

## *Instructions for completion of UNI-17 Care Provider Training Checklist*

Introduction: 7 AAC 130.235(c) requires the NOCM registered nurse to assess the recipient for “Recipient’s health and safety; recipient’s medical care needs and training required for paid and unpaid caregivers ...”. Uni-17 Care Provider Training Checklist is the SDS Approved Form to use in order to document that the training needs have been assessed and that the care providers have been trained in each of the mandatory and specific training categories described below. (Uni-18 NOCM Nursing Plan of Care is the SDS Approved Form to use to document the NOCM Nursing Plan of Care).

### **Section I Demographics.**

Complete all of the demographic information in **Section I**. Select initial or renewal “Care Provider Training Checklist” to indicate the status of the Care Provider Training Checklist you are submitting. If you are submitting an Initial Training Checklist you will not know the “Plan of Care Renewal Date” or the “Training Plan Review Date”, so place “not applicable” in the text box for those items. You should prepare an Initial Care Provider Training Checklist as well as a NOCM Nursing Plan of Care (SDS Approved Form Uni-18), as soon as possible upon receipt of a new referral so that the Care Coordinator is not delayed in submitting the Initial CCMC or IDD Waiver Support Plan.

If you are submitting a Renewal Training Checklist, use the Plan of Care Renewal Date from the cover sheet of the CCMC or IDD Waiver Plan of Care (SDS Approved Form Uni-02). Use the date or dates that you conducted the training review for the “Training Plan Review Date”. \* Note you should prepare the Renewal Training Plan Checklist on a time line consistent with the Care Coordinator’s submission of the Waiver Renewal Application so that the Care Coordinator is not delayed in submitting the Waiver Renewal Support Plan.

### **Section II. Mandatory Training Categories.**

Train to all of the mandatory sections in **Section II**. Place your initials in the fillable text box located on the left hand side of each care provider training category of the form to indicate that you evaluated the training of the care providers by either demonstration or verbalization of the standard of care outlined in the specific category. The Mandatory Training Categories have been so designated to promote the health and safety of each recipient of NOCM services. If there is a reason that a mandatory training category does not apply to the recipient to which this form applies, insert a justification in the “Other” section at the end of the form. If more than one NOCM nurse completes the initial training attestation or the review training attestation, place your initials in only the training evaluation category that you actually completed.

### **Section III. Individualized Training Categories.**

Identify and document training to all of the applicable training categories outlined in Section III. The actual training may be provided by the parents or a health care provider other than the NOCM nurse. Place your initials in the fillable text box located on the left hand side of each care provider training category or the form to indicate that you evaluated the training of the care providers by either demonstration or verbalization of the standard of care outlined in the specific category. **If a specific category is not applicable to the recipient, so indicate by placing “not applicable” in the text box by the category, in addition to your initials.** If more than one NOCM nurse completes the training or the training review, place your initials in only the training evaluation category that you actually completed.

### **Section IV. Unique Training Needs.**

If there are categories of care provider training that the recipient needs, but that are not listed in the training attestation, identify and describe the category or categories in Section IV. Complete the information in the text box provided and record your initials at the end of the description of each category to indicate that you have verified the training described by demonstration or verbalization.

**Section V. Comments/Notes.**

If you wish to make a comment or record information unique to the recipient, you may record notes in Section V. Record your initials at the conclusion of your notes.

**Section VI. NOCM Registered Nurse Attestation.**

Record your name and initials in the appropriate text boxes and sign your name to verify your attestation in Section VI.

**Section VII. Signatures Care Providers.**

Record the name and initials of each care provider in the appropriate text boxes and have each care provider sign their name in Section VII.

**Section I.**

Name of Recipient: \_\_\_\_\_  
Medicaid #: \_\_\_\_\_ Initial Training Checklist \_\_\_\_\_ Renewal Training Checklist \_\_\_\_\_  
Name NOCM Registered Nurse \_\_\_\_\_ Initials NOCM Registered Nurse \_\_\_\_\_  
Plan of Care Renewal Date: \_\_\_\_\_ Training Plan Review Date: \_\_\_\_\_

**Section II Mandatory Training Categories**

Role of NOCM Registered Nurse

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) will describe the roles and responsibilities of the NOCM registered nurse to assess the recipient to determine health and safety needs, medical care needs and training needs for the care providers., They will describe how and when to contact the parents(s) or guardian or the NOCM nurse or physician or EMS.

Role of Care Providers

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) will describe their responsibilities and limitations as unlicensed assistive personnel.

Infection Control/OSHA Guidelines

NOCM Nurse Initials \_\_\_\_\_ The care provider has reviewed all training information related to Universal Precautions/ Infection Control guidelines and completed related trainings, when applicable. Demonstrates proper hand washing technique.

CPR

NOCM Nurse Initials \_\_\_\_\_ The care provider has completed CPR training per National Certification Guidelines with verification of this training on file with their employer. All guidelines and steps to follow should resuscitation and/or EMS response be required have been clearly outlined. The care providers are aware of the code status of the recipient.

Signs of Illness

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have described signs of illness for the recipient. They have demonstrated or verbalized proper respiratory observation and monitoring. A plan for whom to notify in the event of unexpected illness is posted in a location accessible to the care provider(s)

### Diet/Nutrition

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have described the client's dietary plan as outlined by his/her nutritionist, physician, and/or family. This includes describing appropriate food choices and methods of preparation, as well as foods that the client will need to avoid. The care provider(s) have described the importance of the relationship between the recipient's weight/nutritional status on the rest of his/her body systems and how this affects overall endurance, growth and development.

The recipient's known food allergies are: \_\_\_\_\_

The recipient's known food sensitivities are: \_\_\_\_\_

### Fluids/Hydration

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated the signs and symptoms that indicate dehydration. The care provider has verbalized and/or demonstrated the appropriate measures to prevent the recipient from becoming dehydrated and when to contact the parent or guardian to report their concerns.

### Skin Care

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated the signs & symptoms for skin breakdown, compromised pressure areas/points and stated measures to take to prevent skin breakdown. The care provider has stated what observations need to be documented related to skin conditions and when to contact the nurse and/or physician and/or parent or guardian.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated signs and symptoms of skin infection/alteration and will describe steps to be taken in providing care, documentation, and reporting.

### Oral Care

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have verbalized or demonstrated proper oral care/dental hygiene for this recipient as outlined by the parent or guardian or dentist.

### Safety: Car Seats/Restraints

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated safe positioning of the recipient in his/her car seat and the appropriate use of restraints and installation of car seat in vehicle. The care provider(s) have verbalized and/or demonstrated the correct use of safety restraints for the recipient while in the wheelchair, stroller, high chair and the car/van during transport. The care provider(s) have verbalized and/or demonstrated safe practices maneuvering the wheelchair up and down stairs, ramps and/or van lift, safely. The care provider(s) have verbalized and/or demonstrated correct application of the personal floatation device when the recipient is in a boat or near water. The care provider(s) have verbalized and/or demonstrated the correct application of an appropriate size helmet when the recipient is riding a bicycle, all-terrain vehicle, snow machine and/or motorcycle.

Body Mechanics

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have verbalized and/or demonstrated proper body mechanics in lifting, transferring, and positioning the recipient.

Outdoors

NOCM Nurse Initials \_\_\_\_\_ The care provider has described precautions to be taken with the recipient when outdoors and the reasons for these precautions including, but not limited to; appropriate dress, outerwear, hats, sunscreen, insect spray, etc.

Hygiene/Bathing

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated precautions to be taken when performing hygiene related activities such as bathing, showering and/or shaving \_\_\_\_\_ (name of recipient) and the reasons for these precautions, including but not limited to checking that water temperature is below 120 degrees Fahrenheit.

**Section III**

Allergies

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have reviewed the recipient’s known allergies. The recipient’s list of allergies is posted in accessible locations, is listed on the recipient’s medication record and/or in the client record (as required for licensed facilities). The care provider has identified the location of the recipient’s medical information, including list of allergies and medication log. The care provider(s) have stated the signs, symptoms, and steps to take related to an allergic reaction and/or anaphylactic reaction. The care provider has described when to notify the parents/guardian, nurse, physician and/or paramedics. Parents/guardian have been informed where to obtain medical alert bracelets, if appropriate. The clients known food, medication and environmental allergies are: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Blood Pressure

NOCM Nurse Initials \_\_\_\_\_ The care provider has demonstrated or verbalized manual and automatic methods of assessing \_\_\_\_\_ (recipient’s name), blood pressure. They have stated his/her normal blood pressure parameters: systolic range \_\_\_\_\_ to \_\_\_\_\_ and diastolic range \_\_\_\_\_ to \_\_\_\_\_. A plan for whom to notify in the event the recipient’s blood pressure falls outside of the pre-set parameters is posted in a location immediately accessible to the care providers(s)

Tracheostomy

NOCM Nurse Initials \_\_\_\_\_ The Parent or guardian has demonstrated/verbalized the correct technique for changing the tracheostomy tube. The equipment provider has outlined the home cleaning routine for this type of tracheostomy tube and a copy of the directions, are readily available for care providers. There is an extra tracheostomy tube in their “GO BAG.” The client has an extra tracheostomy tube with him/her at all times.

### Artificial Nose

NOCM Nurse Initials \_\_\_\_\_ All care provider(s) have demonstrated competency in care of the client's artificial nose.

### Suctioning

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated proper oral suctioning technique of the client's mouth and nose, using an appropriate size suction catheter or a modified syringe/suction catheter in the nares. The care provider(s) have demonstrated proper suctioning technique of the tracheostomy, using the appropriate size of suction catheter. The catheter size is \_\_\_\_\_.

### Nebulizer

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have been instructed in and have demonstrated the administration of nebulizing treatments and when those treatments are to be administered. They have taken the respiratory vital signs before and after each treatment. Care providers have stated the purposes and expected responses to treatments.

### Chest Percussion Therapy

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated proper Chest Percussion Therapy (CPT) or use of a Compression vest, including appropriate positioning. They have described the respiratory signs and symptoms indicating the need for interventions in the form of CPT and when it is appropriate to provide CPT or use of a Compression Vest (before feeding; usually after nebulizer treatments).

### Monitors/Cardiac/Respiratory Equipment

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated the correct technique in using the oxygen concentrator, back up oxygen tanks and safe storage and cleaning of all equipment, tubing, masks, etc. The care provider(s) will state when the equipment is malfunctioning and when to call the respiratory therapist, physician or vendor. The care providers have an updated list of the name and phone number for the physician, vendor and respiratory therapist. The contact information for the medical equipment vendor for the oxygen and related equipment is: Name \_\_\_\_\_ Phone number \_\_\_\_\_

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated competency in care of recipient's at home ventilator equipment. The care provider(s) can state when the equipment is malfunctioning and when to call the respiratory therapist, physician or vendor. The care providers have an accessible and updated list of the name and phone number for the physician, vendor and respiratory therapist. The ventilator Home Care Training has been provided by: Name \_\_\_\_\_ Title \_\_\_\_\_ and training is complete.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated competency in care of the recipient on BiPAP/CPAP equipment. The care provider(s) can state when the equipment is malfunctioning and when to call the respiratory therapist, physician or vendor. The care providers have an accessible and updated list of the name and phone number for the physician, vendor and respiratory therapist. The Bi-PAP/CPAP Home Care Training has been provided by: Name \_\_\_\_\_ Title \_\_\_\_\_ and training is complete.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated proper use of the cardiac-respiratory monitor including checking of alarm limits; High: \_\_\_\_\_ Low: \_\_\_\_\_. Proper use includes troubleshooting, application of leads, maintenance, cleaning, monitoring of equipment and whom to call should the monitor need to be replaced. The type of monitor is \_\_\_\_\_

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) will state when the cardiac-respiratory monitoring equipment is malfunctioning and when to call the respiratory therapist, physician or vendor. The care provider has an accessible and current list of the name and phone number for the physician, vendor and respiratory therapist.

Pulse Oximetry

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated competence in using the pulse oximeter and have stated the normal parameters for this recipient. High: \_\_\_\_\_ Low: \_\_\_\_\_. The care provider has described the appropriate interventions in the form of observation and monitoring of the client, repositioning, suctioning, adjusting the oxygen flow within physician outlined parameters. Care providers will verbalize understanding of when to contact the physician and/or the parent or guardian, versus when to call 911. The care provider has stated when the equipment is malfunctioning and when to call the respiratory therapist, physician or vendor. The care provider has an accessible and updated list of the name and phone number for the physician, vendor and respiratory therapist

Specialized Feeding Needs

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated proper feeding technique for the needs of the recipient, including if applicable, checking for tube placement prior to feeding, positioning, venting the tube, and other practices, per physician or guardian guidelines, necessary to ensure comfort and safety before, during and after each feeding, including proper skin care around the feeding tube.

Method(s) of feeding (indicate yes or no for each method)

|        |        |        |        |         |
|--------|--------|--------|--------|---------|
| Oral   | NG     | G-Tube | J-Tube | GJ-Tube |
| Yes No  |

The recipient is not to receive any solid foods due to his/her risk of aspiration pneumonia      Yes      No

Care provider(s) will verbalize understanding that accidental dislodgement of a J-Tube requires immediate medical attention. Care provider(s) have demonstrated or verbalized correct technique in replacing the gastrostomy tube should it become dislodged or come out completely. Care provider(s) have demonstrated and/or stated steps to take should they not be successful in replacing the tube.

Name of Formula \_\_\_\_\_ Total daily calorie goal \_\_\_\_\_ Nutritionist \_\_\_\_\_

Pump Yes No Type/Name \_\_\_\_\_ Rate \_\_\_\_\_

Dietary goals and objectives:

Other Instructions:

Central Venous Catheter

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have verbalized awareness of the presence of a central line and its function. The type of central venous catheter is \_\_\_\_\_. The care provider has described precautions to be taken for safety and, including risk of dislodgement, and prevention of infections. They have stated signs of infection and when to contact the parent or guardian and/or physician.

Autonomic Hyperreflexia/Dysreflexia

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have described the signs/symptoms of autonomic hyperreflexia and/or dysreflexia and have demonstrated or verbalized how to monitor the recipient for this event. The care provider(s) have stated interventions to be taken including contacting the parent/guardian, repositioning, loosening clothing, monitoring respirations and the criteria for notification of EMS.

Seizure Management

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated the signs of seizure activity, how to monitor the recipient during and after a seizure: Monitoring vital signs, particularly respirations, onset and duration of seizure, precipitating factors, pre and post ictal observations and documentation of all required information related to seizure activity. Care providers have demonstrated appropriate seizure observations, monitoring, and intervention including ensuring safety, appropriate positioning, and when to activate EMS.

Hydrocephalus/V-P Shunt

NOCM Nurse Initials \_\_\_\_\_ All care providers will be able to describe hydrocephalus, state the signs and symptoms of shunt malfunction/infection and when to report to the parent or guardian and /or physician.

Medications

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated accurately drawing up, administering, and documentation of the client's medications. The care provider(s) have stated the purpose of each medication, any adverse effects, and safe storage standards for all medications. All medications will be kept up out of reach of children and will have childproof lids, when appropriate.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated what constitutes a medication error and the necessary actions to take should a medication error occur per agency policy.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated an understanding that controlled substances may only be delegated by a physician and/or parent or guardian.

NOCM Nurse Initials \_\_\_\_\_ Direct care employees of a provider agency who provide medication have successfully completed an Alaska Board of Nursing approved Medication Administration Training Class.

Catheterization

NOCM Nurse Initials \_\_\_\_\_ The parent or guardian has demonstrated the correct catheterization technique via the client's procedure. The client's type of catheter is \_\_\_\_\_ and the size is \_\_\_\_\_.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated the correct catheterization cleaning and/or removal technique for the client. They have described the signs and symptoms indicative of infection and interventions to be taken should this be discovered. The care provider(s) have described and documented when the client's catheter is to be cleaned/removed and shown how/where to dispose of all contaminated supplies. They have described the relationship between catheter insertion and an increased risk for infection. The care provider(s) can state an understanding that the insertion of catheters and sterile gloving are not tasks which they have been trained, nor are they authorized to perform.

Bowel/Bladder Program

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have assisted the client with his/her bowel program. This includes the following: frequency of program, toileting, enema or medication administration (if needed) and perineal care. The care provider has described the significance of maintaining a bowel program for the client's overall health, signs/symptoms of bowel related problems, information to document and when to report concerns to family, nurse and/or physician.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have described and assisted with the client's urinary program and care of the catheter (if necessary). This includes administering medications and treatments, as well as changing protective undergarments and bed linen and performing preventative skin care. The care provider(s) also have described how hydration and nutrition affect the client's bowel and/or urinary program and the importance of fluid intake, the information to document and when to report concerns to family, nurse and/or physician.

Therapy Goals/ Developmental Interventions

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated the goals that the client and therapists are actively working on. The recipient receives:

| Type of Therapy | Times per Week | Provider(s) |
|-----------------|----------------|-------------|
|                 |                |             |
|                 |                |             |
|                 |                |             |
|                 |                |             |
|                 |                |             |
|                 |                |             |

Range of Motion (ROM)

NOCM Nurse Initials \_\_\_\_\_ The care provider has demonstrated proper positioning and exercises to maintain/increase the clients ROM. Care providers will verbalize or demonstrate an understanding of proper ROM techniques.

Orthotics/Splints

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have demonstrated correct application of splints/orthotics and the schedule for how long they must be worn. The care provider will describe why the recipient needs orthotics/splints; signs/symptoms to watch for following application; to whom and how this information would be reported and the appropriate actions to take should there be complications related to splints/orthotics. The provider for the orthotics is

Name \_\_\_\_\_ Title \_\_\_\_\_ Phone Number \_\_\_\_\_

Generator

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have been trained and have verbalized and/or demonstrated correct use of the generator and have described the necessary safety precautions to be followed should a power outage occur.

Diabetes

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated the parameters of blood sugar levels and described the appropriate steps to follow regarding reporting and documentation.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have verbalized and/or demonstrated steps to be taken in checking the client blood sugar levels including; cleaning, calibration of devices, date of lab strips and necessary documentation.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) have stated steps required in order for the recipient to safely self-administer insulin injections and/or oral medications.

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) will describe signs and symptoms of diabetic ketoacidosis and insulin shock and will outline the appropriate emergency response.

Sensory

NOCM Nurse Initials \_\_\_\_\_ The care provider(s) will describe how visual/sensory impairments affect the recipient's ability to meet his/her needs and will outline interventions necessary to safely and appropriately provide care. The recipient receives training and/or consultation from the following therapists:

| Therapist Name | Consultation/Training | Phone Number |
|----------------|-----------------------|--------------|
|                |                       |              |
|                |                       |              |
|                |                       |              |

**Section IV Training Needs Unique to Recipient**

Additional aspects of care that are unique to this recipient are described below.

**Section V Comments/Notes**

**Section VI. NOCM Registered Nurse Attestation**

A NOCM registered nurse has initialed each area of care for the recipient where the care provider(s) have successfully accomplished the required training. The signature and initials of each care provider listed in Section VII, indicates that he/she is able to verbalize or demonstrate correct techniques of care.

I attest that all areas of training necessary to care for the recipient in their home have been thoroughly reviewed and completed by each caregiver whose signature and initials appear as indicated in Section VII

\_\_\_\_\_  
Signature of NOCM RN

\_\_\_\_\_  
(Printed Name)

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client/Guardian/Parent or Other  
Legal Authority

\_\_\_\_\_  
(Printed Name)

Date: \_\_\_\_\_

