergency procedures, including the Heimlich maneuver;
  - d. Promoting residents' independence; and
  - e. Respecting residents' rights.

<p><b>Name of Curriculum</b></p> <p>_____ (M ust be a State approved curriculum)</p> <p><b>Total Classroom hours:</b></p> <p><b>Total supervised practical training hours:</b></p> <p>_____ To</p> <p><b>Total clinical hours:</b></p>
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## Section VII. Environment

The nurse aide training and competency evaluation program shall provide an environment conducive to learning. This shall include at least, the following; heating and cooling temperature controls; clean and safe conditions; adequate space to accommodate all trainees; adequate lighting; necessary functioning equipment; training materials including audiovisual equipment and freedom from distractions, traffic and

<p><b>Indicate the largest number of trainees the classroom can accommodate:</b></p>
Yes      No      Date      Comments

other activities.

**Temperature Controls 71 - 81 degrees**

Heating Cooling				
<b>Clean, safe conditions</b> Floor clean, uncluttered  Electrical outlets available & working  Wastebaskets  Clock Available  Environmental hazards (identify & list on separate page)				
<b>Space</b> Adequate number of chairs  Adequate number of desks  Adequate space for trainees, equipment & materials.				
<b>Lighting</b> Direct lighting Suitable for tasks to be performed  Indirect lighting Minimal glare				
<b>Equipment &amp; Training Materials</b> IVD system in working order, if needed Overhead projector, if needed Reference books and materials Supplies				
<b>Clinical Skills Lab</b> Clinical skills lab provides space for equipment and trainees  Mannequin, if needed  Basic skills supplies, i.e., bath basin, personal care items, blood pressure equipment, patient beds, among others  Handwashing facility easily accessible				

**Section VIII. Competency Evaluation Program**

**Written Oral Evaluation:**

An approved program shall make the written or oral and skills examinations available to trainees and shall inform the trainee about the competency evaluation program that is available on successful completion of the training program.

<p><b>Describe where/how the written or oral test is made available to trainees and which test your program will administer.</b></p>
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**Clinical Skills Evaluation:**

The clinical skills demonstration shall be:

- (1) performed in a comparable to the setting in which the individual will function as a nurse aide; and
- (2) administered and evaluated by a registered nurse with at least one (1) year experience in providing care for the elderly or chronically ill of any age.

If the skills testing is going to be administered at your training site:

- (1) complete the information below; and
- (2) attach a copy of the certificate of completion of the clinical skills training

<p><b>Indicate where the clinical skills demonstration part of the competency evaluation program will be administered.</b></p>
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## Clinical Skills Observer

Name:

Annual # \_\_\_\_\_ Certificate #

Years experience in providing care to the elderly or chronically ill; must be at least one (1) .

**Attach copy of certificate of completion of skill training. Attachment #**