



Direct Care Training Center, LLC
Nurse Aide Competency Evaluation Program
Maria Raub RN, PC, PI
NATCEP #3654327

Training Hours: 59
Clinical Hours: 16

Description of Training

Nurse aide training prepares the trainees to a future in nursing through lecture, lab, and clinical experience. Training includes a holistic individualized approach to addressing basic physical and psychosocial needs within the health care setting. Trainee will gain understanding to all stages of development with focus of geriatric care. Potential state tested nurse aides will be knowledgeable to the preservation of a person's optimum level of functioning. The education to proper communication/documentation, basic critical thinking/triage, time management, performing skills proficiently, privately, and safely will enable the trainee to be a successful caregiver.

This training is recognized by the Ohio Department of Health as a State Approved Nurse Aide Program. The trainee that completes this training with a grade of 70% (or above) will receive a certificate of completion and will be eligible to take the state test for nurse aides. This standard is mandated by Ohio Administrative Code (3701-18-13)

Objectives

Upon completion of this course students will be able to:

1. Understand the role and responsibility required of a nursing assistant working in health care setting.
2. Perform basic and personal care skills according to the individual needs of patients, residents, and consumers in the healthcare setting.
3. Develop a basic understanding of body structure in functions and the abnormal changes will be observed and reported.
4. Discuss how knowledge of the stages of growth and development prepares the care plan holistically.
5. Discuss how knowledge of the stages of growth and development help one recognize each person's individual needs.



Course Content

As per Ohio Department of Health Curriculum:

- I. Introduction to TCEP
- II. Communications and Interpersonal Skills
- III. Infection Control
- IV. Safety and Emergency Procedures
- V. Promoting Residents' Independence
- VI. Respecting Residents' Rights
- VII. Basic Nursing Skills
- VIII. Personal Care Skills
- IX. Mental Health and Social Service
- X. Basic Restorative Services
- XI. Resident Rights



Policies of Training: Trainee Copy

Rules:

1. Always be courteous, and respectful.
2. Be honest.
3. Time is given to ask questions, please do so.
4. Wear your name badge.
5. Hair pulled back off neck and out of face during any type of evaluation

Course Materials required:

Access to a computer or phone with on-line capabilities

Student resource binder given first day of training

Notes:

Notes are expected and needed.

Note space has been provided loose leaf paper available if needed.

Assignments:

All assignments will be given ample time to be completed.

Grading Policy:

A passing grade and certificate will be given upon completing assignments, quizzes, tests, 59 hours of classroom hours, and 16 hours of clinical.

Methods of Evaluation:

Trainee must achieve 70% of the total training points, and a satisfactory during clinical.

Attendance:

To comply with Federal and State regulations attendance is accounted for, and mandatory. An agreement on attendance policy will be provided and is mandatory to sign.

Classroom/Lab/Clinical Behavior:

- Students are expected to act in an appropriate and professional behavior
- Students who act inappropriately will be asked to leave
- Cell phones must be turned off or on vibrate
- No cell phones allowed during exams and clinicals
- This is a skill-based course and students must participate in all lab activities. Students are expected to practice with other students/instructors in lab.



Dress Code:

- Scrub top and pants during training and clinical
- Shoes should support good body mechanics
- Long hair should be secure and worn away from face
- Name badge given on first day must be worn to all training/clinical experience

I, _____ (trainee name) have been given a copy of Direct Care Training Center Policy (DCTC). The instructor reviewed the policy with this trainee. I have also read DCTC policy. I understand and will comply with Direct Care Training Center training program policies.

Trainee Signature: _____ Date : _____

Maria Raub RN, PC, PI

Contact Information

Phone: (740) 703-3424

Email: maria@directcarentrainingcenter.com

Trainee Copy

Attendance Policy:

Completion of an Ohio Department of Health (ODH)-licensed NATCEP will provide the training needed to become a State Tested Nursing Assistant (STNA). A NATCEP must have training no less than 75 hours in length.

Training will consist of at least 59 hours of classroom experience and skills training and at least 16 hours of supervised clinical.

If a trainee misses ANY time in NATCEP the hours must be made up within 60 calendar days at Direct Care Training Centers convenience, and location. Any absence that requires an additional private day of by a program instructor will be subject to a charge of up to \$32.00 per hour.

Upon successful completion of a NATCEP, students will receive a Certificate of Completion and will be eligible to register for the state nurse aide test.

Signature of Trainee: _____ Date: _____



DCTC

DIRECT CARE TRAINING CENTER

Instructor Copy

I, _____ (trainee name) have been given a copy of Direct Care Training Center Policy (DCTC). The instructor reviewed the policy with this trainee. I have also read DCTC policy. I understand and will comply with Direct Care Training Center training program policies.

Trainee Signature: _____ Date : _____

Maria Raub RN, PC, PI

Contact Information

Phone: (740) 703-3424

Email: maria@directcaretrainingcenter.com

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This attendance policy may only be changed per ODH.

Signature of Trainee: _____ Date: _____



Direct Care Training Center (DCTC), LLC
68 S. Main Street
London, Ohio 43140

PHOTO RELEASE FORM

I hereby grant permission to *Direct Care training Center (DCTC)* to use photographs and/or video of me taken during training (not clinical) in publications, news releases, online, and in other communications related to the mission of DCTC

(Signature of Adult, or Guardian of Children under age 18)

Thank you!

DCTC

DIRECT CARE TRAINING CENTER

CERTIFICATION OF PHYSICAL CONDITION AND MEDICAL CONSENT

Personal Information:

Name: Last _____ First _____ MI _____

DOB: ____/____/____

SSN: _____ - _____ - _____

Address: _____

City: _____ Post Code: _____

Phone: (_____) _____ - _____

Email address _____

Emergency Contact Person: _____

Emergency Contact Phone: (_____) _____ - _____

Relationship to Emergency Contact: _____

Liability Waiver:

I, _____, being aware of my own health and physical condition, and having knowledge that my participation in any NATCEP may be injurious to my health, am voluntarily participating in a physical activities of Direct Care training Center Nurse Aide Training and Competency Evaluation Program 3654327. Having such knowledge, I hereby acknowledge this release, any representatives, agents, and successors from liability of injury or illness which I may incur as a result of participating in the Direct Care training Center Nurse Aide Training and Competency Evaluation Program 3654327. I hereby assume all risks connected there with and consent to participate in said program. I agree I have been educated to the risks and I agree to disclose any physical limitations, disabilities, ailments, or impairments which may affect my ability to participate in the Direct Care training Center Nurse Aide Training and Competency Evaluation Program 3654327.

I certify to the best of my knowledge; I have no physical or mental conditions that prohibit me participating in the Direct Care training Center Nurse Aide Training and Competency Evaluation Program 3654327.

By signing below, thereby consent to any emergency medical treatment as approved by the Direct Care training Center Nurse Aide Training and Competency Evaluation Program 3654327 or other persons associated with Direct Care training Center Nurse Aide Training and Competency Evaluation Program 3654327.

Signature: _____ Date: _____



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Name: Last_____ First_____ MI_____

DOB: ____/____/____

SSN: _____-_____-_____

I authorize the following using or disclosing party:

Direct Care Training Center
68 S. Main St
London Ohio 43140

To use or disclose the following health information:

Any records I have supplied to Direct Care Training Center to adhere to the long term care facilities policy to participate in clinical as a trainee (volunteer) in Direct Care Training Centers Ohio Department of Health Nurse Aide Training and Competency Evaluation.

The above party may disclose my criminal background check and health information to the following recipient:

Friendship Village of Dublin
6000 Riverside Drive
Dublin, Ohio 43017

Signature: _____

Date: ____/____/____



Confidentiality, HIPAA, Security and Integrity of Data

Information security involves three aspects of information protection:

- Preserving the confidentiality of information
- Ensuring its availability and security
- Protecting its integrity

How does staff protect confidentiality and security of information?

- Staff does not discuss resident information with those who have no need to know. If resident information needs to be discussed, staff will find a private area to talk.
- In data collection, numbers are assigned to residents and used in place of resident names.
- Cover sheets on faxes identify the confidentiality of attached information.
- Staff will confirm telephone numbers before sending documents via fax.
- Only necessary information is photocopied.
- Copies of medical records from the FVD must be requested in writing by the resident or the resident's legal representative, court order, subpoena, or third party payer. This procedure is followed whether the copy is to be sent either electronically or sent through the mail on a hard-copy format.
- Department heads approve all signage to ensure resident confidentiality is kept.
- No confidential material can be taken home or removed from FVD by staff or other persons without the Executive Director's approval. (Unless evacuation of building is necessary)
- Non-active recent resident records and all other records (financial, staff) are stored in locked metal cabinets or files. These records are stored in rooms with sprinklers. Records of similar type are stored in the same location.
- FVD's Information Technology systems are provided to associates for business purposes and are to be used solely for the benefit of conducting FVD business.
- Access to computer files and software programs are controlled through password codes, which restrict access to certain operations. Staff does not share their passwords with anyone.
- Staff will log off the computer when they are done.

Types of protected data

- Resident clinical information
- Billing information
- Human resources-related information

Accuracy and Timeliness of Data

All staff is responsible to ensure data is accurate and timely by carefully collecting and communicating information promptly to appropriate staff. Types of data you may collect include:

- Number of meals served
- Supplies to be ordered
- Weights of residents
- Maintenance that needs to be done
- Care concerns you have about a resident
- Safety concerns you find

Protecting the confidentiality, security, and integrity of data begins with your actions.

Associate Confidentiality Acknowledgement

I understand that while performing my NATCEP clinical duties I may have access to information that is confidential, sensitive, or protected health information. Confidential information is information that identifies an individual, information relating to my employer's business operations, such as instructional manuals, and all proprietary information of my employer. Sensitive information includes financial and operational information. Protected health information (PHI) means individually identifiable health information that is transmitted or maintained in any form. Protected health information is not available to the public. Special precautions are necessary to protect this type of information from unauthorized access, use, modification, disclosure, or destruction.

****I agree to protect confidential, sensitive, and protected health information by:

- Accessing, using, or modifying confidential and/or protected health information only for the purpose of performing my official duties.
- Never storing my passwords in a location accessible to unauthorized persons.
- Never accessing or using confidential and/or protected health information out of curiosity, or for personal use or advantage.
- Storing confidential and/or protected health information in a place physically secure from access by unauthorized persons.
- Never removing confidential and/or protected health information from the work area without authorization.
- Disposing of protected health information by utilizing an approved method of destruction, which includes shredding, burning, or certified witnessed destruction. Never disposing of such information in the wastebasket or recycle bins.

Penalties:

Unauthorized access, use, modification, disclosure, or destruction is strictly prohibited by state and federal laws. The penalties for unauthorized access, use, and modification, disclosure, or destruction may include criminal or civil action. Policy of Direct Care training center is immediate expulsion from NATCEP 3654327. All clinical sites reserve the right to monitor and record all network activity with or without notice, and therefore users have no expectations of privacy in the use of these resources.

HIPAA (Health Insurance Portability and Accountability Act)

What is it? HIPAA requires that an individual's health information be protected, whether the information is discussed verbally, in writing, or is electronically displayed/discussed. All clinical sites and Direct Care Training Center adheres to the Resident's Bill of Rights and stresses Confidentiality policies. NATCEP trainees must keep confidentiality in mind even outside of training/clinical premises.

I certify that I have read and understand the Confidentiality, HIPAA, Security, and Integrity of Data provided to me.

Print Full Name (first, middle initial, last)

Signature

NATCEP Trainee of Direct Care Training Center

Date Signed _____