

Long-Term Care Workforce Development Session #2

Monday, July 30, 2018

1:00 p.m. to 5:00 p.m.

Washington Department of Health, Tumwater Campus

Point Plaza East Rooms 152/153,

310 Israel Road SE Tumwater, WA 98501

agenda

- Workgroup Members:** Tracy Rude, Representative Eileen Cody, Senator Steve Conway, Candace Goehring, Rachel McAloon, Trina Crawford, Lori Banaszak, Pamela Pasquale, Abby Solomon, John Ficker, Patricia Hunter, and Alexis Wilson
- DOH Staff:** Paula Meyer, Mindy Schaffner, Amber Zawislak, Kathy Moisio, Bobbi Allison
- Facilitator:** Porsche Everson
- Guest Speakers:** Kathy Moisio, NCQAC Education Consultant
Lorrie Mahar, Office Chief, DSHS/AL TSA
- Please Read:**
- *Long-Term Care Workgroup Plan (revised)*
 - *Packet of Relevant Information*
- Links to the packet material can be found on the project website: <https://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission>*
- Meeting Goals**
- CNA Standardized Curriculum:
- a) Identify and describe current types of CNA training programs, including apprenticeship or apprenticeship-like programs and address curriculum and program length for each type.
 - b) Identify current minimum requirements for all CNA training programs.
 - c) Identify current training requirements for the care of clients with dementia, developmental disabilities, and mental health issues.
 - d) Evaluate and make recommendations for standardized CNA training curriculum
 - a. What to keep
 - b. What to take out
 - c. What to update/change
 - d. Specific training requirements for the care of clients with dementia, developmental disabilities, and mental health issues
 - e) Identify additional work or research that may need to be done
 - f) Brainstorm potential recommendations

agenda

1:00 – 1:05 p.m.	Welcome	Tracy Rude, NCQAC Chair and LTCW Chair
1:05 – 1:15 p.m.	Introductions <i>--Who are you, who do you represent? --Briefly, what is your experience with CNA training programs?</i>	Tracy Rude
1:15 – 1:45	Follow up from Previous Meeting 1) <i>Adjusted Work Plan (10 min)</i> 2) <i>Guiding Principles and Ground Rules (2 min)</i> 3) <i>Report out on ESD work (3 min)</i>	Porsche Everson, Facilitator Mindy Schaffner, Project Manager
1:45 – 2:15 p.m.	Presentation- Current State of CNA Training in WA <i>Descriptive statistical overview for training programs. What are the potential ways for a person to become trained as a CNA? What are the current minimum requirements for CNA training?</i> <i>Q&A</i>	Kathy Moisio, DOH Nursing Education Consultant
2:15 – 2:35 p.m.	Presentation - Training for the care of clients with dementia, developmental disabilities, or mental health issues <i>What are the current requirements for specialized training of CNAs and overview of these training programs?</i> <i>Q&A</i>	Lorri Mahar, DSHS/ALTSA Chief, Training Unit
2:35 – 2:45 p.m.	Break	All
2:45 – 3:15 p.m.	Public Comment	Porsche
3:15 – 3:45	Identify Issues Related to CNA Training <i>What are the top 3 issues you see? As a group, what rises to the top?</i>	Workgroup Members
3:45 – 4:15	Identify Potential Recommendations for CNA Standardized Curriculum <i>What potential recommendations do you have now?</i>	Workgroup Members
4:15 – 4:25	Identify Additional Work to be Done	Workgroup Members

agenda

	<i>What do we need to know or do before deciding on final recommendations?</i>	
4:25 – 4:50 p.m.	Moving Forward <i>Summarize issues and potential recommendations for CNA standardized training</i>	Workgroup Members
4:50 – 5:00 p.m.	Wrap Up and Next Steps <i>--Action Items</i> <i>--Session Evaluation</i>	Tracy, Porsche



DRAFT

Revised 7/18/2018

LONG-TERM CARE WORKGROUP PLAN

2018 Budget Proviso

Nursing Care Quality Assurance Commission
Long-Term Care Workgroup

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Introduction and Background

The baby boomer cohort, as described by the United States Census Bureau, has been a driving change in age structure of the national population for the last several decades and has contributed to a shift in the delivery of healthcare¹. As the citizens of Washington State age, the need for healthcare providers in the sectors of skilled nursing homes, assisted living, and adult family homes correspondingly rises to keep up with demand. In 1997, the percent of Washingtonians over the age of sixty-five had been 11.4% of the total population². By the year 2017, this number had increased to 15.3% of the population and the Washington State Office of Financial Management projects the population of Washingtonians over the age of sixty-five to reach 21.6% of the total population by the year 2037. In addition, chronic disease rates and human longevity continue to steadily increase, but the percent of working adults to support and care for the entire population is not.

The U.S. Department of Health and Human Services recently published a report on nursing workforce demand projections to determine the need for nurses in long-term care settings over the next decade.³

We have strong anecdotal evidence that long-term care providers in Washington State are struggling to fill vacancies; that retention is difficult; that career progression within LTC settings is problematic; and that training requirements and regulatory oversight needs to be reset. We recognize that we need data to confirm the magnitude of the known issues described here.

Addressing the shortage of healthcare workers in long-term care settings will be essential to the way in which Washington strategizes for the continued increase in care that will be demanded of the health system. Barriers need to be identified and solutions developed to address these barriers.

Purpose of Workgroup Plan

The overall purpose of this workgroup plan is to describe the implementation of the requirements of the budget proviso allotted to the Nursing Care Quality Assurance Commission in Engrossed Substitute Senate Bill 6032. The budget proviso directs the Nursing Care Quality Assurance Commission to convene and facilitate a work group to assess the need for nurses and nursing assistants in long-term care settings and to provide recommendations in a report to the Governor and Legislature by December 15, 2018. Recommendations must pertain to worker recruitment, training, and retention challenges for long-term care providers in the sectors of skilled nursing facilities, assisted-living facilities, and adult family homes.

¹ Colby, S. and Ortman, J. (2014). *The Baby Boom Cohort in the United States: 2012 to 2060: Population Estimates and Projections*. Retrieved from: <https://www.census.gov/prod/2014pubs/p25-1141.pdf>

² Washington State Office of Financial Management. (2017). *Washington Data and Research*. Retrieved from <https://ofm.wa.gov/washington-data-research/population-demographics>

³ U.S. Department of Health and Human Services. (2018). *Long-Term Services and Supports: Nursing Workforce Demand Projections 2015-2030*. Retrieved from <https://bhwh.hrsa.gov/national-center-health-workforce-analysis>

Mission and Vision

Mission

To identify barriers, develop solutions, and make recommendations regarding career advancement, reduced vacancies, increased retention and standardized training in long-term care settings to the legislature and governor.⁴

Vision

Washington State citizens will have access to quality services provided by qualified and available nurses and nursing assistants in long-term care. Workers will have opportunities for career progression in long-term care settings.

Requirements of ESSB 6032

The purpose of ESSB 6032 is to assess the need for nurses, including nursing assistants, in long-term care settings and make recommendations regarding worker recruitment, training, and retention challenges for long-term care providers in the sectors of skilled nursing facilities, assisted-living facilities, and adult family homes.

The workgroup must:

1. Determine the current and projected worker vacancy rates in the long-term care sectors compared to the workload projections for these sectors.
2. Develop recommendations for a standardized training curriculum for certified nursing assistants that ensures that workers are qualified to provide care in each sector, including integration into the curriculum of specific training for the care of clients with:
 - a. dementia
 - b. developmental disabilities
 - c. mental health issues
3. Review academic and other prerequisites for training for licensed practical nurses to identify any barriers to career advancement for certified nursing assistants.
4. Identify barriers to career advancement for long-term care workers.
5. Evaluate the oversight roles of the Department of Social and Health Services for nursing training programs and make recommendations for streamlining those roles.

⁴ The final report is due December 15, 2018.

Project Organization and Stakeholders

Project Management Team

Project Management Role	Designated Individual
Project Executive	Paula Meyer, Executive Director
Project Lead	Mindy Schaffner, Associate Director
Workgroup Chair	Tracy Rude, NCQAC Chair
Policy Analyst	Amber Zawislak
Education Consultant	Kathy Moisio
Project Assistant	Bobbi Allison
External Facilitator/Project Advisor	Porsche Everson, Relevant Strategies, LLC

Steering Workgroup Members

Members Required by ESSB 6032	Designated Individual
Nursing Care Quality Assurance Commission	Tracy Rude, NCQAC and Workgroup Chair
Chair of House Health Care and Wellness Committee or designee	Representative Eileen Cody (Sending Thea Bird when unable to attend)
Chair of Senate Health and Long-Term Care Committee or designee	Senator Steve Conway (Sending Kimberly Lelli when unable to attend)
Assistant Secretary of Aging and Disability Support Administration of the Department of Social and Health Services or designee	Candace Goehring
Member of the Washington Apprenticeship and Training Council (Department of Labor and Industries)	Rachel McAloon (Sending Evan Hamilton when unable to attend)
Representative from the Health Services Quality Assurance Commission of the Department of Health	Trina Crawford

Executive Director of the Washington State Board for Community and Technical Colleges or designee	Lori Banaszak
Representative of largest statewide Nursing Agency	Pamela Pasquale (Sending Sharon Christor or Lynette Wells when unable to attend, representing WSNA)
Representative of largest statewide Home Care Workers Union	Abby Solomon (Representing SEIU)
Representative of largest statewide Assisted Living and Skilled Nursing Facilities Association	Alexis Wilson (Representing WHCA)
Representative of the Adult Family Home Council of Washington	John Ficker, Executive Director (Sending Karen Cordero when unable to attend)
Washington State Long-Term Care Ombuds or designee	Patricia Hunter

Sources of Input for Steering Workgroup

As much as possible, the work identified in ESSB 6032 will be performed by the whole steering workgroup.

The steering workgroup may choose to involve workgroup members, staff, expert consultants, or other subject matter experts to provide input and counsel instead of, or in addition to, the potential subcommittees.

If it becomes necessary to appoint subcommittees to develop recommendations for the steering workgroup, subcommittee membership will be derived from the named members of the steering workgroup or their designees.

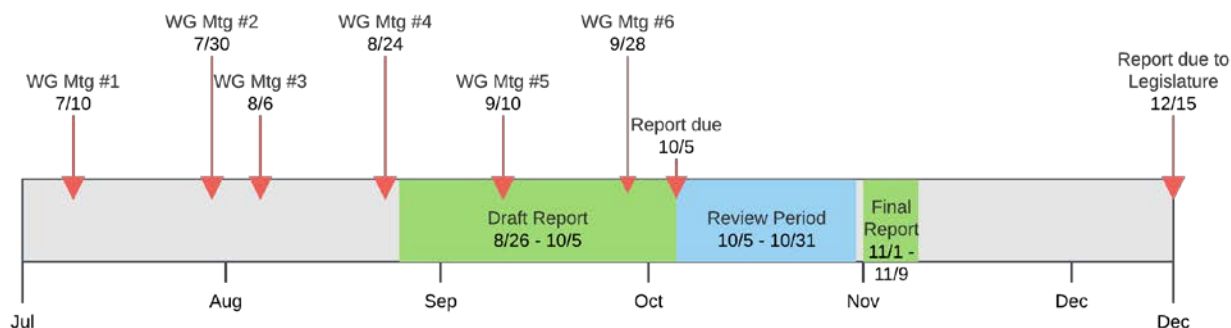
Subcommittees, if formed, will be chaired by a member of the steering workgroup approved by a majority of the steering workgroup. Membership of the subcommittee will be determined by member interest and by the project management team. The project management team will ensure a balance of stakeholder interests on the subcommittee.

The subcommittee's role will be to identify balanced recommendations and choices for consideration by the full steering workgroup. The subcommittees have no delegated authority to make decisions on behalf of the steering workgroup.

Project Plan

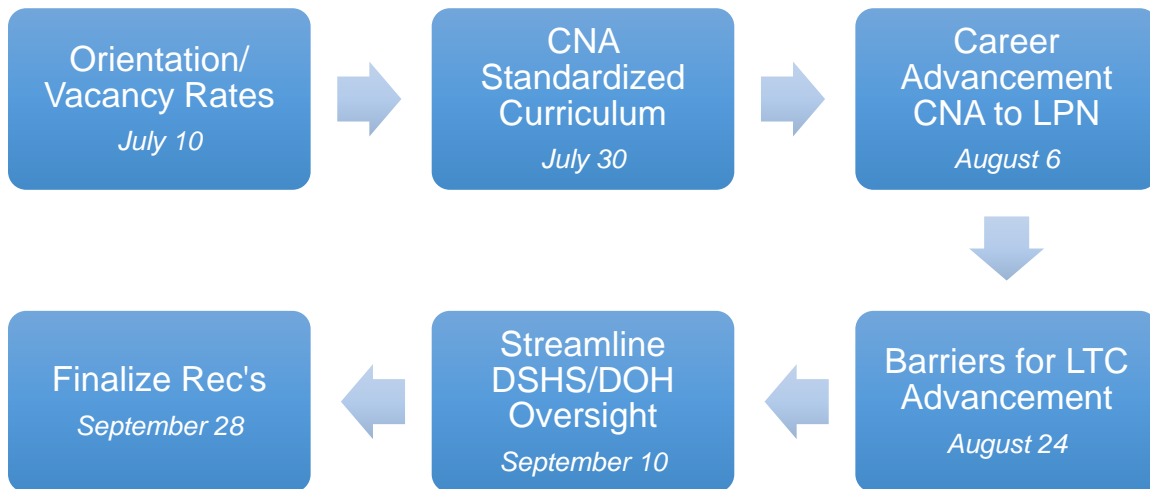
High-Level Timeline/Schedule

LTC Workforce Planning and Development Recommendations Timeline



Workgroup Meetings and Deadlines	
July 10, 2018, 1–5 pm	Session 1: Orientation/Vacancy Rates
July 30, 2018, 1–5 pm	Session 2: CNA Standardized Curriculum
August 6, 2018, 1–5 pm	Session 3: Career Advancement CNA to LPN
August 24, 2018, 1–5 pm	Session 4: Barriers for LTC Advancement
September 10, 2018, 1–5 pm	Session 5: Streamline DSHS/DOH Oversight
September 28, 2018, 8 am–12 pm	Session 6: Finalize Recommendations Review of draft report by Steering Workgroup
October 5, 2018	Report due for DOH review to meet December deadline
October 5-31, 2018	DOH report review period
November 1-9, 2018	Finalize report
December 15, 2018	Report due to Governor and Legislature

Session Activity Plans



1. Orientation/Vacancy Rates (July 10)

(i) Determine the current and projected worker vacancy rates in the long-term care sectors compared to the workload projections for these sectors;⁵

- a. Sense of commitment, timeline, workload
- b. How do we want to work together?
- c. Review data on current and projected vacancy rates and workload projections
 - i. Stakeholder representatives to address 3-4 questions 15 minutes each
 1. What evidence or data do you bring that will inform this work?
 2. What efforts have you been involved in that relates to this work?
 3. Are you aware of examples of solutions outside the state of Washington that relates to this work? If so, what state and work?
- d. Review draft work plan, provide input
- e. Identify additional data needs

⁵ From ESSB 6032.SL, page 218. Accessed from <http://apps2.leg.wa.gov/bills/summary?BillNumber=6032&Year=2017&BillNumber=6032&Year=2017>.

2. CNA Standardized Curriculum (July 30)

(ii) Develop recommendations for a standardized training curriculum for certified nursing assistants that ensures that workers are qualified to provide care in each sector, including integration into the curriculum of specific training for the care of clients with dementia, developmental disabilities, and mental health issues;

- a. Identify and describe current types of CNA training programs, including apprenticeship or apprenticeship-like programs.
- b. Identify current minimum requirements for all CNA training programs.
- c. Identify current training requirements for the care of clients with dementia, developmental disabilities, and mental health issues.
- d. What issues exist with relation to the current state of CNA training programs?
- e. Evaluate and make recommendations for standardized CNA training curriculum
 - i. What are the minimum competencies for a CNA to ensure patient safety and quality of care?
 - ii. What to keep
 - iii. What to take out
 - iv. What to update/change
 - v. Specific training requirements for the care of clients with dementia, developmental disabilities, and mental health issues
- f. Identify additional work or research that may need to be done
- g. Brainstorm potential recommendations

3. Career Advancement CNA to LPN (August 6)

(iii) Review academic and other prerequisites for training for licensed practical nurses to identify any barriers to career advancement for certified nursing assistants;

- a. Identify and describe LPN training programs, including any apprenticeship-like programs.
- b. Identify academic and other prerequisites for LPN training.
- c. How do CNAs typically advance to LPN?
- d. What barriers exist for career advancement for CNAs?
- e. If time available: Discuss HCA training recommendations and career advancement options.
- f. Brainstorm potential recommendations
- g. Identify additional work or research that may need to be done.

4. **Barriers for LTC Worker Advancement** (August 24)
(iv) Identify barriers to career advancement for long-term care workers;
 - a. Theme: Making a career in LTC health care – pathways and progressions, recruitment and retention (HCA, CNA, LPN, RN, MSN, DNP, PhD)
 - b. Identify barriers and issues in nursing assistant training programs.
 - c. Identify barriers in testing and licensing.
 - d. Identify barriers and issues in recruitment and retention.
 - e. Identify barriers and issues in advancement (HCA, CNA, LPN, RN, ARNP).
 - f. Brainstorm potential recommendations for addressing barriers and issues.
 - g. Identify additional work or research that may need to be done.

5. **Discuss DOH/DSHS oversight responsibilities** (September 10)
(v) Evaluate the oversight roles of the department of health and the department of social and health services for nurse training programs and make recommendations for streamlining those roles.
 - a. Describe the oversight roles for DSHS and DOH.
 - b. Identify areas of potential overlap.
 - c. Identify issues and concerns within the regulatory environment
 - i. How does oversight help ensure quality and patient safety?
 - ii. How does oversight hurt efficient care delivery?
 - d. Brainstorm potential recommendations.
 - e. Identify additional work or research that may need to be done.

6. **Finalize recommendations** (September 28)
 - a. Review current and projected vacancy rate data collected to date
 - b. Review draft recommendations related to CNA Standardized Curriculum
 - c. Review draft recommendations related to Career Advancement and Retention
 - d. Review draft recommendations related to Oversight and Evaluation
 - e. Review draft report
 - f. Assess degree of support for each identified recommendation
 - g. Where necessary, identify majority/minority opinions for each recommendation without consensus support.

Project Approach

The steering workgroup is defined by the legislation and is comprised of people who represent various stakeholder groups. The steering workgroup will periodically receive input from selected sources and other interested individuals and groups. The steering workgroup is responsible for identifying and deciding on recommendations.

We will seek consensus in all steering workgroup decisions and recommendations. We will use “common interest” based conversations to reach consensus. If the workgroup cannot reach consensus on a recommendation, and a recommendation has majority support, the recommendation will be listed in the report, along with a brief synopsis of majority and minority opinion about the recommendation.

DOH staff and other participants will provide background research and materials to help inform the work, within the constraints of available time and resources. Some preparation and follow up work will be necessary for steering workgroup members.

The steering workgroup may form subcommittees as necessary. Other interested stakeholders not in the workgroup may be invited to provide input to either the subcommittees or the steering workgroup.

Each steering workgroup session will follow a general pattern. The first half of the meeting will be devoted to workgroup work. The steering workgroup will then take public comment/testimony for up to an hour. This may include time set aside for invited guest speakers. The steering workgroup will then engage in another hour of work together.



The steering workgroup meetings and subcommittee meetings (if any) are open to the public, and the public can observe, but not engage in the work of the workgroup.

Constraints and Assumptions

- Legislative deadline set for report (December 15)
- DOH needs considerable time to have the draft report go through internal review process
- First workgroup meeting must occur by July 15
- Scope and tasks are defined by legislation

Communication and Collaboration

Meeting agendas, advance readings, and other materials will be stored on an accessible DOH project website page available to the public. Periodic drafts of deliverables will be sent to the DOH project lead, for distribution or publication as appropriate.

Most communication with the steering workgroup will occur via email from the DOH project lead, workgroup chair, or administrative contact. On occasion, the facilitator may send information directly to the workgroup.

The facilitator and project management team will meet regularly via web conference or phone conference to plan and evaluate workgroup sessions. At least once per month the external facilitator will check in with the project lead to address scope, schedule, budget, and quality issues as necessary.

Change Management

We don't anticipate changes to the project. In fact, the scope, budget, and schedule are fixed in the legislation. However, scope, budget, or schedule changes may happen for reasons unforeseen at present.

The project management team will address any proposed changes to scope, schedule or budget as quickly as feasible and develop a plan. The overall goal will be to work within the established constraints as best as possible.

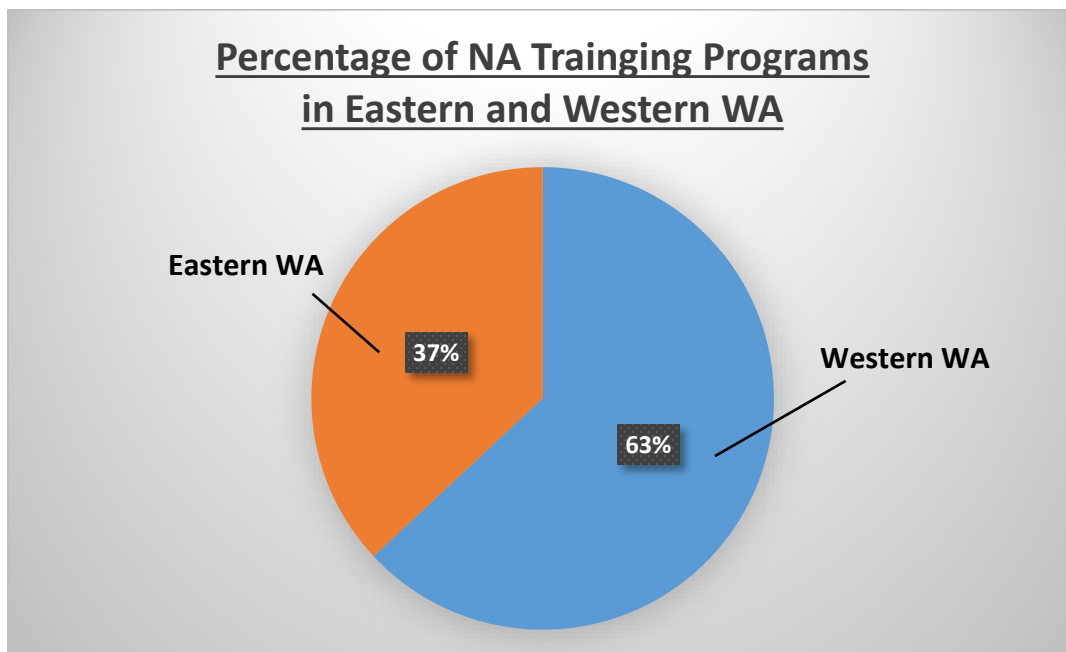
Descriptive Statistics
for
Nursing Assistant Training Programs in Washington

Descriptive Statistics:

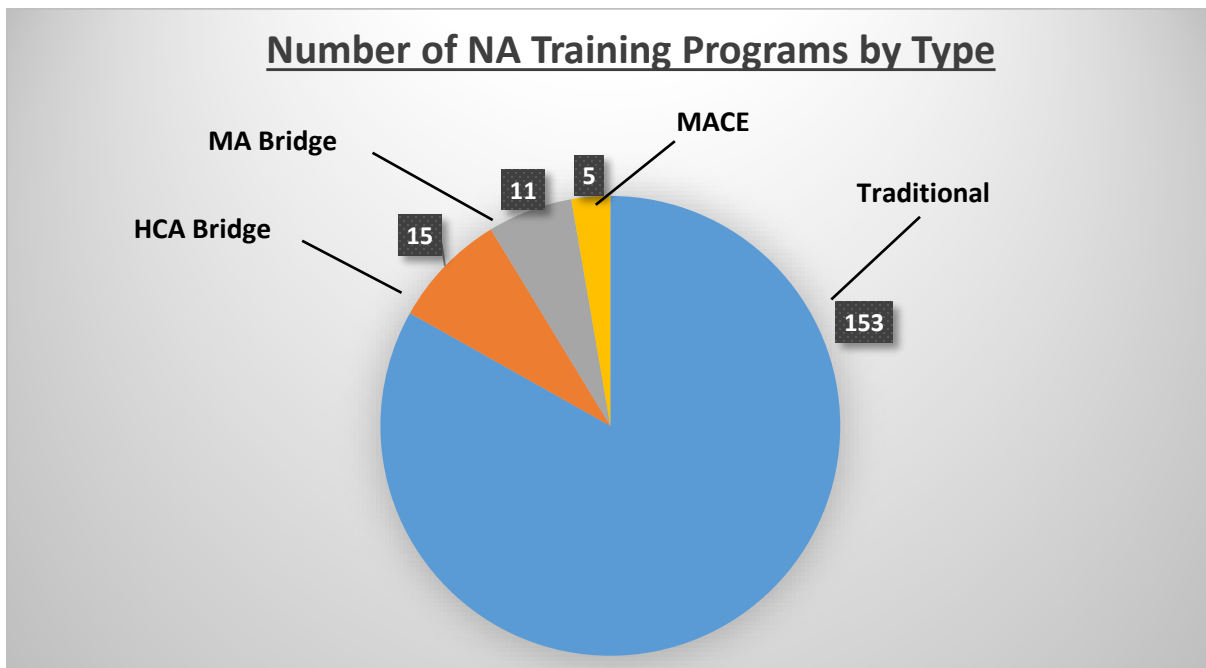
Nursing Assistant (NA) Training Programs in Washington State

Note: This information is a “snapshot in time” (July 2018). While program data change on an ongoing basis, overall ranges have been generally stable over the past several years.

- **There are currently 184 nursing assistant (NA) training programs**
 - **31 of 39 (80%)** of counties have at least one training program
 - **116 (63%)** are on the West side while **68 (37%)** are on the East side
 - **8 (20%)** of counties have no NA training programs:
 - ✓ **5 West Side:** Jefferson, San Juan, Skamania, Wahkiakum, Pacific
 - ✓ **3 East Side:** Douglas, Klickitat, Asotin

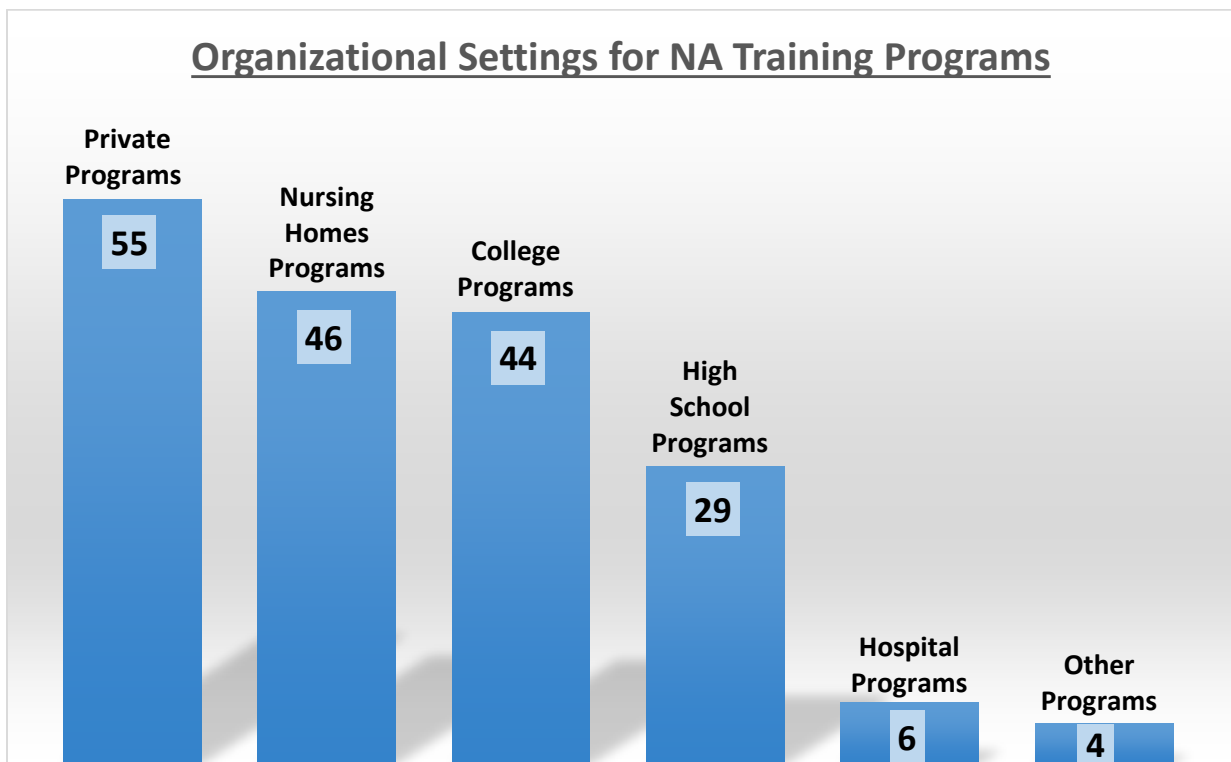


- **There are several different types of NA training programs:**
 - **153 (83%)** are “Traditional” (full-length, entry-level)
 - **15 (8%)** are Home Care Aide (HCA) Alternative or “Bridge” programs (shorter programs for certified HCAs who meet criteria in [WAC 246-841-535\(1\)](#))
 - **11 (6%)** are Medical Assistant Alternative or “Bridge” programs (shorter programs for certified MAs who meet criteria in [WAC 246-841-535\(2\)](#).)
 - **5 (3%)** are Medication Assistant Certification Endorsement (MACE) programs (for NAs who meet criteria in [WAC 246-841-588\(1\)](#))



- **NA training programs are located in a variety of organizational settings:**

- **55 (30%)** are Private Businesses
- **46 (25%)** are in Nursing Homes
- **44 (24%)** are in Colleges
- **29 (16%)** are in High Schools/Skills Centers
- **6 (3%)** are in Hospitals
- **3 (2%)** are in a County Agency (Area Agency on Aging)
- **1 (<1%)** is in a Job Corps Programs



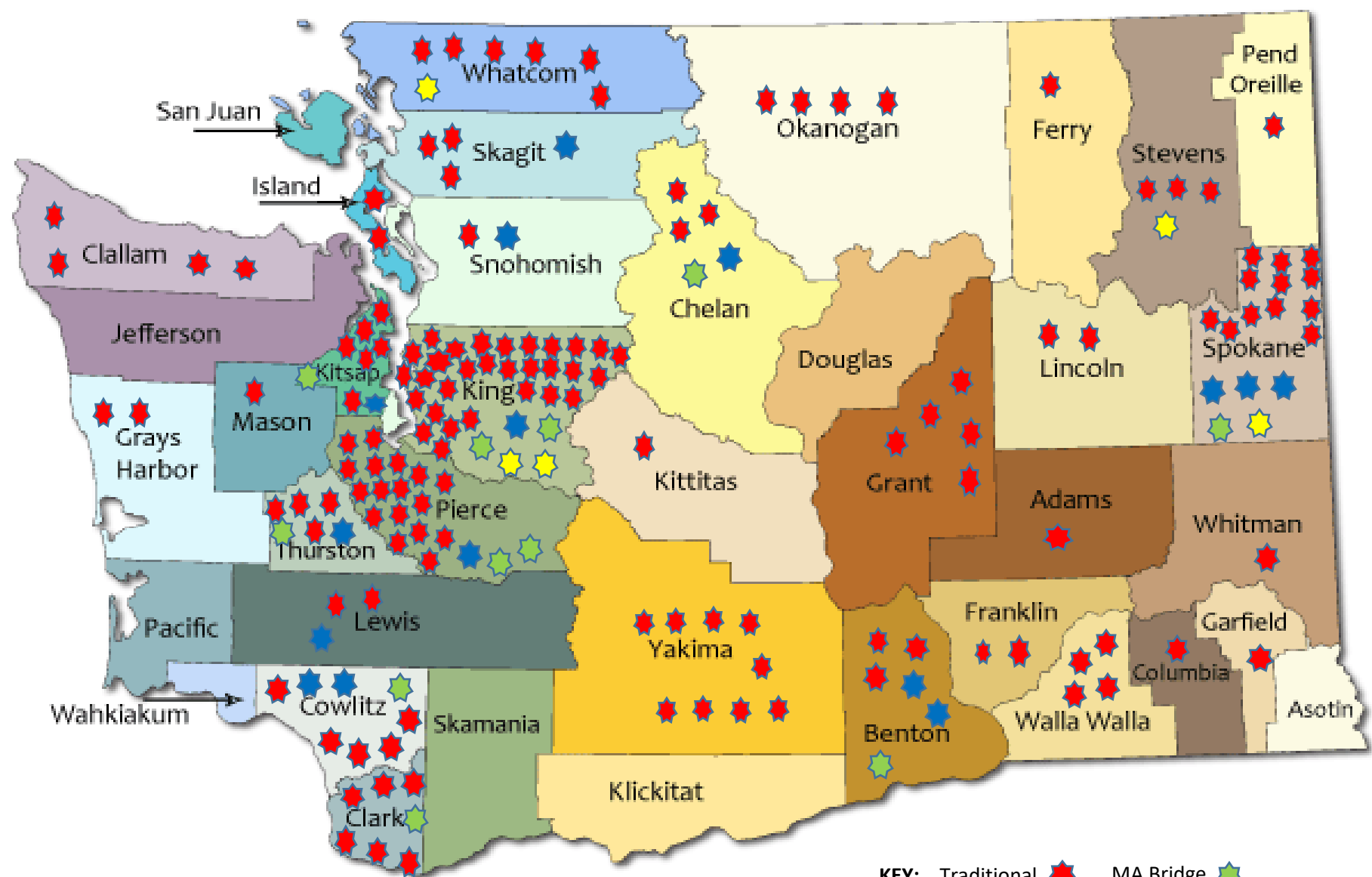
Detailed Data Table: Nursing Assistant Training Program in Washington
(by County/Geography, Type, and Organizational Location)

County	Eastern/ Western Washington	Total # of Programs	Program Types--#	Organizational Location--#
Adams	Eastern	1	Traditional--1	NH--1
Asotin	Eastern	-----	-----	-----
Benton	Eastern	6	Traditional--3 HCA Bridge--2 MA Bridge--1	HS--1 NH--1 Private--4
Chelan	Eastern	5	Traditional--3 HCA Bridge--1 MA Bridge--1	College--4 HS--1
Clallam	Western	4	Traditional--4	HS--1 College--1 NH--1 Hospital--1
Clark	Western	7	Traditional--6 MA Bridge--1	College--1 High School--2 Private--4
Columbia	Eastern	1	Traditional--1	NH--1
Cowlitz	Western	9	Traditional--5 HCA Bridge--2 MA Bridge--2	College--1 HS--1 NH--1 Private--6
Douglas	Eastern	-----	-----	-----
Ferry	Eastern	1	Traditional--1	Hospital--1
Franklin	Eastern	2	Traditional--2	College--1 NH--1
Garfield	Eastern	1	Traditional--1	Hospital--1
Grant	Eastern	5	Traditional--5	College--1 HS--1 Job Corps--1 NH--2
Grays Harbor	Western	2	Traditional--2	College--1 HS--1
Island	Western	2	Traditional--2	College--2
Jefferson	Western	-----	-----	-----
King	Western	35	Traditional--30 HCA Bridge--1 MA Bridge--2 MACE--2	College--9 HS--7 NH--4 Private--15
Kitsap	Western	7	Traditional--6 HCA Bridge--1	College--1 HS--1 NH--3 Private--2

County	Eastern/ Western WA	Total # of Programs	Program Types--#	Organizational Location--#
Kittitas	Eastern	1	Traditional--1	NH--1
Klickitat	Eastern	-----	-----	-----
Lewis	Western	3	Traditional--2 HCA Bridge--1	College--1 Private--2
Lincoln	Eastern	2	Traditional--2	HS--1 Hospital--1
Mason	Western	1	Traditional--1	NH--1
Okanogan	Eastern	4	Traditional--4	College--1 NH--3
Pacific	Western	-----	-----	-----
Pend Oreille	Eastern	1	Traditional--1	Private--1
Pierce	Western	20	Traditional--17 HCA Bridge--1 MA Bridge--2	College--5 HS--3 NH--6 Private--6
San Juan	Western	-----	-----	-----
Skagit	Western	4	Traditional--3 HCA Bridge--1	College--2 HS--1 Private--1
Skamania	Western	-----	-----	-----
Snohomish	Western	12	Traditional--1 HCA Bridge--1	College--3 HS--2 NH--3 Private--4
Spokane	Eastern	17	Traditional--12 HCA Bridge--3 MA Bridge--1 MACE--1	College--3 HS--1 NH--5 Other--2 Private--6
Stevens	Eastern	4	Traditional--3 MACE--1	Hospital--2 NH--2
Thurston	Western	6	Traditional--4 HCA Bridge--1 MA Bridge--1	College--1 HS--1 Private--4
Wahkiakum	Western	-----	-----	-----
Walla Walla	Eastern	4	Traditional--4	College--1 HS--1 NH--2
Whatcom	Western	7	Traditional--6 MACE--1	College--4 NH--3
Whitman	Eastern	1	Traditional--1	NH--1
Yakima	Eastern	9	Traditional--9	College--1 HS--3 NH--4 Other--1

**Map
of
Nursing Assistant Training Programs in Washington**

MAP of Nursing Assistant Training Programs in Washington



KEY: Traditional ★ MA Bridge ★
 HCA Bridge ★ MACE ★

National Data:

Required Hours for Nursing Assistant Training Programs

Required Nursing Assistant Training Program Hours by State

Narrative Summary

Federal regulations (established in 1987)* require state-approved nursing assistant (NA) training programs to provide a minimum of 75 hours of training including at least 16 hours of clinical training. Most states require more hours, but several maintain the minimum federal requirements.

As the table of states below demonstrates, there is great variability in required training hours across states. A roll-up summary indicates the following:

- The average minimum for NA training program hours across all states is **100** (range is from 75 to 180 hours).
- About **two-thirds of states (33)** require hours above minimum federal requirements while about **one-third of states (17)** maintain the minimum federal hours' requirements.
- A comparison of 2002 “snapshot” data from a US Department of Health and Human Services report** with 2018 “snapshot” data demonstrates a shift by states toward program hours' requirements above federal minimums:

Minimum Required Program Hours	2002 (% of States Requiring)	2018 (% of States Requiring)
75	47%	34%
>75-100	26.5%	36%
>100	26.5%	30%

- The average number of classroom hours among states is **64.5** (range is **30 to 110** hours).
- The average number of clinical hours is **35.5** (range is from **16 to 100** hours).
- Complicating comparisons of classroom and clinical hours is the fact that states do not always “call out” skill lab hours and when they do, they vary on whether they are included in classroom hours or clinical hours (for example, Oregon includes 24 hours of skills lab in the 80 class hours required whereas Washington requires 50 clinical hours of which 40 must occur in a clinical facility (leaving 10 for skills lab—or more, depending on how the program configures its curriculum).

See Data Table Next Page



Minimum Required Nursing Assistant Training Program Hours by State

Data Table

State	Minimum Required Program Hours	Class	Clinical
Alabama	75	59	16
Alaska	140	60	80
Arizona	120	80	40
Arkansas	90	74	16
California	150	50	100
Colorado	75	50	25
Connecticut	100	76	24
Delaware	150	75	75
Florida	120	80	40
Georgia	85	61	24
Hawaii	100	70	30
Idaho	120	80	40
Illinois	120	80	40
Indiana	105	30	75
Iowa	95	75	50 (20 pre-course interaction with patients and 30 clinical hours after 75 hours of classroom training)
Kansas	90	45	45
Kentucky	75	59	16

State	Minimum Required Program Hours	Class	Clinical
Louisiana	80	40	40
Maine	180	110	70
Maryland	100	60	40
Massachusetts	100	75	25
Michigan	75	59	16
Minnesota	75	59	16
Mississippi	75	59	16
Missouri	175	75	100
Montana	75	50	25
Nebraska	75	59	16
Nevada	75	59	16
New Hampshire	100	75	25
New Jersey	90	50	40
New Mexico	75	59	16
New York	100	70	30
North Carolina	75	59	16
North Dakota	75	59	16
Ohio	75	59	16

State	Minimum Required Program Hours	Class	Clinical
Oklahoma	75	59	16
Oregon	155	80	75
Pennsylvania	80	42.5	37.5
Rhode Island	124	92	32
South Carolina	100	80	20
South Dakota	75	59	16
Tennessee	75	59	16
Texas	100	60	40
Utah	100	76	24
Vermont	80	50	30
Virginia	120	80	40
Washington	85	35	50
West Virginia	120	65	55
Wisconsin	120	88	32
Wyoming	75	59	16

*Omnibus Budget Reconciliation Act

**Source: US Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Region V (OEI-05-01-00031, August 2002), "State Nurse Aide Training: Program Information and Data."

Washington Data:
Nursing Assistant Training Program Hours

Nursing Assistant Training Program Hours in Washington State

- The minimum requirement for the length of traditional nursing assistant (NA) training programs in Washington is **85 total hours**:
 - ✓ **35 classroom hours**, which included **7 hours** of HIV/AIDS education;
 - ✓ **50 clinical hours**, of which **40 hours** must be in the clinical setting (with patients); the remaining **10 hours** may occur in the skills laboratory.
- There is **great variability** in the number of hours Washington's NA training programs provide. Most NA training programs in Washington provide more than the minimum hours required: The overall average for total program hours in the state is ~**169 hours** (range is 85 to 605). The highest-range hours come from high school/skills center programs that include many more hours of foundational content in accordance with the requirements of the Office of the Superintendent of Public Instruction (OSPI). With attempts to adjust for the OSPI hours, the general average for the state is ~ **132 hours**. Only **10 (6.5%)** traditional programs offer **85- to 88-hour** programs.
 - ✓ **Classroom hours** provided by NA training programs in Washington show wide variability. Hours range from the minimum required (**35 hours**) to a high of **393 hours** in a high school/skills center. The average for programs in the state is **93 hours**, but drops to **63 hours** with attempts to adjust for the high ranges of the high school/skills center hours.
 - ✓ **Clinical and skills lab hours** are more difficult to calculate precisely in that programs configure their reporting of these hours differently (some include skills lab hours as a subset of clinical hours; others include them as a subset of classroom hours; work to get all programs to report hours for each category separately and similarly is in progress. That said, analysis indicates that programs generally offer between **46 to 52 clinical hours** and between **21 to 25 skills lab hours**.

- Currently, there is **one approved online curriculum** that Washington NA training programs can adopt for the classroom or theory hours and integrate it with skills lab and clinical training hours. To date, three programs are approved to use this curriculum (two on the West side of the mountains and one on the East). The average program hours for these three programs is **134 total hours** (range is 109 to 175). For classroom/theory content, the average is **58 hours** (range is 46-79); the average for skills lab is **27 hours** (range is 18-40); and the average for clinical is **49 hours** (range of 45-56). These programs demonstrate hours' variability as NA training programs do in general, and their hours' averages are in a similar range.
- Five college programs (all on the West side of the mountains) offer **I-BEST NA training programs** (Integrated Basic Education and Skills Training). IBEST programs provide two teachers working in tandem: one is the content/training expert and the other provides supportive teaching in basic skills such as reading, math or English language. The average program hours for the IBEST programs is a bit higher at **147 total hours** (range is 117 to 190): For classroom/theory content, the average is **70 hours** (range is 44-125); the average for skills lab is **31 hours** (range is 20-60); and the average for clinical is **53 hours** (range of 40-60). Hours' variability is again noted among these programs.
- All **Alternative or "Bridge" Programs** (for certified home care aides [HCAs] and certified medical assistants [MAs]) are **24 hours** in length as stipulated in statute; as a result, programs are unable to provide more hours at this time. These "Bridge" programs commonly provide 8 hours each of class, skills lab, and clinical. Many involved with NA training have identified that more hours are needed to meet the needs of student in the HCA Bridge Program, in particular.
- **The Medication Assistant Certified Endorsement (MACE)** programs use the curriculum provided by the National Council of State Boards of Nursing (NCSBN), which is **100 hours** in length. Programs may opt to provide more hours, but not less. Currently, there are five approved MACE programs in

Washington (three on the West side of the state and two on the East side).
They all provide **100 hours** of training, except for one that provides **105 hours**.

Research Article:
Nursing Assistant Training Program Hours

Determining the CNA Training-Hour Requirement for Quality Care in U.S. Nursing Homes

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Introduction: Critical gaps in knowledge exist regarding the training hours needed for optimal quality of care in U.S. nursing homes (NHs). **Aims:** This study provides empirically derived estimates of the numbers of CNA training hours that yield the best nursing NH resident care outcomes. **Methods:** CNA training regulatory information was linked to 2014 quality indicator data from 13,608 U.S. NHs. Training hour requirements that yielded the best outcomes were estimated using multivariate regression models with generalized estimating equations. **Results:** Lower proportions of residents with quality indicators (activities of daily living, falls with injuries, and pain) were found in states requiring more than the federal minimum of 75 CNA training hours compared with states requiring only 75 hours (all $p < .001$). The findings suggest that 151.6 total training hours and a ratio of twice as many clinical hours to didactic hours are needed to promote quality care in NHs. **Conclusion:** Given the increasing complexity of clinical settings in NHs, regulatory changes in U.S. CNA training requirements may be indicated.

Keywords: CNAs, CNA training hour requirements, nursing homes, nursing regulation

As the U.S. population ages, the demand for residential long-term care services increases (National Institutes of Health, 2011). Nursing homes (NHs) currently accommodate the complex, acute-care needs of more than 2 million older adults (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013; Harrington, Carrillo, & Garfield, 2013; Health in Aging, 2016). To meet these needs and maintain the quality of care, NHs require adequately trained direct-care workers.

Certified nursing assistants (CNAs) are the frontline direct-care workers most extensively employed in U.S. NHs. Typical duties of CNAs include assisting with activities of daily living (ADLs), monitoring residents' needs, and working with physical and mental health conditions. To become certified, CNAs must have a minimum total training of 75 hours, including 16 clinical hours, per federal regulations in the Omnibus Budget Reconciliation Act of 1987 (Requirements for states and long term care facilities, 2012). Training includes basic nursing skills, personal care skills, mental health and social service skills, care of cognitively impaired residents, basic restorative skills, and residents' rights (American Health Care Association, 2009). Federal regulations also require each CNA to have at least 12 hours of in-service training per year (Requirements for states and long term care facilities, 2012).

These regulations have been unchanged since 1987, and many argue that the CNA training requirement is insufficient to accommodate the current needs of aging NH populations

(Paraprofessional Healthcare Institute [PHI], 2014; American Health Care Association, 2013; Hernández-Medina, Eaton, Hurd, & White, 2006). In a previous study, CNAs indicated that the 75-hour minimum was insufficient for adequate training (Hernández-Medina et al., 2006). Moreover, inadequate training may be related to increased job dissatisfaction, turnover, and quality care problems in NHs (Wiener, 2003; Han et al., 2014).

Acknowledging these concerns, many U.S. states have increased their CNA training-hour requirements beyond the federal minimums; thus, training-hour regulations now differ widely by state. As of 2014, only 19 states still used the federal minimum of 75 hours, and only 18 states still required the federal minimum of 16 clinical training hours (PHI, 2014). In previous studies, the authors of the present article found that more CNA training hours—including total training hours, clinical hours, higher ratios of clinical to didactic training hours, and in-service hours—were related to better NH resident outcomes (Trinkoff et al., 2013; Trinkoff, Storr, Lerner, Yang, & Han, 2016). Although the authors noted that NHs in states requiring more CNA training hours had increased odds of better resident outcomes, current evidence lacks specific information about how many training hours would be needed to provide a higher quality of care, as assessed using NH resident care quality indicator (QIs) (Trinkoff et al., 2013, 2016).

According to the Systems Engineering Initiative for Patient Safety, or SEIPS, model of care, patient safety is promoted by identifying and evaluating the impact of care demands on outcomes

TABLE 1

Proportion of Residents Having Problems With Activities of Daily Living, Falls With Injuries, or Pain by Required Number of CNA Training Hours^a

Training Hours	Activities of Daily Living		Falls With Injuries		Pain	
	Median (MAD)	<i>p</i> ^b	Median (MAD)	<i>p</i> ^b	Median (MAD)	<i>p</i> ^b
Total		< .001		< .001		< .001
Federal minimum (75 hours)	15.15 (1.66)		3.20 (0.62)		7.09 (1.61)	
More than federal minimum	14.68 (3.08)		2.65 (1.01)		5.75 (2.59)	
Clinical		< .001		< .001		< .001
Federal minimum (16 hours)	15.00 (1.63)		3.15 (0.60)		7.25 (1.59)	
More than federal minimum	14.72 (3.10)		2.67 (1.03)		5.73 (0.00)	

Note. CNA = certified nursing assistant. MAD = median absolute deviation.

^a Data from 2014, quarter 4 (CMS, 2016a).

^b *p* values determined using the Wilcoxon signed rank sum test.

(Holden et al., 2013). This model emphasizes the importance of the relationship between care workers' training and their performance of quality care in the facility (Carayon & Gurses, 2005; Gurses & Carayon, 2007). The purpose of this study was to determine the number of CNA training hours (total, clinical, and ratio of clinical to didactic hours) associated with optimal resident care outcomes in NHs. The results are important to policymakers and regulatory nursing providers because the empirical evidence can be used to promote changes in CNA training in the United States.

Methods

Design and Sampling

This cross-sectional study used data from Medicare- and Medicaid-enrolled NHs in all 50 states and the District of Columbia (DC). The initial number of facilities identified from the NH Compare data sets (Centers for Medicaid and Medicare Services [CMS], 2016a) was 15,303. A total of 1,695 facilities (11%) had missing information on all QIs, so the authors excluded them from the analysis, resulting in a final number of 13,608 NHs in the study sample. Overall, the excluded facilities tended to be smaller and to have greater resident care needs compared with the facilities included in this study.

Data Source

The NH Compare data archives contained annual information on NH facility characteristics, staffing, and quarterly quality measures in the form of care QIs (CMS, 2016a). Each NH is required to report the percentage of residents with specific conditions quarterly via the Minimum Data Set (MDS) 3.0. In the current study, QI data from the fourth quarter of 2014 were linked to 2014 CNA state-level training requirements. Training requirements for all 50 states and DC were retrieved from the PHI website (PHI, 2014). Missing training-hour information for three states (Nebraska, Nevada, and New Mexico) was obtained by contacting the states.

Measures

Quality Indicators

QIs were reported in the form of risk-adjusted facility-level rates (CMS, 2016b). These QIs provide resident outcomes data designed to assess NH performance and quality of care (Research Triangle Institute [RTI], 2014). QIs capture the residents' physical and cognitive status, acute medical conditions, and behavioral and emotional status to create a comprehensive view of care at the facility level (RTI, 2014). For this study, the authors selected three long-stay resident QIs that were thought to be nursing sensitive and related to the types of custodial care activities in which CNAs would be involved: ADLs, pain, and falls with injuries (Phillips, Chen, & Sherman, 2009; Leland et al., 2015; Russell, Madsen, Flesner, & Rantz, 2010; Nakrema et al., 2009). The definitions of these QIs are as follows (RTI, 2014):

- ADLs: Percentage of long-stay residents whose need for help with late-loss ADLs has increased when compared with the prior assessment (The goal of this indicator is to support the need to preserve independent function in residents)
- Pain: Percentage of long-stay residents reporting either almost constant or frequent moderate-to-severe pain in the past 5 days or any extremely severe pain in the past 5 days
- Falls with injuries: Percentage of long-stay residents who have experienced one or more falls with a major injury reported in the target period or look-back period.

The reported reliability and validity of MDS QI measures was found to be satisfactory. An interrater trial based on a cumulative correlation coefficient for risk-adjusted cases was reported as 0.74 (Hawes et al., 1997). A variety of QIs have been related to NH characteristics in previous studies (Bostick, Rantz, Flesner, & Riggs, 2006; Collier & Harrington, 2008; Horn et al., 2010) and support the validity of the QI data examined.

TABLE 2

Relationship Between CNA Training Hours and Resident Care Outcomes^a

	Polytomous resident-care outcomes (assistance with ADLs, falls with injuries, and pain)	
	β	95% CI
Model 1: Total hours		
z total = z score of total training hours	-0.11	(-0.12 to -0.10)
(z total) ²	-0.09	(-0.10 to -0.07)
(z total) ³	0.04	(0.04 - 0.05)
Ownership (government affiliated vs. for profit)	0.12	(0.09 - 0.15)
Ownership (not for profit vs. for profit)	0.01	(-0.01 to 0.02)
Facility size	-0.01	(-0.02 to -0.00)
Expected staffing	-0.11	(-0.12 to -0.09)
Model 2: Clinical hours		
z clinical = z score of clinical training hours	0.08	(0.06 - 0.09)
(z clinical) ²	0.08	(0.06 - 0.09)
(z clinical) ³	-0.07	(-0.08 to -0.06)
Ownership (government affiliated vs. for profit)	0.10	(0.07 - 0.13)
Ownership (not for profit vs. for profit)	0.01	(-0.01 to 0.03)
Facility size	-0.01	(-0.01 to -0.01)
Expected staffing	-0.13	(-0.15 to -0.11)
Model 3: Ratio of clinical to didactic hours		
Ratio = clinical hours/didactic hours	0.67	(0.55 - 0.78)
(Ratio) ²	-0.78	(-0.89 to -0.67)
(Ratio) ³	0.21	(0.18 - 0.24)
Ownership (government affiliated vs. for-profit)	0.12	(0.09 - 0.15)
Ownership (not-for-profit vs for-profit)	0.01	(-0.01 to 0.03)
Facility size	-0.01	(-0.01 to -0.01)
Expected staffing	-0.11	(-0.13 to -0.09)

Note. ADL = activities of daily living, CI = confidence interval, CNA = certified nursing assistant.

^aData from Nursing Home Compare quality measures, 2014, quarter 4 (CMS, 2016a).

Training Hours

Training hours served as the main independent variable and included total and clinical training hours. Training hours were measured at the state level and consisted of the required hours for each type of training in that state. Clinical-to-didactic training hour ratios were generated by dividing clinical by didactic training hours (didactic hours obtained by subtracting clinical from total training hours). Standardized values (z scores) for total and clinical training hours were then calculated.

Facility Characteristics

Facility characteristics included ownership status, facility size, and expected staffing. Ownership status was divided into three categories: for profit, government affiliated, and not for profit. Facility size was based on the number of beds. Because of variations in NH resident care needs, analyses involving NH quality care should include an adjustment for case mix (Harrington & Swan, 2003). The authors followed the approach of CMS (2016b) and the Cowles Research Group (Cowles, 2014), which used expected staffing as a proxy for case mix. Expected staffing represents "the minimum staff time below which residents are at substantially higher risk of quality problems" (Cowles, 2014, pp. 7,8). Expected staffing hours were calculated by adding the nursing times derived from Kramer and Fish's study (2001) for each group of residents across all residents and categories in the Research Utilization Group, or RUG-III (Cowles, 2014).

Analysis

Descriptive Analysis

STATA 14.0 (StataCorp LP, College Station, TX) was used in all analyses. Descriptive statistics were used to examine the number and proportion of facilities by training hours and the selected QIs. The authors also compared the proportion of residents with QIs in NHs in states requiring the federal minimum CNA training hours (75 hours for total training and 16 hours for clinical training) with the proportion of residents with QIs in NHs in states that required hours beyond federal minimums, using the Wilcoxon signed rank sum test.

Estimating Optimal Training Hours

To estimate optimal hours, the authors used multivariate polynomial regression models with generalized estimating equations (GEEs) to examine the relationship between training hours and the QIs simultaneously. The three QIs were examined simultaneously through use of polytomous outcomes (all three QIs were entered as outcomes in one analytic model) in the GEEs, which can account for possible correlations among three QIs measured in the same facility. In addition, this approach allowed the authors to find the training-hour requirement that minimized the three QIs (Hanley, Negassa, Edwards, & Forrester, 2003; Martins, Ghandour, & Chilcoat, 2007).

Separate models were conducted for each type of training hour as a predictor:

- Model 1: Total training hours
- Model 2: Clinical training hours
- Model 3: Ratio of clinical to didactic training hours.

The authors included a squared and cubic term of standardized training hours (z score) as explanatory variables in each model. The addition of squared and cubic terms for standardized training hours in the model allowed the authors to examine whether a significant nonlinear relationship existed between training hours

and the QIs. All models were adjusted for facility size, ownership, and expected staffing.

Identifying the Optimal Requirement for Best Resident Care Outcomes

The optimal requirement was defined as the hours at which the QIs reached the minimum point (i.e., the lowest QI score, wherein lower scores indicate better resident care) in the regression models. The maximum point in the model indicates the highest QI scores reflecting lower quality resident care. After coefficients for the explanatory variables were estimated, training hours for minimum or maximum values of the QIs were calculated by applying the derivative of the regression function (dy/dx). This derivative was set at zero to identify the point at which the slope of the regression equation was equal to zero.

Results

Training-Hour Requirements

One-third of NHs were in states ($n=19$) where the total or clinical training hours were based only on the federal minimum requirements. Total training hours ranged from 75 (federal minimum) to 180, with a mean (standard deviation [SD]) of 99.79 (27.70) hours. Clinical-training hour requirements ranged from 16 (federal minimum) to 100, with a mean (SD) of 39.97 (25.86) hours. For the ratio, approximately 75% of facilities in 36 states required fewer clinical hours than didactic hours, and 15 states required more clinical than didactic training hours. As shown in Table 1, facilities in states with training hours greater than federal minimums had lower proportions of residents reporting ADL assistance (median = 14.68% vs. 15.15%), falls with injuries (median = 2.65% vs. 3.20%), or pain (median = 5.75% vs. 7.09%) compared with those at the federal minimum. These differences were statistically significant ($p < .001$), with the same patterns found for clinical training hours (See Table 1).

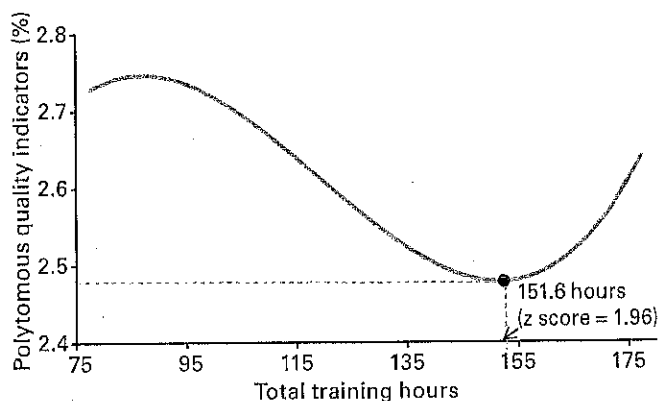
Training Hours and Ratio of Clinical to Didactic Hours

Table 2 shows the results of the GEE models for total training hours (Model 1), clinical training hours (Model 2), and ratio of clinical-to-didactic hours (Model 3) on QIs. The coefficients from the cubic terms in all three models were significant: standardized total ($\beta = 0.04$; 95% confidence interval [CI], 0.04–0.05), clinical ($\beta = -0.07$; 95% CI, -0.08 to -0.06) and ratio of clinical-to-didactic hours ($\beta = 0.21$; 95% CI, 0.18–0.24), indicating a significant polynomial relationship between each type of training hours and the QIs. The authors also found significant negative relationships of QIs with facility size and expected staffing among all three Models. Compared with for-profit NHs, government-affiliated NHs were more likely to have higher QIs.

Figures 1, 2, and 3 illustrate the analytic models built on the cubic functions from Models 1, 2, and 3. In these figures, the point where the QIs were the lowest was $z = 1.96$ for standard-

FIGURE 1

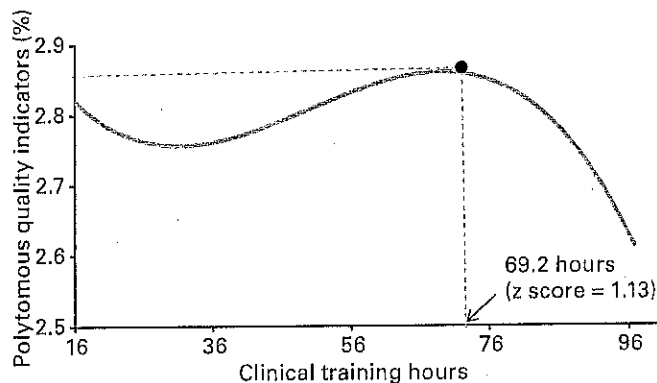
Graph of Analytic Model (Cubic Function) for the Polynomial Relationship Between Total Training Hours and Polytomous Quality Indicators



Note. The black point indicates the optimal total training hour threshold where quality indicators reached the lowest score (the best resident outcomes).

FIGURE 2.

Graph of Analytic Model (Cubic Function) for the Polynomial Relationship Between Clinical Training Hours and Polytomous Quality Indicators

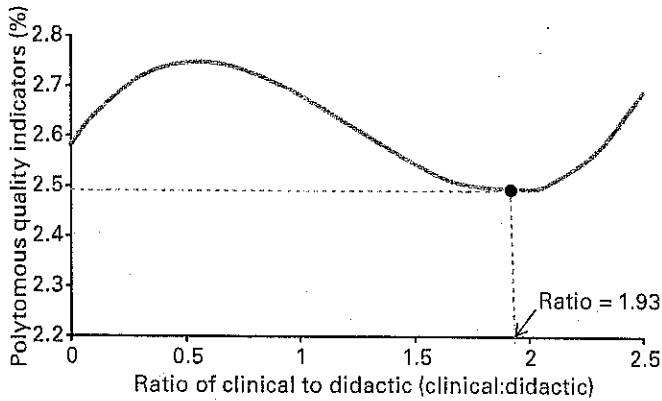


Note. The black point indicates the clinical training hour threshold where nursing home quality indicators started decreasing on a consistent basis (the point where the clinical training makes a steady improvement in nursing home resident care quality).

ized total training hours (See Figure 1) and $z = 1.93$ for the ratio of clinical-to-didactic training hours (See Figure 3). After these points, the QIs start to increase again. For clinical training hours (See Figure 2), the authors found the Model to be the inverse shape of Model 1 and Model 3. Instead of estimating a minimum point, the authors could estimate the maximum point of $z = 1.13$ (standardized clinical training hours), where improved QI scores start to be consistently related to increases in the number of clinical hours.

FIGURE 3

Graph of Analytic Model (Cubic Function) for the Polynomial Relationship Between Ratio of Clinical-to-Didactic Hours and Polytomous Quality Indicators



Note. The black point indicates that the optimal threshold of ratio of clinical to didactic training hours where nursing home quality indicators reached the lowest score (best resident outcomes).

To obtain the optimal training-hour estimates, the authors converted the estimated standardized scores (*z* scores) into hours. For total training hours, the estimate with the best outcome (i.e., lowest QI scores) was 151.6 total hours with at least 69.2 clinical training hours. The optimal ratio of clinical-to-didactic hours was 1.93; thus, based on the optimal 151.6 hours of total training, the breakdown between clinical and didactic training hours should be approximately 100 clinical and 51.6 didactic hours. Based on the estimates from the three Models, the range of clinical training hours that were related to better resident care outcomes in NHs was 69.2 (maximum point from Model 2) to 100 hours (calculated hours based on optimal ratio from Model 3).

Discussion

This analysis estimated the optimal point for training hours where the proportion of NH residents with ADL assistance, pain, and falls with injuries was at the lowest level. The optimal hours were estimated to be 151.6 hours of total training with a 1.93 ratio of clinical-to-didactic hours (100 clinical hours vs. 51.6 didactic hours). For clinical training hours, QI rates began to steadily decrease after 69.2 hours until they leveled off at 100 hours. When these hours are considered on a weekly basis, the findings suggest that CNAs should receive approximately 4 weeks of training with at least 2 to 2.5 weeks of clinical training to promote optimal quality of care in NHs.

The authors also note that QIs start to increase after the optimal (minimum) points for total training hours and ratio of clinical-to-didactic hours. Because of the limited variability in the upper range of training hours, the current data cannot reveal the

reasons for this finding. Further study examining training hours and QIs using simulation models may be indicated.

Research has shown that well-trained CNAs are essential to providing quality care in NHs (Trinkoff et al., 2013, 2016). Furthermore, receiving adequate training can increase CNA job satisfaction and retention (Han et al., 2014; Menne, Ejaz, Noelker, & Jones, 2007) and decrease turnover rates (Sengupta, Harris-Kojetin, & Ejaz, 2010; Fujisawa & Colombo, 2009)—important factors that may affect care quality. In fact, CNAs themselves felt that their training did not adequately prepare them for their jobs and expressed the need for more training hours, particularly for more clinical time (Hernández-Medina et al., 2006; Sengupta et al., 2010). Recently, the Institute of Medicine recommended that at least 120 total hours, or 3 weeks, of total training be required for CNAs. The current study's finding of 4 weeks for total training hours adds 1 week to that recommendation. This extra week of training could be critical. Even at 4 weeks, the required CNA training time in the United States would be much less than that in many Western European countries and Canada (Fujisawa & Colombo, 2009).

CNAs in Demark must receive 16 to 22 months of training with practical training experience included over two-thirds of the training period (Fujisawa & Colombo, 2009). In the Netherlands, CNA training is a 2- to 3-year curriculum, and, in Japan, the curriculum ranges from 1 to 4 years (Fujisawa & Colombo, 2009). In Spain, the 445-hour CNA training program is heavily focused on clinical training (Johansson & Moss, 2004).

In the U.S. since 2010, some states have begun to increase the required training hours, and no states requiring more than federal minimums have decreased their requirements. South Carolina now requires an additional 20 total training hours over its 2010 requirements, and DC has increased its clinical training requirements by 30 hours. Texas increased total hours by 25 and clinical training hours by 16 (PHI, 2014). Despite these increases, training hours in most states are still far below the estimated optimal thresholds found in this study (151.6 total with 1.93 ratio of clinical to didactic). The study's findings highlight the need to consider more extensive CNA training hours to promote quality care in NHs.

The estimated optimal ratio of almost twice the number of clinical hours compared with didactic hours supports the importance of clinical training in the CNA curriculum. According to Benner's (1982) stages of clinical competence, novices can improve their skills mostly through hands-on clinical experiences. Additional clinical hours would give novice CNAs more opportunities to practice clinical skills before employment—an important benefit given the increasing complexity of clinical settings in NHs and the increased numbers of residents with dementia or other chronic illnesses.

Limitations

Several potential limitations should be considered when interpreting the findings. First, a lack of variability in total and clinical training hours (restricted number of categories) may have limited the ability to estimate optimal training hour points beyond the range of the hours observed. For example, based on the optimal ratio estimates, clinical training should equal 100 of the 151.6 total hours. However, the authors were unable to observe points beyond 100 clinical hours in the data, requiring them to estimate the point of clinical training where resident outcomes started to consistently improve. Second, the authors did not consider the specific content offered (such as dementia education and pain recognition) during the training. Content may have an impact on CNA competency.

Finally, the results might differ if other QI outcomes were used. Nonetheless, previous studies reported that the selected QIs were highly nursing care sensitive (Phillips, Chen, & Sherman, 2009; Leland et al., 2015; Russell et al., 2010) and more highly related to CNA training hours than other QIs (Trinkoff et al., 2016). Despite these limitations, this study fills a critical knowledge gap by providing new empirical evidence for policymakers to consider when setting federal or state regulations for CNA training. Findings also can guide NH administrators and educators in developing CNA clinical and didactic training programs.

Conclusion

This study estimated that the optimal CNA training hours yielding the lowest QIs for pain, falls with injury, and loss of ADLs in NHs was 151.6 total hours (with a 2:1 ratio of clinical to didactic hours) and at least 69.2 to 100 clinical hours. Current U.S. federal requirements for CNA training are much lower than these estimates and much lower than requirements in most Western European countries. Fortunately, many U.S. states already have begun to require additional training hours, although few states require the numbers the study estimates as optimal. This study supports the need for increased CNA training hours and suggests that regulatory changes in U.S. CNA training requirements may be indicated.

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**Federal Requirements:
Nursing Assistant Training Programs**

NOTE TO READER: Federal Requirements and NA Training

This document contains language from the Code of Regulations that most directly relates to requirements for nursing assistant training program approval and curriculum (including testing). The headings for each of three main sections are highlighted as are some key text points related to program approval and curriculum/testing requirements. The text was taken directly from:

https://www.ecfr.gov/cgibin/textidx?SID=797db153643b31bdd3bbc1b951f660fe&mc=true&node=pt42.5.483&rgn=div5#se42.5.483_1151

§483.151 State review and approval of nurse aide training and competency evaluation programs.

(a) *State review and administration.* (1) The State—

(i) Must specify any nurse aide training and competency evaluation programs that the State approves as meeting the requirements of §483.152 and/or competency evaluations programs that the State approves as meeting the requirements of §483.154; and

(ii) May choose to offer a nurse aide training and competency evaluation program that meets the requirements of §483.152 and/or a competency evaluation program that meets the requirements of §483.154.

(2) If the State does not choose to offer a nurse aide training and competency evaluation program or competency evaluation program, the State must review and approve or disapprove nurse aide training and competency evaluation programs and nurse aide competency evaluation programs upon request.

(3) The State survey agency must in the course of all surveys, determine whether the nurse aide training and competency evaluation requirements of §§483.35(c) and (d) and 483.95(g) are met.

(b) *Requirements for approval of programs.* (1) Before the State approves a nurse aide training and competency evaluation program or competency evaluation program, the State must—

(i) Determine whether the nurse aide training and competency evaluation program meets the course requirements of §483.152;

(ii) Determine whether the nurse aide competency evaluation program meets the requirements of §483.154; and

(iii) In all reviews other than the initial review, visit the entity providing the program.

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

(i) In the case of a skilled nursing facility, has operated under a waiver under section 1819(b)(4)(C)(ii)(II) of the Act;

(ii) In the case of a nursing facility, has operated under a waiver under section 1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours per week;

(iii) Has been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act;

(iv) Has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) of 1919(h)(2)(A)(ii) of the Act of not less than \$5,000 as adjusted annually under 45 CFR part 102; or

(v) Has been subject to a remedy described in sections 1819(h)(2)(B) (i) or (iii), 1819(h)(4), 1919(h)(1)(B)(i), or 1919(h)(2)(A) (i), (iii) or (iv) of the Act.

(3) A State may not, until two years since the assessment of the penalty (or penalties) has elapsed, approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility that, within the two-year period beginning October 1, 1988—

(i) Had its participation terminated under title XVIII of the Act or under the State plan under title XIX of the Act;

(ii) Was subject to a denial of payment under title XVIII or title XIX;

(iii) Was assessed a civil money penalty of not less than \$5,000 as adjusted annually under 45 CFR part 102 for deficiencies in nursing facility standards;

(iv) Operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of its residents; or

(v) Pursuant to State action, was closed or had its residents transferred.

(c) *Waiver of disapproval of nurse aide training programs.* (1) A facility may request that CMS waive the disapproval of its nurse aide training program when the facility has been assessed a civil money penalty of not less than \$5,000 as adjusted annually under 45 CFR part 102 if the civil money penalty was not related to the quality of care furnished to residents in the facility.

(2) For purposes of this provision, “quality of care furnished to residents” means the direct hands-on care and treatment that a health care professional or direct care staff furnished to a resident.

(3) Any waiver of disapproval of a nurse aide training program does not waive any requirement upon the facility to pay any civil money penalty.

(d) *Time frame for acting on a request for approval.* The State must, within 90 days of the date of a request under paragraph (a)(3) of this section or receipt of additional information from the requester—

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

(e) *Duration of approval.* The State may not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years. A program must notify the State and the State must review that program when there are substantive changes made to that program within the 2-year period.

(f) *Withdrawal of approval.* (1) The State must withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in paragraph (b)(2) of this section.

(2) The State may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the State determines that any of the applicable requirements of §483.152 or §483.154 are not met by the program.

(3) The State must withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the State.

(4) If a State withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program—

(i) The State must notify the program in writing, indicating the reason(s) for withdrawal of approval of the program.

(ii) Students who have started a training and competency evaluation program from which approval has been withdrawn must be allowed to complete the course.

[56 FR 48919, Sept. 26, 1991, as amended at 75 FR 21179, Apr. 23, 2010; 81 FR 61563, Sept. 6, 2016; 81 FR 68871, Oct. 4, 2016.

§483.152 Requirements for approval of a nurse aide training and competency evaluation program.

(a) For a nurse aide training and competency evaluation program to be approved by the State, it must, at a minimum—

(1) Consist of no less than 75 clock hours of training;

(2) Include at least the subjects specified in paragraph (b) of this section;

(3) Include at least 16 hours of supervised practical training. *Supervised practical training* means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse;

(4) Ensure that—

(i) Students do not perform any services for which they have not trained and been found proficient by the instructor; and

(ii) Students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse;

(5) Meet the following requirements for instructors who train nurse aides;

(i) The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;

(ii) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides;

(iii) In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and

(iv) Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields;

(6) Contain competency evaluation procedures specified in §483.154.

(b) The curriculum of the nurse aide training program must include—

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

(i) Communication and interpersonal skills;

(ii) Infection control;

(iii) Safety/emergency procedures, including the Heimlich maneuver;

(iv) Promoting residents' independence; and

(v) Respecting residents' rights.

(2) Basic nursing skills;

(i) Taking and recording vital signs;

(ii) Measuring and recording height and weight;

(iii) Caring for the residents' environment;

(iv) Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and

(v) Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to—

(i) Bathing;

(ii) Grooming, including mouth care;

(iii) Dressing;

(iv) Toileting;

(v) Assisting with eating and hydration;

(vi) Proper feeding techniques;

(vii) Skin care; and

(viii) Transfers, positioning, and turning.

(4) Mental health and social service needs:

(i) Modifying aide's behavior in response to residents' behavior;

(ii) Awareness of developmental tasks associated with the aging process;

(iii) How to respond to resident behavior;

(iv) Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and

(v) Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

(i) Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer's and others);

(ii) Communicating with cognitively impaired residents;

(iii) Understanding the behavior of cognitively impaired residents;

(iv) Appropriate responses to the behavior of cognitively impaired residents; and

(v) Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

(i) Training the resident in self care according to the resident's abilities;

(ii) Use of assistive devices in transferring, ambulation, eating, and dressing;

(iii) Maintenance of range of motion;

(iv) Proper turning and positioning in bed and chair;

(v) Bowel and bladder training; and

(vi) Care and use of prosthetic and orthotic devices.

(7) Residents' Rights.

(i) Providing privacy and maintenance of confidentiality;

(ii) Promoting the residents' right to make personal choices to accommodate their needs;

(iii) Giving assistance in resolving grievances and disputes;

(iv) Providing needed assistance in getting to and participating in resident and family groups and other activities;

(v) Maintaining care and security of residents' personal possessions;

(vi) Promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff;

(vii) Avoiding the need for restraints in accordance with current professional standards.

(c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials).

(2) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

§483.154 Nurse aide competency evaluation.

(a) *Notification to Individual.* The State must advise in advance any individual who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the State's nurse aid registry.

(b) *Content of the competency evaluation program—(1) Written or oral examinations.* The competency evaluation must—

(i) Allow an aide to choose between a written and an oral examination;

(ii) Address each course requirement specified in §483.152(b);

(iii) Be developed from a pool of test questions, only a portion of which is used in any one examination;

(iv) Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations; and

(v) If oral, must be read from a prepared text in a neutral manner.

(2) *Demonstration of skills.* The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in §483.152(b)(3).

(c) *Administration of the competency evaluation.* (1) The competency examination must be administered and evaluated only by—

(i) The State directly; or

(ii) A State approved entity which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide competency evaluation program may be charged for any portion of the program.

(3) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

(4) The skills demonstration part of the evaluation must be—

(i) Performed in a facility or laboratory setting comparable to the setting in which the individual will function as a nurse aide; and

(ii) Administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

(d) *Facility proctoring of the competency evaluation.* (1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is described in §483.151(b)(2).

(2) The State may permit the competency evaluation to be proctored by facility personnel if the State finds that the procedure adopted by the facility assures that the competency evaluation program—

(i) Is secure from tampering;

(ii) Is standardized and scored by a testing, educational, or other organization approved by the State; and

(iii) Requires no scoring by facility personnel.

(3) The State must retract the right to proctor nurse aide competency evaluations from facilities in which the State finds any evidence of impropriety, including evidence of tampering by facility staff.

(e) *Successful completion of the competency evaluation program.* (1) The State must establish a standard for satisfactory completion of the competency evaluation. **To complete the competency evaluation successfully an individual must pass both the written or oral examination and the skills demonstration.**

(2) A record of successful completion of the competency evaluation must be included in the nurse aide registry provided in §483.156 within 30 days of the date if the individual is found to be competent.

(f) *Unsuccessful completion of the competency evaluation program.* (1) If the individual does not complete the evaluation satisfactorily, the individual must be advised—

(i) Of the areas which he or she; did not pass; and

(ii) That he or she has at least three opportunities to take the evaluation.

(2) The State may impose a maximum upon the number of times an individual upon the number of times an individual may attempt to complete the competency evaluation successfully, but the maximum may be no less than three.

Relevant Statutes:
Nursing Assistant Training Programs

NOTE TO READER: Statutes Related to Nursing Assistant Training

This document contains key statutes related to nursing assistant training programs. The "Definitions" section is provided for reference/clarity. The headings of each of the three main sections are highlighted as are a few text items related to program approvals and curriculum/testing. The text was taken directly

from: <http://app.leg.wa.gov/rcw/default.aspx?cite=18.88A>

RCW 18.88A.020 Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Alternative training" means a nursing assistant-certified program meeting criteria adopted by the commission under RCW **18.88A.087** to meet the requirements of a state-approved nurse aide competency evaluation program consistent with 42 U.S.C. Sec. 1395i-3(e) and (f) of the federal social security act.

(2) "Approved training program" means a nursing assistant-certified training program approved by the commission to meet the requirements of a state-approved nurse aide training and competency evaluation program consistent with 42 U.S.C. Sec. 1395i-3(e) and (f) of the federal social security act. For community college, vocational-technical institutes, skill centers, and secondary school as defined in chapter **28B.50** RCW, nursing assistant-certified training programs shall be approved by the commission in cooperation with the board for community and technical colleges or the superintendent of public instruction.

(3) "Commission" means the Washington nursing care quality assurance commission.

(4) "Competency evaluation" means the measurement of an individual's knowledge and skills as related to safe, competent performance as a nursing assistant.

(5) "Department" means the department of health.

(6) "Health care facility" means a nursing home, hospital licensed under chapter **70.41** or **71.12** RCW, hospice care facility, home health care agency, hospice agency, licensed or certified service provider under chapter **71.24** RCW other than an individual health care provider, or other entity for delivery of health care services as defined by the commission.

(7) "Medication assistant" means a nursing assistant-certified with a medication assistant endorsement issued under RCW **18.88A.082** who is authorized, in addition to his or her duties as a nursing assistant-certified, to administer certain medications and perform certain treatments in a nursing home under the supervision of a registered nurse under RCW **18.88A.082**.

(8) "Nursing assistant" means an individual, regardless of title, who, under the direction and supervision of a registered nurse or licensed practical nurse, assists in the

delivery of nursing and nursing-related activities to patients in a health care facility. The two levels of nursing assistants are:

(a) "Nursing assistant-certified," an individual certified under this chapter; and

(b) "Nursing assistant-registered," an individual registered under this chapter.

(9) "Nursing home" means a nursing home licensed under chapter 18.51 RCW.

(10) "Secretary" means the secretary of health.

[2018 c 201 § 9008; 2015 c 158 § 1; 2012 c 208 § 2. Prior: 2010 c 169 § 2; 1994 sp.s. c 9 § 708; 1991 c 16 § 2; (1991 c 3 § 221 repealed by 1991 sp.s. c 11 § 2); 1989 c 300 § 4; 1988 c 267 § 2. Formerly RCW 18.52B.020.]

NOTES:

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2012 c 208 §§ 2-10: "Sections 2 through 10 of this act take effect July 1, 2013." [2012 c 208 § 12.]

Findings—Rules—2012 c 208: See notes following RCW 18.88A.082.

Conflict with federal requirements—2010 c 169: See note following RCW 18.88A.010.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Nursing care quality assurance commission: Chapter 18.79 RCW.

RCW 18.88A.050 Powers of secretary.

In addition to any other authority provided by law, the secretary has the authority to:

(1) Set all nursing assistant certification, registration, medication assistant endorsement, and renewal fees in accordance with RCW 43.70.250 and to collect and deposit all such fees in the health professions account established under RCW 43.70.320;

(2) Establish forms, procedures, and the competency evaluation necessary to administer this chapter;

(3) Hire clerical, administrative, and investigative staff as needed to implement this chapter;

(4) Issue a nursing assistant registration to any applicant who has met the requirements for registration;

(5) After January 1, 1990, issue a nursing assistant certificate to any applicant who has met the training, competency evaluation, and conduct requirements for certification under this chapter;

(6) Issue a medication assistant endorsement to any applicant who has met the requirements of RCW 18.88A.082;

(7) Maintain the official record for the department of all applicants and persons with registrations, certificates, and medication assistant endorsements under this chapter;

(8) Exercise disciplinary authority as authorized in chapter 18.130 RCW;

(9) **Deny registration** to any applicant who fails to meet requirement for registration as a nursing assistant;

(10) Deny certification to applicants who do not meet the training, competency evaluation, and conduct requirements for certification as a nursing assistant; and

(11) Deny medication assistant endorsement to applicants who do not meet the requirements of RCW 18.88A.082.

[2012 c 208 § 5; 2010 c 169 § 5; 1991 c 16 § 6; (1991 c 3 § 222 repealed by 1991 sp.s. c 11 § 2); 1989 c 300 § 7; 1988 c 267 § 6. Formerly RCW 18.52B.060.]

NOTES:

Effective date—2012 c 208 §§ 2-10: See note following RCW 18.88A.020.

Findings—Rules—2012 c 208: See notes following RCW 18.88A.082.

Conflict with federal requirements—2010 c 169: See note following RCW 18.88A.010.

RCW 18.88A.060 Commission—Powers.

In addition to any other authority provided by law, **the commission may:**

(1) **Determine minimum nursing assistant education requirements and approve training programs;**

(2) **Approve education and training programs and examinations for medication assistants** as provided in RCW 18.88A.082;

(3) **Define the prescriber-ordered treatments a medication assistant is authorized to perform** under RCW 18.88A.082;

(4) **Prepare, grade, and administer, or determine the nature of, and supervise the grading and administration of, the competency evaluation for applicants** for nursing assistant certification, using the same competency evaluation for all applicants, whether qualifying to take the competency evaluation under an approved training program or alternative training;

(5) **Establish forms and procedures for evaluation of an applicant's alternative training** under criteria adopted pursuant to RCW 18.88A.087;

(6) **Define and approve any experience requirement** for nursing assistant certification;

(7) **Adopt rules implementing a continuing competency evaluation program** for nursing assistants; and

(8) **Adopt rules** to enable it to carry into effect the provisions of this chapter.

[2012 c 208 § 6; 2010 c 169 § 6; 1994 sp.s. c 9 § 710; 1991 c 16 § 8; 1989 c 300 § 8; 1988 c 267 § 7. Formerly RCW 18.52B.070.]

NOTES:

Effective date—2012 c 208 §§ 2-10: See note following RCW 18.88A.020.

Findings—Rules—2012 c 208: See notes following RCW 18.88A.082.

Conflict with federal requirements—2010 c 169: See note following RCW 18.88A.010.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

**Washington Administrative Code:
Nursing Assistant Training Programs**

NOTE TO THE READER: Washington Administrative Code

This document contains the Washington Administrative Code (WAC) chapter that pertains directly to nursing assistant training programs. The section headings related to program requirements and curriculum are highlighted for each type of nursing assistant training program (Traditional, Home Care Aide “Bridge” or Alternative Program, Medical Assistant “Bridge” or Alternative Program, and the Medication Assistant Certification Endorsement (MACE) Program. Key sections of text are also highlighted for easy reference. All text was taken from: <https://app.leg.wa.gov/wac/default.aspx?cite=246-841>

Chapter 246-841 WAC

Last Update: 7/8/16

NURSING ASSISTANTS

WAC Sections

- 246-841-400 Standards of practice and competencies for nursing assistants.
- 246-841-405 Nursing assistant delegation.
- 246-841-410 Purpose of the review and approval of nursing assistant-certified training programs.
- 246-841-420 Requirements for approval of nursing assistant-certified training programs.
- 246-841-430 Denial or withdrawal of approval for nursing assistant-certified training programs.
- 246-841-440 How does a nursing assistant training program whose approval has been withdrawn become reinstated?
- 246-841-450 Appeal rights of a nursing assistant-certified training program when the commission has denied or withdrawn approval.
- 246-841-460 Closure of an approved nursing assistant-certified training program.
- 246-841-470 Program directors and instructors in approved nursing assistant-certified training programs.
- 246-841-490 Core curriculum in approved nursing assistant-certified training programs.
- 246-841-500 Physical resources required for approved nursing assistant-certified training programs.
- 246-841-510 Administrative procedures for approved nursing assistant-certified training programs.
- 246-841-520 Expired license.
- 246-841-530 Alternative program—Purpose.
- 246-841-535 Alternative program—Definitions.
- 246-841-545 Home care aide-certified alternative program requirements.
- 246-841-550 Medical assistant-certified alternative program requirements.
- 246-841-555 Responsibilities of the program director in alternative programs.
- 246-841-560 Alternative program application for approval, denial, or withdrawal.
- 246-841-570 Recordkeeping and administrative procedures for approved alternative programs.
- 246-841-573 Closure of an alternative program.

- 246-841-575** Alternative program—Eligibility to complete the nursing assistant-certified competency examination.
- 246-841-578** Application requirements.
- 246-841-585** Application for nursing assistant-certified from an alternative program.

MEDICATION ASSISTANT ENDORSEMENT

- 246-841-586** Applicability.
- 246-841-587** Definitions.
- 246-841-588** Application requirements.
- 246-841-589** Medication administration and performing prescriber ordered treatments.
- 246-841-590** Requirements for approval of education and training programs.
- 246-841-591** Commission review and investigation.
- 246-841-592** Commission action for violations.
- 246-841-593** Reinstatement of approval.
- 246-841-594** Appeal rights.
- 246-841-595** Medication assistant endorsement program renewal.
- 246-841-610** AIDS prevention and information education requirements.

DISCIPLINARY PROCEDURES

- 246-841-720** Mandatory reporting.

FEES

- 246-841-990** Nursing assistant—Fees and renewal cycle.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS TITLE

- 246-841-480 Students (trainees) in approved training programs. [Statutory Authority: RCW **18.88A.060**. WSR 91-07-049 (Order 116B), recodified as § 246-841-480, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW **18.88.080**. WSR 90-20-018 (Order 091), § 308-173-265, filed 9/21/90, effective 10/22/90.] Repealed by WSR 08-06-100, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW **18.88A.060**(1) and **18.88A.030**(5).
- 246-841-710 General provisions. [Statutory Authority: RCW **18.88A.050**, **18.130.050** and **18.130.080**. WSR 92-02-018 (Order 224), § 246-841-710, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-841-710, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **18.130.070**. WSR 89-14-092 (Order PM 842), § 308-173-010, filed 6/30/89.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW **43.70.040**.
- 246-841-730 Courts. [Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-841-730, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **18.130.070**. WSR 89-14-092 (Order PM 842), § 308-173-070, filed 6/30/89.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW **43.70.040**.
- 246-841-740 State and federal agencies. [Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-841-740, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **18.130.070**. WSR 89-14-092 (Order PM 842), § 308-173-080, filed 6/30/89.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW **43.70.040**.
- 246-841-750 Cooperation with investigation. [Statutory Authority: RCW **18.88A.050**, **18.130.050** and **18.130.080**. WSR 92-02-018 (Order 224), § 246-841-750, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-841-750, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **18.130.070**. WSR 89-14-092 (Order PM 842), § 308-173-090, filed 6/30/89.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW **43.70.040**.

246-841-400

Standards of practice and competencies for nursing assistants.

Competencies and standards of practice are statements of skills and knowledge, and are written as descriptions of observable, measurable behaviors. All competencies are performed under the direction and supervision of a licensed registered nurse or licensed practical nurse as required by RCW **18.88A.030**. The following competencies are considered standards of practice for both nursing assistant-certified and nursing assistant-registered:

(1) Basic technical skills. A nursing assistant demonstrates basic technical skills which facilitate an optimal level of functioning for client or resident, recognizing individual, cultural, and religious diversity. A nursing assistant:

(a) Demonstrates proficiency in cardiopulmonary resuscitation (CPR) and can perform CPR independently.

(b) Takes and records vital signs.

(c) Measures and records height and weight.

(d) Measures and records fluid and food intake and output.

(e) Recognizes normal body functions, deviations from normal body functions and the importance of reporting deviations in a timely manner to a supervising nurse.

(f) Recognizes, responds to and reports client's or resident's emotional, social, cultural and mental health needs.

(g) Recognizes, responds to and reports problems in client's or resident's environment to ensure safety and comfort of client.

(h) Participates in care planning and nursing reporting process.

(2) Personal care skills. A nursing assistant demonstrates basic personal care skills. A nursing assistant:

(a) Assists client or resident with bathing, oral care, and skin care.

(b) Assists client or resident with grooming and dressing.

(c) Provides toileting assistance to client or resident.

(d) Assists client or resident with eating and hydration.

(e) Uses proper oral feeding techniques.

(3) Mental health and social service needs. A nursing assistant demonstrates the ability to identify psychosocial needs of all clients or residents based upon awareness of the developmental and age specific processes. A nursing assistant:

(a) Addresses individual behavioral needs of the client or resident.

(b) Knows the developmental tasks associated with the developmental and age specific processes.

(c) Allows the client or resident to make personal choices, but provides and reinforces behaviors consistent with the client's or resident's dignity.

(d) Is sensitive and supportive and responds to the emotional needs of the clients or residents and their sources of emotional support.

(4) Care of cognitively impaired residents. A nursing assistant demonstrates basic care of cognitively impaired clients or residents. A nursing assistant:

(a) Uses techniques for addressing the unique needs and behaviors of individuals with cognitive impairment including Alzheimer's, dementia, delirium, developmental disabilities, mental illnesses and other conditions.

(b) Communicates with cognitively impaired clients or residents in a manner appropriate to their needs.

(c) Demonstrates sensitivity to the behavior of cognitively impaired clients or residents.

(d) Appropriately responds to the behavior of cognitively impaired clients or residents.

(5) Basic restorative services. The nursing assistant incorporates principles and skills in providing restorative care. A nursing assistant:

(a) Demonstrates knowledge and skill in using assistive devices in ambulation, transferring, eating, and dressing.

(b) Demonstrates knowledge and skill in the maintenance of range of motion.

(c) Demonstrates proper techniques for turning and positioning a client or resident in a bed and chair.

(d) Demonstrates proper techniques for transferring and ambulating client or resident.

(e) Demonstrates knowledge about methods for meeting the elimination needs of clients or residents.

(f) Demonstrates knowledge and skill for the use and care of prosthetic devices by client or resident.

(g) Uses basic restorative services by training the client or resident in self care according to the client's or resident's capabilities.

(6) Client or resident rights and promotion of independence. A nursing assistant demonstrates behavior which maintains and respects client or resident rights and promotes independence, regardless of race, religion, life-style, sexual preference, disease process, or ability to pay. A nursing assistant:

(a) Recognizes that client or resident has the right to participate in decisions about his or her care.

(b) Recognizes and respects clients' or residents' need for privacy and confidentiality.

(c) Promotes and respects the client or resident right to make personal choices to accommodate their needs.

(d) Reports client or resident concerns.

(e) Provides assistance to client or resident in getting to and participating in activities.

(f) Respects the property of client or resident and employer and does not take equipment, material, property or medications for his, her or other's use or benefit. A nursing assistant may not solicit, accept or borrow money, material or property from client or resident for his, her or other's use or benefit.

(g) Promotes client or resident right to be free from abuse, mistreatment, and neglect.

(h) Intervenes appropriately on the client's or resident's behalf when abuse, mistreatment or neglect is observed.

(i) Complies with mandatory reporting requirements by reporting to the department of health and the department of social and health services instances of neglect, abuse, exploitation or abandonment.

(j) Participates in the plan of care with regard to the use of restraints in accordance with current professional standards.

(7) Communication and interpersonal skills. A nursing assistant uses communication and interpersonal skills effectively to function as a member of the nursing team. A nursing assistant:

(a) Reads, writes, speaks, and understands English at the level necessary for performing duties of the nursing assistant.

(b) Listens and responds to verbal and nonverbal communication in an appropriate manner.

(c) Recognizes how his or her own behavior influences client's or resident's behavior and uses resources for obtaining assistance in understanding the client's or resident's behavior.

(d) Adjusts his or her own behavior to accommodate client's or resident's physical or mental limitations.

(e) Uses terminology accepted in the health care setting to record and report observations and pertinent information.

(f) Appropriately records and reports observations, actions, and information accurately and in a timely manner.

(g) Is able to explain policies and procedures before and during care of the client or resident.

(8) Infection control. A nursing assistant uses standard and transmission based precautions to prevent the spread of microorganisms. A nursing assistant:

(a) Uses principles of medical asepsis and demonstrates infection control techniques and standard and transmission based precautions.

(b) Explains how disease causing microorganisms are spread.

(c) Is knowledgeable regarding transmission of bloodborne pathogens.

(d) Demonstrates knowledge of cleaning agents and methods which destroy microorganisms on surfaces.

(9) Safety and emergency procedures. A nursing assistant demonstrates the ability to identify and implement safety and emergency procedures. A nursing assistant:

(a) Provides an environment with adequate ventilation, warmth, light, and quiet.

(b) Promotes a clean, orderly, and safe environment including equipment for a client or resident.

(c) Identifies and utilizes measures for accident prevention.

(d) Demonstrates principles of good body mechanics for self and client or resident, using the safest and most efficient methods to lift and move clients, residents, or heavy items.

(e) Demonstrates proper use of protective devices in care of clients or residents.

(f) Demonstrates knowledge and follows fire and disaster procedures.

(g) Identifies and demonstrates principles of health and sanitation in food service.

(h) Demonstrates the proper use and storage of cleaning agents and other potentially hazardous materials.

(10) Rules and regulations knowledge. A nursing assistant demonstrates knowledge of and can explain the practical implications of the laws and regulations which affect nursing assistant practice including but not limited to:

(a) Mandatory reporting procedures related to client or resident abuse, neglect, abandonment, and exploitation.

(b) Scope of practice.

(c) Workers right to know.

(d) The Uniform Disciplinary Act.

[Statutory Authority: RCW **18.88A.060**(1) and **18.88A.030**(5). WSR 08-06-100, § 246-841-400, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW **18.88A.060**. WSR 91-23-077 (Order 214B), § 246-841-400, filed 11/19/91, effective 12/20/91; WSR 91-07-049 (Order 116B), recodified as § 246-841-400, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW **18.88.080**. WSR 90-20-018 (Order 091), § 308-173-210, filed 9/21/90, effective 10/22/90.]

246-841-405

Nursing assistant delegation.

Provision for delegation of certain tasks.

(1) Nursing assistants perform tasks delegated by a registered nurse for patients in community-based care settings or in-home care settings each as defined in RCW **18.79.260** (3)(e).

(2) Before performing any delegated task:

(a) Nursing assistants-registered must show the certificate of completion of both the basic caregiver training and core delegation training from the department of social and health services to the registered nurse delegator.

(b) Nursing assistants-certified must show the certificate of completion of the core delegation training from the department of social and health services to the registered nurse delegator.

(c) All nursing assistants must comply with all applicable requirements of the nursing care quality assurance commission in WAC **246-840-910** through **246-840-970**.

(d) All nursing assistants, registered and certified, who may be completing insulin injections must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator.

(e) All nursing assistants must meet any additional training requirements identified by the nursing care quality assurance commission. Any exceptions to additional training requirements must comply with RCW **18.79.260**(3)(e)(v).

(3) Delegated nursing care tasks described in this section are:

(a) Only for the specific patient receiving delegation;

(b) Only with the patient's consent; and

(c) In compliance with all applicable requirements in WAC **246-840-910** through **246-840-970**.

(4) A nursing assistant may consent or refuse to consent to perform a delegated nursing care task. The nursing assistant is responsible for their own actions with the decision to consent or refuse to consent and the performance of the delegated nursing care task.

(5) Nursing assistants shall not accept delegation of, or perform, the following nursing care tasks:

(a) Administration of medication by injection, with the exception of insulin injections;

(b) Sterile procedures;

(c) Central line maintenance;

(d) Acts that require nursing judgment.

[Statutory Authority: RCW **18.79.110**, **18.79.260**, 18.88A060 [18.88A.060], and **18.88A.210**. WSR 09-06-006, § 246-841-405, filed 2/18/09, effective 3/21/09. Statutory Authority: RCW **18.88A.060** and 2003 c 140. WSR 04-14-064, § 246-841-405, filed 7/2/04, effective 7/2/04. Statutory Authority: Chapter **18.88A** RCW. WSR 96-06-029, § 246-841-405, filed 2/28/96, effective 3/30/96.]

246-841-410

Purpose of the review and approval of nursing assistant-certified training programs.

The nursing care quality assurance commission (commission) approve nursing assistant-certified training programs. The commission reviews and approves training programs to:

(1) Assure preparation for safe practice as a nursing assistant-certified by requiring nursing assistant-certified programs meet minimum standards.

(2) Provide guidance for development of new nursing assistant-certified training programs.

(3) Facilitate career mobility of nursing assistants-certified into nursing educational programs in other levels of nursing.

(4) Identify training standards and achieved competencies of nursing assistants-certified in the state of Washington for the purpose of interstate communications and endorsements.

[Statutory Authority: RCW **18.88A.060**(1) and **18.88A.030**(5). WSR 08-06-100, § 246-841-410, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW **18.88A.060**. WSR 91-23-077 (Order 214B), § 246-841-410, filed 11/19/91, effective 12/20/91; WSR 91-07-049 (Order 116B), recodified as § 246-841-410, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW **18.88.080**. WSR 90-20-018 (Order 091), § 308-173-220, filed 9/21/90, effective 10/22/90.]

246-841-420

Requirements for approval of nursing assistant-certified training programs.

To qualify as a nursing assistant-certified training program, an institution or facility must:

(1) **Submit a completed application packet** provided by the department of health.

The packet will include forms and instructions to submit the following:

(a) **Program objectives.**

(b) **Curriculum content outline.**

- (c) Qualifications of program director and additional instructional staff.
- (d) Contractual agreements related to providing this training. For any program that uses another facility to provide clinical training, this includes an affiliation agreement between the training program and the facility. The affiliation agreement must describe how the program will provide clinical experience in the facility. The agreement must specify the rights and responsibilities of both parties, students and clients or residents.
 - (e) Sample lesson plan for one unit.
 - (f) Skills checklist.
 - (g) Description of classroom facilities.
 - (h) Declaration of compliance with administrative guidelines signed by the program director.
 - (i) Verification that the program director has completed a course on adult instruction as required by WAC 246-841-470(3) or has one year of experience in the past three years teaching adults. Acceptable experience does not include in-service education or patient teaching. A program director working exclusively in a postsecondary educational setting is exempt from this requirement.
 - (j) Verification that the nursing assistant-certified training program or school is approved to operate in the state of Washington by:
 - (i) The state board for community and technical colleges;
 - (ii) The superintendent of public instruction; or
 - (iii) The workforce training and education coordinating board.
- (2) Agree to on-site survey of the training program, as requested by the commission. This on-site will be coordinated with other on-site review requirements when possible.
- (3) Participate in the renewal process every two years. Failure to renew results in automatic withdrawal of approval of the program.
- (4) Comply with any changes in training standards and guidelines in order to maintain approved status.
- (5) Notify the commission and any other approving agency of any changes in overall curriculum plan or major curriculum content changes prior to implementation.
- (6) Notify the commission and any other approving agency of changes in program director or instructors.

[Statutory Authority: RCW 18.88A.060(1) and 18.88A.030(5). WSR 08-06-100, § 246-841-420, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW 18.88A.060. WSR 91-07-049 (Order 116B), recodified as § 246-841-420, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW 18.88.080. WSR 90-20-018 (Order 091), § 308-173-230, filed 9/21/90, effective 10/22/90.]

246-841-430

Denial or withdrawal of approval for nursing assistant-certified training programs.

(1) When the commission determines that a nursing assistant-certified training program fails to meet the standards for training as contained in this chapter, the commission may:

- (a) Deny approval to a new program; or
- (b) Withdraw approval from existing programs.
- (2) The commission may conduct a review or site visit to investigate:
 - (a) Complaints relating to violations of this chapter.
 - (b) Failure to notify the commission of any changes in the overall curriculum plan or major content changes prior to implementation.
 - (c) Failure to notify the commission of changes in program director or instructor.
 - (d) Providing false or misleading information to students or the public concerning the nursing assistant-certified training program.
 - (e) Failure to secure or retain a qualified program director resulting in substandard supervision and teaching of students.
 - (f) Failure to maintain an average passing rate of eighty percent on the state-approved examination. If a program:
 - (i) Fails to maintain an average passing rate of eighty percent of first time test takers for two consecutive years, the commission will require the program to assess the problem and submit a plan of correction.
 - (ii) Fails to maintain an average passing rate of eighty percent of first time test takers for three consecutive years, the program must complete an assessment of possible problem areas within six months and the commission may conduct an evaluation visit. The commission may offer technical assistance.
 - (iii) Fails to maintain an average passing rate of eighty percent of first time test takers for four out of five consecutive years, the commission may place the program on conditional approval and require an evaluation visit.
- (3) Commission approval is automatically terminated if the program does not renew.

[Statutory Authority: RCW [18.88A.060](#)(1) and [18.88A.030](#)(5). WSR 08-06-100, § 246-841-430, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW [18.88A.060](#). WSR 91-23-077 (Order 214B), § 246-841-430, filed 11/19/91, effective 12/20/91; WSR 91-07-049 (Order 116B), recodified as § 246-841-430, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW [18.88.080](#). WSR 90-20-018 (Order 091), § 308-173-240, filed 9/21/90, effective 10/22/90.]

246-841-440

How does a nursing assistant training program whose approval has been withdrawn become reinstated?

(1) The commission may consider reinstatement of a nursing assistant-certified training program upon submission of satisfactory evidence that the program meets the standards of nursing assistant training as contained in this chapter.

(2) A program that is automatically terminated for failure to participate in the renewal process may be immediately reinstated upon meeting all conditions for a new application approval.

[Statutory Authority: RCW [18.88A.060](#)(1) and [18.88A.030](#)(5). WSR 08-06-100, § 246-841-440, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW [18.88A.060](#). WSR 91-23-077 (Order 214B), § 246-841-440, filed 11/19/91, effective 12/20/91; WSR 91-07-049 (Order 116B),

recodified as § 246-841-440, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW **18.88.080**. WSR 90-20-018 (Order 091), § 308-173-245, filed 9/21/90, effective 10/22/90.]

246-841-450

Appeal rights of a nursing assistant-certified training program when the commission has denied or withdrawn approval.

A nursing assistant-certified training program that has been denied or had approval withdrawn shall have the right to a hearing to appeal the commission's decision according to the provisions of chapter **18.88A** RCW and chapter **34.05** RCW, the Administrative Procedure Act, Parts IV and V.

[Statutory Authority: RCW **18.88A.060**(1) and **18.88A.030**(5). WSR 08-06-100, § 246-841-450, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW **18.88A.060**. WSR 91-07-049 (Order 116B), recodified as § 246-841-450, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW **18.88.080**. WSR 90-20-018 (Order 091), § 308-173-250, filed 9/21/90, effective 10/22/90.]

246-841-460

Closure of an approved nursing assistant-certified training program.

When an approved nursing assistant-certified training program closes, it shall notify the commission in writing, stating the reason and the date of intended closing.

[Statutory Authority: RCW **18.88A.060**(1) and **18.88A.030**(5). WSR 08-06-100, § 246-841-460, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW **18.88A.060**. WSR 91-07-049 (Order 116B), recodified as § 246-841-460, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW **18.88.080**. WSR 90-20-018 (Order 091), § 308-173-255, filed 9/21/90, effective 10/22/90.]

246-841-470

Program directors and instructors in approved nursing assistant-certified training programs.

(1) The program director must hold a current license in good standing as a registered nurse (RN) in the state of Washington.

(2) The commission may deny or withdraw a program director's approval if there is or has been any action taken against the director's health care license or any license held by the director which allows him or her to work with vulnerable populations.

(3) The program director must complete a training course on adult instruction or have demonstrated that he or she has one year experience teaching adults.

(a) Acceptable experience does not include in-service education or patient teaching.

(b) The training course on adult instruction must provide instruction in:

(i) Understanding the adult learner.

(ii) Techniques for teaching adults.

(iii) Classroom methods for teaching adults.
(iv) Audio visual techniques for teaching adults.
(c) A program director working exclusively in a postsecondary educational setting is exempt from this requirement.

(4) The program director will have a minimum of three years of experience as an RN, of which at least one year will be in direct patient care.

(5) The program director must meet the requirements for additional staff under subsection (7)(b) of this section if the program director will also be acting as an instructor.

(6) Program director responsibilities:

(a) Develop and implement a curriculum which meets as a minimum the requirements of WAC 246-841-490. The program director is responsible for all classroom and clinical training content and instruction.

(b) Assure compliance with and assume responsibility for meeting the requirements of WAC 246-841-490 through 246-841-510.

(c) Assure that all student clinical experience is directly supervised. Direct supervision means that an approved program director or instructor is observing students performing tasks.

(d) Assure that the clinical instructor has no concurrent duties during the time he or she is instructing students.

(e) Create and maintain an environment conducive to teaching and learning.

(f) Select and supervise all other instructors involved in the course, including clinical instructors and guest lecturers.

(g) Assure that students are not asked to, nor allowed to, perform any clinical skill with patients or clients until first demonstrating the skill satisfactorily to an instructor in a practice setting.

(h) Assure evaluation of knowledge and skills of students before verifying completion of the course.

(i) Assure that students receive a verification of completion when requirements of the course have been satisfactorily met.

(7) The program director may select instructional staff to assist in the teaching of the course.

(a) Instructional staff must teach in their area of expertise.

(b) Instructional staff must have a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age or both.

(c) All instructional staff must hold a current Washington state license to practice as a registered or licensed practical nurse. The commission may deny or withdraw an instructor's approval if there is or has been any action taken against a health care license or any license held by the applicant which allows him or her to work with vulnerable populations.

(d) Instructional staff may assist the program director in development of curricula, teaching modalities, and evaluation. The instructor will be under the supervision of the program director at all times.

(e) A guest lecturer, or individual with expertise in a specific course unit may be used in the classroom setting for teaching without commission approval, following the program director's review of the currency of content. The guest lecturer, where

applicable, must hold a license, certificate or registration in good standing in their field of expertise.

[Statutory Authority: RCW 18.88A.060(1) and 18.88A.030(5). WSR 08-06-100, § 246-841-470, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW 18.88A.060. WSR 91-23-077 (Order 214B), § 246-841-470, filed 11/19/91, effective 12/20/91; WSR 91-07-049 (Order 116B), recodified as § 246-841-470, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW 18.88.080. WSR 90-20-018 (Order 091), § 308-173-260, filed 9/21/90, effective 10/22/90.]

246-841-490

Core curriculum in approved nursing assistant-certified training programs.

(1) The curriculum must be competency based. It must be composed of learning objectives and activities that will lead to knowledge and skills required for the graduate to demonstrate mastery of the core competencies as provided in WAC 246-841-400.

(2) The program director will determine the amount of time required in the curriculum to achieve the objectives. The time designated may vary with characteristics of the learners and teaching or learning variables. There must be a minimum of eighty-five hours total, with a minimum of thirty-five hours of classroom training and a minimum of fifty hours of clinical training.

(a) Of the thirty-five hours of classroom training, a minimum of seven hours must be in AIDS education as required by chapter 246-12 WAC, Part 8.

(b) Of the fifty hours of clinical training, at least forty clinical hours must be in the practice setting.

(c) Training to orient the student to the health care facility and facility policies and procedures are not to be included in the minimum hours above.

(3) Each unit of the core curriculum will have:

(a) Behavioral objectives, which are statements of specific observable actions and behaviors that the learner is to perform or exhibit.

(b) An outline of information the learner will need to know in order to meet the objectives.

(c) Learning activities such as lecture, discussion, readings, film, or clinical practice designed to enable the student to achieve the stated objectives.

(4) Clinical teaching in a competency area is closely correlated with classroom teaching to integrate knowledge with manual skills.

(a) Students must wear name tags clearly identifying them as students when interacting with patients, clients or residents, and families.

(b) An identified instructor(s) will supervise clinical teaching or learning at all times. At no time will the ratio of students to instructor exceed ten students to one instructor in the clinical setting.

(5) The curriculum must include evaluation processes to assess mastery of competencies. Students cannot perform any clinical skill on clients or residents until first demonstrating the skill satisfactorily to an instructor in the practice setting.

[Statutory Authority: RCW 18.88A.060(1) and 18.88A.030(5). WSR 08-06-100, § 246-841-490, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW 18.88A.060. WSR 91-23-077 (Order

214B), § 246-841-490, filed 11/19/91, effective 12/20/91; WSR 91-07-049 (Order 116B), recodified as § 246-841-490, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW 18.88.080. WSR 90-20-018 (Order 091), § 308-173-270, filed 9/21/90, effective 10/22/90.]

246-841-500

Physical resources required for approved nursing assistant-certified training programs.

- (1) Classroom facilities must provide adequate space, lighting, comfort, and privacy for effective teaching and learning.
- (2) Adequate classroom resources, such as white board or other writing device, audio visual materials, and written materials must be available.
- (3) Appropriate equipment must be provided for teaching and practicing clinical skills and procedures before implementing the skills with clients or residents.

[Statutory Authority: RCW 18.88A.060(1) and 18.88A.030(5). WSR 08-06-100, § 246-841-500, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW 18.88A.060. WSR 91-07-049 (Order 116B), recodified as § 246-841-500, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW 18.88.080. WSR 90-20-018 (Order 091), § 308-173-275, filed 9/21/90, effective 10/22/90.]

246-841-510

Administrative procedures for approved nursing assistant-certified training programs.

- (1) The program must establish and maintain a file for each student enrolled. The file must include:
 - (a) Dates attended.
 - (b) Test results.
 - (c) A skills evaluation checklist with dates of skills testing and signature of instructor.
 - (d) Documentation of successful completion of the course, or documentation of the course outcome.
- (2) Each student file must be maintained by the program for a period of five years, and copies of documents made available to students who request them.
- (3) Verification of successful completion of the course of training will be provided to the commission on forms provided by the commission.

- (4) For those programs based in a health care facility: Verification of program completion and the application for state testing will not be withheld from a student who has successfully met the requirements of the program. Successful completion will be determined by the training program director separately from other employer issues. [Statutory Authority: RCW 18.88A.060(1) and 18.88A.030(5). WSR 08-06-100, § 246-841-510, filed 3/5/08, effective 4/5/08. Statutory Authority: RCW 18.88A.060. WSR 91-07-049 (Order 116B), recodified as § 246-841-510, filed 3/18/91, effective 4/18/91. Statutory Authority: RCW 18.88.080. WSR 90-20-018 (Order 091), § 308-173-280, filed 9/21/90, effective 10/22/90.]

246-841-520

Expired license.

(1) If the certificate has expired for three years or less, the practitioner must meet the requirements of chapter **246-12** WAC, Part 2.

(2) If the certificate has expired for over three years the practitioner must:

(a) Demonstrate competence to the standards established by the nursing care quality assurance commission;

(b) Meet the requirements of chapter **246-12** WAC, Part 2.

[Statutory Authority: RCW **43.70.280**. WSR 98-05-060, § 246-841-520, filed 2/13/98, effective 3/16/98.]

246-841-530

Alternative program—Purpose.

The commission intends to establish criteria for an alternative program for home care aide-certified and medical assistant-certified that will provide continued opportunity for recruitment and career advancement in nursing, recognize relevant training, and maintain a single standard for competency.

The alternative program is intended to provide twenty-four hours of additional training, including clinical training, on topics not addressed in the specified training for certification as a home care aide or medical assistant, that will meet the requirements necessary to take the nursing assistant-certified competency evaluation.

Successful completion of an approved alternative program may allow the home care aide-certified and medical assistant-certified to meet requirements to complete a competency evaluation. Successful completion of the competency evaluation may allow an applicant who is a home care aide-certified or medical assistant-certified to become a nursing assistant-certified. The nursing assistant-certified credential may then qualify an individual for entry into a nursing program.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-530, filed 7/27/11, effective 8/27/11.]

246-841-535

Alternative program—Definitions.

The definitions in this section apply throughout WAC **246-841-530** through **246-841-585**.

(1) **Home care aide-certified** means any person certified under chapter **18.88B** RCW.

(2) **Medical assistant-certified** under chapter **18.88A** RCW, means a person who holds a current certification from one of the certifying organizations in WAC **246-827-0200**(2).

(3) **Nursing assistant-certified** means any person certified under chapter **18.88A** RCW.

[Statutory Authority: RCW **18.88A.087**. WSR 15-21-068, § 246-841-535, filed 10/20/15, effective 11/20/15. Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-535, filed 7/27/11, effective 8/27/11.]

246-841-545

Home care aide-certified alternative program requirements.

The commission may approve alternative programs for individuals credentialed as home care aides-certified to successfully complete in order to qualify to take the nursing assistant-certified competency evaluation.

- (1) **An alternative program shall:**
 - (a) **Meet the requirements of WAC 246-841-420.**
 - (b) **Have a competency based curriculum composed of learning objectives and activities. The curriculum content shall include:**
 - (i) **Measuring vital signs, height and weight, fluid and food input and output.**
 - (ii) **Developmental tasks associated with developmental and age specific processes.**
 - (iii) **Use and care of prosthetic devices.**
 - (iv) **Provision of adequate ventilation, warmth, light, and quiet for the client.**
 - (v) **Principles of good body mechanics for self and clients to lift and move clients or heavy items.**
 - (vi) **Achieving competence in reading, writing, speaking and understanding English at the level necessary to:**
 - (A) **Use terminology accepted in health care settings.**
 - (B) **Accurately record and report observations, actions and information in a timely manner.**
 - (vii) **The scope of practice of nursing assistant-certified.**
 - (viii) **The workers right to know law.**
 - (ix) **The Uniform Disciplinary Act, including RCW 18.130.180.**
 - (c) **Have a program director:**
 - (i) **Who is currently licensed as a registered nurse (RN) in good standing in the state of Washington and has a minimum of three years of experience as an RN with at least one year of experience in direct patient care; and**
 - (ii) **Who has successfully completed a training course on adult instruction or can demonstrate that he or she has one year experience teaching adults, unless the program director works exclusively in a secondary educational setting.**
 - (A) **The training course on adult instruction must provide instruction in understanding the adult learner, techniques for teaching adults, classroom methods for teaching adults and audio-visual techniques for teaching adults.**

(B) Acceptable experience does not include in-service education or patient teaching.

(iii) Who has a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age or both if also acting as an instructor.

(2) The program director may select instructional staff to assist in the teaching of the course. Instructional staff must meet the following requirements:

(a) Hold a current Washington state license to practice as a registered or licensed practical nurse in good standing; and

(b) Have a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age.

(3) Instructional staff may assist the program director in development of curricula, teaching modalities, and evaluation. The instructor must be under the supervision of the program director at all times.

(4) A guest lecturer or individual with expertise in a specific course unit may be used in the classroom setting for teaching without commission approval, following the program director's review of the currency of content. The guest lecturer, where applicable, must hold a license, certificate or registration in good standing in their field of expertise.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-545, filed 7/27/11, effective 8/27/11.]

246-841-550

Medical assistant-certified alternative program requirements.

The commission may approve alternative programs for individual medical assistant-certified to successfully complete in order to qualify to take the nursing assistant-certified competency evaluation.

(1) An alternative program shall:

(a) Submit documentation of meeting all requirements of WAC **246-841-420**.

(b) Have a competency based curriculum composed of learning objectives and activities. The curriculum content shall include:

(i) Measurement of fluid and food input and output.

(ii) Participation in planning and nursing reporting process.

(iii) Bathing, oral care, and skin care.

(iv) Personal care tasks, appropriate to chronological age and developmental stage of residents.

(v) Grooming and dressing.

(vi) Toileting.

(vii) Eating and hydration, including:

(A) Techniques to prevent choking and aspiration; and

(B) Health and sanitation in food services.

(viii) Basic restorative services.

(A) Use of assistive devices in ambulation, transferring, eating and dressing.

(B) Range of motion.

(C) Turning and positioning.

(D) Transferring and ambulating.

(E) Use and care of prosthetic devices.

(ix) Client resident rights and promotion of independence.

(A) Assistance in getting to and joining in activities appropriate to chronological age of resident.

(B) Respect for client's property.

(C) Use of restraints and acknowledges agency policies that may apply to restraints.

(x) An environment with adequate ventilation, warmth, light, and quiet.

(xi) Rules and regulations, including:

(A) The scope of practice, nursing assistant-certified.

(B) The workers right to know law.

(C) The Uniform Disciplinary Act, including RCW **18.130.180**.

(c) Have a program director:

(i) Who is currently licensed as a registered nurse (RN) in good standing in the state of Washington and has a minimum of three years of experience as an RN, with at least one year of experience in direct patient care.

(ii) Who has successfully completed a training course on adult instruction or can demonstrate that he or she has one year experience teaching adults unless the program director works exclusively in a secondary educational setting.

(A) The training course on adult instruction must provide instruction in understanding the adult learner, techniques for teaching adults, classroom methods for teaching adults and audio-visual techniques for teaching adults.

(B) Acceptable experience does not include in-service education or patient teaching.

(iii) Who has a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age if also acting as an instructor.

(2) The program director may select instructional staff to assist in the teaching of the course. Instructional staff must meet the following requirements:

(a) Hold a current Washington state license to practice as a registered or licensed practical nurse in good standing; and

(b) Have a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age.

(3) Instructional staff may assist the program director in development of curricula, teaching modalities, and evaluation. The instructor must be under the supervision of the program director at all times.

(4) A guest lecturer or individual with expertise in a specific course unit may be used in the classroom setting for teaching without commission approval, following the program director's review of the currency of content. The guest lecturer, where applicable, must hold a license, certificate or registration in good standing in their field of expertise.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-550, filed 7/27/11, effective 8/27/11.]

246-841-555

Responsibilities of the program director in alternative programs.

The program director of an alternative program is responsible for:

- (1) Development and use of a curriculum which:
 - (a) Meets the requirements of WAC [246-841-545](#); or
 - (b) Meets the requirements of WAC [246-841-550](#).
 - (2) Ensuring compliance with the requirements of WAC [246-841-500](#) and [246-841-510](#).
 - (3) Verifying home care aides-certified have a valid certification before admission to the alternative program.
 - (4) Verifying medical assistants-certified have certification before admission to the alternative program.
 - (5) Direct supervision of all students during clinical experience. Direct supervision means an approved program director or instructor observes students performing tasks.
 - (6) Ensuring the clinical instructor has no concurrent duties during the time he or she is instructing students.
 - (7) Maintaining an environment acceptable to teaching and learning.
 - (8) Supervising all instructors involved in the course. This includes clinical instructors and guest lecturers.
 - (9) Ensuring students are not asked to, or allowed to perform any clinical skill with patients or clients until the students have demonstrated the skill satisfactorily to an instructor in a practice setting.
 - (10) Evaluating knowledge and skills of students before verifying completion of the course.
 - (11) Providing students a verification of completion when requirements of the course have been satisfied.
 - (12) Providing adequate time for students to complete the objectives of the course. The time may vary with skills of the learners and teaching or learning variables.
 - (13) Establishing an evaluation process to assess mastery of competencies.
- [Statutory Authority: RCW [18.88A.087](#) and [18.88A.060](#). WSR 11-16-042, § 246-841-555, filed 7/27/11, effective 8/27/11.]

246-841-560

Alternative program application for approval, denial, or withdrawal.

- (1) An applicant for an alternative program must submit a completed application provided by the department of health. The application will include forms and instructions to submit the following:
 - (a) Program objectives;
 - (b) Required curriculum and content.
- (2) The commission shall comply with WAC [246-841-430](#) when denying or withdrawing an approval of an alternative program.
- (3) An alternative program that has been denied or had an approval withdrawn shall have the right to a hearing to appeal the commission's decision according to the

provisions of chapters **18.88A** and **34.05** RCW, the Administrative Procedure Act, Parts IV and V.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-560, filed 7/27/11, effective 8/27/11.]

246-841-570

Recordkeeping and administrative procedures for approved alternative programs.

An alternative program shall comply with all the requirements in WAC **246-841-510**.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-570, filed 7/27/11, effective 8/27/11.]

246-841-573

Closure of an alternative program.

Before an approved alternative program closes it shall notify the commission in writing, stating the reason and the date of intended closing.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-573, filed 7/27/11, effective 8/27/11.]

246-841-575

Alternative program—Eligibility to complete the nursing assistant-certified competency examination.

Graduates of alternative programs who meet all application requirements are deemed eligible to complete the nursing assistant-certified competency evaluation approved by the commission.

Competency evaluation means the measurement of an individual's knowledge and skills as related to safe, competent performance as a nursing assistant-certified.

[Statutory Authority: RCW **18.88A.087** and **18.88A.060**. WSR 11-16-042, § 246-841-575, filed 7/27/11, effective 8/27/11.]

246-841-578

Application requirements.

To be eligible to apply for nursing assistant-certified from an alternative program the applicant must:

- (1) Be currently credentialed as a home care aide-certified; or

- (2) Be a medical assistant-certified as defined in WAC [246-841-535](#);
 - (3) Have completed a cardiopulmonary resuscitation course;
 - (4) Have completed seven hours of AIDS education and training as required in chapter [246-12](#) WAC, part 8; and
 - (5) Have successfully completed the competency evaluation.
- [Statutory Authority: RCW [18.88A.087](#) and [18.88A.060](#). WSR 11-16-042, § 246-841-578, filed 7/27/11, effective 8/27/11.]

246-841-585

Application for nursing assistant-certified from an alternative program.

(1) An applicant for nursing assistant-certified who has successfully completed an approved alternative program as a home care aide-certified must submit to the department:

- (a) A completed application for nursing assistant-certified.
- (b) A copy of certificate of completion from an approved alternative program for home care aides-certified.
- (c) Documentation verifying current certification as a home care aide.
- (d) Evidence of completion of a cardiopulmonary resuscitation course.
- (e) Evidence of completion of seven hours of AIDS education and training.
- (f) Applicable fees as required in WAC [246-841-990](#).

(2) An applicant for nursing assistant-certified who successfully completed an approved alternative program as a medical assistant-certified must submit to the department:

- (a) A completed application for nursing assistant-certified;
- (b) A copy of certificate of completion from approved alternative program for medical assistant-certified;
- (c) An official transcript from the nationally accredited medical assistant program;
- (d) Evidence of completion of an adult cardiopulmonary resuscitation course;
- (e) Evidence of completion of seven hours of AIDS education and training; and
- (f) Applicable fees as required in WAC [246-841-990](#).

[Statutory Authority: RCW [18.88A.087](#) and [18.88A.060](#). WSR 11-16-042, § 246-841-585, filed 7/27/11, effective 8/27/11.]

246-841-586

Applicability.

WAC [246-841-587](#) through [246-841-595](#) apply to the endorsement of a nursing assistant-certified as a medication assistant. A nursing assistant-certified with a medication assistant endorsement administers medications and nursing commission-approved treatments to residents in nursing homes, under the direct supervision of a designated registered nurse.

Nothing in these rules requires a nursing home to employ a nursing assistant-certified with a medication assistant endorsement. A medication assistant's employer may limit or restrict the range of functions permitted in these rules but may not expand those functions.

WAC 246-841-587 through 246-841-595 also apply to the approval of education and training programs and competency evaluations for medication assistants.

A medication assistant is responsible and accountable for his or her specific functions.

[Statutory Authority: 2012 c 208 and RCW 18.88A.060. WSR 13-15-012, § 246-841-586, filed 7/8/13, effective 7/8/13.]

246-841-587

Definitions.

The definitions in this section apply to WAC 246-841-586 through 246-841-595 unless the context clearly requires otherwise.

(1) "Competency evaluation" means the measurement of an individual's knowledge and skills related to the safe, competent performance as a medication assistant.

(2) "Direct supervision" means that the licensed registered nurse who directs medication administration and nursing commission-approved treatments to a medication assistant is on the premises, is immediately accessible in person and has assessed the residents prior to performance of these duties.

(3) "Medication assistant" means a nursing assistant-certified with a medication assistant endorsement issued under chapter 18.88A RCW.

(4) "Nursing home" means a nursing home licensed under chapter 18.51 RCW.
[Statutory Authority: 2012 c 208 and RCW 18.88A.060. WSR 13-15-012, § 246-841-587, filed 7/8/13, effective 7/8/13.]

246-841-588

Application requirements.

(1) **Initial applicant requirements:** Applicants for an initial medication assistant endorsement must meet the following requirements:

(a) Be certified as a nursing assistant-certified, with a certification in good standing, under chapter 18.88A RCW;

(b) Successfully complete a nursing commission-approved medication assistant education and training program, as described in WAC 246-841-590 (6) and (7) within the immediate year prior to the date of application;

(c) Complete at least one thousand hours of work experience in a nursing home as a nursing assistant-certified within the immediate year prior to the date of application; and

(d) After completing the requirements in (a) through (c) of this subsection, pass the nursing commission-approved medication assistant competency evaluation. Each applicant must successfully complete a written competency evaluation. The competency evaluation must measure an individual's knowledge and skills related to the safe, competent performance as a medication assistant. The evaluation assesses the competency specification required in the core curriculum as listed in WAC 246-841-590(6).

(2) Application requirements:

(a) To obtain an initial medication assistant endorsement credential, the nursing assistant-certified must submit to the department:

(i) An application on forms approved by the secretary.

(ii) The applicable fees under WAC 246-841-990.

(iii) Proof of completion of a nursing commission approved medication assistant:

(A) Education and training program under WAC 246-841-590 (6) and (7); and

(B) Competency evaluation under subsection (1) of this section; and

(iv) Employer documentation of work experience as required in subsection (1)(c) of this section.

(b) An applicant who is currently credentialed as a medication assistant in another state or jurisdiction may qualify for a medication assistant endorsement credential under this chapter. An applicant must submit to the department:

(i) An application on forms approved by the secretary;

(ii) Written verification directly from the state or jurisdiction in which the applicant is credentialed, attesting that the applicant holds a credential substantially equivalent to the medication assistant endorsement credential in Washington in good standing, and is not subject to charges or disciplinary action;

(iii) Verification of completion of the required education that is substantially equivalent to the education requirements as described in WAC 246-841-590 (6) and (7);

(iv) Employer documentation of work experience as required in subsection (1)(c) of this section; and

(v) The applicable fees under WAC 246-841-990.

(3) Renewal requirements: To renew a medication assistant endorsement credential, the medication assistant must have a current nursing assistant-certified credential in good standing, and meet the requirements of WAC 246-12-030.

(4) Continuing competency requirements: A medication assistant shall meet the following requirements on an annual basis to coincide with renewal of their nursing assistant-certified credentials:

(a) Employer documentation of successful completion of two hundred fifty hours of employment as a medication assistant in a nursing home setting under the direct supervision of a registered nurse;

(b) Documentation of eight hours of continuing education specific to medications, medication administration, and performance of selected patient treatments. Continuing education hours must be obtained through a nursing commission-approved medication education and training program as described in WAC 246-841-590 (6) and (7), continuing education programs approved by a professional association, or staff development programs offered in a nursing home. The education hours must directly

relate to the medication assistant's role of medication administration and the performance of selected patient treatments.

[Statutory Authority: 2012 c 208 and RCW 18.88A.060. WSR 13-15-012, § 246-841-588, filed 7/8/13, effective 7/8/13.]

246-841-589

Medication administration and performing prescriber ordered treatments.

(1) A medication assistant working in a nursing home shall only accept direction to perform medication administration and prescriber ordered treatments from a designated registered nurse within the medication assistant's scope of practice, education, and demonstrated competency.

(2) It is the responsibility of the designated registered nurse to assess the individual needs of each resident and determine that the direction of medication administration or selected treatment tasks poses minimal risks to each resident. The designated registered nurse determines the frequency of resident assessments and decides the number and types of medications to be administered.

(3) The medication assistant under the direct supervision of a registered nurse in a nursing home, may:

(a) Administer over-the-counter medications;

(b) Administer legend drugs, with the exception of chemotherapeutic agents and experimental drugs;

(c) Administer schedule IV and V medications orally, topically, and through inhalation;

(d) Perform simple prescriber-ordered treatments which include blood glucose monitoring, noncomplex clean dressing changes, pulse oximetry readings, and oxygen administration. "Prescriber ordered treatment" means an order for drugs or treatments issued by a practitioner authorized by law or rule in the state of Washington to prescribe drugs or treatments in the course of his or her professional practice for a legitimate medical purpose.

(4) The medication assistant shall document accurately the administration of medication and performance of resident treatments that he or she undertakes into the resident's medical records on facility-approved forms.

(5) Performance of the tasks identified in subsection (1) of this section will be the sole work assignment to the medication assistant.

(6) A medication assistant may not perform the following tasks:

(a) Assessment of resident need for, or response to medication;

(b) Acceptance of telephone or verbal orders from prescribers;

(c) Conversion or calculation of drug dosages;

(d) Injection of any medications;

(e) Administration of chemotherapeutic agents and experimental drugs;

(f) Performance of any sterile task or treatment;

(g) Medication administration through a tube;

(h) Administration or participation in the handling, including counting or disposal, of any schedule I, II, or III controlled substances;

(i) Participation in any handling, including counting or disposal, of schedule IV and V controlled substances other than when administering these substances as authorized by subsection (3)(c) of this section;

(j) Performance of any task requiring nursing judgment, such as administration of as necessary or as needed (prn) medications.

[Statutory Authority: 2012 c 208 and RCW 18.88A.060. WSR 13-15-012, § 246-841-589, filed 7/8/13, effective 7/8/13.]

246-841-590

Requirements for approval of education and training programs.

(1) A medication assistant endorsement education and training program must:

(a)(i) Be a nursing commission-approved nursing assistant certified training program in good standing; or

(ii) Be a nursing commission-approved nursing educational program in good standing; and

(b) Have a program director and instructional staff who each hold current, active, Washington state licenses in good standing as a registered nurse. The commission may deny or withdraw approval of a program director or instructor if there is or has been any action taken against that person's health care license, or any license that restricts his or her permission to work with vulnerable adults.

(2) To apply, the program must submit a completed application packet and application forms provided by the department of health to the nursing commission. The packet must include:

(a) Program objectives;

(b) Curriculum outline and content as detailed in subsection (6) of this section;

(c) Written contractual agreements related to the provision of the training. For any program that uses another facility for the clinical practicum, this includes an affiliation agreement between the training program and the facility. "Clinical practicum" means clinical experience under the supervision of a qualified registered nurse instructor. The affiliation agreement must describe how the program will provide clinical experience in the facility. The agreement must specify the rights and responsibilities of students, the residents, the clinical facility, and the school;

(d) Sample lesson plan for one unit;

(e) Skills checklists for student lab performance and clinical performance during the practicum with dates of skills testing and signature of the instructor;

(f) Description of classroom, lab, and clinical practicum facilities;

(g) Declaration of compliance with administrative guidelines signed by the program director;

(h) Verification that the program director has completed a course on adult instruction or has one year of experience in the past three years teaching adults. Acceptable experience does not include staff development or patient teaching. A

program director working exclusively in post secondary educational setting is exempt from this requirement; and

(i) Verification that the medication assistant training program or school is approved to operate in the state of Washington by the state board for community and technical colleges; the superintendent of public instruction; or the workforce training and education coordinating board.

(3) Failure to submit a completed application packet within ninety days will result in closure of the application.

(4) If a program application is pending for more than ninety days, the proposed program must submit a revised program application.

(5) The program director, or designee shall:

(a) Agree to allow and cooperate with on-site surveys and investigations of the training programs, as requested by the nursing commission;

(b) Comply with any changes in training standards and guidelines in order to maintain approved status;

(c) Notify the nursing commission and any other approving agency of any changes in overall curriculum plan or major curriculum content changes prior to implementation such as changes in program hours, clinical practice facilities, program name or ownership, legal status, and credit status impacting the program's ability to sustain itself financially;

(d) Notify the nursing commission and any other approving agency of changes in program director or instructors; and

(e) Maintain an average annual student pass rate of eighty percent for first-time test takers of the medication assistant competency evaluation.

(6) Core curriculum competency requirements.

(a) The program curriculum must include training on the specific tasks that a medication assistant may perform as well as training on identifying tasks that may not be performed by a medication assistant as listed in WAC246-841-589.

(b) The program curriculum must include the complete medication assistant-certified model curriculum adopted by the National Council of State Boards of Nursing. The education and training program may add to the required curriculum as stated in these rules but may not delete any content from the required curriculum.

(c) The curriculum must include a minimum of sixty hours of didactic training which must include work in a skills lab or simulation facility.

(7) Practicum. The curriculum will include a minimum of forty hours of supervised and progressive clinical practicum in the administration of medications to residents in a nursing home. At no time will the ratio of students to instructor be allowed to exceed ten students to one instructor during clinical practicum.

(8) The program director must attest to the student's successful completion of the course on forms or electronic methods established by the commission.

[Statutory Authority: 2012 c 208 and RCW 18.88A.060. WSR 13-15-012, § 246-841-590, filed 7/8/13, effective 7/8/13.]

246-841-591

Commission review and investigation.

(1) The nursing commission may conduct a review or investigation of the training program, or site visit of the training facility to evaluate:

- (a) Complaints relating to violations of the rules;
- (b) Failure to notify the nursing commission of any changes in the overall curriculum plan or major content changes prior to implementation;
- (c) Failure to notify the nursing commission of changes in program director or instructors;
- (d) Providing false or misleading information to students or the public concerning the medication assistant education and training program;
- (e) Failure to secure or retain a qualified program director resulting in substandard supervision and teaching of students;
- (f) Failure to maintain an average annual passing rate of eighty percent of first time test takers for two consecutive years. The nursing commission will require the program to assess the problem and submit a plan of correction.

(2) If a medication assistant education and training program fails to maintain an annual average passing rate of eighty percent of first time test takers for three out of four consecutive years, the nursing commission may withdraw program approval.

[Statutory Authority: 2012 c 208 and RCW [18.88A.060](#). WSR 13-15-012, § 246-841-591, filed 7/8/13, effective 7/8/13.]

246-841-592

Commission action for violations.

(1) When the nursing commission determines that a medication assistant education and training program fails to meet the requirements in WAC [246-841-590](#) through [246-841-595](#), the nursing commission may issue a statement of deficiencies or notice of intent to withdraw approval from an existing program.

(2) **Statement of deficiencies.** The program must within ten calendar days of notification of the cited deficiencies prepare, sign, date, and provide to the commission a detailed written plan of correction. Such plan of correction will provide notification to the commission of the date by which the program will complete the correction of cited deficiencies. The commission will review the program's plan of correction to determine if it is acceptable. A plan of correction must:

- (a) Address how corrective action will be accomplished;
- (b) Address what measures will be put into place or systematic changes made to assure that the deficient practice will not recur;
- (c) Indicate how the program plans to monitor its performance to assure that solutions are sustained;
- (d) Give the name and title of the person who is responsible for assuring the implementation of the plan of correction;
- (e) Give the day by which the correction will be made.

(3) **Notice of intent to withdraw approval.** The commission may issue a notice of intent to withdraw approval from ongoing programs if it determines that a medication assistant endorsement program fails to substantially meet the standards contained in the law and this chapter.

When the commission withdraws approval, and the program does not appeal the withdrawal under WAC **246-841-594**, the program shall submit an action plan to the commission providing for enrolled students to complete the program.

[Statutory Authority: 2012 c 208 and RCW **18.88A.060**. WSR 13-15-012, § 246-841-592, filed 7/8/13, effective 7/8/13.]

246-841-593

Reinstatement of approval.

The nursing commission may consider reinstatement of a medication assistant education and training program upon submission of satisfactory evidence that the program meets the requirements as contained in these rules.

A program that is automatically terminated for failure to renew may be immediately reinstated upon meeting all conditions for a new application approval.

[Statutory Authority: 2012 c 208 and RCW **18.88A.060**. WSR 13-15-012, § 246-841-593, filed 7/8/13, effective 7/8/13.]

246-841-594

Appeal rights.

A medication assistant education and training program that has been denied approval or was issued a notice of intent to withdraw approval has the right to a hearing to appeal the nursing commission's decision according to the provisions of chapters **18.88A** and **34.05** RCW, the Administrative Procedure Act, Parts IV and V.

[Statutory Authority: 2012 c 208 and RCW **18.88A.060**. WSR 13-15-012, § 246-841-594, filed 7/8/13, effective 7/8/13.]

246-841-595

Medication assistant endorsement program renewal.

(1) Programs must submit a renewal application on the forms provided by the commission and be approved by the commission every two years. The renewal application is due ninety days before the two-year anniversary of the date approval was originally granted.

(2) Commission approval is automatically terminated if the program does not renew.

(3) The commission may deny renewal approval or grant renewal with provisional status if the program fails to substantially meet the standards contained in the law and

this chapter or has pending a statement of deficiencies, plan of correction, intent to withdraw approval, or withdrawal of approval.

(4) If a program application renewal is not completed within ninety days of its receipt, the commission may close the application renewal.

[Statutory Authority: 2012 c 208 and RCW **18.88A.060**. WSR 13-15-012, § 246-841-595, filed 7/8/13, effective 7/8/13.]

246-841-610

AIDS prevention and information education requirements.

Applicants must complete seven clock hours of AIDS education as required in chapter **246-12** WAC, Part 8.

[Statutory Authority: RCW **43.70.280**. WSR 98-05-060, § 246-841-610, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW **18.88A.050**, **18.130.050**, **18.130.080** and **70.24.270**. WSR 92-02-018 (Order 224), § 246-841-610, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW **43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-841-610, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **70.24.270**. WSR 88-22-077 (Order PM 786), § 308-173-100, filed 11/2/88.]

246-841-720

Mandatory reporting.

(1) All reports required by this chapter shall be submitted to the department as soon as possible, but no later than twenty days after a determination is made.

(2) A report should contain the following information if known:

(a) The name, address, and telephone number of the person making the report.

(b) The name and address and telephone numbers of the nursing assistant being reported.

(c) The case number of any patient whose treatment is a subject of the report.

(d) A brief description or summary of the facts which gave rise to the issuance of the report, including dates of occurrences.

(e) If court action is involved, the name of the court in which the action is filed along with the date of filing and docket number.

(f) Any further information which would aid in the evaluation of the report.

(3) Mandatory reports shall be exempt from public inspection and copying to the extent permitted under RCW **42.17.310** or to the extent that public inspection or copying of the report or any portion of the report would invade or violate a person's right to privacy as set forth in RCW **42.17.255**.

(4) A person is immune from civil liability, whether direct or derivative, for providing information to the department pursuant to RCW **18.130.070**.

(5) The administrator, executive officer, or their designee of any nursing home shall report to the department of health when any nursing assistant under chapter **18.130** RCW is terminated or such person's services are restricted based on a

determination that the nursing assistant has committed an act or acts which may constitute unprofessional conduct as defined in RCW 18.130.180 or that the nursing assistant may be mentally or physically impaired as defined in RCW 18.130.170.

(6) The administrator, executive officer, or their designee of any nursing home shall report to the department of health when any person practices, or offers to practice as a nursing assistant in the state of Washington when the person is not registered or certified in the state; or when a person uses any title, abbreviation, card, or device to indicate the person is registered or certified when the person is not.

(7) The department of health requests the assistance of responsible personnel of any state or federal program operating in the state of Washington, under which a nursing assistant is employed, to report to the department whenever such a nursing assistant is not registered or certified pursuant to this act or when such a nursing assistant has committed an act or acts which may constitute unprofessional conduct as defined in RCW 18.130.180 or may be mentally or physically impaired as defined in RCW 18.130.170.

[Statutory Authority: RCW 18.88A.050, 18.130.050 and 18.130.080. WSR 92-02-018 (Order 224), § 246-841-720, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-841-720, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.130.070. WSR 89-14-092 (Order PM 842), § 308-173-020, filed 6/30/89.]

246-841-990

Nursing assistant—Fees and renewal cycle.

(1) Credentials must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

(2) The following nonrefundable fees will be charged for registration credentials:

Title of Fee	Fee
Application - Registration	\$65.00
Renewal of registration	70.00
Duplicate registration	10.00
Registration late penalty	50.00
Expired registration reissuance	52.00

(3) The following nonrefundable fees will be charged for certification credentials:

Title of Fee	Fee
Application for certification	\$65.00
Certification renewal	70.00
Duplicate certification	10.00
Certification late penalty	50.00
Expired certification reissuance	52.00

(4) The following nonrefundable fees will be charged for medication assistant endorsement credentials:

Title of Fee	Fee
Application for endorsement	\$25.00
Endorsement renewal	10.00

[Statutory Authority: RCW **43.70.250** and **43.70.280**. WSR 16-15-013, § 246-841-990, filed 7/8/16, effective 10/1/16. Statutory Authority: 2012 c 208, 2012 c 23, 2012 c 137, 2012 c 153, RCW **43.70.110**, and **43.70.250**. WSR 12-24-015, § 246-841-990, filed 11/27/12, effective 7/1/13. Statutory Authority: RCW **43.70.110**, **43.70.250**, and 2010 c 37. WSR 10-19-071, § 246-841-990, filed 9/16/10, effective 10/15/10. Statutory Authority: RCW **43.70.110**, **43.70.250**, 2008 c 329. WSR 08-15-014, § 246-841-990, filed 7/7/08, effective 7/7/08. Statutory Authority: RCW **43.70.250**, [43.70.]280 and **43.70.110**. WSR 05-12-012, § 246-841-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW **18.88A.050**(1). WSR 99-24-062, § 246-841-990, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW **43.70.280**. WSR 98-05-060, § 246-841-990, filed 2/13/98, effective 3/16/98. Statutory Authority: Chapter **18.88A** RCW. WSR 96-03-051, § 246-841-990, filed 1/12/96, effective 3/1/96. Statutory Authority: RCW**43.70.040**. WSR 91-02-049 (Order 121), recodified as § 246-841-990, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW **43.70.250**. WSR 90-04-094 (Order 029), § 308-173-130, filed 2/7/90, effective 3/10/90. Statutory Authority: RCW **43.24.086**. WSR 88-20-075 (Order 783), § 308-173-130, filed 10/5/88.]

**Curriculum Verification Form:
Nursing Assistant Training Programs**

NOTE TO READER: This form is completed by all training programs for approval; it is a quality assurance tool to verify that all federal and state requirements are addressed within the training program curriculum.

Nursing Assistant Training Program Curriculum Verification of Requirements

Name of School	Date of Application/Renewal
Please Check One: <input type="checkbox"/> New Program <input type="checkbox"/> Program Renewal	Program Number

This form is to reference the curriculum outline you submit with your application. Forms that are completed that reference the text book will not be accepted. Be sure to check with both if a curriculum requirement is met and identify where in the curriculum outline the specific requirement is addressed.

Example: Infection Control: Page 7 #2 - a,b,c.

Requirements	Where is the requirement met in the curriculum?
1. Communication and interpersonal skills	
2. Infection control	
3. Safety and emergency procedures (including the heimlich maneuver)	
4. Promoting client independence	
5. Respecting client rights	
6. Taking and recording vital signs	
7. Measuring and recording height and weight	
8. Caring for client's environment	
9. Recognizing abnormal changes in body functioning and the importance of reporting changes to a supervisor	
10. Bathing	
11. Caring for clients when death is imminent	
12. Grooming (including mouth care)	
13. Dressing	
14. Toileting	
15. Assisting with eating and hydration	
16. Proper feeding techniques	
17. Skin care	
18. Transfers, position, and turning	
19. Modifying aides behavior in response to client's behavior	

20. Awareness of developmental tasks associated with the aging process	
21. How to respond to client's behavior	
22. Allowing the client to make personal choices, providing and reinforcing other behavior consistent with resident dignity.	
23. Using the client's family as a source of emotional support.	
24. Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others).	
25. Communicating with cognitively impaired clients.	
26. Understanding the behavior of cognitively impaired clients.	
27. Appropriate responses to the behavior of cognitively impaired clients.	
28. Methods of reducing effects of cognitive impairments.	
29. Training the client in self-care according to the client's ability.	
30. Use of assistive devices in transferring, ambulation, eating and dressing.	
31. Maintenance of range of motion	
32. Proper turning and position in a bed or chair.	
33. Bowel and bladder training	
34. Care and use of prosthetic and orthotic devices	
35. Providing privacy and maintenance of confidentiality	
36. Promoting the client's right to make personal choices to accommodate their needs	
37. Giving assistance in resolving grievances and disputes	
38. Providing needed assistance in getting to and participating in client and family group activities	
39. Maintaining, care and security of client's personal possessions.	

40. Promoting client's right to be free from abuse, mistreatment and neglect and the need to report any such treatment to appropriate facility staff.	
41. Avoiding the need for restraints in accordance with professional standards.	
42. CPR Training	
43. Measures and records fluid and food intake and output of client.	
44. Reports client concerns	
45. AIDs education	
46. Reads, writes, speaks and understands English at the level necessary for performing duties of the nursing assistant.	
47. Listens and responds to verbal and nonverbal communication in an appropriate manner.	
48. Recognizes how the aide's own behavior influences client's behavior and knows resources for obtaining assistance in understanding client's behavior.	
49. Makes adjustments for client's physical or mental limitations.	
50. Uses terminology accepted in the health care facility to report and record observation and other pertinent information.	
51. Demonstrates ability to explain policies and procedures before and during client care.	
52. Uses principles of medical asepsis and demonstrates infection control techniques and universal precautions.	
53. Explains how disease causing microorganisms are spread and lists ways that HIV and Hepatitis B can be spread from one person to another.	
54. Demonstrates knowledge of cleaning agents and methods which destroy microorganisms on surfaces.	
55. Provides adequate ventilation, warmth, light and quiet measures.	
56. Uses measures that promote comfort, rest, and sleep.	
57. Promotes a clean, orderly, and safe environment and equipment for the client.	

58. Identifies and utilizes measures for accident prevention.			
59. Identifies and demonstrates principles of body mechanics.			
60. Demonstrates knowledge of fire and disaster procedures.			
61. Identifies and demonstrates principles of health and sanitation in food service.			
62. Proper use and storage of cleaning agents and other hazardous materials.			
63. Demonstrates knowledge of and is responsive to the laws and regulation including client abuse and neglect, client complaint procedures, worker's right to know and the uniform disciplinary act.			
64. Respect clients property and does not take client's property for own or other use or benefit. Does not solicit, accept, or borrow money or property from clients.			
Total number of hours of training program	Number of clinical hours	Number of lab hours	Number of classroom hours
Name of Training Program		Phone (enter 10 digit #)	
Program Director Signature		Date	

LTC Session 2 Evaluation Form

1	2	3	4
Poor	Satisfactory	Good	Excellent

You have four areas to evaluate, please use the numeric system above to evaluate the Content – Process – Outcomes and Facilities as noted in the boxes below:

Content:	Process:
Outcomes:	Facilities:

Additional comments:

Are there other topics you would like to hear about?

1 (33) \$670,000 of the general fund—state appropriation for fiscal
2 year 2019 is provided solely for a collaboration between local public
3 health, accountable communities of health, and health care providers
4 to reduce preventable hospitalizations. This one-year initiative will
5 take place in the Tacoma/Pierce county local health jurisdiction.

6 (34) \$556,000 of the general fund—state appropriation for fiscal
7 year 2019 is provided solely to replace the comprehensive hospital
8 abstract reporting system and is subject to the conditions,
9 limitations, and review provided in section 724, chapter 1, Laws of
10 2017 3rd sp. sess.

11 (35) \$40,000 of the general fund—state appropriation for fiscal
12 year 2019 is provided solely for the department, in partnership with
13 the department of social and health services and the health care
14 authority, to assist a collaborative public-private entity with
15 implementation of recommendations in the state plan to address
16 alzheimer's disease and other dementias.

17 (36) In accordance with RCW 70.96A.090, 71.24.035, 43.20B.110,
18 and 43.135.055, the department is authorized to adopt fees for the
19 review and approval of mental health and substance use disorder
20 treatment programs in fiscal years 2018 and 2019 as necessary to
21 support the costs of the regulatory program. The department's fee
22 schedule must have differential rates for providers with proof of
23 accreditation from organizations that the department has determined
24 to have substantially equivalent standards to those of the
25 department, including but not limited to the joint commission on
26 accreditation of health care organizations, the commission on
27 accreditation of rehabilitation facilities, and the council on
28 accreditation. To reflect the reduced costs associated with
29 regulation of accredited programs, the department's fees for
30 organizations with such proof of accreditation must reflect the lower
31 cost of licensing for these programs than for other organizations
32 which are not accredited.

33 (37) \$30,000 of the general fund—state appropriation for fiscal
34 year 2019 is provided solely for the nursing care quality assurance
35 commission to convene and facilitate a work group to assess the need
36 for nurses in long-term care settings and to make recommendations
37 regarding worker recruitment, training, and retention challenges for
38 long-term care providers in the sectors of skilled nursing
39 facilities, assisted-living facilities, and adult family homes.

1 (a) The work group must:

2 (i) Determine the current and projected worker vacancy rates in
3 the long-term care sectors compared to the workload projections for
4 these sectors;

5 (ii) Develop recommendations for a standardized training
6 curriculum for certified nursing assistants that ensures that workers
7 are qualified to provide care in each sector, including integration
8 into the curriculum of specific training for the care of clients with
9 dementia, developmental disabilities, and mental health issues;

10 (iii) Review academic and other prerequisites for training for
11 licensed practical nurses to identify any barriers to career
12 advancement for certified nursing assistants;

13 (iv) Identify barriers to career advancement for long-term care
14 workers; and

15 (v) Evaluate the oversight roles of the department of health and
16 the department of social and health services for nurse training
17 programs and make recommendations for streamlining those roles.

18 (b) The members of the work group must include the following:

19 (i) The chair of the house health care and wellness committee or
20 his or her designee;

21 (ii) The chair of the senate health and long-term care committee
22 or his or her designee;

23 (iii) The assistant secretary of the aging and disability support
24 administration of the department of social and health services, or
25 his or her designee;

26 (iv) A member of the Washington apprenticeship and training
27 council, chosen by the director of the department of labor and
28 industries;

29 (v) A representative from the health services quality assurance
30 division of the department of health, chosen by the secretary;

31 (vi) The executive director of the Washington state board for
32 community and technical colleges or his or her designee;

33 (vii) A representative of the largest statewide association
34 representing nurses;

35 (viii) A representative of the largest statewide union
36 representing home care workers;

37 (ix) A representative of the largest statewide association
38 representing assisted living and skilled nursing facilities;

39 (x) A representative of the adult family home council of
40 Washington; and

1 (xi) The Washington state long-term care ombuds or his or her
2 designee.

3 (d) The work group must meet at least three times, and the first
4 meeting must occur no later than July 15, 2018. The commission must
5 report no later than December 15, 2018, to the governor and the
6 legislature regarding the work group's assessments and
7 recommendations.

8 (38) \$150,000 of the general fund—state appropriation for fiscal
9 year 2019 is provided solely for the department to implement training
10 and education recommendations described in the 2016 report of the
11 community health worker task force. The department shall report to
12 the legislature on the progress of implementation no later than June
13 30, 2019. These moneys shall only be used to cover the cost of the
14 department's staff time, meeting expenses, and community outreach.

15 (39) \$3,000,000 of the general fund—state appropriation for
16 fiscal year 2019 is provided solely to Seattle and King county public
17 health for core public health services that prevent and stop the
18 spread of communicable disease, including but not limited to zoonotic
19 and emerging diseases and chronic hepatitis B and hepatitis C.

20 (40) \$100,000 of the general fund—state appropriation for fiscal
21 year 2018 and \$360,000 of the general fund—state appropriation for
22 fiscal year 2019 are provided solely for the department to coordinate
23 with local health jurisdictions to establish and maintain
24 comprehensive Group B programs to ensure safe and reliable drinking
25 water. These amounts shall be used to support the costs of the
26 development and adoption of rules, policies and procedures, and for
27 technical assistance, training, and other program-related costs.

28 (41) \$485,000 of the general fund—state appropriation for fiscal
29 year 2019 is provided solely for the implementation of Second
30 Substitute House Bill No. 2671 (behavioral health/agricultural
31 industry). If the bill is not enacted by June 30, 2018, the amounts
32 provided in this subsection shall lapse.

33 (42) \$113,000 of the general fund—local appropriation is provided
34 solely to implement Engrossed Substitute Senate Bill No. 6037
35 (uniform parentage act). If this bill is not enacted by June 30,
36 2018, the amount provided in this subsection shall lapse.

37 (43) \$19,000 of the health professions account—state
38 appropriation is provided solely to implement Substitute Senate Bill

Long-Term Care Workgroup

Session 1: July 10, 2018

Meeting Recap

Materials Included:

- Session 1 Meeting Notes
- Webinar Comment Log
- Meeting Evaluation Results
- PowerPoint Slides- *Industry and Occupational Employment Projections, presented by Cynthia Forland*
- PowerPoint Slides- *Long-Term Care Nursing Workforce Data, presented by Sue Skillman*
- PowerPoint Slides- *Long-Term Care Workforce: Data and Trends, presented by Carma Matti-Jackson*

LCT Workgroup – July 10, 2018

Session #1 - Notes

Workgroup session began at 1:00 pm.

Workgroup members in attendance: Tracy Rude, Senator Steve Conway, Candace Goehring, Rachel Mc Aloon, Trina Crawford, Lori Banaszak, Pamela Pasquale, Abby Solomon, Alexis Wilson, John Ficker, Patricia Hunter and Representative Eileen Cody by telephone.

WELCOME:

- Tracy Rude called the meeting to order and welcomed everyone.

- Paula R. Meyer gave an overview of the purpose of the workgroup and expressed her excitement of this workgroup and its potential to affect long-term care state wide.

- The panel members introduced themselves.

INTRODUCTIONS:

- Mindy Schaffner presented the project timelines and asked each panel member to introduce themselves.

GUIDING PRINCIPLES AND GROUND RULES:

- Porsche Everson the facilitator for the workgroup presented the guiding principles and ground rules which will keep the workgroup on task and their ability to meet the deadlines imposed by the legislature.

- The groups are to circle the top 5 of these principles that the workgroup will use during this process.

- Principles agreed upon while discussing and deliberating during the workshops were:
 1. Stay focused
 2. Create space for disagreements
 3. Evidence based decision making
 4. Open to new concepts

- The workgroup also agreed to stay with the five directives as outlined in the proviso which are:
 - i. Determine the current and projected worker vacancy rates in the long-term care sectors compared to the workload projections for these sectors;
 - ii. Develop recommendations for a standardized training curriculum for certified nursing assistants that ensures that workers are qualified to provide care in each sector, including integration into curriculum of specified training for the care of clients with dementia, developmental disabilities, and mental health issues;

- iii. Review academic and other prerequisites for training for licensed practical nurses to identify any barriers to career advancement for certified nursing assistants;
- iv. Identify barriers to career advancement for long-term care workers; and
- v. Evaluate the oversight roles of the department of health and the department of social and health services for nurse training programs and make recommendations for streamlining those roles.

DATA PRESENTATIONS:

Cynthia Forland, presented her data on industry and occupational employment projections. Employment current and projected were 5% of the total state workforce and by 2026 long-term care will increase by over 27,000; occupational employment currently stands at over 94,000 people and projected to increase by 18,000; and there are more job vacancies than available workforce.

Sue Skillman, presented long-term care nurse workforce and the recent supply and demand findings from the 2018 survey of WA RNs and WA workforce Sentinel Network. She discussed exceptionally long vacancies and/or increased demand; and training changes in long-term care facilities.

Carma Matti-Jackson, presented data and trends on the long term workforce recruitment and retention. Points covered included, but not limited to: 28% of the nursing workforce are employed by LTC skilled nursing facilities and residential services/homes; 55% of CNAs and 52% of LPNs are employed by SNFs and ALs; WA State demand for these services is expected to increase dramatically over the next few years; and within five years there will be a need of approximately 8,600 more direct care workers.

OPEN MIC:

Cheryl Carino-Berr, Welcome Back from Highline College
Debra Clegg
Glenna Wickett, Brookdale
Julie Ferguson – Advanced-healthcare owner
Leslie Emerick – Director of Public Outreach
Marlene Jones

Wrap up:

Tracy announced the next meeting on Monday, July 30th at 1 pm here in the same room of PPE 152-153, Department of Health campus.

Workgroup session concluded at 5:00 PM

**To view the LTC Session 1 recording, please register for the meeting at the following link and access to the recording will be provided by GoToWebinar.

<https://attendee.gotowebinar.com/recording/4888358720348466440>

Questions Log: Long-Term Care Webinar Session 1: July 10, 2018

Audience Questions:

Q: Can those on the web comment at open mike? [Cheryl Carino-Burr]

A: If we could please get comments in written form through this chat box then comments will be read by Porsche during the Open Mic segment. (We will also save written comments through this mechanism.) Thank you all in advance.

Q: Perhaps I missed it but are there any representatives from any of the colleges to discuss some of the obstacles they are experiencing with training, processes, etc.? [Denise Cooksey] A: The State Board of Technical Colleges is represented and we hope that there are others here to speak during Open Mic. We encourage representatives from our WA colleges to attend and provide testimony.

Q: Were the materials for the meeting emailed to everyone prior? [Carl mason]

A: Yes, the materials and agenda are posted on our website and were sent out to our email listserv. I also just attached the PDF agenda/materials to the handouts section below.

Q: Is there an agenda for today's meeting? If so, could that be shared with the Webinar folks? [Hilke Faber]

A: Hello Hilke, There is an agenda/materials packet and it is now in the handouts tab below.

Q: A note for Cynthia, rural areas do not advertise all openings and they use Agencies. [Cindy Crisler]

A: Thank you Cindy, we will forward your comment to Cynthia.

Q: I would like to speak at the open mike. [Cheryl Carino-Burr]

A: Hello Cheryl, would you be willing to provide your comments in written form?

Q: Yes, that is great. Should I input now so you have time to look it over? [Cheryl Carino-Burr]]

A: Yes please, that would be great. Thank you!

Q: Cheryl Carino-Burr, Educational Case Manager for Healthcare at Puget Sound Welcome Back Center at Highline College. I've been working with internationally educated healthcare professionals for over 8 years. There are 8 Welcome Back Centers around the country, all work with nurses. We have over 800 internationally educated nurses (IENs) in our program. Two

thirds of these IENs currently hold NAC certs in Washington State, yet only one-tenth of these IENs hold an RN license in WA State. I would like to see more representation of this underrepresented group. The barriers to LPN and RN licensure is known by NCQAC, but there is little change. Please look at how moving IENs through the process in a more timely will help with the employment shortages, grow the economy of many communities, and grow the economic mobility of immigrants and refugees. [Cheryl Carino-Burr]

Q: Some Barriers for LPN/RN, how do you propose to get around these problem areas? Colleges such as Clark and Spokane area colleges have done reports that characterized registered nursing as a “surplus” program. These reports were used to justify a 30 percent reduction in the college’s nursing programs (per Washington Center for Nursing-07/2016) LPN’s are constantly feeling pressure that the LPN programs will be discontinued. The number of licensed practical nurses (LPNs) continues to decline. Currently, Washington has 10,338 LPNs, dwindling by about a thousand each year (per Washington Center for nursing -07/2016)

1) It is extremely difficult to get into a nursing program (RN) due to lack of available program spots.

2) LPN’s feel that their roles are being phased out and usually are offered low pay.

3)Nurses / CNA’s are being forced to wade through a huge work load and harassed for any overtime needed to complete patient care (this includes part time employees who need to work over their 8 hours.). [Deborah Clegg]

A: Thank You Deborah, your comments will be shared with the workgroup.

Q: Thank you. Am wondering how the Center for Nursing and Sofia Aragon are involved with all this? [Hilke Faber]

A: Hello Hilke, I know that Sofia Aragon is aware through the work being done on Action Now and we encourage any/all additional participation. The workgroup members were specifically named in the Budget Proviso included in the handout below.

Q: I noticed on the agenda that reading materials were provided to workgroup members in advance and wonder if any advanced materials can be made available in advance to registered webinar participants? [Mary Baroni]

A: Hello Mary, we did post the materials/agenda on the web, but I think you are correct and we should definitely look at getting the materials out to all those registered for the next meeting. Thank you!

Q: Regarding employment and retention of CNAs. [Marlene Jones]

Q: There are incentives for Home Care Agencies to retain employees (HCAs mostly) due to the existing training partnership that exists between SEIU and Washington state. This partnership enables Home Care Agencies to hire and train staff free of charge (subsidized by the partnership). Low cost insurance is also offered to Home Care Agency employees which is another benefit of the partnership. If these incentives were available to nursing homes and assisted living facilities who need to hire CNAs, that attraction to keep the job would increase. I

am acquainted with employees of Home Care Agencies that say because they have benefits, they are holding on to their jobs because the insurance cost to them monthly is approx. \$25. Long term care patients are more debilitated these days and are in need of workers who can care for them with adequate health care training. CNA education encompasses health care tasks and their scope of practice is broader, which is why Home Care Aides cannot work in skilled nursing. SNFs could possibly attract and retain them if they made the job more attractive, not only with monetary enticement, but with a change of culture where the patient is placed first and the employee is valued. These attributes of employers rarely exist in the Nursing Home setting. It's a little better in the ALF. [

[Marlene Jones]

A: Thank you Marlene, your comments will be shared with the workgroup members.

Q: I was offered 50k/year to instruct at a community college IF I obtained my MSN. Just couldn't afford to live on that. [Lisa Dellaquila]

Q: From a few nurses who are currently in the field, LPN's are pushed to become RN (preferably 4-year) and this "new students" are encourage to bypass the LPN programs. There has been an on- going rumor that LPN programs are being phased out. [Deborah Clegg]

Q: Actually, the benefits in a nursing faculty position are excellent, even though the salary is lower than desired. [Marlene Jones]

Q: LPN is actually doing RN jobs. [Lena Spohn]

Q: I hope that sometime during the work of this council, the topic of foreign nurse recruitment is discussed. [Alex Candalla]

Q: In order for us to comply with the 24-HR RN requirement, despite all efforts to find RNs locally, we struggle remaining in compliance. [Alex Candalla]

Q: We resorted to hiring a recruiting agency, paid a hefty amount of money to bring in 4 RNs in the state. When they arrived here, we had to put them on payroll but it took them 4-6 months to get their valid WA license. [Alex Candalla]

Q: How can we make it easier for their foreign recruits to get their licenses approved faster than half a year? [Alex Candalla]

Q: Our Company is assisting RN's with immigration to the US from the Philippines. [Kristina Hart]

Q: Facilities are being given high-level citations for staffing related issues (call-lights/skin/quality of care) and part of the punishment for that is the facility is no longer allowed to have a CNA certification program. How does that make sense? If a county has a particularly intense survey team, they can systematically knock out all the CNA programs in the area. Even if someone wanted to become certified, there is nowhere to go in their vicinity. Maybe high-level citations shouldn't automatically disqualify a facility from having a CNA program, but instead prompt a survey of that program to ensure it isn't part of the problem? Facilities are being given high-level citations for staffing related issues (call-lights/skin/quality of care) and part of the punishment for that is the facility is no longer allowed to have a CNA certification program. How does that make sense? If a county has a particularly intense survey team, they can systematically knock out all the CNA programs in the area. [Lisa Dellaquila]

Q: Thank you, Mindy. You put forth my concerns very well. [Cheryl Carino-Burr]

Q: The American Nurses Association wants all RNs to be BSNs at the entry level. It was stated that this would be a prerequisite by 2018 for getting a nursing job in a hospital here in Washington. This development would eliminate the LPN alternative. [Marlene Jones]

A: Thank you all for the additional comments and any that were not included during the Public Comment segment of the meeting will be added to the meeting notes.

Long-Term Care Workshop

Evaluation of Session 1

Eleven filled out the Session 1 Evaluation Forms. From the eleven (11), ten (10) completed numeric ratings and seven (7) provided narrative ratings/comments as noted. The results are as follows:

Content:

Average – **3 Stars**

Comments specific to Content:

- Good, especially the Carma Matti-Jackson presentation

Outcomes:

Average – **3 Stars**

Comments specific to Outcomes:

- Difficult to assess.
- Work plan revisions.
- Would prefer more action items.

Process:

Average – **3 Stars**

Comments specific to Process:

- The final presentation addressed the proviso requirements.
- A little slow in process.

Facilities:

Average – **4 Stars**

Comments specific to Facilities:

- Great
- Room cold

General comments:

- At least we got started! Much more to do and members and homework assigned before they go home.
- Insure presentations are aligned to the answering proviso questions.
- I am in the right place to help more LTC/Community Based Care into a more respected/appreciated care setting employment.
- I think things went well all things considered. I appreciate the Senator and Representative input.

- If you could please send and speaking questions posed to the workgroup before the meeting that would be great. More short breaks to allow team to refresh themselves.
- Good Start! Thank you!

Other topics:

- ❖ Registered Apprenticeship
- ❖ As was stated, I hope we align to the goals of the proviso to maximize our effectiveness.

Long term care workforce- What can the data tell us?

Long Term Care Workgroup
July 10, 2018

Cynthia Forland, CIO and Assistant Commissioner
Workforce Information & Technology Services



Long term care industries

Long term care services and supports are primarily provided in the following industries:

- ▶ Home health care services
- ▶ Nursing care facilities
- ▶ Residential mental health facilities
- ▶ Community care facilities for the elderly
- ▶ Other residential care facilities
- ▶ Individual and family services
- ▶ Vocational rehabilitation services
- ▶ Private households

Long term care industry employment (current and projected)

- ▶ Long term care industry currently employs over 165,000 people—5% of total state workforce.
- ▶ By 2026, long term care industry is projected to increase by over 27,000—an annualized increase of 1.5%.

Industry	2017Q2	Estimated employment	
		2021	2026
Home health care services	11,550	12,714	14,050
Nursing care facilities	22,744	22,889	23,079
Residential mental health facilities	8,145	8,821	9,905
Community care facilities for the elderly	31,103	34,768	39,166
Other residential care facilities	1,622	1,810	2,032
Individual and family services	75,147	83,333	87,908
Vocational rehabilitation services	8,208	8,846	9,497
Private households	7,253	7,357	7,345
Total	165,771	180,538	192,981

Source: Employment Security Department/WITS, 2018 Industry Employment Projections; Bureau of Labor Statistics, Quarterly Census of Employment and Wages

Long term care occupations

Long term care services and supports are primarily provided by the following occupations:

- ▶ Home health aides
- ▶ Psychiatric aides
- ▶ Nursing assistants
- ▶ Personal care aides

Long term care occupational employment (current and projected)

- ▶ Long term care occupations currently employ over 94,000 people—2.5% of total state workforce.
- ▶ By 2026, long term care occupations are projected to increase by over 18,000—an annualized increase of 1.8%.

Occupation	2017Q2	Estimated employment	
		2021	2026
Home health aides	9,327	10,230	11,023
Psychiatric aides	94	103	112
Nursing assistants	31,459	33,659	35,775
Personal care aides	53,447	60,191	65,689
Total	94,327	104,183	112,599

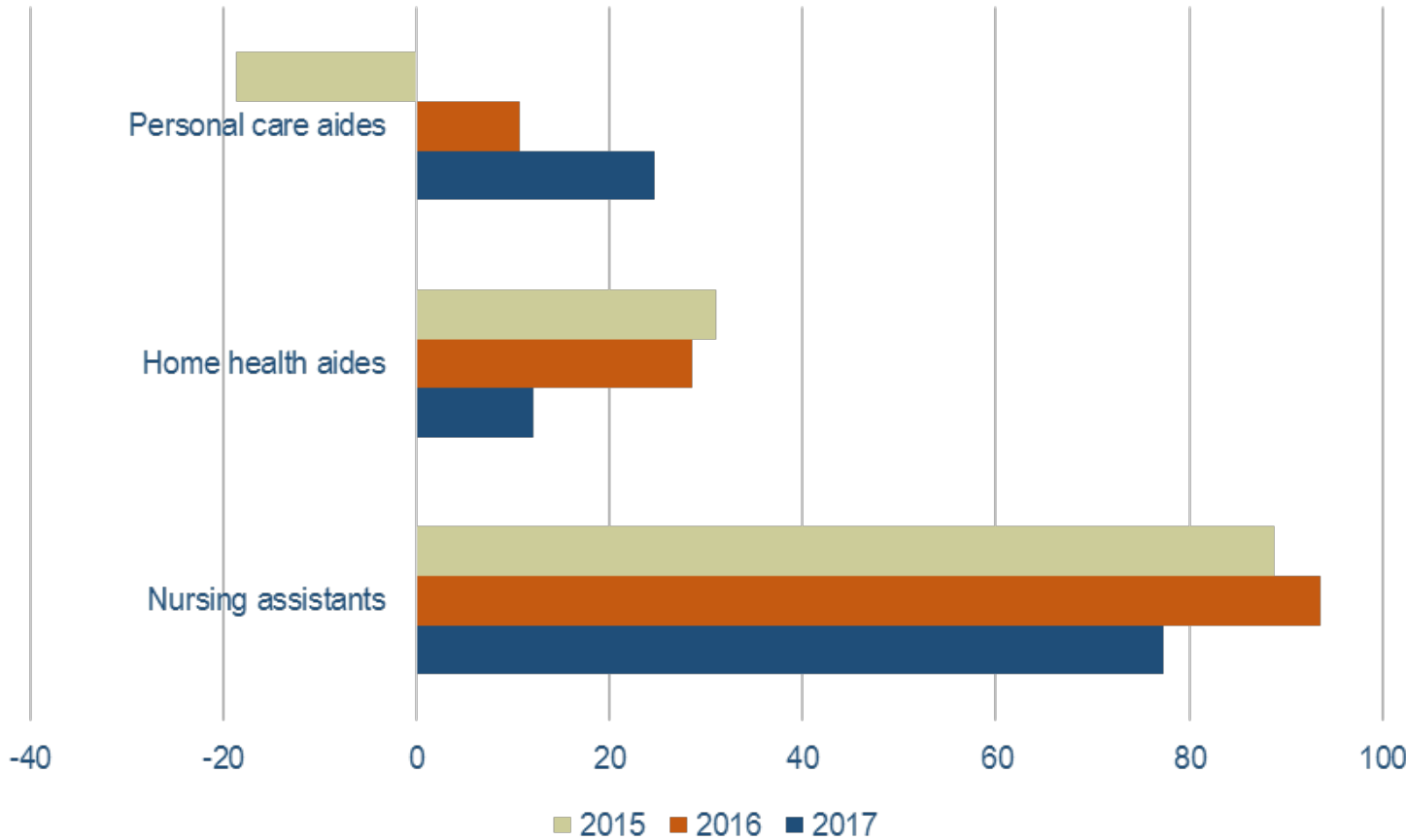
Source: Employment Security Department/WITS, 2018 Occupational Employment Projections; Bureau of Labor Statistics, Occupational Employment Statistics

Long term care job vacancies

Occupation	Job postings (May 2018)
Home health aides	184
Psychiatric aides	-
Nursing assistants	353
Personal care aides	383
Total	920

Source: Employment Security Department/WITS; WANTED Analytics

Long term care job vacancies vs. available workforce



Source: Employment Security Department/WITS; WANTED Analytics

Any questions?

Cynthia Forland

CIO and Assistant Commissioner
Workforce Information & Technology Services
Employment Security Department
(360) 507-9501

Cforland@esd.wa.gov

esd.wa.gov/labormarketinfo

Washington State's Nurses in Long Term Care: Recent Research Findings

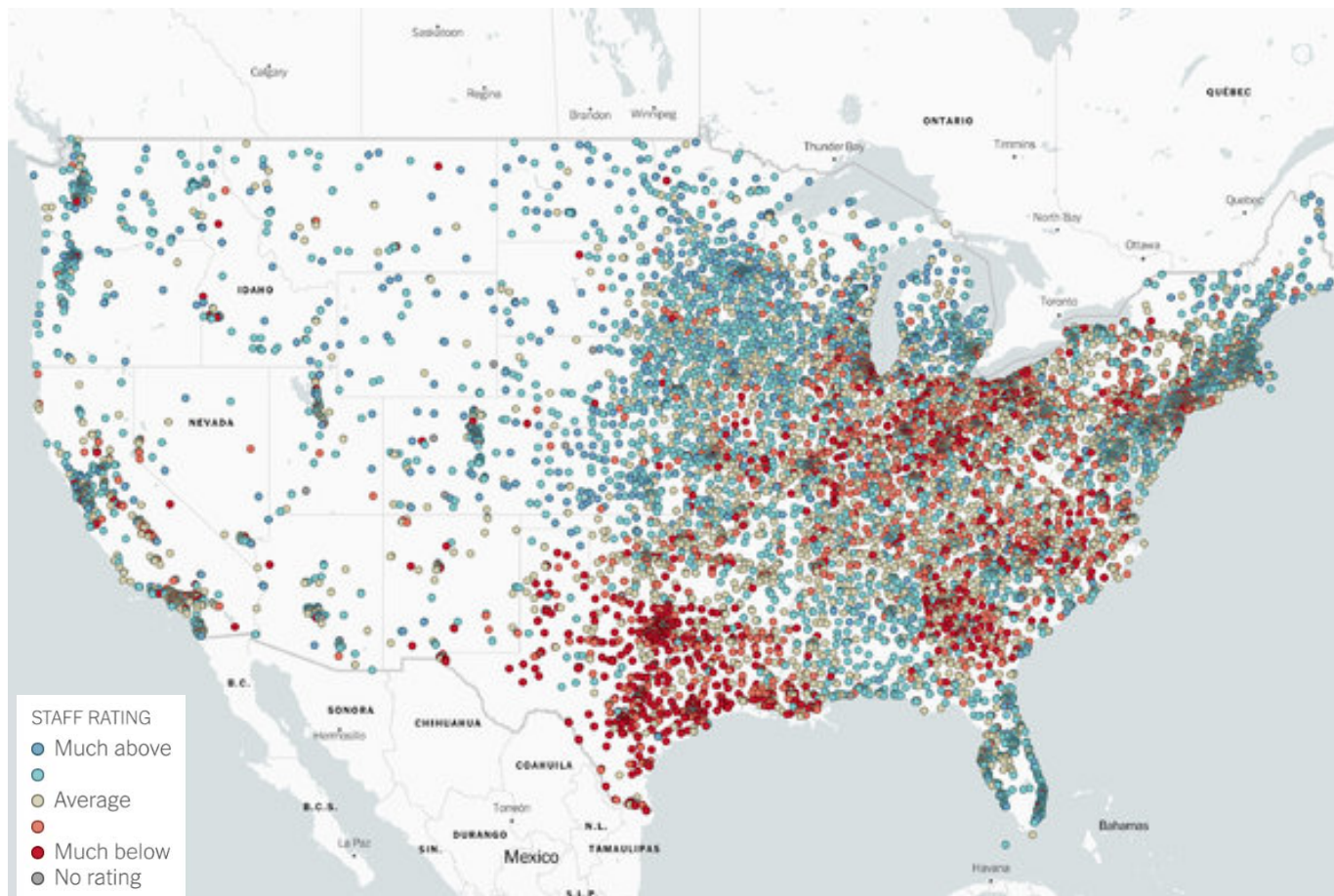
Nursing and Long Term Care Workshop
Tumwater, WA
July 10, 2018

Sue Skillman, Deputy Director
Center for Health Workforce Studies
University of Washington

How Staffing Fluctuates at Nursing Homes Around the United States

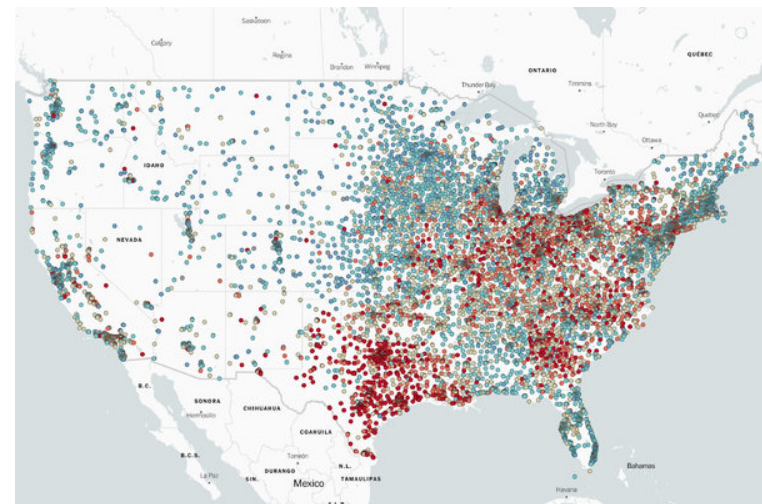
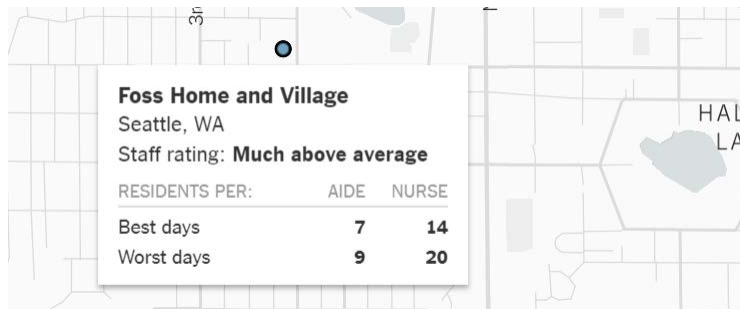
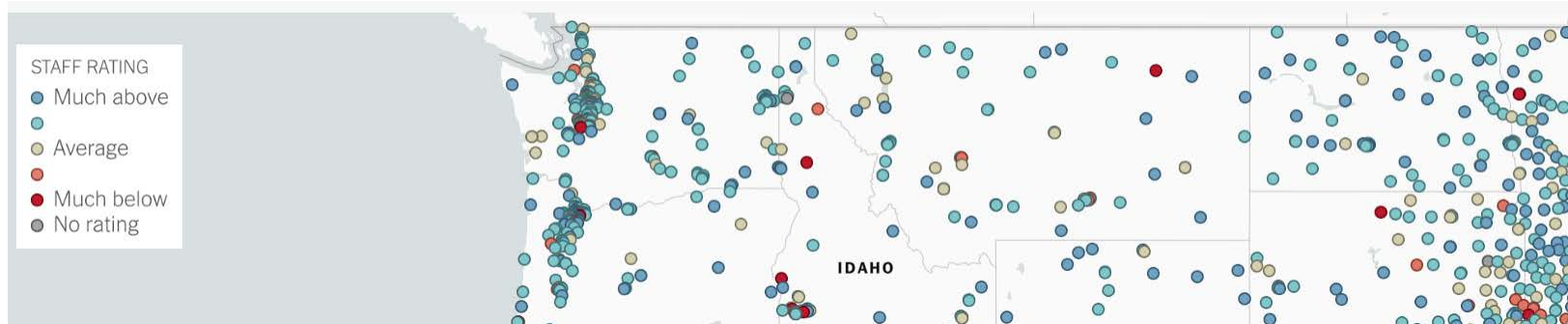
By JEREMY WHITE JULY 7, 2018

The number of staff members at nursing homes varies drastically at facilities across the country. See how more than 14,000 nursing homes rate using Medicare's assessment of overall staffing.



“The data, analyzed by [Kaiser Health News](#), come from daily payroll records Medicare only recently began gathering and publishing from more than 14,000 nursing homes, as required by the Affordable Care Act of 2010.”

The good news ...



Although worthy of more discussion.

Preliminary Findings: Washington State RN Survey

Survey of Washington's Registered Nurses

Thank you for participating in this survey. Your confidential input will strengthen understanding of Washington's current nursing workforce, and inform policymakers and educators about future needs. The information from this survey will be used to create a baseline profile of the state's nurses that can be compared with findings from data collected through license renewals in the years to come.



**CENTER FOR HEALTH
WORKFORCE STUDIES**
UNIVERSITY of WASHINGTON

Survey Design and Analysis Team

Sue Skillman, Deputy Director

Ben Stubbs, Research Scientist

UW Center for Health Workforce Studies

Survey Contractor

Social and Economic Sciences Research

Center, Washington State University

Funding

Washington Center for Nursing, through
Washington State Department of Health
Grant #N14191



WA RN Survey Design

Questionnaire:

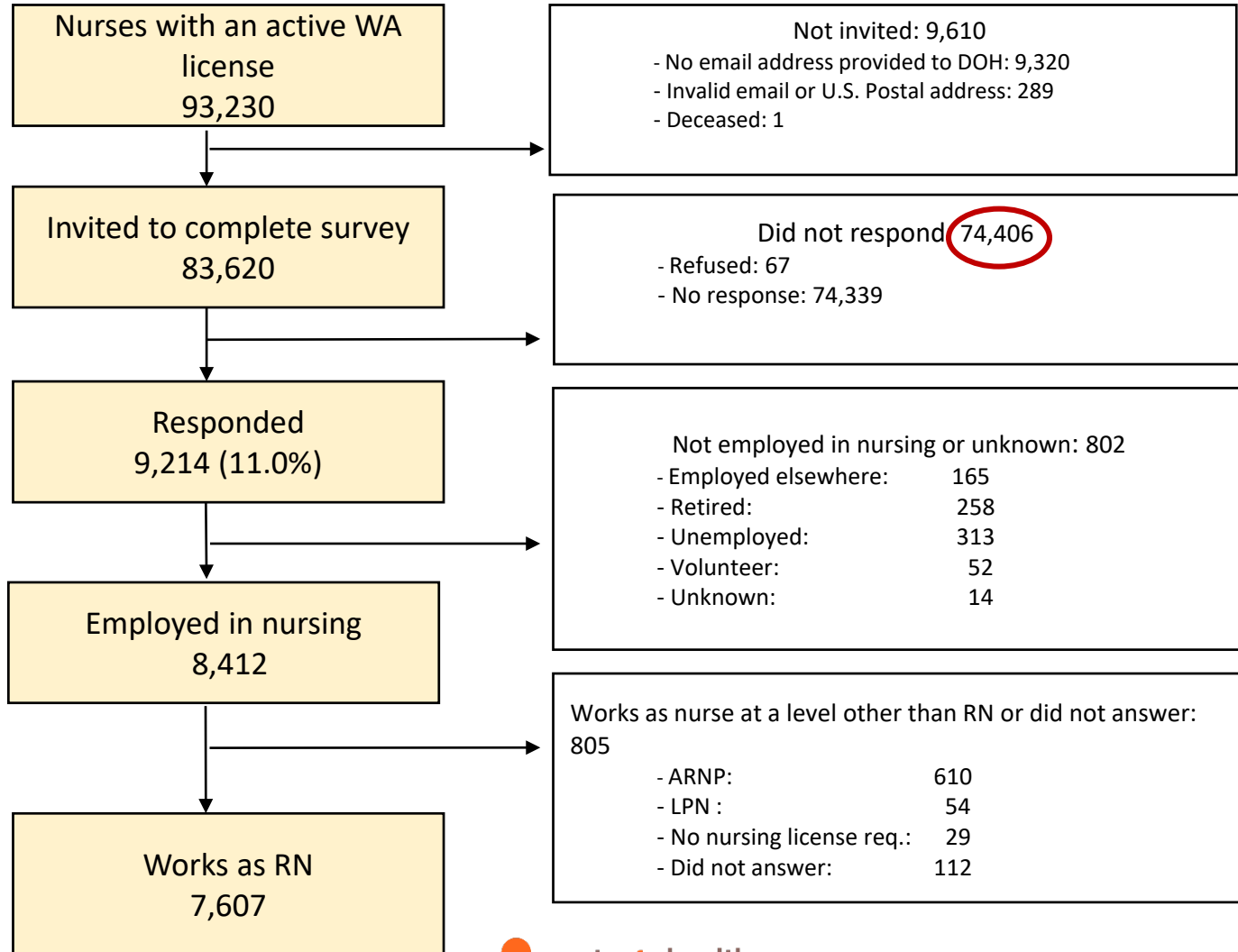
- Nursing Minimum Data Set questions PLUS 12 job/career satisfaction questions

Survey included all RNs with email addresses and a random sample for mailed contact (to ensure inclusion of those with no email addresses and to reduce possible bias)

Among all 93,230 RN licenses in Fall 2017:

- Paper questionnaire and online survey
- Randomly selected 5,000 for survey recruitment via paper invitation letter (directing to online survey) and paper questionnaire followup with postcard reminder (US mail)
- Email invitation to all with email addresses in license record
- Up to 5 email contact attempts and 3 paper mailed contacts

Washington RN Survey: Responses



RN Survey Respondents (9,214)

Compared with non-respondents (from licensure file data) on age and geographic distribution :

- Somewhat fewer respondents in youngest age groups and more in older age groups
- Respondents similarly distributed by health planning regions, but some differences

Therefore, data weights were applied to adjust for age and geographic differences.

Washington RN Survey: Satisfaction, Career Plans

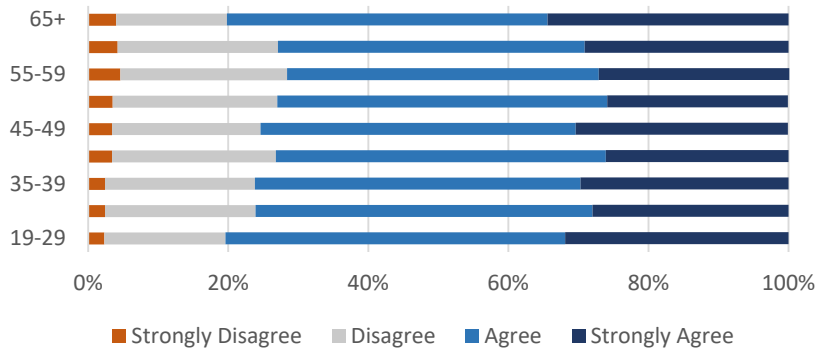
Definitions: **Primary nursing position** is the position at which you work the most hours during your regular work year. **Secondary nursing position** is the position at which you work the second greatest number of hours during your regular work year, if applicable.

Q3. Please rate your level of agreement with the following statements about your **primary nursing position** (select **one** answer for each statement).

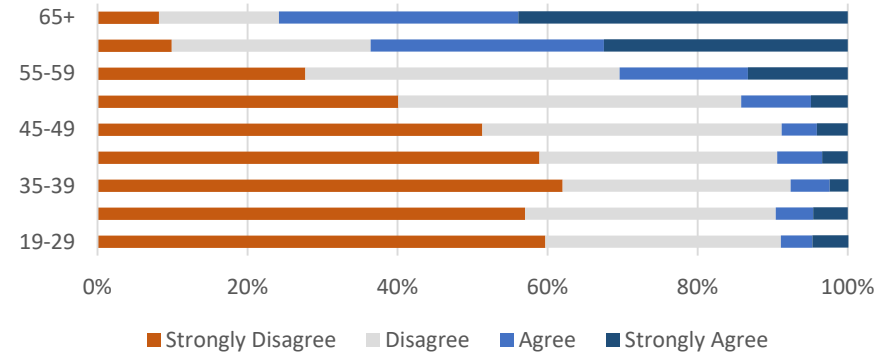
	Strongly Agree	Agree	Disagree	Strongly Disagree
I am satisfied with my primary nursing position	④	③	②	①
I have opportunities at work to learn and grow	④	③	②	①
My work gives me a feeling of accomplishment	④	③	②	①
I am satisfied with my opportunities for career advancement	④	③	②	①
My place of work provides high quality patient care	④	③	②	①
The number of nursing staff where I work is adequate	④	③	②	①
I feel overwhelmed by the amount of work that I am given	④	③	②	①
My workplace provides care in a culturally sensitive manner	④	③	②	①
I would recommend nursing as a career to a close friend or family member	④	③	②	①
I plan to seek training and/or employment in another nursing role in the next 5 years	④	③	②	①
I plan to complete a higher level of nursing education within the next 5 years	④	③	②	①
I do not plan to be employed in nursing 5 years from now	④	③	②	①

Washington RN Survey: Satisfaction by Age Groups

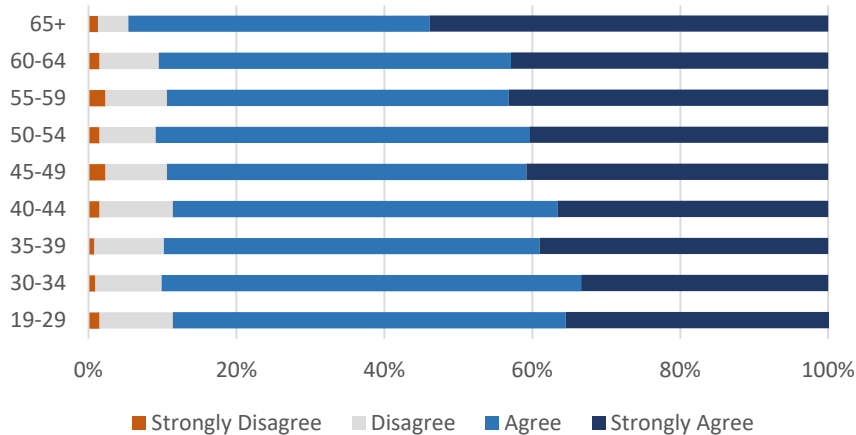
I am satisfied with my opportunities for career advancement



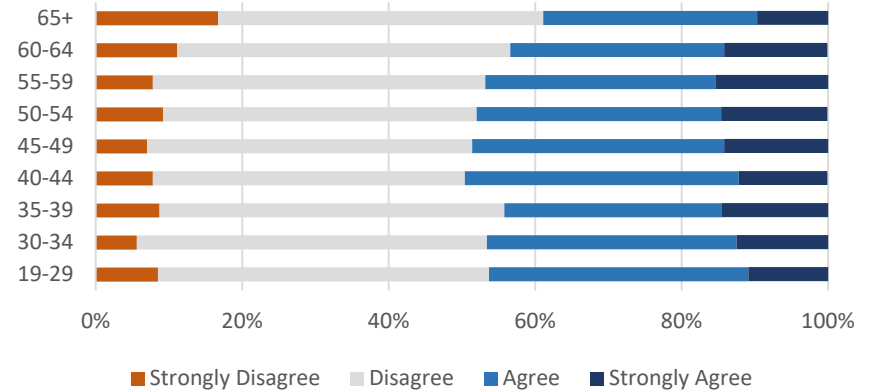
I do not plan to be employed in nursing 5 years from now



I am satisfied with my primary nursing position

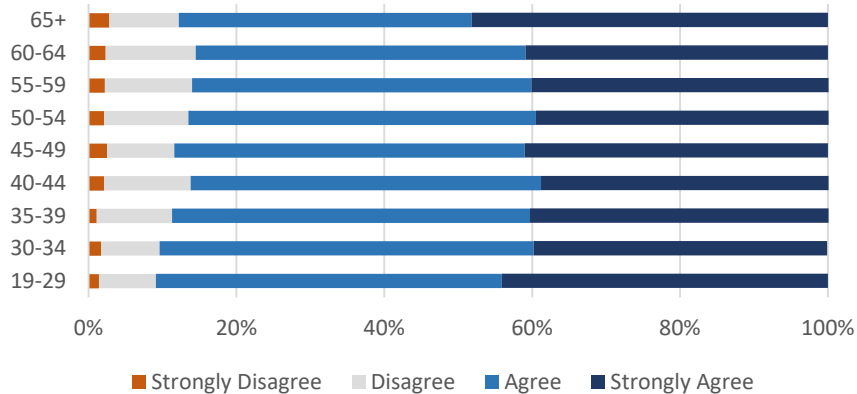


I feel overwhelmed by the amount of work that I am given

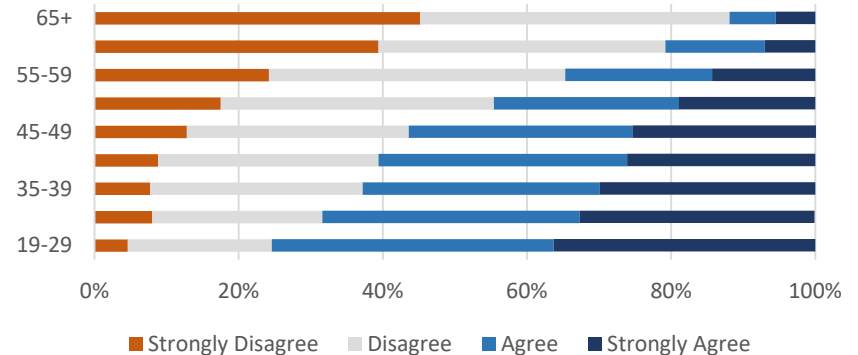


Washington RN Survey: Satisfaction by Age Groups

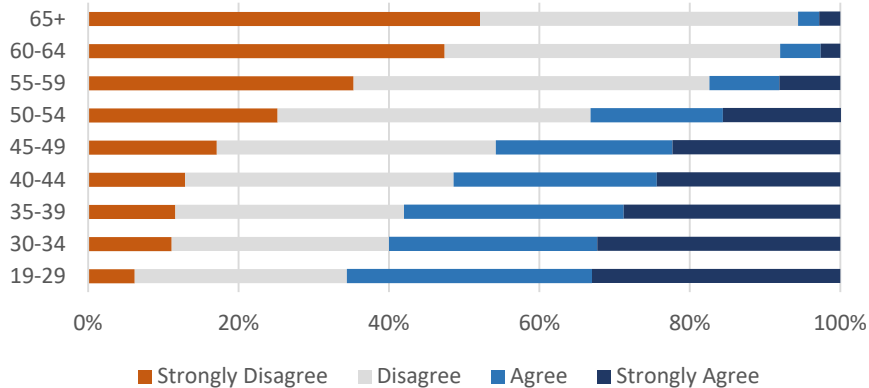
I have opportunities at work to learn and grow



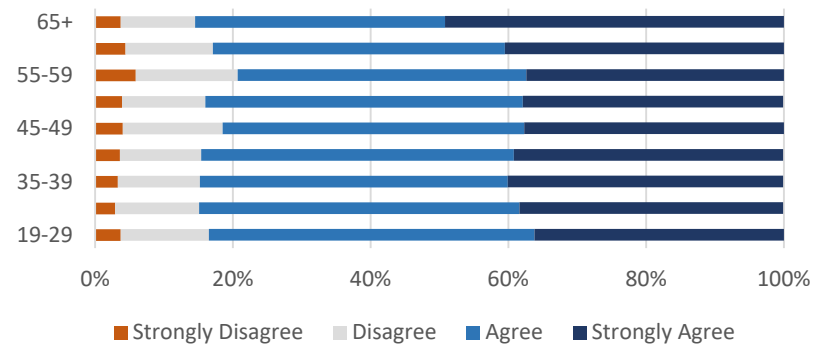
I plan to seek training and/or employment in another nursing role in the next 5 years



I plan to complete a higher level of nursing education within the next 5 years

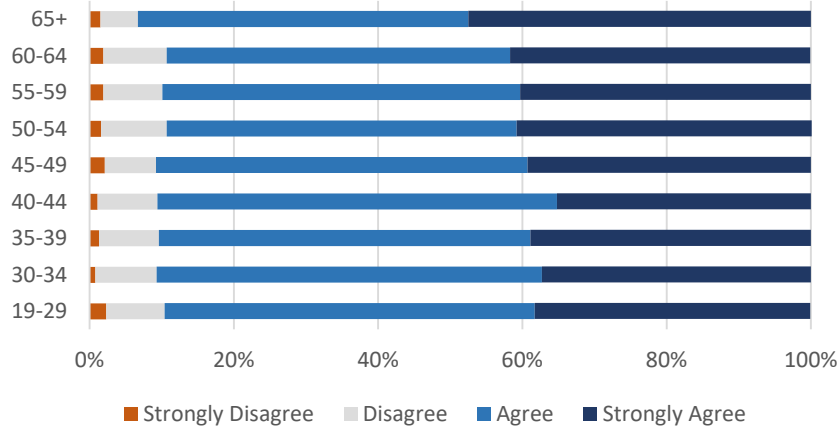


I would recommend nursing as a career to a close friend or family member

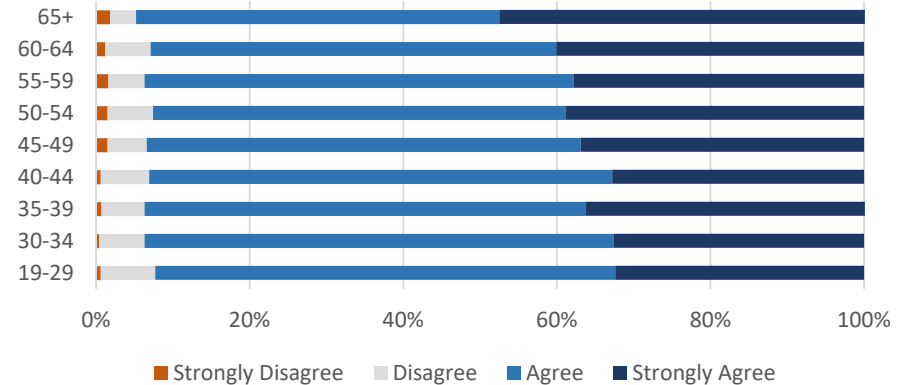


Washington RN Survey: Satisfaction by Age Groups

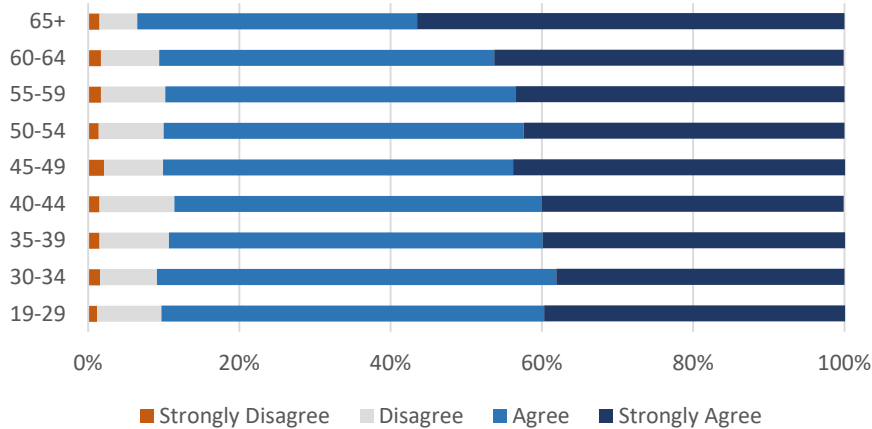
My place of work provides high quality patient care



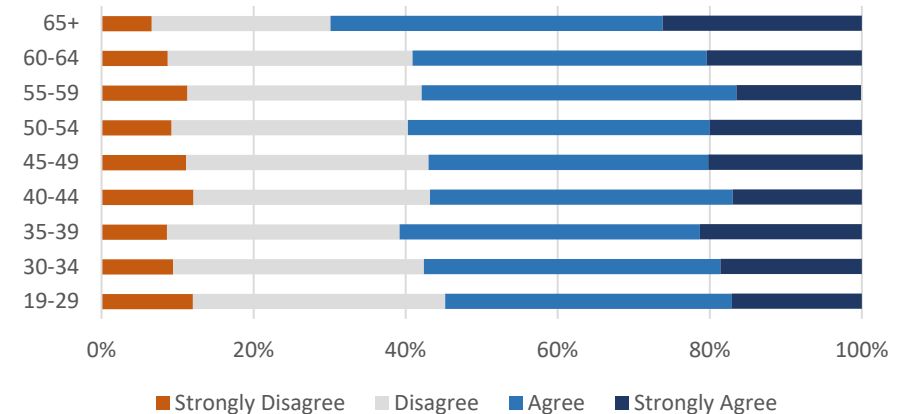
My workplace provides care in a culturally sensitive manner



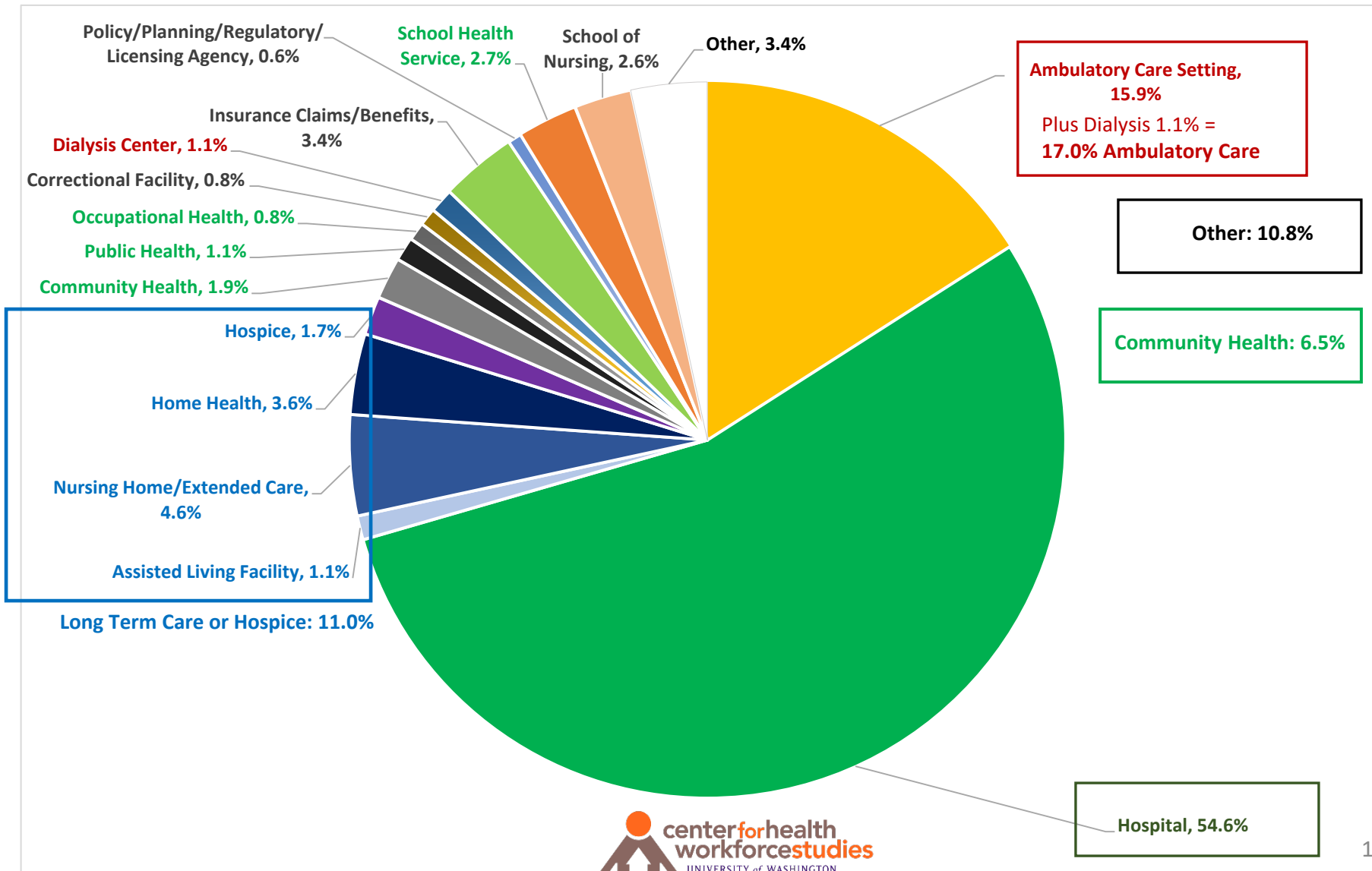
My work gives me a feeling of accomplishment



The number of nursing staff where I work is adequate

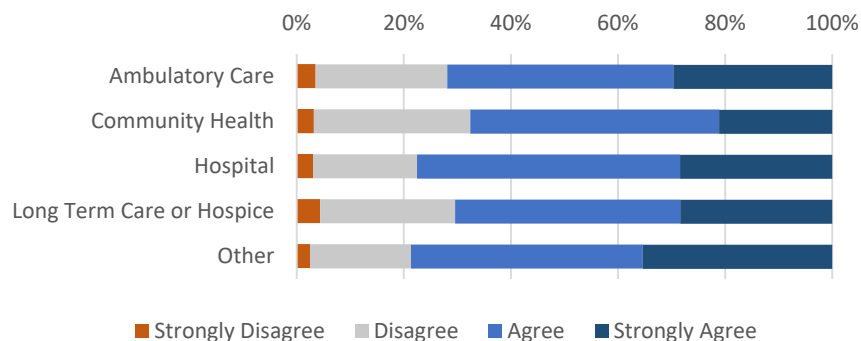


Washington RN Survey: Setting Groupings

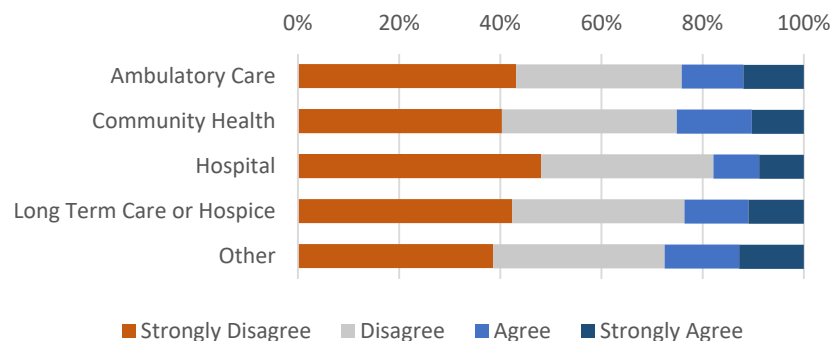


Washington RN Survey: Satisfaction by Setting

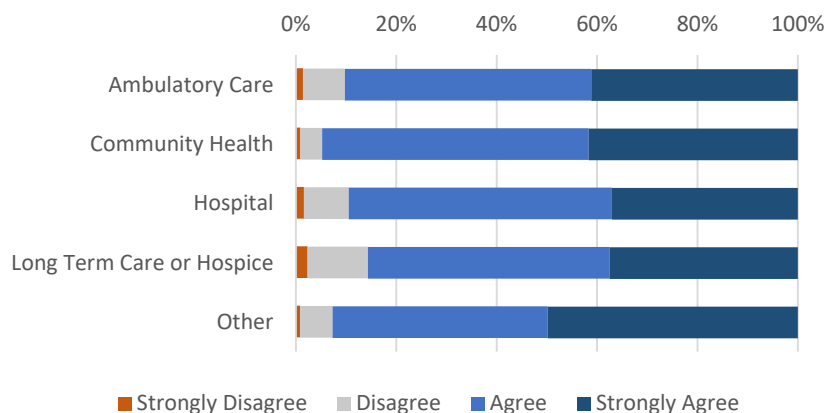
I am satisfied with my opportunities for career advancement



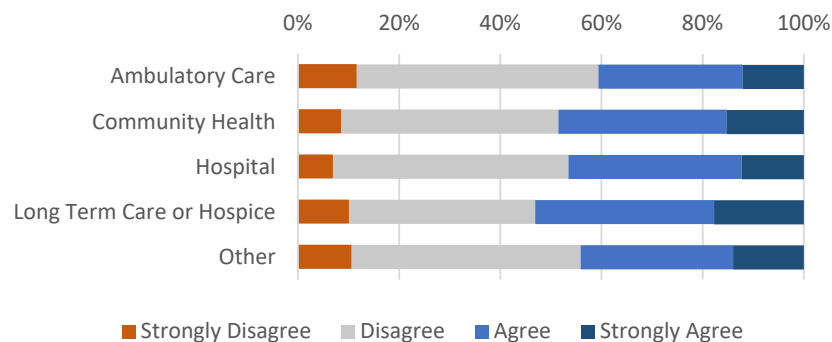
I do not plan to be employed in nursing 5 years from now



I am satisfied with my primary nursing position

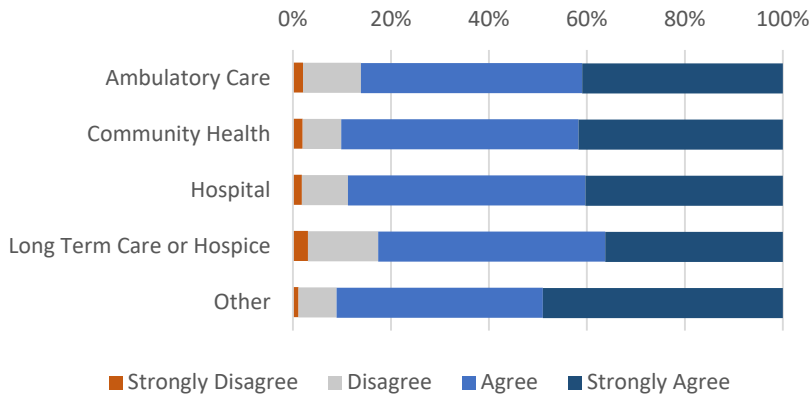


I feel overwhelmed by the amount of work that I am given

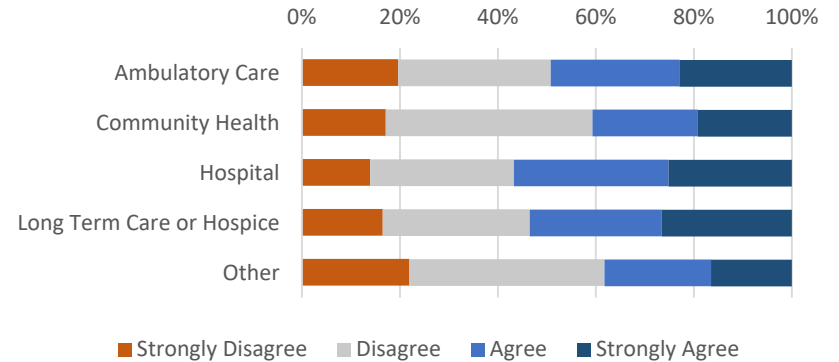


Washington RN Survey: Satisfaction by Setting

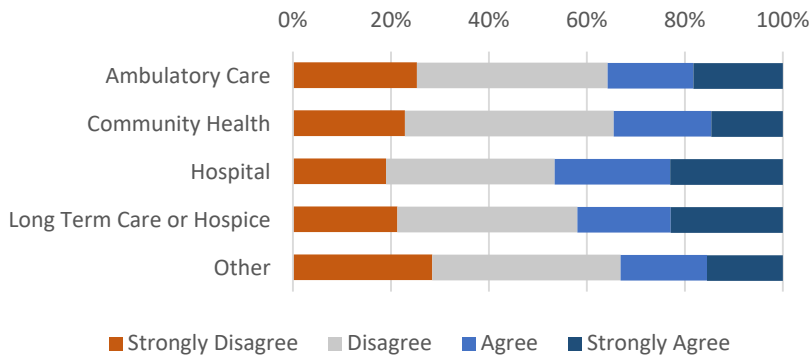
I have opportunities at work to learn and grow



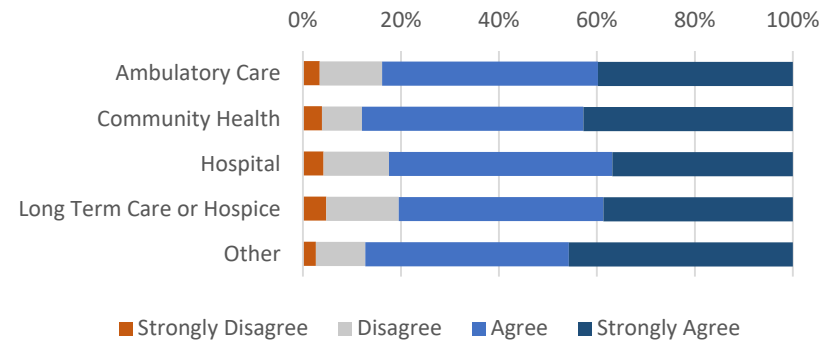
I plan to seek training and/or employment in another nursing role in the next 5 years



I plan to complete a higher level of nursing education within the next 5 years

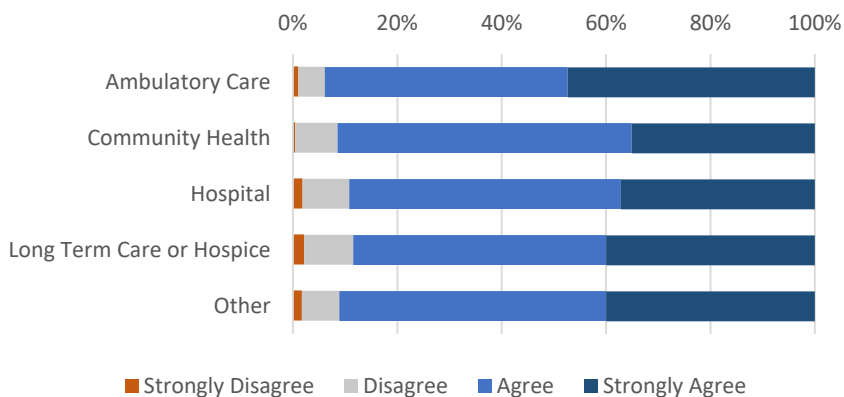


I would recommend nursing as a career to a close friend or family member

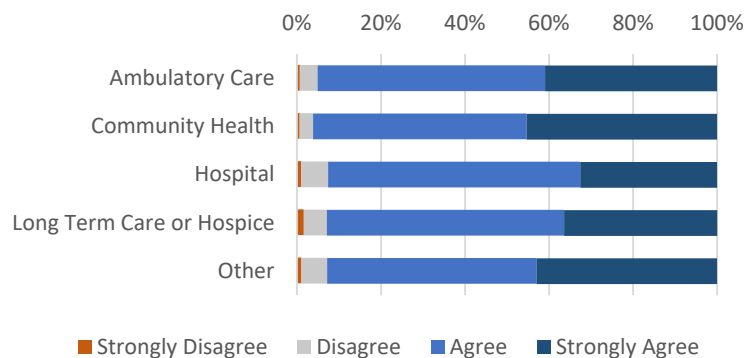


Washington RN Survey: Satisfaction by Setting

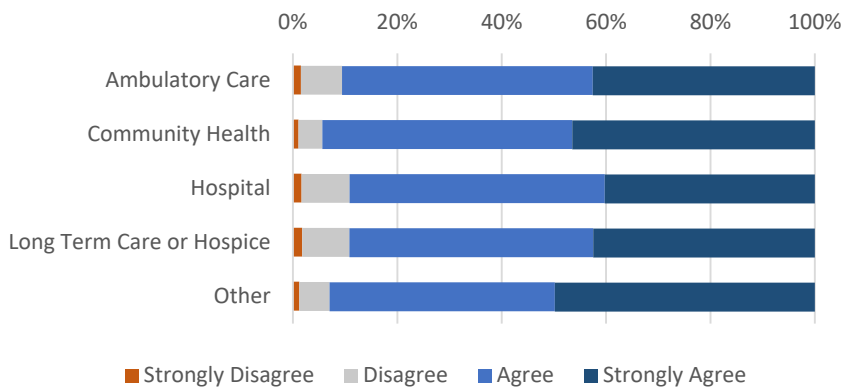
My place of work provides high quality patient care



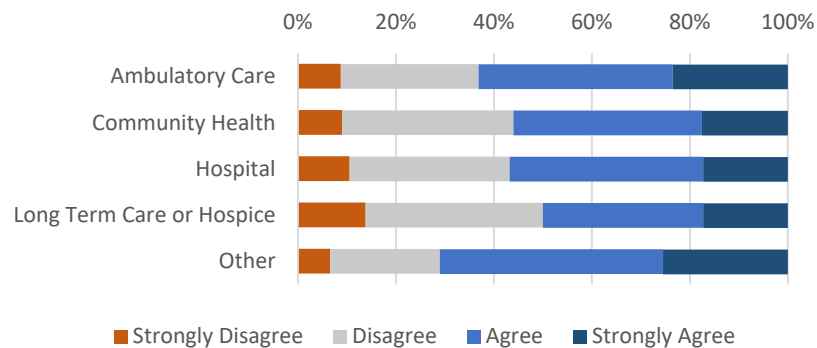
My workplace provides care in a culturally sensitive manner



My work give me a feeling of accomplishment



The number of nursing staff where I work is adequate



Washington State's RN Survey – Lessons Learned (so far)

- *Washington's RNs are quite satisfied with their jobs and roles*
- *More to come – analyses in process*

Workforce Demand in Long Term Care Facilities

Findings from the Washington State Health Workforce Sentinel Network

Project Team:

Susan Skillman, Deputy Director

Ben Stubbs, Research Scientist

Amy Clark, Web/Social Media Manager

University of Washington

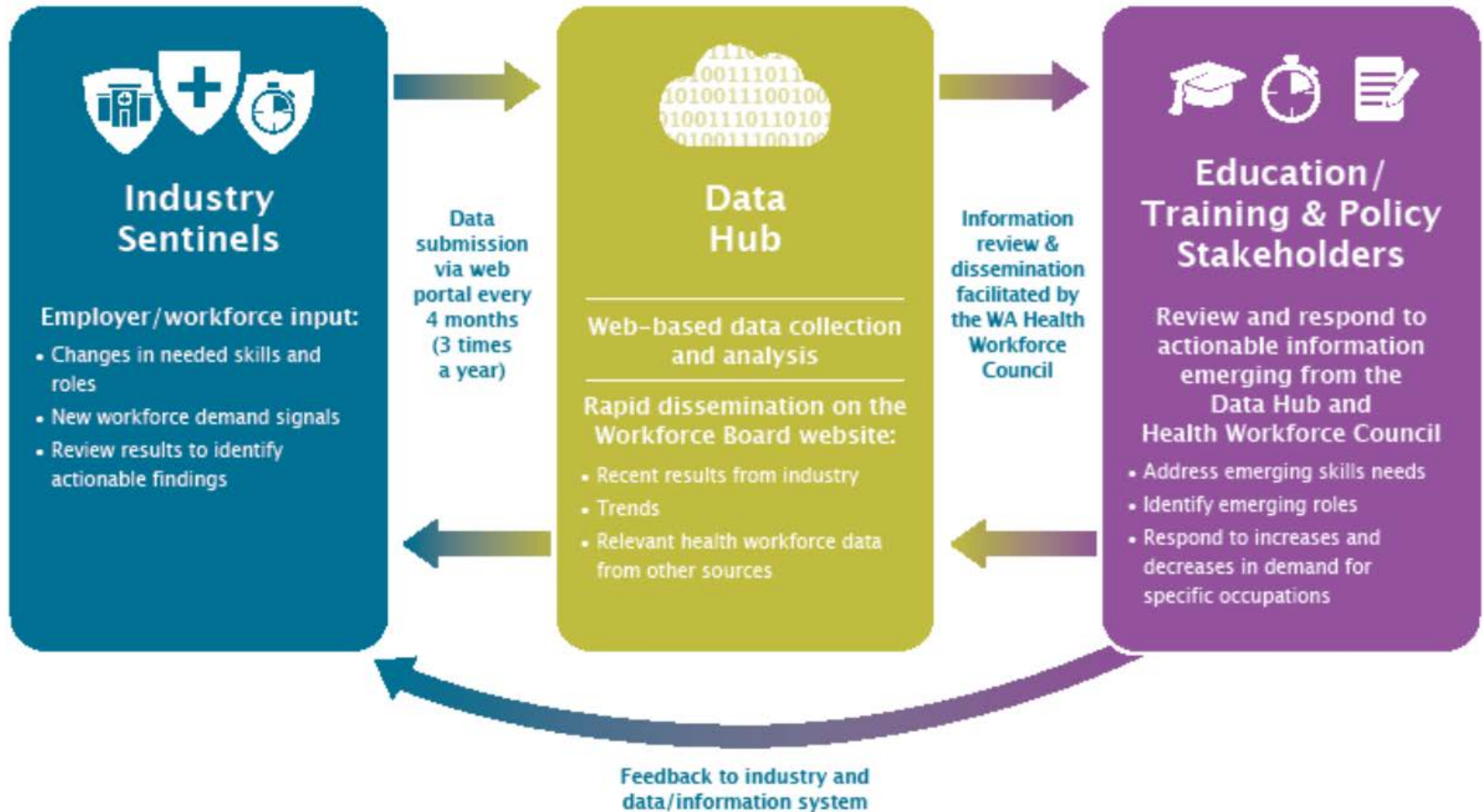
Center for Health Workforce Studies



In collaboration with
the Washington State Health Workforce Council



Washington's Health Workforce Sentinel Network



Funding

Initial: Washington State *Healthier Washington* Initiative (CMMI SIM grant & CMS DSRIP – Medicaid Transformation), subcontract

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Current: Workforce Innovation and Opportunity Act (WIOA) Governor's Discretionary Funds

To: Washington State Workforce Training and Education Coordinating Board, subcontracting with University of Washington Center for Health Workforce Studies

Registration and Questions

Questions

Recently (in the past 3–4 months):

- *Occupations experiencing exceptionally long vacancies*
- *Occupations with increased or decreased demand*
- *New occupations that they did not previously employ*
- *New roles for existing employees*
- *Changes in orientation/onboarding procedures for new employees*
- *Changes in training priorities for existing employees*

AND qualitative input about which, how, and reasons why

Sentinel Data Collection Dates

Round 1:
Jun/Jul
2016

Round 3:
Apr/May
2017

Round 5:
begins
July 16, 2018

Round 2:
Nov/Dec
2016

Round 4:
Sept/Oct
2017

Round 6, 7....
Dates to be
determined



Phase I

Phase II

Screen Shot – Sentinel Network Dashboard

www.wasentinelnetwork.org

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Washington State Health Workforce Sentinel Network

HOME TEAM FINDINGS

Findings as reported by facility type

Click on the buttons to explore the results by question topic; use the menu that will appear in the sidebar as you scroll to explore findings by other questions.
[Click here to see all questions asked of Sentinels.](#)

Vacancies Demand Increase Demand Decrease Onboarding Training New Roles
New Occupations

Who We Are
What We Do
What's New
State Strategic Plan
Research & Reports
Private Career Schools
Veterans Programs
Career Resources

Washington Career Bridge
Find the education & training you need to get the job you want

Washington State's Sentinels Report --

Long Term Care facilities - 7/16 to 10/17

(skilled nursing, home health, nursing and personal care, intermediate care)

Experiencing exceptionally long vacancies and/or increased demand

- Nursing assistants, registered nurses, and licensed practical nurses were the top occupations
- Home health aides, home care aides, physical therapists, nurse practitioners, occupational therapists, and clinical social workers were also mentioned

New roles and new occupations

- For new regulatory requirements specific to LTC facilities, including updating internal policies/procedures, data collection and interpretation
- Organizing new training activities

Washington State's Sentinels Report --

Registered Nurses

Examples of reasons for RNs' exceptionally long vacancies:

Long Term Care (home health, skilled nursing, nursing and personal care)

- Not enough RNs for all the facilities and hospitals and a new regulation requiring skilled nursing facilities to have 24 hour RN coverage (SNF)
- Nursing homes are unattractive to potential candidates, low candidate pool, competition with local hospital (pay/environment) (NH)
- A local hospital opened over 100 RN positions. Severe impact on community. Not enough RNs to fill open positions.
- Lack of experienced RNs willing to work in this capacity (HH)
- Multiple new jobs being opened to RNs. (SNF)
- Wage compression from new minimum wage (SNF)
- In rural areas, it's hard to find enough local candidates

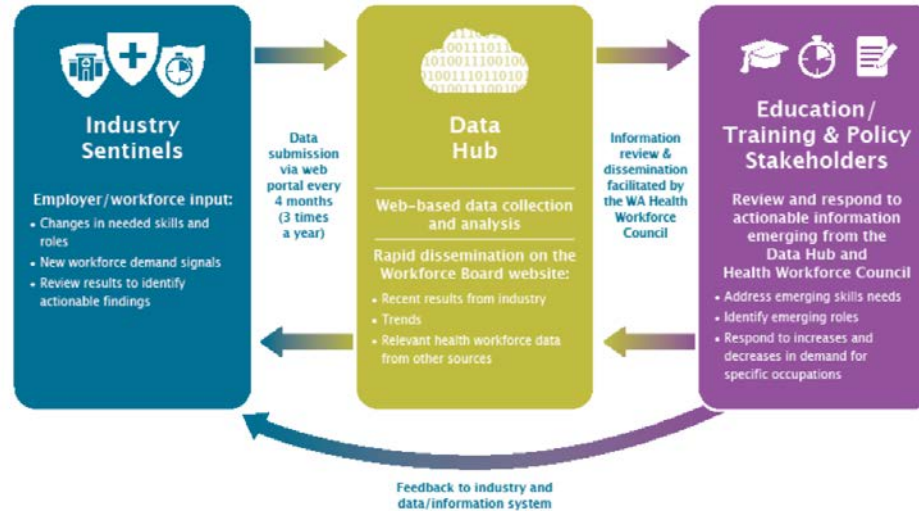
Washington State's Sentinels Report --

Examples of reasons for exceptionally long vacancies and demand increase:

Long Term Care

- **Nursing assistants (SNF):** low compensation for experienced NACs, workforce does not meet demand; State approval of training classes not forthcoming despite very high need; Not enough people staying in the position. Many go on to nursing school.
- **LPNs (Intermediate care facility):** Low compensation, low benefits, unemployment rate, high nursing demand.
(Nursing & Personal Care Facility not SNF): No local training program.
(SNF): more jobs than there are LPN to fill positions. Wage rates increased, still multiple openings. Retirement, more career options, schools not producing enough new nurses, regulatory staffing requirements, wage rates not competitive.

Washington's Health Workforce Sentinel Network



Next Sentinel Network data submission opportunity opens July 16!
www.wasentinelnetwork.org

*Register now and join other employers
to make your workforce needs known*

Thank you! Questions?

Sue Skillman, MS, Deputy Director

Website: <https://depts.washington.edu/fammed/chws>

Facebook: <https://www.facebook.com/uwchws>

Twitter: @uwchws using #uwchws20



C.Matti Consulting, LLC
Simplifying Complexities for Senior Service Providers

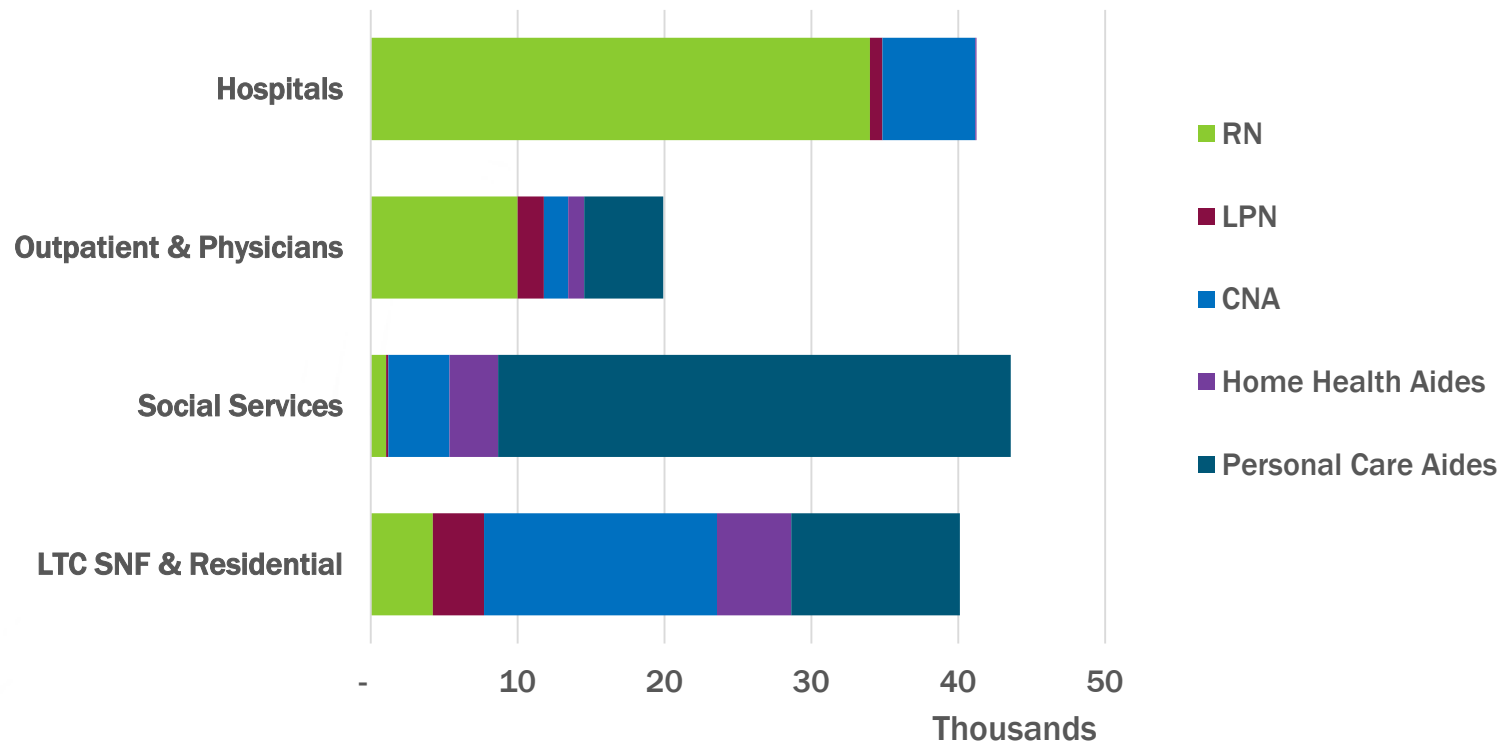


LTC Workforce: Data and Trends

Carma Matti-Jackson, MBA (TIM)
CEO, C.Matti Consulting
7.10.2018

Washington's Nursing Workforce is about 145,000 Employees

28% are Employed by LTC Skilled Nursing Facilities & Residential Services

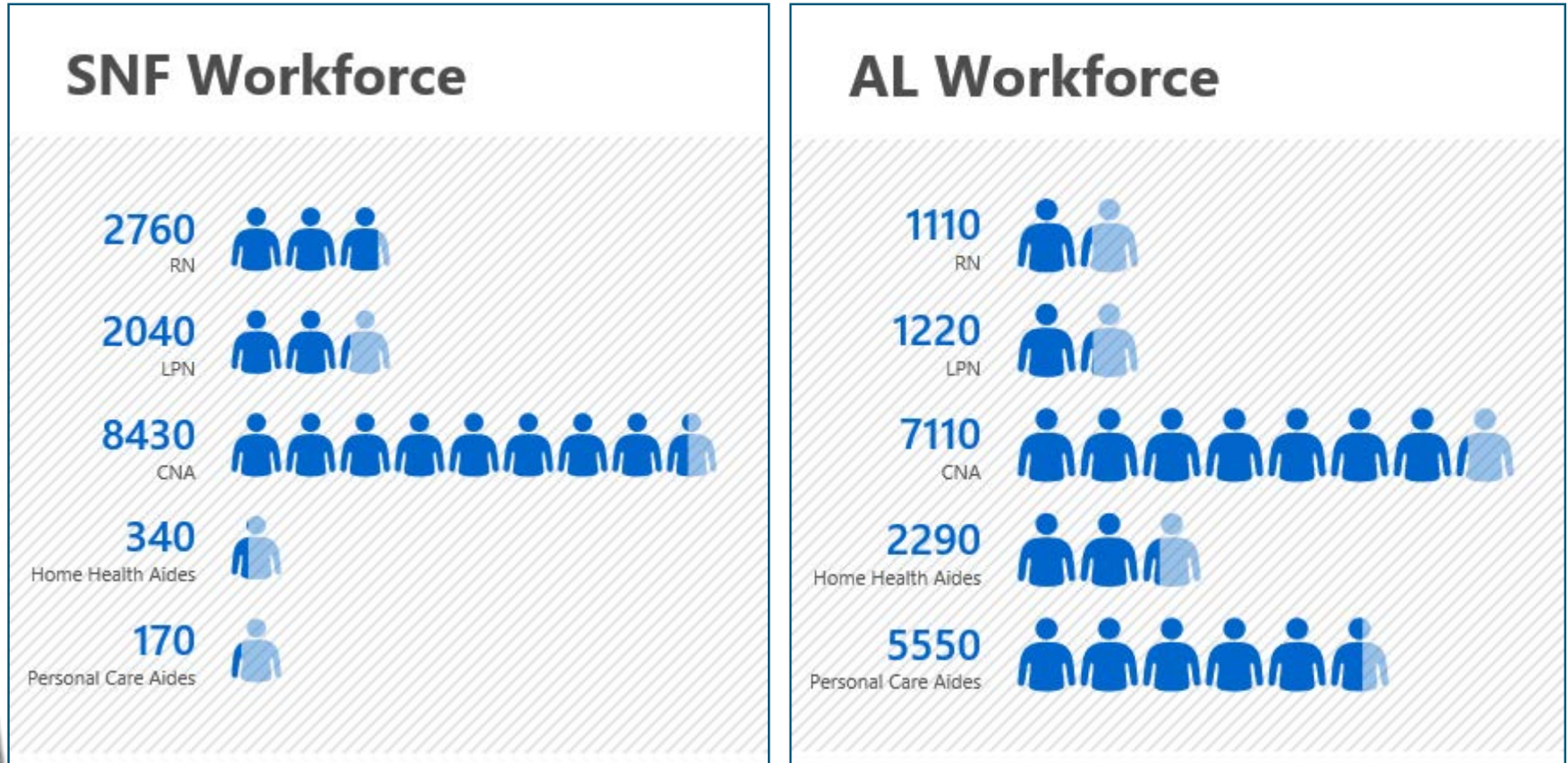


Data Source: May 2017 OES Research Estimates. Occupational Employment Statistics (OES) Survey Bureau of Labor Statistics, Department of Labor. Website: [//www.bls.gov/oes](http://www.bls.gov/oes)

NOTE: LTC Skilled & Residential includes Skilled Nursing Facilities, Assisted Living, Continuing Care Retirement Communities, and LTC Residential for behavior health and persons with developmental disabilities.

Assisted Living¹ (AL) and Skilled Nursing Facilities (SNF) Employ Just Over 31,000 Direct Care Workers

LPNs and CNAs make up 61% of the Workforce for SNFs and ALs

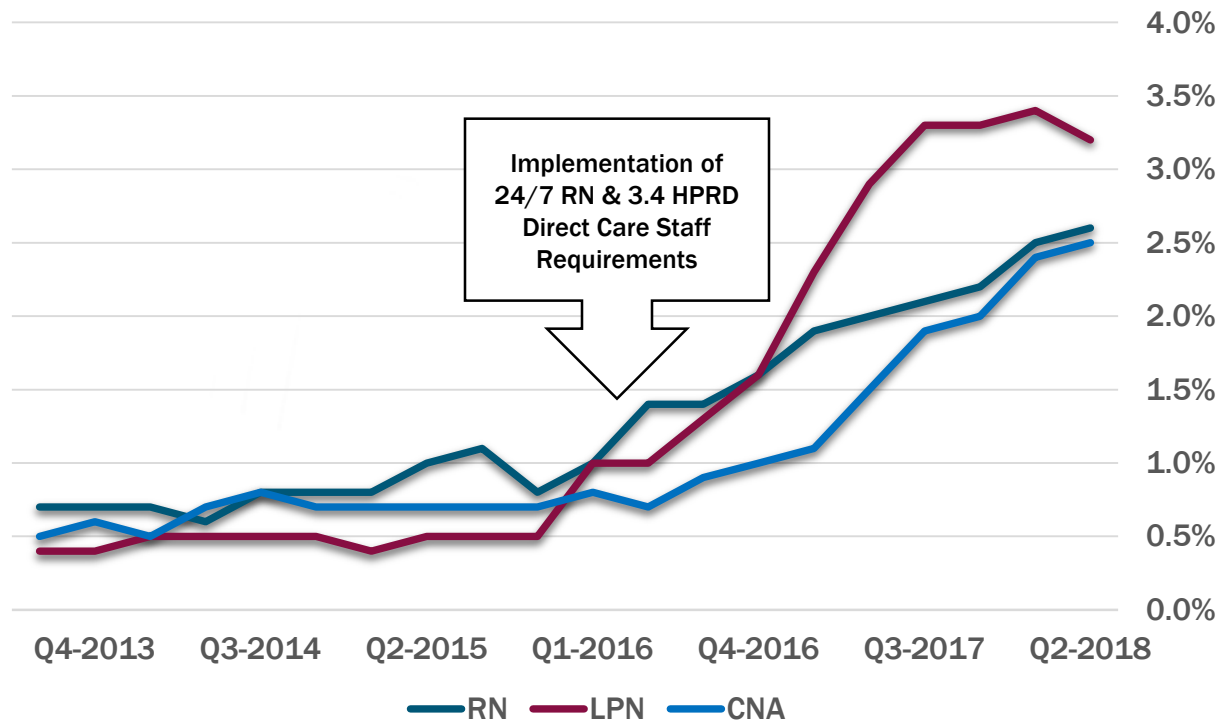


Data Source: May 2017 OES Research Estimates. Occupational Employment Statistics (OES) Survey
Bureau of Labor Statistics, Department of Labor. Website: [//www.bls.gov/oes](http://www.bls.gov/oes)

¹ Assisted Living counts include Continuing Care Retirement Communities (CCRCs)

The Use of Agency Staff by SNFs has Grown to over 650,000 Hours Annually. This is the Equivalent to about 360 FTEs.

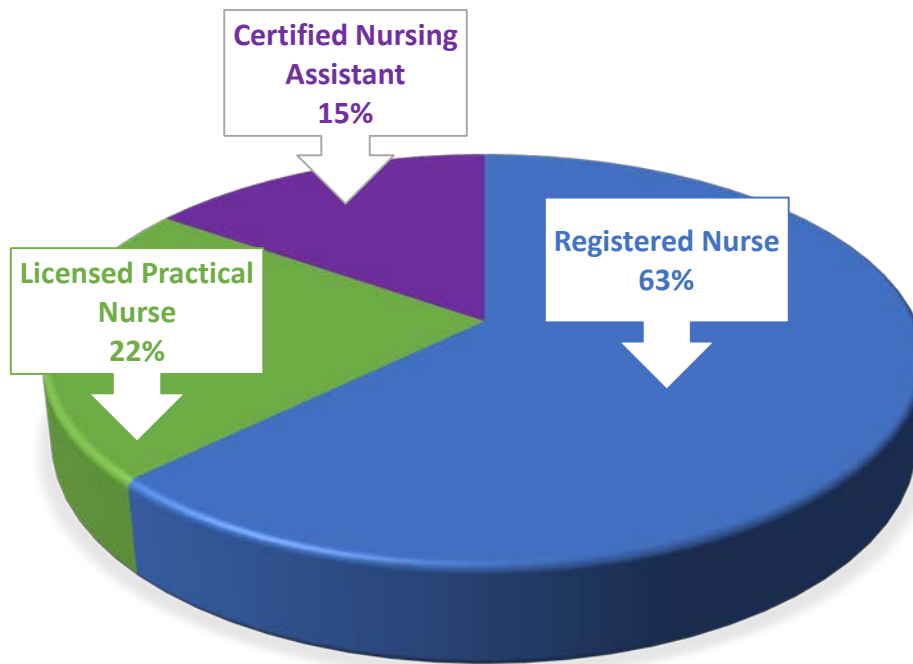
SNF use of Contracted Staff



Data Source: CMS CASPER data based on CMS 671 Application for Medicare and Medicaid.
AHCA: LTC Trend Tracker Casper Staffing Report
Data Last Updated: Jun 2018

Help Wanted Ads Are a Reflection of Employer Demand for Direct Care Staff

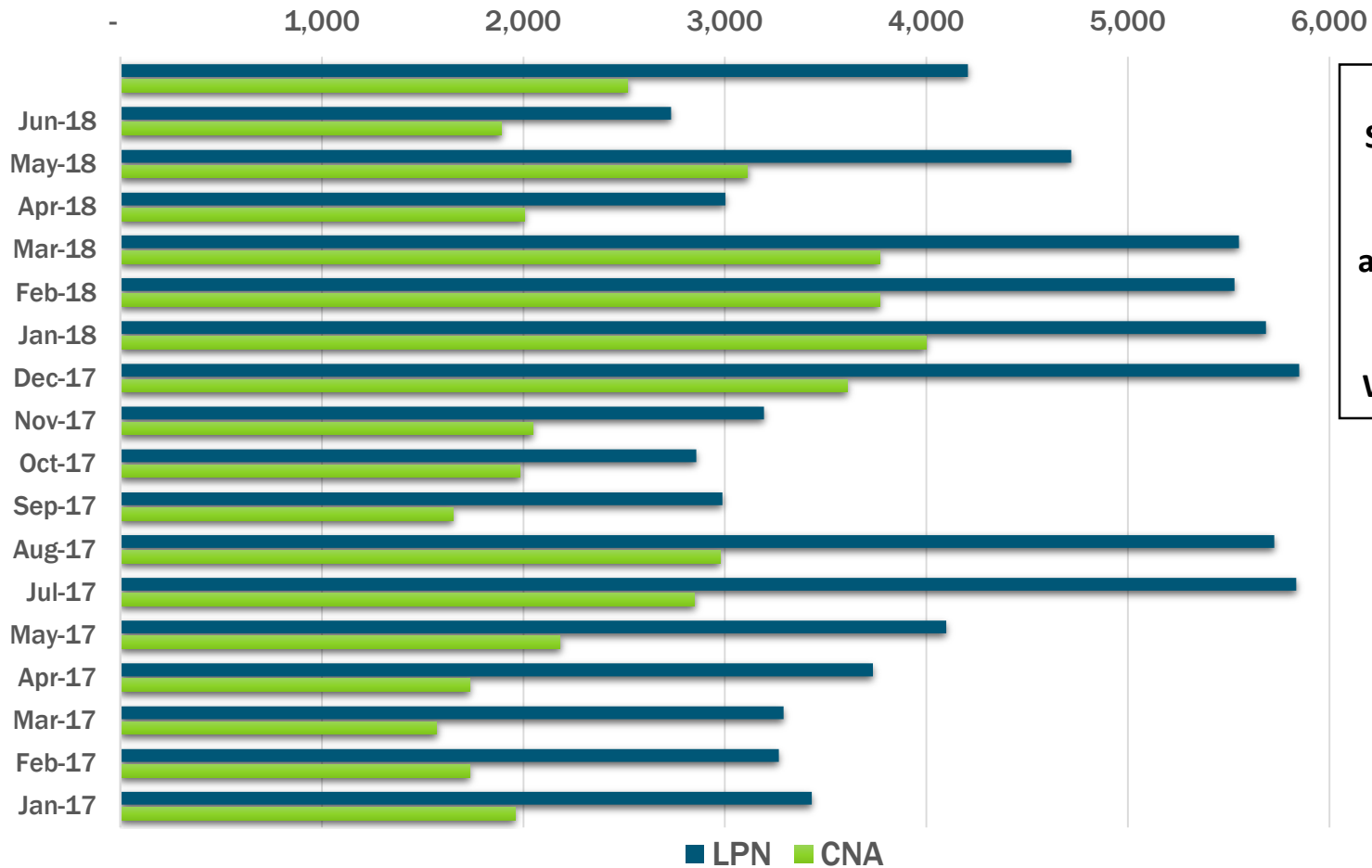
JUNE 2018 WA - 12,385 DIRECT CARE STAFF
HELP WANTED ADS



Source: Employment Security Department/WITS; Wanted Analytics
Top 25 certifications from online ads
Washington state, March 2018 through June 2018

Over the Last 18 Months, Monthly Help Wanted Ads Have Averaged 4,200 for LPNs & 2,500 for CNAs

Monthly Help Wanted Ads for LPNs and CNAs



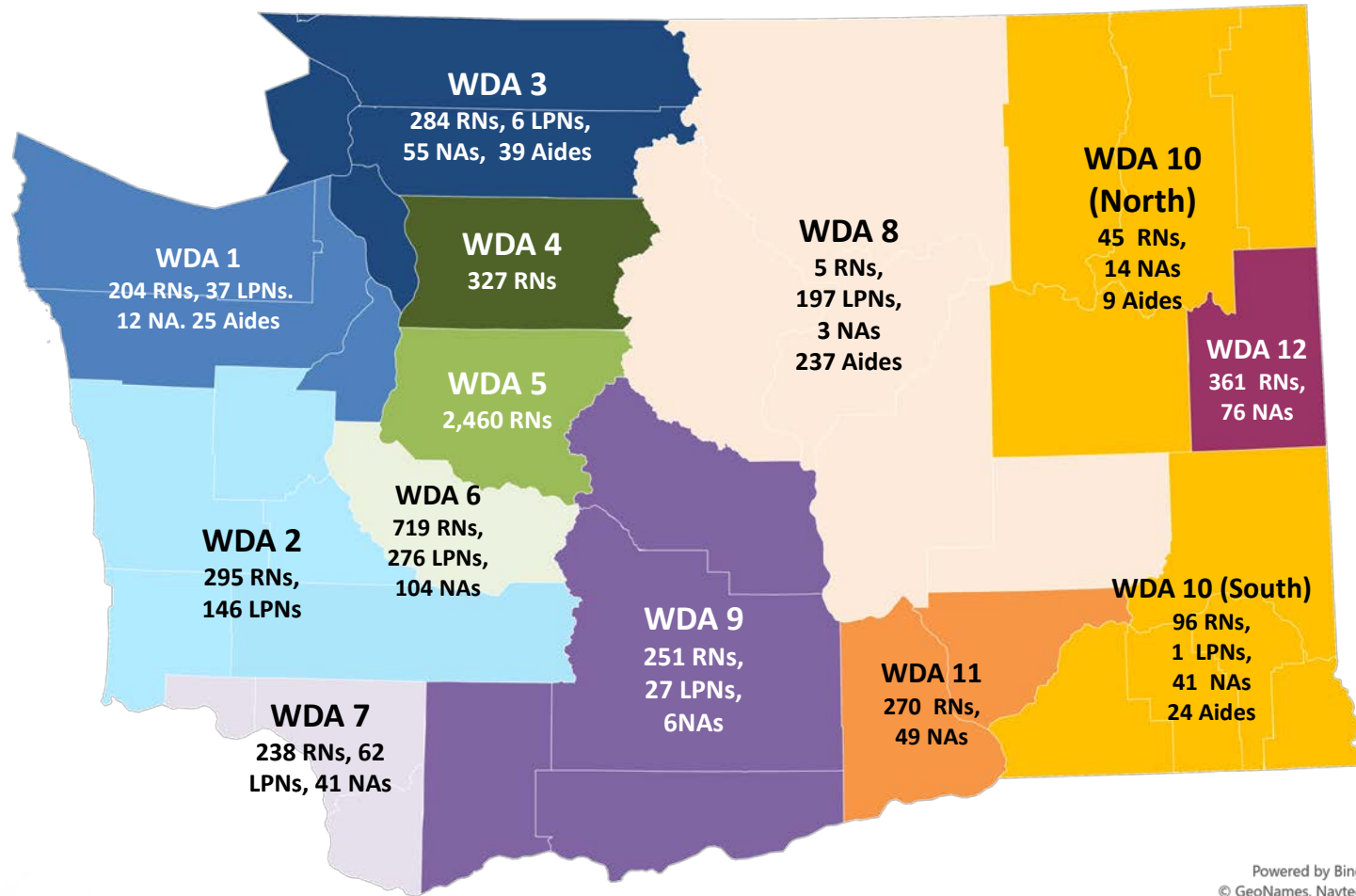
Collectively, SNFs and ALs Employ 55% of all CNAs and 52% of all LPNs in the State of Washington.²

Source: Employment Security Department/WITS; Wanted Analytics. Top 25 certifications from online ads Washington state, March 2018 through June 2018

² Based on May 2017 OES Research Estimates. Occupational Employment Statistics (OES) Survey Bureau of Labor Statistics.

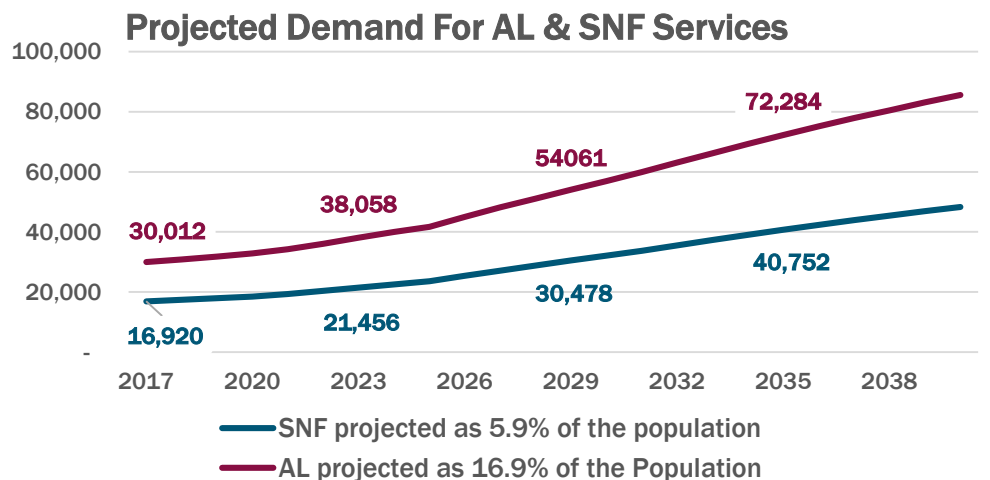
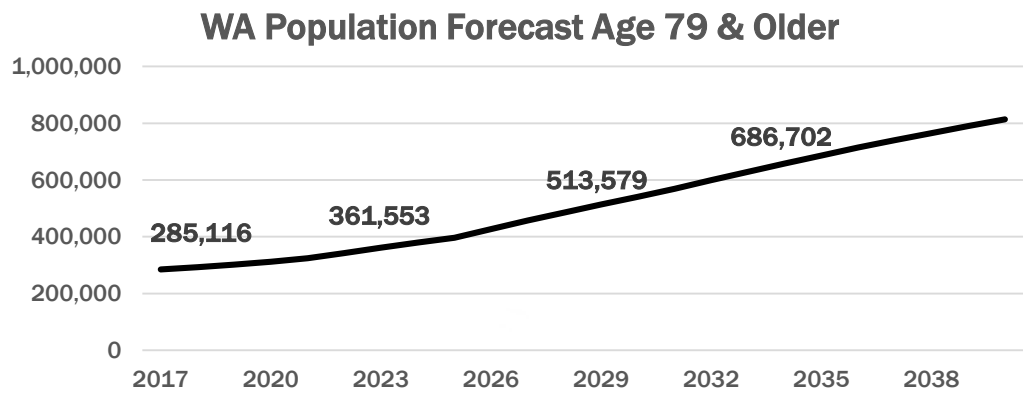
The County's Top 25 Online Ad Postings Hint at Workforce Demand Specific to Workforce Areas

Direct Care Occupations in the Top 25 Advertised Online Job Postings



Source: Employment Security Department/WITS, Occupational Employment Statistics; The Conference Board, Help Wanted OnLine job announcements
Top 25 occupations advertised online. County Data sorted By Workforce Development Area.
Washington state and counties, May, 2018

Washington's Demand for SNF and AL Services is Expected to Increase Dramatically Over the Next Few Years



Today, SNFs & ALs collectively serve about 47,000 people. The average age of residents is about 80 years old.

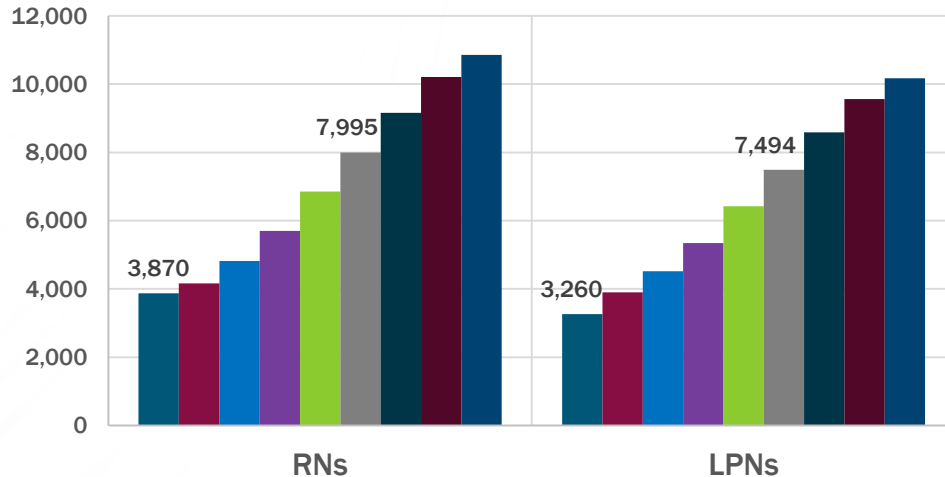
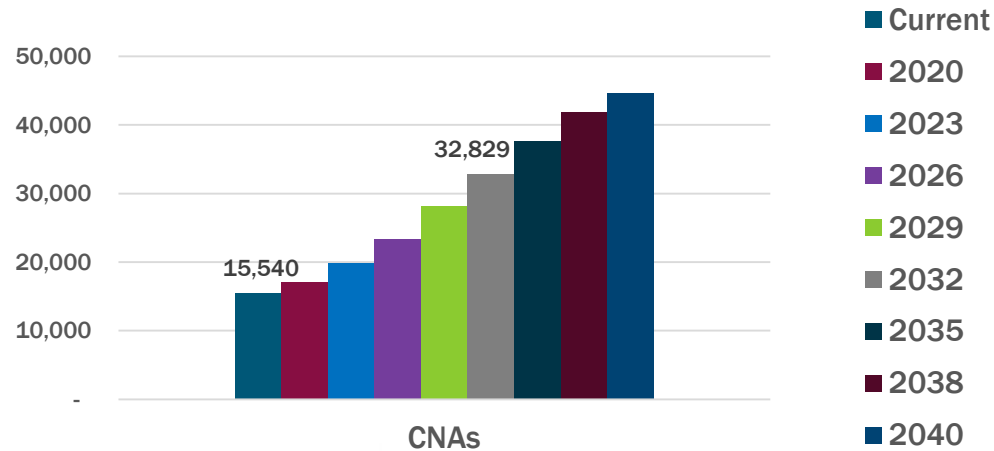
To Continue Serving the Current Proportion of Elderly at the Current Hours Per Resident Day (HPRD), the Workforce Must Grow with the Aging Population

- In the Next Five Years... SNFs and ALs will need to serve about 60,000 people.
- In Ten Years... SNFs and ALs will need to serve about 80,000 people.
- The Populations Served in SNF & AL will double by 2031

Source: See Appendices for HPRD information. Washington State Office of Financial Management, Forecasting and Research Division. "Excel utility to interactively summarize population by user-defined age groups" <https://ofm.wa.gov/washington-data-research/population-demographics/population-forecasts-and-projections/state-population-forecast>

NOTE: 2017 SNF resident count is from CASPER report. 2017 AL resident count is estimated based on occupancy rates reported in the 2017 State of Senior Housing Report.

In the Next Five Years, ALs & SNFs Will Need About 8,600 more Direct Care Workers than are in Today's Workforce



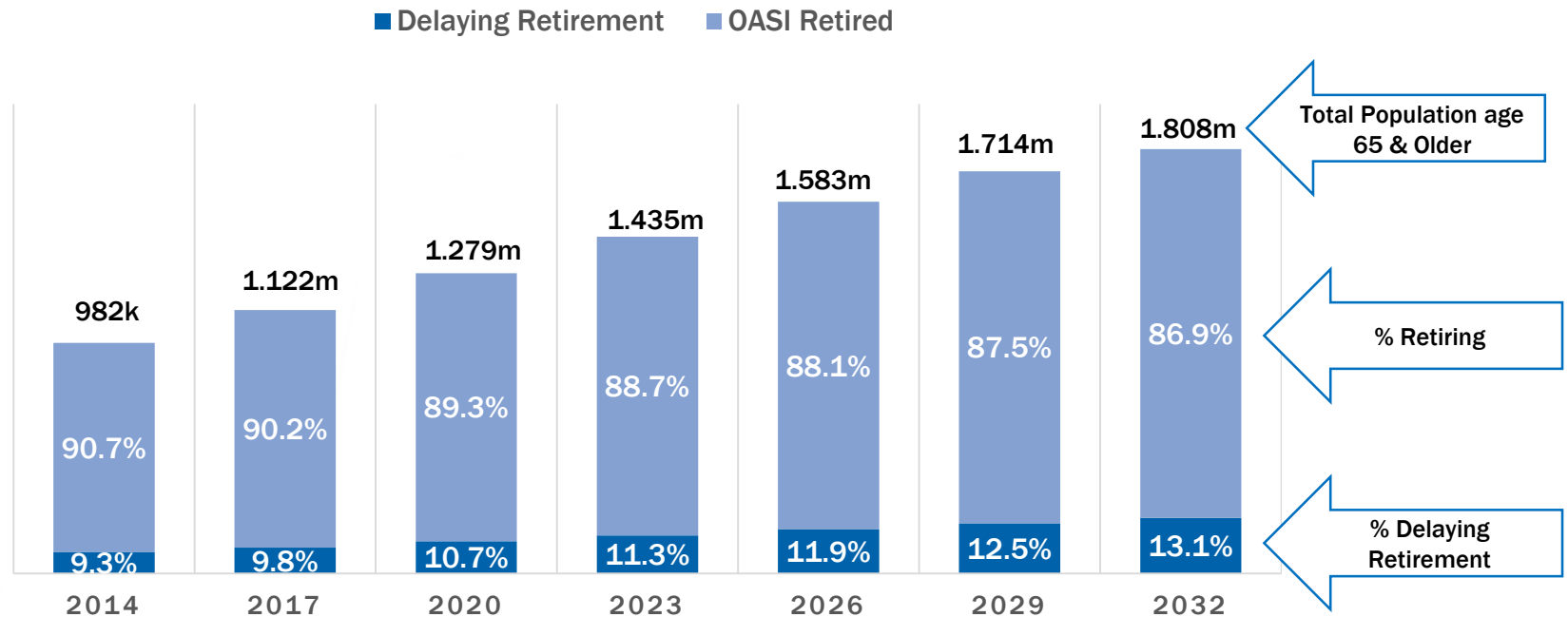
Using Simple Projections Based on HPRD and the Aging Population Forecasts, it is estimated that:

- Ten years from now, the demand for AL and SNF direct care workers will grow to nearly 16,000 more than today.
- By 2032, the number of direct care workers will need to double from its current 31,000 in order to maintain our current HPRD and the percentage of populations served in AL and SNF.

Source: See Appendices for HPRD information. Washington State Office of Financial Management, Forecasting and Research Division. "Excel utility to interactively summarize population by user-defined age groups" <https://ofm.wa.gov/washington-data-research/population-demographics/population-forecasts-and-projections/state-population-forecast>

The Number of Retirees is Projected to be 26% Greater in the Next Five Years than it was in 2017.

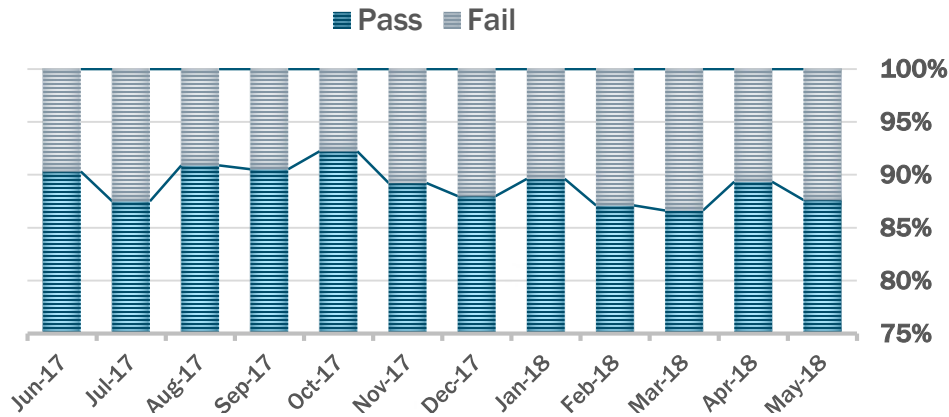
PROJECTED NUMBER OF WA RETIREMENTS BASED ON OASI BENEFITS AS A % OF POPULATION AGE 65 AND OLDER



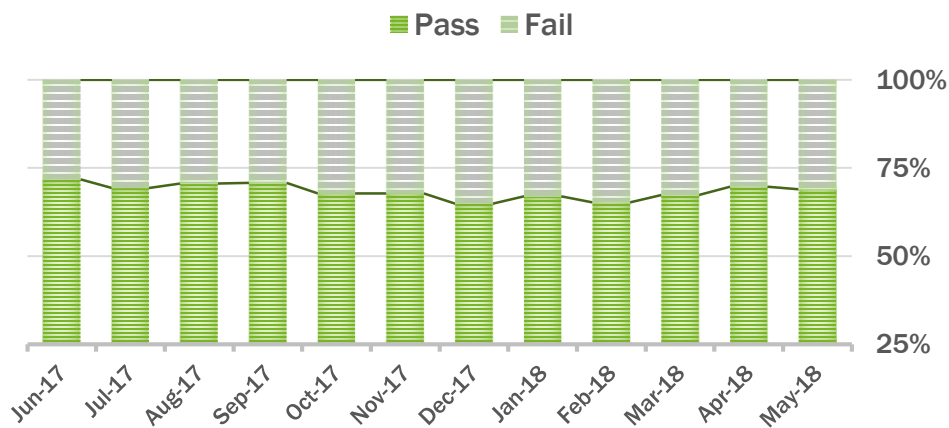
Historic % retirement taken from SSA's Old Age and Survivor's Insurance (OASI) Table 1: "Beneficiaries as a percentage of the total resident population and of the population aged 65 or older, by state." Actuals percentages were used for 2014 and 2017. Remaining years are projected based on retirement trends since 2007. https://www.ssa.gov/policy/docs/statcomps/oasdi_sc/2017/index.html
 Age 65 and Older Population Data is OFM population forecast by age. <https://ofm.wa.gov/washington-data-research/population-demographics/population-forecasts-and-projections/state-population-forecast>

Nurse Assistant Certifications

CNA WRITTEN EXAM AVERAGE PASS RATES = 89%



CNA SKILLS EXAM AVERAGE PASS RATES = 68%



Monthly Exams

<u>Month</u>	<u>Written</u>	<u>Skills</u>
Jun-17	887	1051
Jul-17	768	882
Aug-17	823	953
Sep-17	876	1054
Oct-17	681	868
Nov-17	622	803
Dec-17	749	933
Jan-18	539	678
Feb-18	559	693
Mar-18	680	854
Apr-18	695	843
May-18	897	1068
Average	731	890

Source: DSHS Aging and Long Term Services
Nursing Assistant Training and Competency Evaluation

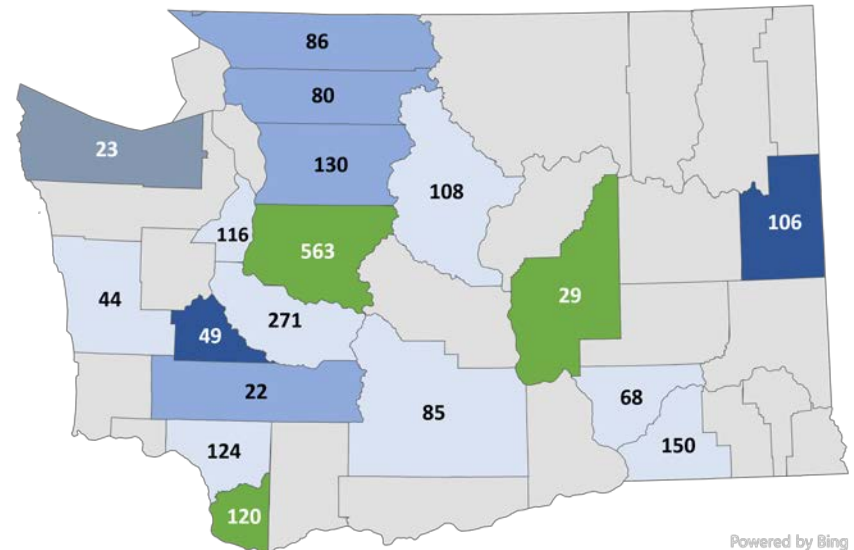
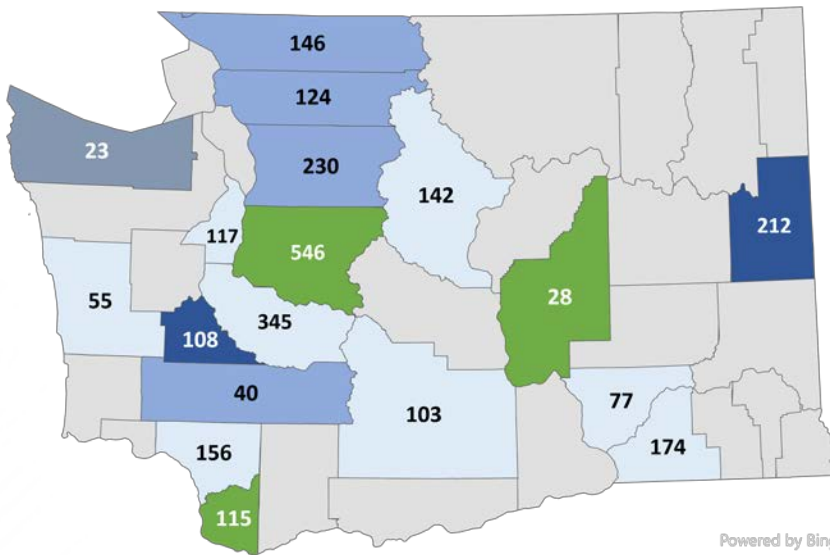
Since 2013, College Nurse Credentials have Decreased by 21%

Change From 2013 to 2017



2013: Total College Credentialed Nurses = 2,741

2017: Total College Credentialed Nurses = 2,174



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Credential Type	2012-13	2013-14	2014-15	2015-16	2016-17
Workforce AA (ADN)	1708	1896	1788	1761	1527
Short Cert					
Transfer AA (ADN)				24	198
Applied Baccalaureate	31	28	38	44	58
Long Cert (LPN)	1002	791	741	569	391

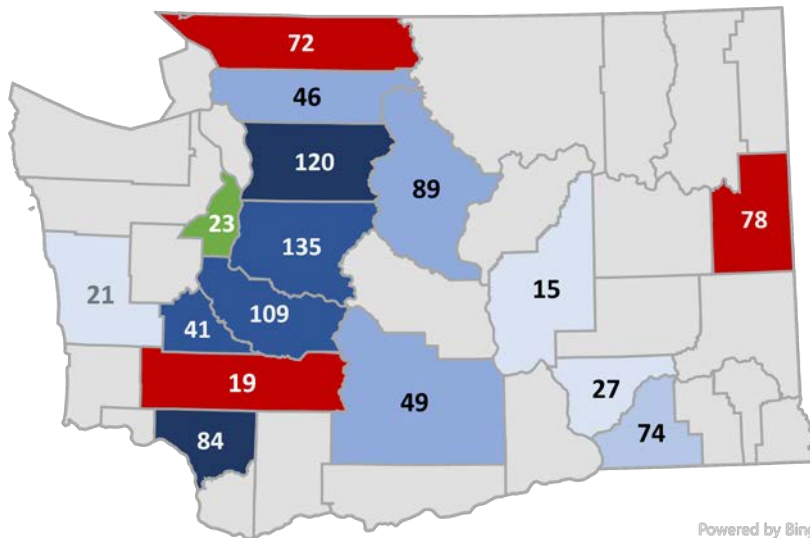
Resource: Washington State Board of Community and Technical Colleges' Public Data: "Credentials Awarded Dashboard." <https://www.sbctc.edu/colleges-staff/research/data-public/credentials-awarded-dashboard.aspx>

But, LPN Credentials Have Decreased by 61% During that Same Time Period

Change From 2013 to 2017

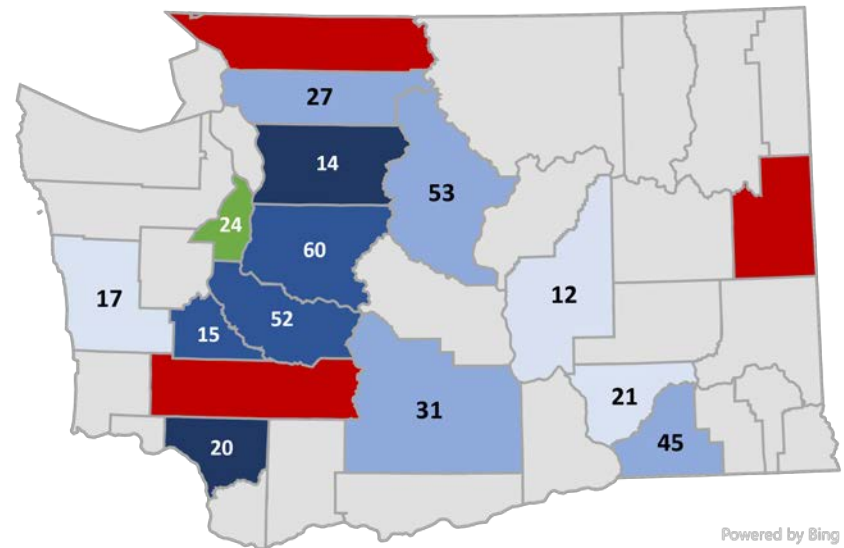


2013: Annual Credentialed LPNs = 1,002



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2017: Annual Credentialed LPNs = 391



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Resource: Washington State Board of Community and Technical Colleges' Public Data: "Credentials Awarded Dashboard." <https://www.sbctc.edu/colleges-staff/research/data-public/credentials-awarded-dashboard.aspx>

Our Work Continues...

We continue our research and analysis:

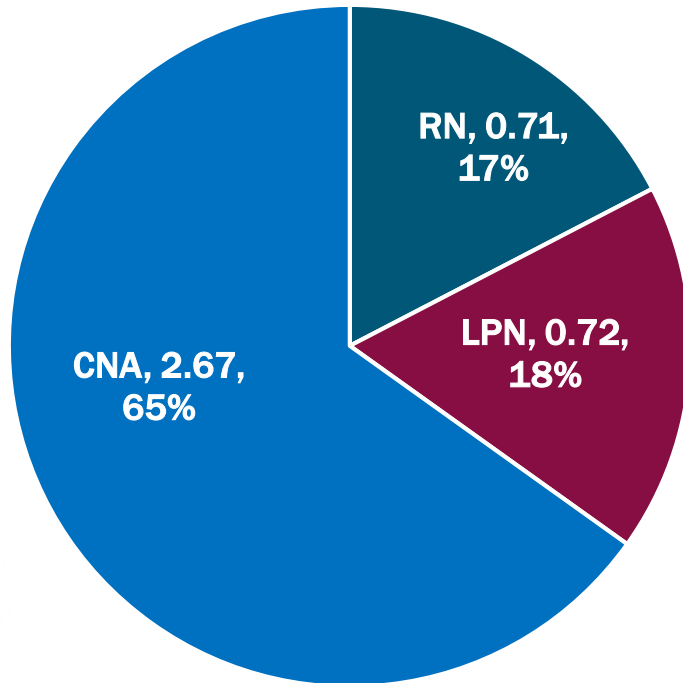
- ❑ Average wages by occupation for each Workforce Development Area (WDA)
- ❑ Comparative analysis of wages by industry for the same occupation
- ❑ Mapping of certifications for CNAs and Home Health/Personal Care Aides (similar to the college credential maps)
- ❑ Deeper dive into the aging populations:
 - Age 79 & older projections by WDA or county (indication of demand for LTC services by area)
 - Age 65 & older projections by WDA or county (indication of retirements by area)
- ❑ Deeper dive into turnover & vacancy rates

Questions

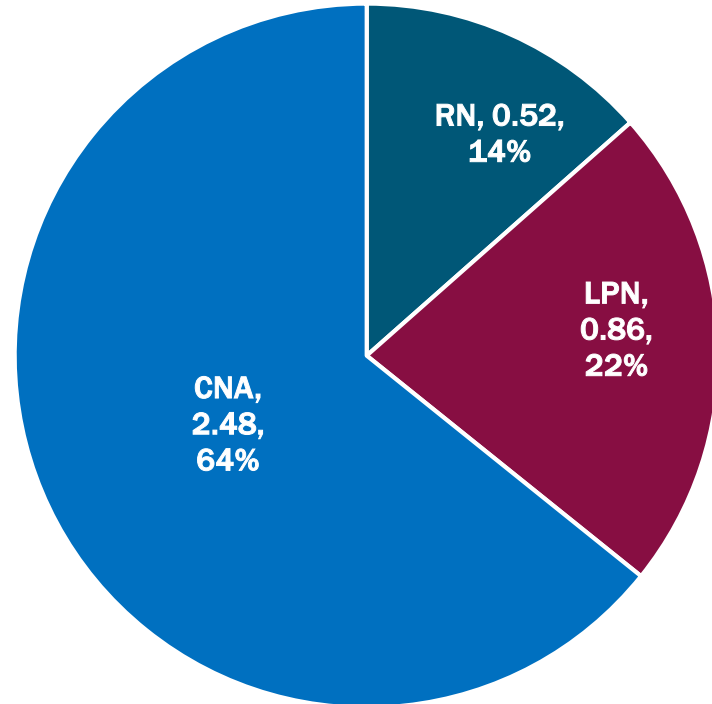


Appendix A - Compared to the Nation, Washington SNFs Staff More Direct Care Hours Per Resident

Washington Average SNF 4.10 HPRD
(16,500 Residents)



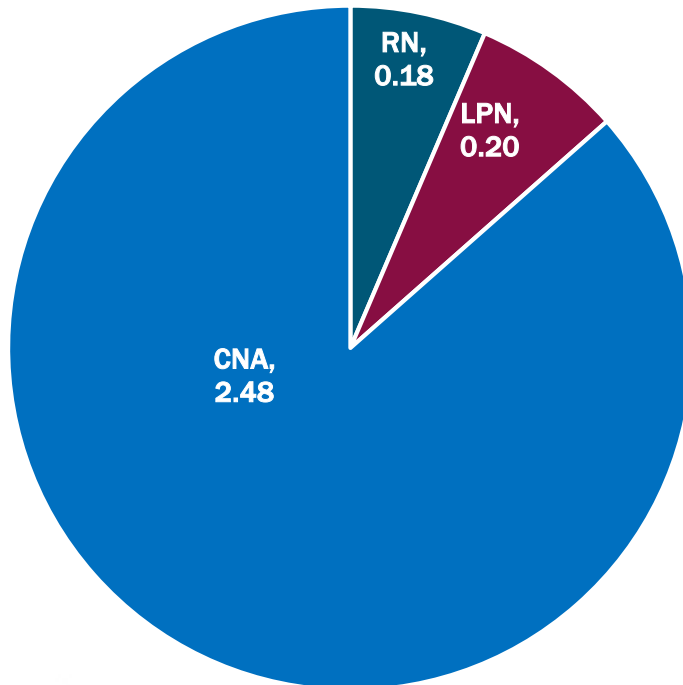
National Average SNF 3.86 HPRD



Source: CMS CASPER data based on CMS 671 Application for Medicare and Medicaid.
AHCA: LTC Trend Tracker Casper Staffing Report
Data Last Updated: Jun 2018

Appendix B - WA Assisted Living Estimate Direct Care Hours Per Resident Day (HPRD)

WA Assisted Living's Estimated HPRD is 2.87
Based on ESD Employment #s and Estimated
of Residents as an Occupancy %

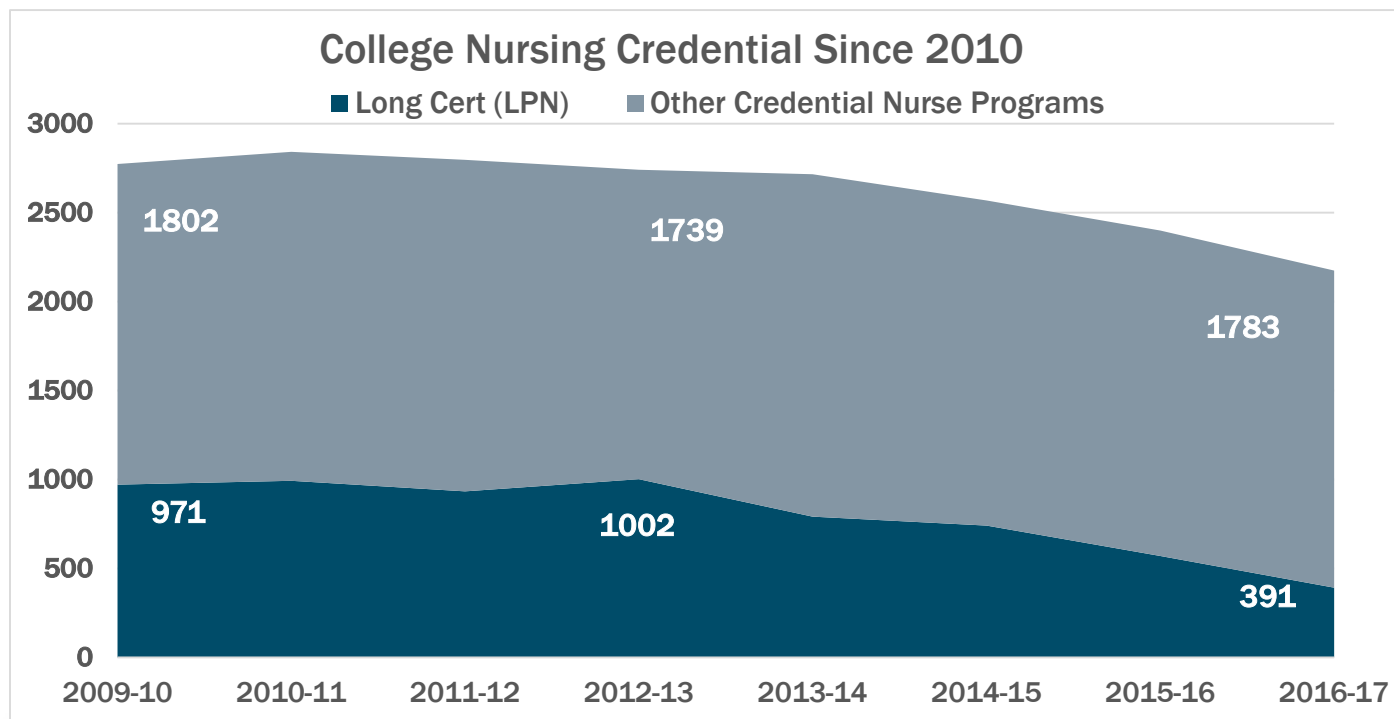


The number of AL residents is estimated to be 30,012. This assumes an occupancy rate of 90.6% on all licensed beds.³

AL Employee Counts Based On OES data	
RN	1,110
LPN	1,220
CNA (includes all Aides)	14,950

³ State of Senior Housing Report 2017, American Senior Housing Association.
www.seniorshousing.org (Page 46, Table 7.2, All Communities, Occupancy for AL beds).

Appendix C - College Nurse Credentials



Credential Type	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Workforce AA (ADN)	1790	1799	1818	1708	1896	1788	1761	1527
Short Cert	6	43	19					
Transfer AA (ADN)							24	198
Applied Baccalaureate	6	7	27	31	28	38	44	58
Total "Other Nurse Programs"	1802	1849	1864	1739	1924	1826	1829	1783
Long Cert (LPN)	971	992	932	1002	791	741	569	391

Resource: Washington State Board of Community and Technical Colleges' Public Data: "Credentials Awarded Dashboard." <https://www.sbctc.edu/colleges-staff/research/data-public/credentials-awarded-dashboard.aspx>