



Virginia Department of
Health Professions
Board of Nursing

VIRGINIA BOARD OF NURSING
PROGRAM SELF-STUDY

TO BE COMPLETED BY NURSE AIDE EDUCATION PROGRAMS

February 2024

NURSE AIDE EDUCATION PROGRAM SELF-STUDY

PROCESS: A Board of Nursing program inspector will contact the program coordinator to establish a date for the survey visit. The visit length and dates will be discussed with the program coordinator upon scheduling the visit.

A letter will be emailed to the program coordinator to confirm the date of the visit and provide additional instructions regarding the submission of the survey visit documents. Complete the following Self-Study and email it to the Board Inspector. In addition to the Self-Study, submit evidence of compliance with regulatory requirements along with the agenda for the visit by the date listed in your letter OR a minimum of 4 weeks prior to the survey visit.

The program will establish the agenda to include the following:

Agenda Item	Time allotted*
Meeting with program coordinator	45 minutes
Tour of program classroom/skills lab	45 minutes
Meeting with students	45 minutes
Meeting with instructors – all primary and other instructors, other persons that provide expertise	45 minutes
Time to review student records/files/supporting documents	1 hour
Meeting with program administration	30 minutes

*Agenda items and allotted times may differ. The Board inspector completing the survey will discuss the specifics with the program coordinator. A copy will be submitted to the inspector by the program with the below evidence prior to the survey visit.

Supporting evidence to assist in inspector verification of regulatory compliance may include **but is not limited to:**

Prior to Survey Visit (emailed to inspector)	Date of Survey Visit
<ul style="list-style-type: none"> • Signed and dated letter of financial support specifically detailing financial support and resources or current annual budget • Written communication indicating the facility has not been subject to penalty as provided in 42 CFR 483.151(b)(2) or has received a waiver from the state survey agency in accordance with federal law – within the past 2 years – nursing facility-based programs only • BON Curriculum with <i>Teaching Tools/Resources</i> and <i>Student Evaluation</i> completed unique to your program • Instructional calendar with classroom/skills lab and clinical hours • Clinical affiliation agreement(s) or other written communication verifying a clinical relationship with the program provider • Course Syllabus • Student policies 	<ul style="list-style-type: none"> • Current student and graduate records • Current and past attendance rosters since last survey visit • Completed skills performance records • Certificates of completion • Evidence that each student has received a certificate of completion and copy of skills performance record • Evidence that students have received a copy of Virginia law regarding criminal history records • Course outline • Complaint Record • Resumes and/or proof of required coursework to teach in a nurse aide education program for all instructional staff • Documentation of substantive changes being provided to the Board • Student ID badge • State testing results • Interviews with program coordinator, students, graduates

PROGRAM SELF-STUDY

NOTE: A separate form must be completed for each board approval number in your institution.

Program Name: **Board Approval Number:**

Physical Address:
Street City Zip

Mailing Address:
Street City Zip

Coordinator: **Email Address:**

*This will be the official email address listed in board records.

Program Phone Number:

*This will be posted publicly on the VBON website

Date of Visit:

Date of Last Visit:

BON Inspector:

Summary of Factual Data

Classroom Hours: **Lab Hours:** **Clinical Hours:** **Total Hours:**

Current Student Enrollment: **Start and End Dates of Current Class:** -

Enter beginning and ending dates of classes **since the last onsite survey inspection date:**

Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Number of Students Admitted	Number of Students Completing Course

FACULTY ROSTER

18VAC90-26-30

Following the example, list **all** instructors and resource personnel that have taught/assisted **since the last** on-site survey visit and include **all** table contents.

Full Name	Hire Date (mm/dd/yyyy)	Resignation Date (mm/dd/yyyy)	Role	Area of Instruction (check all that apply)	Date of Course-Work or Refresher Training (mm/dd/yyyy)	Nursing Credential/State of Licensure/License Number/Expiration Date (mm/dd/yyyy)
Example: Mary Who	01/02/2016	02/05/2022	<input checked="" type="checkbox"/> Coordinator <input checked="" type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Classroom <input checked="" type="checkbox"/> Skills Lab <input checked="" type="checkbox"/> Clinical	12/06/2018	RN VA 00011112 11/30/2024
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other Person	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		

Following the example, list **all** clinical facilities utilized by students since the last onsite survey visit.

CLINICAL AGENCIES ROSTER

Clinical Agency Name and Address Miles from Campus	Date of Last VDH Survey (mm/yyyy)	Agency Representative Name, Title, Phone Number and Email	Date of Contract/Expiration Date (mm/dd/yyyy)	Date Last Used for Student Clinical Experiences (mm/dd/yyyy)	Number of Students/Hours per Clinical Unit per Day	Total Students/Hours in Direct Client Care
Example: The Best Nursing Home, 1010 Wonder Way, Richmond, VA 4 miles	01/2020	Mary Lou Who, RN Director of Nursing (331) 111-1111 mlw@Bestplace.com	03/10/2019-03/10/2023	03/09/2022	6 students per day/8 hours each	12 students per term/80 clinical hours direct care per student

Complete the table below for those who should be copied on Board communications:

For high school programs, please include information for the CTE Coordinator, Principal, Superintendent and VDOE. For colleges, please include the college President.

Name	Title	Address	Phone number	Email
Example: Roberta Heart, RN	Coordinator	125 Lung Circle Richmond, VA 23233	(804)111-1111	rheart@htlg.com

ATTESTATIONS

Initial each box and sign the completed form.

I attest that the clinical setting being used is not subject to penalties pursuant to 42 CFR 483.151(b)(2).
 N/A *(Required only for nursing facility-based programs; all others N/A)* **18VAC90-26-20(B)(1)(e)**

I attest that that board representatives may make unannounced site visits to the program.
18VAC90-26-20(B)(1)(g)

I attest that no fees for any portion of the program have been imposed on any nurse aide who, on the date on which the nurse aide begins the program, is either employed or has an offer of employment from a nursing facility. *(Required only for nursing facility-based programs; all others N/A)* **18VAC90-26-20(B)(2)**
 N/A

I attest that students received a copy of the applicable Virginia law regarding criminal history records checks for employment in certain health care facilities and the list of crimes which pose a barrier to such employment.
18VAC90-26-20(B)(3)

I attest that all substantive changes to include a change in program coordinator, primary instructor, program ownership, physical location of the program or licensure status of the clinical facility will be reported to the board within 10 days of the change.
18VAC90-26-20(B)(4)

I attest that the original documentation is maintained for a period of two years following each site or survey visit.
18VAC90-26-50(A)(1)

I attest that the program develops and maintains individual student records of major skills taught and date of performance. At the completion of the program the student receives a copy of the record and a certificate of completion.
18VAC90-26-50(A)(1)

I attest that a record of the reports of graduates' performance on the state-approved nurse aide certification examination is maintained.
18VAC90-26-50(A)(2)

I attest that a record that documents the disposition of complaints against the program is maintained.
18VAC90-26-50(A)(3)

I attest that at least 24 hours of instruction are provided prior to direct contact of a student with a client.
18VAC90-26-50(C)(2)

I attest clinical training is at least 40 hours of providing direct client care and that hours of observation are **not** included in the required 40 hours of skills training.
18VAC90-26-50(C)(3)

I attest that if the program does not hold class for a period of one year, the program shall notify the board and the program will be placed on inactive status.
18VAC90-26-70(A)(1)

(Continued on next page)

By typing my signature below, I attest that the information submitted in this report is correct and demonstrates that the nurse aide education program is in compliance with Board of Nursing regulations.

Name and Title of Person Completing this Report:

Date Signed:

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