nebraska
health care learning center

Welcome to the Nebraska Health care Learning Center Medication aide training program. The medication aide training program is a 40 hour training that meets the state requirements to sit for the medication aide state exam. The following are the competency requirements.

Competency Requirements

Medication aides, child care providers, and staff members of schools must demonstrate competency in the provision of medication. Prior to placement of a medication aide on the registry, documentation of the competency assessment must be submitted to the Credentialing Division. The competencies include recognition of:

1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights;
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having an awareness of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Attendance: To sit for the state examination a student must complete a 40 hour training program. Attendance for the entire 40 hours is mandatory.

Class Cancelation: In the event of inclement weather, students may call 402-435-3551 and listen for class cancelation information.

Grading: A **72%** is required to successfully pass the medication aide training program. There are two components. There will be regular scheduled quizzes to assess knowledge and an average of all of the quizzes must be **72%** or higher.

In addition there are several skills that will be required and graded. A **72%** must be achieved on each of the skills to successfully pass this training. Critical steps are identified in each skill. If a critical step is missed, it is an automatic no pass on the procedure. The procedure may be repeated up to three times.

Upon successful completion, the student will receive documentation of competency which the student is expected to submit to the state to schedule administration of the state competency. This training does not guarantee placement on the medication aide registry.

Contact List

Web page for Medication aides www.medicationaide.org
Web page for Med Aide forms: http://dhhs.ne.gov/licensure/Pages/Medication-Aide.aspx
Med Aide Registry: 402-471-4322
Nebraska License Information System Search: http://www.nebraska.gov/LISSearch/search.cgi

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Evaluation for speakers

Directions: Indicate your response by filling in the appropriate circle with either a pen or pencil.

		Excellent				Poor
1	Speaker					
	a. Demonstrated expertise in the content	1	2	3	4	5
	b. Teaching strategies were effective	1	2	3	4	5
	c. To what extent did the speaker achieve the objectives?	1	2	3	4	5
2	Level of information (1 = too complex to 5 = too simple)	1	2	3	4	5
3	Amount of time for topic (1 = too long to 5 = too short)	1	2	3	4	5
4	Type of facility at which you work: 1 = assisted living, 2 = nursing facility, 3 = combo facility (NF & AL), 4 = hospital, 5 = consultant/government agency, Other (fill in the blank) _____	1	2	3	4	5
5	Mark your primary job role: 1 = Activities, 2 = Administrator (manager, director, resident services coordinator), 3 = dietary (RD, LMNT, dietary manager, dietary tech, food service supervisor, cook), 4 = nursing (RN, LPN, direct care staff, nursing assistant, medication aide, paid dining assistant, universal worker), 5 = social service, other (please identify) _____	1	2	3	4	5
6	Length of time in job role: 1 = less than 1 year, 2 = 1-2 years, 3 = 2-4 years, 4 = 4-6 years, 5 = greater than 6 years	1	2	3	4	5

Write any comments below.

Medication Aide Skills Competency

Placing your initials in the box next to each competency indicates you have practiced this procedure on another student.

Student Name: _____

Skills Competency	Student Initials	Date	Instructor Initials
Hand washing			
Glove Removal			
Oral Medication			
Topical Medication			
Sublingual Medication			
Instillation Medication - Eyes			
Instillation Medication – Nose			
Instillation Medication - Ears			
Inhaler Medication			
Nebulizer Medication			
Oxygen			

Instructor Signature: _____ Date: _____

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health & Human Services Division of Public Health, Licensure Unit Office of Nursing &Nursing Support
PO Box 94986
Lincoln, NE 68509-4986
Phone: (402) 471-4364 or (402) 471-4910

Application for Medication Aide Registration *Reminder: Include a check/money order for the $18 non-refundable registration fee. Make payable to DHHS Licensure Unit.*

Section 1: Personal Information

(Please note that in order to change a name that is already on our system, we must have documentation of proof of name change.)

Name _____
Last First Middle Maiden Previously used names

Address: _____
Street Apt# City State Zip code

Telephone number: Home _____ Cell _____

Date of birth: _____ Place of birth: _____ Social Security Number: _____
(city/state)

Section 2: Background

Have you been convicted of a crime other than speeding? ☐Yes ☐No

If you answered YES, you MUST list the date of conviction, county/state in which the conviction occurred and the type of conviction(s). (Attach additional sheet(s) of paper if necessary to list crimes/convictions.) On an additional sheet of paper, please include a brief description of the conviction including what the conviction was for, what happened and who was involved. You **must** submit **certified** copies of the following information for each conviction: All Charges; All Pleas; All Sentencing & Probation Orders; and All Documentation pertaining to completion of probation requirements. ****Please note that a conviction is not necessarily a disqualification for placement on the Registry.*

Date of Conviction	County/State	Type of Conviction

Have you provided medications without being active on the Medication Aide Registry? ☐Yes ☐No

If you answered yes, how many partial or whole days did you provide medications? _____
Please explain why you have been providing medication without being registered as a Medication Aide _____

_____

Section 3: Applicant's Attestation of Lawful Presence in the United States:

For the purpose of complying with Nebraska Revised Statutes §4-108 through §4-114, I attest as follows:

Please check the appropriate choice below:

_____ I am a citizen of the United States

_____ I am a qualified alien under the Federal Immigration and Nationality Act. My Immigration status is _____and alien/USCIS number is _____-_____-_____. I agree to provide a copy of my United States Citizenship and Immigration Services documentation upon request.

I hereby attest that my response and the information provided on this form and any related applications for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Section 4: Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good moral character

Print Name of Applicant: _____

Applicant's Signature: _____ Date: _____

The following section is to be completed by the Licensed Health Care Professional conducting your competency assessment and/or directing a registered Medication Aide to conduct the competency assessment and/or the 40-hour course completion, if applicable.

Section 5: Documentation of Competency Assessment

This is to certify that _____ has successfully demonstrated competency in the following areas: (Print Medication Aide Applicant's Name)

Demonstrated the ten (10) competencies as identified in Nebraska Revised Statute §71-6725

1. Maintaining confidentiality,
2. Complying with a recipient's right to refuse to take medications,
3. Maintaining hygiene and current accepted standards for infection control,
4. Documenting accurately and completely,
5. Providing medications according to the five rights,
6. Having the ability to understand and follow instructions,
7. Practicing safety in application of medication procedures,
8. Complying with limitations and conditions under which a medication aide may provide medications,
9. Having an awareness of abuse and neglect reporting requirements, and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Demonstrated providing routine medications by the routes identified in Title 172, NAC 95-005.01

1. Oral (mouth, sublingual, buccal, sprays),
2. Inhalation (inhalers, nebulizers, oxygen),
3. Topical (sprays, creams, ointments, lotions, transdermal patches), and
4. Instillation (drops, ointments, and sprays in eyes, ears, and nose)

_____ _____ _____ _____

Signature of Licensed Health Care Professional | Profession | Professional License # | Date competency completed

_____ _____

Place of employment of Licensed Health Care Professional | Telephone number

If the competency assessment was conducted by a registered Medication Aide, the following information must be provided:

_____ _____ _____

Signature of registered Medication Aide conducting the competency assessment | Registry # | Date

_____ _____

Place of employment of Medication Aide conducting the competency assessment | Telephone number

Medication Aide 40-Hour Course Completion – According to Nebraska Revised Statute §71-6725(4) to work in assisted living facility, a nursing home, or an intermediate care facility for persons with developmental disabilities, the applicant must have completed a 40-hour course. Please complete the following as documentation of course completion if the applicant wishes to be authorized to work in these settings.

_____ _____

Name of College or Facility Providing the Training Program | Date of Completion

_____ _____

Instructor's Signature | Profession and License Number