

# **WISCONSIN DHFS NURSE AIDE PROGRAM ONSITE REVIEW PROTOCOL**

## **NURSE AIDE PROGRAM PRE-SURVEY INFORMATION INSTRUCTIONS**

### **NURSE AIDE PROGRAM DUTIES**

#### **Announced Monitoring Reviews**

1. Prior to the onsite review, please collect documentation to substantiate compliance. Documentation should be collected in the following manner:
  - a. Place in a folder a copy of the following documents:
    1. Facility agreements with clinical site(s) (if applicable).
    2. Date of most recent DQA survey(s) of the clinical site(s).
    3. Copy of the long-term care facility license and signed agreement for the clinical experience (if applicable).
    4. Copy of the private school license (if applicable).
    5. Copy of contractual agreements with provider nurse aide training (if applicable).
    6. Copy of current nursing license and social security number for each Primary Instructor associated with the nurse aide training program.
  - b. Have available for the reviewer:
    1. Program content documentation, including course outlines, lecture notes, lesson plans and skills checklist.
    2. Program policies.
    3. Course calendar.
    4. Instructor schedules.
    5. Nurse aide graduate reports.
    6. Grade records.
    7. Facility qualifications and job descriptions.
    8. Evaluation of Program by students.
    9. Evaluation of Primary Instructor by students.
  - c. Verify clinical setting status with the administration(s) of the clinical site(s).
2. Provide verification of implementation of plan of correction or recommendation from last onsite visit.

#### **Appeal Process**

1. Review the statement of findings with appropriate staff. If there are any disputes or objections to a finding, mail a letter and documentation to support the dispute within 15 days of the receipt of the statement of findings to the Department of Health and Family Services, Division of Quality Assurance, Office of Caregiver Quality.
2. Develop a plan that enumerates remedial activities to bring the Program into compliance. The plan must be mailed to the Department of Health and Family Services, Division of Quality Assurance, Office of Caregiver Quality within the specified time frame following the receipt of the statement of findings.

Failure to develop an acceptable Compliance Plan and/or failure to complete activities specified in the Program's Compliance Plan may result in denying approval of the Nurse Aide Training Program.

### **DQA NURSE AIDE PROGRAM REVIEWER DUTIES**

1. Review program documentation on file before the onsite review.
2. Interview appropriate personnel and instructors during the onsite review,
3. Visit and observe the nurse aide classroom, labs and clinical sites. Make notes related to compliance and share notes with the program coordinator.
4. Prepare the final report enumerating items of compliance and noncompliance.
5. Mail a letter and statement of findings enumerating items of deficiency or noncompliance to the administrator within 30 days following the onsite review.
6. Conduct a follow-up onsite review (prior to the next scheduled onsite review) in situations of noncompliance to assure that remedial activities have been completed.
7. Approve the Program for the specified time period based on the type on-site survey conducted. If all activities have been satisfactorily completed.





### Instructional Program Information

<input type="checkbox"/>	<b>Program Type</b>	<input type="checkbox"/> Facility Based only  Classroom program type with facility based clinical site(s): <input type="checkbox"/> Technical College <input type="checkbox"/> High School <input type="checkbox"/> University <input type="checkbox"/> Independent			Facility Type <input type="checkbox"/> Nursing Home <input type="checkbox"/> ICF/MR <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____	
<input type="checkbox"/>	<b>Program Length</b>	Total Hours	Classroom Hours	Clinical Hours	Minimum 16 Instructional Hours prior to Resident Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/>	<b>Program Branches</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No			How Many:	
<input type="checkbox"/>	<b>Textbooks Used</b>	Title		Author	Date of Publication	
<input type="checkbox"/>	<b>Videos Used</b>	Title		Author	Date of Publication	
		Title		Author	Date of Publication	
		Title		Author	Date of Publication	
<input type="checkbox"/>	<b>Curriculum</b>	Program Content <input type="checkbox"/>	Course Outline <input type="checkbox"/>	Lecture Notes <input type="checkbox"/>	Lessons Plans <input type="checkbox"/>	
<input type="checkbox"/>		Training Skill Checklist <input type="checkbox"/> Yes <input type="checkbox"/> No	Skills Checklist covers all required skills <input type="checkbox"/> Yes <input type="checkbox"/> No			All skills initialed and dated <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>BID Completed</b>	Who:		When:	Where Maintained:	
<input type="checkbox"/>	<b>Health Requirements</b>	TB Skin Test		Physical	Where: Maintained:	
<input type="checkbox"/>	<b>Achievement Level</b>	Achievement level required to pass course satisfactorily?		Pass Score	Comment	
<input type="checkbox"/>	<b>Class Records</b>	Class Calendar <input type="checkbox"/>	Class Attendance <input type="checkbox"/>	Grade Records <input type="checkbox"/>	Graduate Records <input type="checkbox"/>	
<input type="checkbox"/>	<b>Student Record Contents</b>	Student Assessment (reading, language proficiency, etc.) <input type="checkbox"/>		Quizzes <input type="checkbox"/>	Training Skills Checklist <input type="checkbox"/>	Final Written Test <input type="checkbox"/>
<input type="checkbox"/>	<b>Record Security</b>	Records are securely maintained with adequate disclosure protection		<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment	
<input type="checkbox"/>	<b>Record Confidentiality</b>	Student's personal identity information is maintained in a confidential manner		<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment	
<input type="checkbox"/>	<b>Record Retention</b>	Training records are maintained for minimum of 3 years		<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment	
<input type="checkbox"/>	<b>Student Evaluation</b>	Student Evaluation of Program for last 2 calendar years		<input type="checkbox"/> Yes <input type="checkbox"/> No	Student evaluation of Primary Instructor for last 2 calendar years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>120 Day Hire</b>	Documentation that all hired nurse aides have successfully completed NATCEP and on Registry within 120 days of hire		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
<input type="checkbox"/>	<b>Training Fee</b>	Nurse aide student charged for nurse aide training program		<input type="checkbox"/> Yes <input type="checkbox"/> No	Fee Amount \$	
<input type="checkbox"/>	<b>Testing Fee</b>	Who pays for NNAAP		Fee Amount \$		
<input type="checkbox"/>	<b>Last Class Date</b>	Enrollment Date		Finish Date		Projected Date of Next Class
<input type="checkbox"/>	<b>Class Size</b>	Last Class Size Start	Last Class Size Finish	Average Class Size	Maximum Class Size	Student/Instructor Ratio



Classroom Information						
<input type="checkbox"/>	Location Name		Address		City	Zip
<input type="checkbox"/>	<b>Classroom</b>	Classroom Location Room #:	Room Dimensions (Width X Length, in feet)	Total Square Footage		Square Feet per Student
		Classroom appropriate for teaching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom quiet, minimal interruption	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has comfortable temperature (between 68°– 72° Fahrenheit)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temperature during Survey		
		Classroom has comfortable ventilation	Heating Vents <input type="checkbox"/> Yes <input type="checkbox"/> No	Return Vents <input type="checkbox"/> Yes <input type="checkbox"/> No	Fans <input type="checkbox"/> Yes <input type="checkbox"/> No	Windows <input type="checkbox"/> Yes <input type="checkbox"/> No
		Classroom is clean, clutter-free	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has access to restrooms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom illuminated appropriately	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
<input type="checkbox"/>	<b>Classroom Equipment</b>	Classroom has access to running water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has adequate, comfortable seating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has adequate, desks, writing surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has chalkboard or large easel	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has sufficient resources	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has complete patient care equipment	Bed <input type="checkbox"/> Yes <input type="checkbox"/> No	Overbed Table <input type="checkbox"/> Yes <input type="checkbox"/> No	Night Stand <input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hoyer Lift <input type="checkbox"/> Yes <input type="checkbox"/> No	Gait Belt <input type="checkbox"/> Yes <input type="checkbox"/> No	Mannequin <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/>	<b>Program Safety</b>	Posted evacuation plan, noting exit routes, fire extinguishers and alarms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Functioning communication system available to classroom	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Public Address System	<input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone Address System	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Classroom has clear, unobstructed path to exits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Exit signs are well marked and lit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has posted diagram of exit route (evacuation plan)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
		Classroom has access to fire extinguishers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:		
<input type="checkbox"/>	<b>If Skilled Nursing Facility, Prohibition Status</b>	Staffing Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Extended Survey <input type="checkbox"/> Yes <input type="checkbox"/> No	Civil Money Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare/Medicaid Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Administration Denial <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Management <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility Closed by State <input type="checkbox"/> Yes <input type="checkbox"/> No	Residents Transferred <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/>	<b>Waiver</b>	Waiver Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	No facility within 30 minutes/45 miles <input type="checkbox"/> Yes <input type="checkbox"/> No	Ombudsman Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates, if applicable:	

### Clinical Site Information

<input type="checkbox"/>	<b>Start Date</b>	Training Program day that students start clinical
<input type="checkbox"/>	<b>Assignment</b>	Name and Title of person who makes student assignments at clinical site

<input type="checkbox"/>	<b>Clinical Site</b>	Name	Address	City	Zip
<input type="checkbox"/>	<b>Facility Type</b>	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Unskilled Nursing Facility		
<input type="checkbox"/>	<b>Supervision</b>	Name and Title of person who supervises students at clinical site		RN <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility clinical site employee <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>Partner</b>	Paired with CNA from facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Paired with nurse aide student classmate <input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<input type="checkbox"/>	<b>Skills Checklist</b>	Skills checked off during clinical <input type="checkbox"/> Yes <input type="checkbox"/> No	Each skill individually initialed and dated by Primary Instructor <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:		
<input type="checkbox"/>	<b>Primary Instructor</b>	Present at clinical site <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/>	<b>If Skilled Nursing Facility, Prohibition Status</b>	Staffing Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Extended Survey <input type="checkbox"/> Yes <input type="checkbox"/> No	Civil Money Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare/Medicaid Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No
		Date:	Date:	Date:	Date:
<input type="checkbox"/>	<b>Waiver</b>	Administration Denial <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Management <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility Closed by State <input type="checkbox"/> Yes <input type="checkbox"/> No	Residents Transferred <input type="checkbox"/> Yes <input type="checkbox"/> No
		Waiver Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	No facility within 30 minutes/45 miles <input type="checkbox"/> Yes <input type="checkbox"/> No	Ombudsman Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Date, if applicable:
<input type="checkbox"/>	<b>Status</b>	Clinical Site Prohibition Free <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Facility Survey:	

<input type="checkbox"/>	<b>Clinical Site</b>	Name	Address	City	Zip
<input type="checkbox"/>	<b>Facility Type</b>	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Unskilled Nursing Facility		
<input type="checkbox"/>	<b>Supervision</b>	Name and Title of person who supervises students at clinical site		RN <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility clinical site employee <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>Partner</b>	Paired with CNA from facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Paired with nurse aide student classmate <input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<input type="checkbox"/>	<b>Skills Checklist</b>	Skills checked off during clinical <input type="checkbox"/> Yes <input type="checkbox"/> No	Each skill individually initialed and dated by Primary Instructor <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:		
<input type="checkbox"/>	<b>Primary Instructor</b>	Present at clinical site <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/>	<b>If Skilled Nursing Facility, Prohibition Status</b>	Staffing Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Extended Survey <input type="checkbox"/> Yes <input type="checkbox"/> No	Civil Money Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare/Medicaid Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No
		Date:	Date:	Date:	Date:
<input type="checkbox"/>	<b>Waiver</b>	Administration Denial <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Management <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility Closed by State <input type="checkbox"/> Yes <input type="checkbox"/> No	Residents Transferred <input type="checkbox"/> Yes <input type="checkbox"/> No
		Waiver Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	No facility within 30 minutes/45 miles <input type="checkbox"/> Yes <input type="checkbox"/> No	Ombudsman Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Date, if applicable:
<input type="checkbox"/>	<b>Status</b>	Clinical Site Prohibition Free <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Facility Survey:	

<input type="checkbox"/>	<b>Clinical Site</b>	Name	Address	City	Zip
<input type="checkbox"/>	<b>Facility Type</b>	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Unskilled Nursing Facility		
<input type="checkbox"/>	<b>Supervision</b>	Name and Title of person who supervises students at clinical site		RN <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility clinical site employee <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>Partner</b>	Paired with CNA from facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Paired with nurse aide student classmate <input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<input type="checkbox"/>	<b>Skills Checklist</b>	Skills checked off during clinical <input type="checkbox"/> Yes <input type="checkbox"/> No	Each skill individually initialed and dated by Primary Instructor <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:		
<input type="checkbox"/>	<b>Primary Instructor</b>	Present at clinical site <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/>	<b>If Skilled Nursing Facility, Prohibition Status</b>	Staffing Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Extended Survey <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Civil Money Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Medicare/Medicaid Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No Date:
		Administration Denial <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Management <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility Closed by State <input type="checkbox"/> Yes <input type="checkbox"/> No	Residents Transferred <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>Waiver</b>	Waiver Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	No facility within 30 minutes/45 miles <input type="checkbox"/> Yes <input type="checkbox"/> No	Ombudsman Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Date, if applicable:
<input type="checkbox"/>	<b>Status</b>	Clinical Site Prohibition Free <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Facility Survey:	

<input type="checkbox"/>	<b>Clinical Site</b>	Name	Address	City	Zip
<input type="checkbox"/>	<b>Facility Type</b>	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Unskilled Nursing Facility		
<input type="checkbox"/>	<b>Supervision</b>	Name and Title of person who supervises students at clinical site		RN <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility clinical site employee <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>Partner</b>	Paired with CNA from facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Paired with nurse aide student classmate <input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<input type="checkbox"/>	<b>Skills Checklist</b>	Skills checked off during clinical <input type="checkbox"/> Yes <input type="checkbox"/> No	Each skill individually initialed and dated by Primary Instructor <input type="checkbox"/> Yes <input type="checkbox"/> No – Explain:		
<input type="checkbox"/>	<b>Primary Instructor</b>	Present at clinical site <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/>	<b>If Skilled Nursing Facility, Prohibition Status</b>	Staffing Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Extended Survey <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Civil Money Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Medicare/Medicaid Terminated <input type="checkbox"/> Yes <input type="checkbox"/> No Date:
		Administration Denial <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Management <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility Closed by State <input type="checkbox"/> Yes <input type="checkbox"/> No	Residents Transferred <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<b>Waiver</b>	Waiver Requested <input type="checkbox"/> Yes <input type="checkbox"/> No	No facility within 30 minutes/45 miles <input type="checkbox"/> Yes <input type="checkbox"/> No	Ombudsman Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Date, if applicable:
<input type="checkbox"/>	<b>Status</b>	Clinical Site Prohibition Free <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Facility Survey:	







## NURSE AIDE PROGRAM EVALUATION – PRIMARY INSTRUCTOR INTERVIEW FORM

DQA Reviewer's Name	Date of Interview	Time of Interview
Program Name	Program Number	
Name of Primary Instructor	Work Telephone Number (       )	

### PRIMARY INSTRUCTOR INTERVIEW QUESTIONS

**1. Have you reviewed your Competency Evaluation Quarterly Report and noted the comparison to other programs in Wisconsin? If so, what is your reaction?**

Response

**2. Are students meeting expected outcomes and competencies?**

Response:

**3. What methods do you use to determine expected outcomes and competencies?**

Response:

**4. What competencies appear to be most difficult?**

Response:

**5. What is the primary reason(s) for students leaving the program before completion?**

Response:

**6. Do you have the materials and supplies necessary to meet the stated program objectives?**

Response:

**7. What criteria do you use to select residents for your students?**

Response:

**8. Are there any additional materials or learning opportunities that would help you do a better job?**

Response

**9. Is there any way that DQA can assist in improving the nurse aide training programs?**

Response

## NURSE AIDE PROGRAM EVALUATION – STUDENT INTERVIEW FORM

DQA Reviewer's Name		Date of Interview		Time of Interview
Program Name		Program Number		
Name of Nurse Aide Student	Social Security Number	Work Telephone Number (      )	Home Telephone Number (      )	
Training Program Enrollment Date	Training Program Completion Date	Competency Test Date	Current Status <input type="checkbox"/> Student <input type="checkbox"/> Graduate	

### NURSE AIDE STUDENT INTERVIEW QUESTIONS

<b>Who were your instructors?</b>	Response
<b>How many hours were you in class?</b>	Response
<b>How did you demonstrate your skills?</b>	Response
<b>How were you supervised?</b>	Response
<b>When did you begin your clinical?</b>	Response
<b>Did others help you to learn your job?</b>	Response
<b>Who?</b>	Response
<b>How?</b>	Response
<b>When?</b>	Response
<b>Where?</b>	Response
<b>What did they help to teach you?</b>	Response
<b>Were you checked off on the skills as you learned? Please describe how this was done.</b>	Response
<b>Did you receive a copy of your training skills checklist?</b>	Response
<b>Did you feel you received adequate support from your program instructor(s)?</b>	Response
<b>Do you feel your training program success was important to your instructors?</b>	Response
<b>How do you rate your training program(s) From a range of 1 (low) to 10 (high)?</b>	Response <div style="text-align: center; margin-top: 5px;"> <span style="font-size: 1.2em;">❶</span> 1 2 3 4 5 6 7 8 9 10         </div>
<b>What did you like best about your nurse aide training program experience?</b>	Response

<b>Did you receive a test admission letter?</b>	Response
<b>How long did you wait to test?</b>	Response

<b>Where did you test? How far did you have to travel?</b>	Response
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<b>Did you receive your written exam and skills exam score results the day of your test?</b>	Response
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<b>Overall, how was your testing experience?</b>	Response
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<b>Did you receive a Wisconsin Nurse Aide Registry certificate and wallet card in the mail?</b>	Response
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<b>Are you currently employed?</b>	Response
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<b>If yes, what facility employed you?</b>	Response
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<b>Please describe your first two days of employment. What do you remember learning?</b>	Response
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<b>Do you feel your training and competency test adequately prepared you for the job? If no, why not?</b>	Response
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<b>Did you complete your nurse aide training and testing in order to pursue a professional license (RN, LPN, etc.)?</b>	Response
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<b>If you could, how would you change or improve the nurse aide training and testing program?</b>	Response
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<b>Any last comments?</b>	
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**DQA USE ONLY**

**NURSE AIDE PROGRAM ONSITE REVIEW ASSESSMENT**

<b>Initial review deficiency free</b>	<input type="checkbox"/> Issue Preliminary Approval of Nurse Aide Instructional Program. Issue notice within 30 days.
<b>Verification review deficiency free</b>	<input type="checkbox"/> Approve Nurse Aide Instructional Program. Issue notice within 30 days.
<b>2-year review deficiency free</b>	<input type="checkbox"/> Re-approve Nurse Aide Instructional Program. Issue notice within 30 days.

<input type="checkbox"/> <b>Paper record keeping deficiencies only</b>	<input type="checkbox"/> Issue Statement of Deficiency on: _____ <input type="checkbox"/> Require Plan of Correction to correct deficiencies. POC due: _____ <input type="checkbox"/> Conduct Follow-up Onsite Review for noncompliance on: _____ <input type="checkbox"/> Verification of Plan of Correction Implementation on: _____ <input type="checkbox"/> Revoke Nurse Aide Instructional Program if deficiencies continue.
<input type="checkbox"/> <b>Program deficiencies resulting in improperly trained aides</b>  <input type="checkbox"/> <b>Program deficiencies resulting in improperly tested aides</b>	<input type="checkbox"/> Issue Statement of Deficiency on: _____ <input type="checkbox"/> Require Plan of Correction to correct deficiencies, including re-training and/or re-testing nurse aides in question. POC due: _____ <input type="checkbox"/> Conduct Follow-up Onsite Review for noncompliance on: _____ <input type="checkbox"/> Verification of Plan of Correction Implementation on: _____ <input type="checkbox"/> Revoke Nurse Aide Instructional Program if deficiencies continue.

**Comments**

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Signature – Onsite Reviewer	Date
Signature – QA Reviewer (Deficiency Free)	Date
Signature – Supervisor (Deficient)	Date