



State of Alaska • Department of Health and Social Services
Senior and Disabilities Services
NOCM Care Provider Training Plan

The NOCM nurse initiates the NOCM service upon receipt of the recipient's approved Support Plan and Services overview & Cost Sheet. During the initial (intake) visit, the NOCM nurse must assess:

- 1) The recipient's health and safety needs and medical care task needs (to complete the NOCM Nursing Care Plan Uni-18), and
- 2) The training needs of the recipient's paid and unpaid care providers in order to perform the recipient's medical care tasks (to complete the Uni-19 NOCM Care Provider Training Plan).

The NOCM COP requires the Uni-19 and Uni-18 to be submitted within 10 days of receiving the Support Plan and Services Overview & Cost Sheet. It is therefore important to schedule the first visit of the support plan year in a timely manner.

Instructions for Uni-19:

The Uni-19 documents the medical care tasks that are to be provided by the recipient's care providers and verifies that those care providers **either** have demonstrated competency in each of the medical care tasks (through care provider signature) **or** that there is a plan in place to verify each care provider's competency.

First: Complete Section I, II and III.

Section I records the recipient's demographics.

Section II Universal Medical Care Tasks. This section lists tasks that are applicable to **every** recipient;

- All care providers need to demonstrate competency in each of these tasks.
- Review this section and include each task in your assessment and oversight responsibilities.
- Note: Section VI includes verification of the medical care tasks in Section II.

Section III Individualized Medical Care Tasks. This section requires the selection of medical care tasks required by the recipient.

- Put "X" in the box of each medical care task that you determine applies to the recipient
- Put "N/A" in the box of each medical care task that does not apply to the recipient

Next: Complete Section IV Unique Medical Care Task Training Needs (if applicable)

Next: Complete Section VI: Verification Care Provider(s) Competency

- List all paid and unpaid care providers, using their full name.
- Oversee and document that the parent/guardian/primary care provider is competent in each of the universal and individualized medical care tasks that are marked with an "X". **This is a mandatory step for a complete initial Uni-19.**
- To the extent possible within the 10 business day time frame, oversee and document that the named care provider(s) are competent in each of the universal and individualized medical care tasks that are marked with an "X".
- Document the care provider(s)' competency by observing the person sign next to their name in Section VI. Add the date of the first oversight and verification in the "initial date" column.
- **Pending oversight and documentation by the NOCM nurse, the parent/guardian/primary care provider is responsible for training and oversight of the paid and unpaid care providers.**

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- Sign and date the statement and observe the signature of the parent/guardian/primary care provider.
- Submit a complete Uni-19 (and Uni-18) to SDS through the Care Coordinator within **10 business days from the date you received the approved Support Plan and Services Overview and Cost Sheet** and provide a copy to each care provider. NOCM Conditions of Participation Section III.C.

Finally: Complete Section V Comments/Notes: Use this section for ongoing documentation of events or activities (if any) during the support plan year that are of concern or need follow-up.

Instructions for submission of subsequent Uni-19 (Uni-18):

When the recipient is in the second and subsequent support plan years the Uni-19 reflects training activities completed and competencies observed during the previous support plan year. It should be updated at each oversight visit during the support plan year by adding care provider signatures as provider competency is verified, but submitted only once, based on the time frame in the NOCM COP. A copy of the previous year's Uni-19 may be used or a new Uni-19 may be started as long as the information from the previous support plan year is included, and signatures are updated.

First: Update Section III. Individualized Medical Care Tasks

- Document any changes to the recipient's needed medical care tasks by replacing the current designation with either an "X" or "N/A" and making a note in Section V.
- If there are no changes in the medical care tasks, make a note in Section V.

Next: Complete Section VI. Verification Care Provider(s) Competency

- Add the date in the "Renewal Date" column that the ongoing competency was observed for any care providers who had their competency verified on the initial intake visit.
- Check for accurate documentation that all care providers who had been identified on the initial Uni-19 prior to oversight and verification of competency have signed and dated the Uni-19 when their competency was verified.
- Remove (line through) any names (verified or unverified) who are no longer providing care.
- Complete the list, if applicable of new, unverified providers.

Finally: Remember is it necessary to also submit an updated Uni-18 at the same time the Uni-19 is submitted. Submit the forms through the Care Coordinator within 10 business days of the receiving the Support Plan and Services Overview and Cost Sheet to comply with the prerequisite to billing for the service. 7 AAC 130.235(c)

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Section I.

Name of Recipient: _____

Medicaid #: _____

_____ Initial Training Checklist or _____ Renewal Training Checklist

Name NOCM Registered Nurse _____

Plan of Care Renewal Date: _____ Training Plan Renewal Date: _____

Section II. Universal Medical Care Task Categories

Training oversight has occurred in each of the medical care tasks listed below.

The care provider has demonstrated or verbalized the following standards of the medical care tasks listed below:

Role of the NOCM Registered Nurse: The care provider can:

- Describe the roles and responsibilities of the NOCM registered nurse to assess the recipient to determine health and safety needs, medical care task needs and training needs for the care providers.
- Describe how and when to contact the parents(s) or guardian(s), the NOCM nurse, physician or EMS.

Role of Care Providers: The care provider can:

- Describe the responsibilities and limitations of unlicensed assistive personnel.

Infection Control/OSHA Guidelines: The care provider has:

- Reviewed training information related to Universal Precautions/ Infection Control guidelines and completed related trainings, if assigned.
- Demonstrated proper handwashing technique.

CPR: The care provider has:

- Completed CPR training per National Certification Guidelines.
- Demonstrates knowledge of guidelines and steps to follow should resuscitation and/or EMS response be required.
- Knowledge of the code status of the recipient.

Signs of Illness: The care provider can:

- Described signs of illness for the recipient and proper respiratory observation and monitoring.
- Locate the plan for who to notify in the event of unexpected illness.

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Hygiene/Bathing: The care provider can:

- State precautions to be taken when performing hygiene related activities such as bathing, showering and/or shaving, including but not limited to checking that the water temperature is below 120 degrees Fahrenheit.

Diet/Nutrition: The care provider knows:

- The recipient's prescribed dietary plan
- Appropriate food choices and methods of preparation
- Foods the recipient needs to avoid
- Relationship between the recipient's weight/nutritional status on overall health

Fluids/Hydration: The care provider knows:

- Signs and symptoms of dehydration
- Methods to prevent dehydration
- When to contact parent(s)/guardian(s)

Skin Care: The care provider knows:

- Signs and symptoms of skin breakdown
- Signs and symptoms of compromised pressure areas/points
- Measures to prevent skin breakdown
- Observations that require documentation
- When to contact physician/nurse/parent(s)/guardian(s)

Oral Care: The care provider knows how to provide:

- The proper oral care prescribed for the recipient

Safety Car Seats/Restraints: As it applies to this recipient, the care provider knows:

- Safe positioning of recipient in his/her car seat
- Appropriate use of restraints and installation of car seat in vehicle
- Appropriate use of safety restraints for wheelchair, stroller, high chair during transport
- Safe practices maneuvering a wheelchair
- Correct application of a floatation device
- Correct sizing and application of a safety helmet

Body Mechanics: The care provider can:

- Demonstrate proper body mechanics in lifting, transferring and positioning the recipient.

Outdoors: The care provider knows:

- Appropriate outdoor dress for the weather
- Appropriate precautions such as sunscreen and insect spray

Section III. Individualized Medical Care Task Oversight Categories

The NOCM Nurse has assessed the medical care tasks that are required for the recipient and has indicated the necessary tasks by placing an "X" in the fillable text box by the side of the standard

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for the task. If a task is not applicable to the recipient, the nurse has put “N/A” in the fillable text box by the side of the standard for the task.

The care provider has demonstrated or verbalized the following standards of the medical care tasks listed below:

Allergies The care provider can:

- State the recipient’s known allergies (see list below).
- Identify the location of the recipient’s medical information, including the posted list of allergies and medication log.
- State the signs, symptoms, and steps to take related to an allergic reaction and/or anaphylactic reaction.
- Describe when to notify the parents/guardian, nurse, physician and/or paramedics. Parents/guardians have been informed where to obtain medical alert bracelets, if appropriate.

The recipient's known food, medication and environmental allergies are:

- Blood Pressure:** The care provider can:
 - Use manual and/or automatic method of assessing blood pressure.
 - State recipient’s normal blood pressure parameters: systolic range _____ to _____ and diastolic range _____ to _____.
 - Verbalize who to notify in the event Recipient’s blood pressure falls outside of the pre-set parameters.

- Tracheostomy:** The care provider can:
 - Demonstrate or verbalize the correct technique for changing Recipient’s tracheostomy tube.
 - Describe the home cleaning routine for this type of tracheostomy tube and locate a copy of the cleaning instructions.
 - Locate an extra tracheostomy tube in the recipient’s “GO BAG.”
 - Ensure the client has an extra tracheostomy tube with him/her at all times.

- Artificial Nose:** The care provider knows:
 - How to take care of the recipient’s artificial nose

- Suctioning:** The care provider knows:
 - Proper equipment and technique for oral suctioning
 - Proper equipment and technique for suctioning a tracheostomy

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- Nebulizer:** The care provider can:
 - Administer the recipient's prescribed nebulizer treatment according to the recipient's treatment protocol

- Chest Percussion Therapy:** In compliance with the recipient's prescribe treatment, the care provider can demonstrate:
 - Proper Chest Percussion Therapy (CPT)
 - Proper use of a chest percussion vest

- Oxygen Equipment:** The care provider knows:
 - Correct technique for the use of the oxygen concentrator
 - Location of back-up oxygen tanks
 - Safe cleaning and storage of all equipment
 - When equipment is malfunctioning
 - Location of list of physician, respiratory therapist and vendor

- Home ventilator equipment:** The care provider can:
 - Operate the recipient's home ventilator equipment
 - Identify malfunctions of the home ventilator
 - Locate the contact list for physician, respiratory therapist and vendor

- BiPAP/CPAP Equipment:** The care provider can:
 - Operate and care for the recipient's BiPAP/CPAP
 - Locate the list for physician, respiratory therapist and vendor

- Cardiac/Respiratory Monitor:** The care provider can:
 - Check alarm rates
 - Apply leads
 - Clean and maintain the equipment
 - Troubleshoot routine problems; call for assistance when equipment is malfunctioning
 - Locate the contact list for physician, vendor and respiratory therapist

- Pulse Oximeter:** The care provider can:
 - Properly connect the pulse oximeter
 - State the normal high/low parameters prescribed for this recipient
 - Intervene when necessary to reposition, suction adjust oxygen flow as prescribed
 - Call physician, parent/guardian, or 911 when necessary
 - Identify equipment malfunction and notify physician, parent/guardian, or vendor
 - Locate the list for contact information for physician, parent/guardian, or vendor

- Specialized Feeding Needs:** The care provider can:
 - Demonstrate or verbalize proper feeding technique for the needs of the recipient
 - Demonstrate or verbalize (if applicable) checking for tube placement prior to feeding, positioning and venting the tube
 - Verbalize physician or guardian guidelines to ensure comfort and safety before, during and after each feeding

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- Demonstrate or verbalize proper skin care around the feeding tube
- Verbalize the method(s) of feeding as indicated below:

Oral	NG		G-Tube		J-Tube		GJ-Tube		
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Verbalize measures to take should the feeding tube become dislodged
- Verbalize the name of the formula: _____ Total calorie goal: _____
- Verbalize name of pump if present: Yes No
 Name of pump: _____ Rate: _____

Dietary Goals and Objectives:

Other Instructions:

- Central Venous Catheter:** The Care Provider knows:
 - The purpose of a central venous catheter
 - Type of central venous catheter: _____
 - Measures to take to prevent dislodgement or infection
 - Signs of infection
 - Location of contact information for parent/guardian and physician

- Autonomic Hyperreflexia/Dysreflexia:** The care provider knows:
 - Signs/symptoms of autonomic hyperreflexia
 - Signs/symptoms of dysreflexia
 - How to monitor recipient during and after a seizure
 - When to notify EMS
 - Location of contact information for parents/guardian and EMS

- Seizure Management:** The care provider knows:
 - Signs and symptoms of seizure activity
 - How to monitor the recipient before, during and after a seizure
 - Essential observations for documentation
 - When to notify EMS
 - Location of contact information for parent/guardian and EMS

- Hydrocephalus/V-P Shunt:** The care provider can:
 - Describe hydrocephalus
 - State sign/symptoms of shunt malfunction/infection
 - Locate the contact information for parent/guardian and physician

- Medications:** The care provider can:
 - Accurately draw up, administer and document each medication prescribed for the recipient
 - State the purpose and possible adverse effects of each medication prescribed for the recipient

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- Safely store the recipient’s medications
- State the criteria for a medication error and agency policy for reporting a medication error
- State that controlled substances may only be delegated by a physician and/or parent or guardian

Note: Direct care employees of a provider agency who provide medication must have successfully completed an Alaska Board of Nursing approved Medication Administration Training Class.

- Catheterization:** The care provider knows:
- Sterile catheterization is only performed by the parent(s) or guardian(s)
 - Proper procedure for cleaning and removing a catheter per recipient’s prescribed routine
 - Sign/symptoms of infection and action to take should infection occur
 - Use and disposal of catheterization supplies

- Bowel/Bladder Program:** The care provider knows:
- The bowel/bladder program prescribed for the recipient
 - The importance of maintaining the program for overall health
 - Sign/symptoms of bowel/bladder related problems
 - The relationship of hydration and nutrition to the success of the bowel/bladder program
 - Preventative skin care
 - Use of protective undergarments
 - Documentation of each aspect of the bowel/bladder program

- Therapy Goals/Developmental Interventions:** The care provider can:
- State the goals that the recipient and therapist(s) are actively working on. The recipient receives:

Type of Therapy	Times per week	Provider(s)

- Range of Motion (ROM):** The care provider:
- Demonstrates or verbalizes an understanding of proper ROM techniques
 - Knows and can follow the ROM plan for the recipient

- Orthotics/Splints:** The care provider knows:
- Proper application of the orthotic ordered for the recipient and the schedule for wear
 - Signs/symptoms indicating complications after application
 - Action(s) to take should complications occur
 - How to document the prescribed plan for orthotics

The provider for the orthotic is:

Name: _____ Title: _____ Phone Number: _____

- Generator:** The care provider:
- Received training from an individual/materials with knowledge of the generator at recipient’s home

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- Verbalized or demonstrated correct use of the generator
- Described safety precautions to be followed should a power outage occur

- Diabetes:** The care provider has:
- Stated the parameters of blood sugar levels
 - Demonstrated proper use, cleaning and maintenance of equipment to test blood sugar levels
 - Demonstrated the ability to properly oversee recipient's self-administration of medication by injection or oral route
 - Described the signs/symptoms of diabetic ketoacidosis and insulin shock and the appropriate emergency response

- Sensory:** The care provider:
- Can describe the recipient's particular visual/sensory impairment
 - Knows how the recipient's impairment affects the recipient's ability to meet his/her needs
 - Knows interventions necessary to safely and appropriately provide care

The recipient receives training and/or consultation from the following therapists:

Therapist Name	Consultation/Training	Phone #

Section IV. Unique Medical Care Task Training Needs

If there is a medical care task that the recipient needs, but that is not listed in the training plan, identify and describe the category or categories in Section IV. Complete the information in the text box provided and sign and date your name at the end of the description of each task added. The signature of the NOCM nurse indicates that he/she has verified the training for the task described.

Section V. Comments/Notes

Use this section to make a comment or record information unique to the recipient, or to justify why a medical care task has not been verified for a particular care provider. Sign and date each entry; add additional pages if necessary.

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Section VI Verification Care Provider(s) Competency

The dated signature of the person(s) listed below indicates that the person has demonstrated or verbalized competency in each of the medical care task categories listed in Section II and identified in III. Names listed without a signature or date indicate care providers named and supervised by the primary care provider; these care providers will need to demonstrate or verbalize competency during the upcoming support plan year.

Care provider's Name	Care provider's Signature	Initial Date	Renewal Date

The signature of each care provider listed in Section II indicates that the NOCM nurse has verified that he/she is able to verbalize or demonstrate the standard of care for the medical care tasks identified as necessary for the recipient. The "Initial Date" column records the date that the initial oversight and verification of competence occurred. The "Renewal Date" column records the date the NOCM nurse renewed the care provider's competence. Documentation of annual renewal is required.

I attest that all areas of training for medical care tasks necessary to care for the recipient at home, have been identified by a NOCM nurse and each care provider whose signature appears in Section II has demonstrated or verbalized competency in the standard set for the identified task.

Signature of NOCM RN

(Printed Name)

Date: _____

Signature parent/guardian/primary care provider

(Printed Name)

Date: _____