# Training Requirements for Adult Care Homes and 122C Facilities

# Chapter 5

## Overview

Individuals living in adult and family care homes (ACH) are there because they need assistance with activities of daily living (e.g., bathing, dressing, or eating) or medication management and supervision. As discussed in earlier chapters, these individuals may be frail elderly or they may be individuals with disabilities. In ACHs, they receive assistance with these activities. Workers in ACHs receive varying degrees of training and specialization, but most of the training is focused on providing basic personal or medical care to individuals. Training requirements for most ACH staff provide very limited or no information on working with individuals with disabilities. Because individuals with disabilities account for more than 60% of residents of ACHs, more training on ways to interact with and to care for individuals with disabilities is needed to ensure the safety and well-being of residents and staff.

**Training requirements for most ACH staff provide very limited or no information on working with individuals with disabilities.**

Although data from 2009 show that more than 60% of individuals in ACHs have a mental health problem, intellectual and developmental disability, or Alzheimer disease/dementia, very little of the training for workers in ACHs focuses on the specific needs of these populations.[1] Although not all individuals with these diagnoses manifest inappropriate behavior, many of them do exhibit aggressive or combative behaviors that pose a threat to the safety of other residents and staff. Such behavioral problems can often be safely managed by well-trained staff. Unfortunately, workers in ACHs are not required to receive specific training in managing individuals with behavioral problems, such as de-escalation skills to use during a crisis. This lack of formal training for staff contributes to the safety risks associated with co-locating older individuals with personal care needs with individuals who manifest aggressive or combative behaviors.[2]

## Types of Workers in Adult and Family Care Homes

ACHs employ various types of workers with different levels of training based on their job responsibilities and interactions with residents. The most common type of staff is referred to as a "direct care worker." The North Carolina Office of Long-Term Services and Supports defines direct care workers as certified nursing assistants, personal care aides, and other unlicensed paraprofessionals who help individuals with disabilities and elderly adults with activities of daily living and other personal care tasks.[3] For a more comprehensive list of the various types of workers in adult care homes, see Table 5.1 below.

**Table 5.1**
**Types of Health Professionals Who Could Work in an Adult or Family Care Home and Their Training Requirements**

| Type of Staff | Degree Requirements | Certification/Licensure Requirements | State Required Training Curriculum | State Examination Required to Practice? |
|---|---|---|---|---|
| Personal Care Aides in Adult and Family Care Homes | No degree required | No licensure or certification required | 25 or 80 hours of state-approved educational curriculum and training | No, however, 70% or higher required on written or oral examination and competency evaluation (developed and administered by approved training program) |
| Nursing Assistant I | High school diploma or equivalent | Certification required | 75 hours of state-approved educational curriculum and training | Yes |
| Nursing Assistant II | High school diploma or equivalent | Certification required | 160 hours of state-approved educational curriculum and training | Yes |
| Medication Aide | No degree required | Competency validation and state exam | 24 hours of state-approved educational curriculum | Yes |
| Geriatric Aide | Certified Nursing Assistant | Certification required | State-approved geriatric aide training course | Yes |
| Licensed Practical Nurse | Completion of appropriate nursing program | Licensure required | State-approved programs and curricula | Yes |
| Registered Nurse | Completion of appropriate nursing program | Licensure required | State-approved programs and curricula | Yes |
| Activity Director | High school diploma or equivalent, or by passage of an alternative exam established by the Department of Health & Human Services. | No licensure or certification required | 50 hours of state-approved educational curriculum and training | No |

Sources: 10A NCAC 13G/F .0501, .0502, 21 NCAC 36 .0403, 21 NCAC 36 .03, 10A NCAC 13F .0404.

**Training Requirements for Adult Care Home Staff**

In North Carolina, direct care workers working in ACHs are called personal care aides. Personal care aides provide personal care, such as assistance with bathing, dressing, or eating, to residents. ACH personal care aide training and competency requirements are divided into two groups: workers with 25 hours of training and workers with 80 hours of training. The 25 hour training and competency evaluation is required for personal care aides working in family care homes with seven or fewer beds and without heavy-needs residents.[a,b] Personal care aides working in adult care homes with seven or more beds or those working in family care homes with heavy-needs residents must complete the 80-hour personal care training and competency evaluation.[c] Not all staff are required to take the 25- or 80-hour training course. Staff can apply for an exemption if they qualify under one of the two categories listed below:

1. They are already a licensed health professional or certified nursing assistant (CNA); or
2. They have been employed to perform comparable tasks in a comparable long-term care setting for at least one year during the three years prior to January 1, 1996, or the date they are hired, whichever is later.

Most staff that qualify for exemption are licensed health professionals or CNAs.

If they do not qualify for an exemption, personal care aides in adult care homes must complete training within six months of being hired by an ACH through either through the North Carolina Community College System or under a licensed nurse with at least two years of clinical experience. Course training using a state-approved curriculum must be conducted by an instructor (a licensed nurse) and a program coordinator. The program coordinator should be a licensed nurse, physician, gerontologist, social worker, psychologist, mental health professional, or other health professional with at least two years of experience in adult education or long-term care or a four-year college graduate with four years of experience in aging or long-term care.[d] Because most community colleges do not regularly offer the 25- or 80-hour training course, direct care workers usually receive training from a licensed nurse within the ACH that hired them.[4] Nurses who want to be able to teach personal care training must submit an application to the Division of Health Service Regulation.

**More [staff] training on ways to interact with and to care for individuals with disabilities is needed to ensure the safety and well-being of residents and staff.**

a For the purposes of this Rule, personal care tasks which require an 80-hour training program are as follows: assist with feeding residents with swallowing difficulty; assist with gait training using assistive devices; assist with or perform range of motion exercises; empty and record drainage of catheter bag; administer enemas; bowel and bladder retraining to regain continence; test urine or fecal specimens; use of physical or mechanical devices attached to or adjacent to the resident which restrict movement or access to one's own body used to restrict movement or enable or enhance functional abilities; nonsterile dressing procedures; force and restrict fluids; apply prescribed heat therapy; care for noninfected pressure ulcers; and vaginal douches.

b 10 NCAC 13G .0501 and 13G .0502

c 10A NCAC 13G .0501, 10A NCAC 13F .0501.

d 10A NCAC 13G .0502 (c).

Training includes both classroom instruction and supervised practical training. As specified by North Carolina law, both training courses cover personal care tasks such as toileting; mobility and transferring of residents; personal hygiene; feeding; basic first aid; and taking and recording temperature, pulse, blood pressure, and routine height and weight measurements.[e] The 80-hour training course covers the personal care competences required for the 25-hour course as well as personal care tasks such as use of physical or mechanical devices used by residents, assisting with or performing range of motion exercises, caring for noninfected pressure ulcers, and forcing and restricting fluids.[f] In addition, at least five hours of classroom instruction must focus on interpersonal skills and behavioral interventions, which include recognition of residents' usual patterns of responding to people as well as interpersonal distress and behavior problems; knowledge of and use of techniques as alternatives to the use of restraints; and knowledge of procedures for obtaining consultation and assistance regarding safe, humane management of residents' behavioral problems.[g]

Upon completing the 25- or 80-hour course of training, students must score at least 70% on a written examination of classroom content (or oral examination if the worker has limited reading or writing abilities).[h] In addition to showing knowledge of classroom content, students also complete a competency requirement. During the competency exam, students must satisfactorily perform *all* the personal care skills and interpersonal and behavioral intervention skills required in the training program without assistance from the instructor, as well as explain the procedure to the instructor and the reason it is being done.

**Training Requirements for Certified Nurse Aides**

As mentioned above, CNAs are exempt from personal care training. Rather than hiring direct care workers who require training, many ACHs turn to CNAs to fill staff positions because they are deemed to have met the requirements of the 80-hour training course by virtue of their CNA training. Currently 6,946 (or 6%) of CNAs are employed by adult or family care homes.[5] Certified nurse aides are certified health professionals who must satisfy certain state and federal requirements before practicing. Federal requirements for Nurse Aide I Training (NAT) include a minimum of 75 hours of training, including 16 hours in communication skills, infection control, safety procedures, promoting residents' independence, and residents' rights *before* having contact with residents and 16 hours of supervised practical training with residents. In addition to the subject areas listed above, NAT programs must include basic nursing skills, personal care skills, mental health and social service needs, care of cognitively impaired residents, and basic restorative services. All of North Carolina's state-approved

e For a full list of personal care tasks covered under the 25-hours course requirements see 10A NCAC 13G 0501(h).
f For full list see of personal care tasks covered under the 80-hour course requirements, see 10A NCAC 13G .0501 (i).
g For full list of interpersonal skills and behavioral interventions, see 10A NCAC 13G .0501 (j).
h 10A NCAC 13G .0502 (c).

NAT programs meet, or exceed, federal training requirements. North Carolina NAT programs require proficiency in 69 skills.[5]

Upon completion of training, CNA students are required to take the nurse aide I competency evaluation established by the federal government. The evaluation includes a choice of written or oral exam (offered in English and Spanish) and a competency exam (involving successful skill demonstration of five randomly drawn skills that are usually performed by CNAs). For the written/oral component of the evaluation, North Carolina uses the National Nurse Aide Assessment Program (NNAAP) exam, which is administered by a nationally recognized provider of assessment services to regulatory agencies and national associations, Pearson VUE. For the competency exam component, a registered nurse with at least three years experience, with one or more years of experience caring for the elderly or chronically ill, serves as the evaluator. If a student fails any part of the competency exam or evaluation, they fail the entire exam—students have three opportunities to pass the exam. In addition, CNAs in adult care homes are required to have 12 hours of continuing education annually.[5]

In North Carolina, the state is required to review and to approve (or disapprove) all NAT programs. The state can revoke a program if it fails to meet any of the federal requirements or if a NAT program fails to allow the state to review its program. Nurse aide I training programs are offered in nursing homes, home care agencies, hospitals, community colleges, high schools, and nursing schools. The majority of programs are housed within high schools, community colleges, and nursing schools. The NAT program coordinator must be a registered nurse with a minimum of three years experience, one of which was spent in a skilled nursing facility—or a director of nursing in a skilled nursing facility. Faculty must be registered nurses with at least two years experience and have met at least one of the following requirements: 1) completed a course in teaching, 2) have experience teaching adults, or 3) have experience supervising nurse aides.[5]

As shown in Appendix 7, CNAs receive a more thorough and standardized training regimen than either the 25- or 80-hour ACH staff training. However, both programs lack a comprehensive overview and training for behavioral health care.

**Training Requirements for 122C Staff**

Staff of 122C facilities include qualified professionals, associate professionals, and paraprofessionals. Qualified professionals are required to have at least a bachelor's or master's degree and, depending on their degree field, from one to four years of experience in working with populations that have mental health, developmental disabilities, or substance abuse (MA/DD/SA) issues, or they can be a substance abuse professional with one to four years of supervised experience in alcoholism and drug abuse counseling, or a registered nurse with four years of experience in MA/DD/SA.[i] Qualified professionals with a clinical background

i 10A NCAC 27G .0104 (19)

provide supervision for associate professionals and paraprofessionals. Associate professionals are required to have at least a bachelor's or master's degree and, depending on their degree field, from two to four years of experience in MA/DD/SA, or they can be a registered nurse with less than four years of experience working in MA/DD/SA.[j] Paraprofessionals must have either a GED or high school diploma—if they do not have a GED or diploma, they must have been employed before November 1, 2001, in the field of MA/DD/SA—and must complete core training requirements described below.[k] Paraprofessionals are responsible for providing direct care to the facility's residents.[6]

**In 2002, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funded 20 Geriatric/Adult Mental Health Specialty Teams to help provide additional training for staff of adult care homes and nursing homes with at least one resident with a mental illness at the request of the facility.**

As opposed to training requirements for ACH staff and certified nurse aides, training requirements for staff of 122C facilities are not medically based.[6] Core training for staff includes, at a minimum, general orientation to the 122C; training on client rights and confidentiality; training to meet the mental health, developmental disability, and substance abuse needs of the clients; and training on infectious diseases and bloodborne pathogens.[l] The competencies of qualified and associate professionals are loosely defined; the law requires that they "demonstrate the knowledge, skills, and abilities required by the population being served."[m] There is no standardized training curriculum for 122C staff and no strict guideline as to who can conduct training. Currently, there is no competency exam required for 122C staff, although work has begun on a competency-based requirement that would require specific skills.[6]

Because a competency-based requirement does not exist for 122C facilities, the Division of Health Service Regulation (DHSR) is responsible for determining staff competency through an annual review. Each year, DHSR assembles teams to survey and to review all 122C facilities. The annual review teams observe staff interactions with clients at the facility and also interview clients about the quality of care they are receiving to determine whether the facility is meeting client needs.[6]

## Geriatric/Adult Mental Health Specialty Teams

In 2002, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funded 20 Geriatric/Adult Mental Health Specialty Teams (GASTs) to help provide additional training for staff of adult care homes and nursing homes with at least one resident with a mental illness at the request of the facility.[n,7] Each county in North Carolina is assigned to a GAST. Each team comprises at least one nurse and a master's-level mental health clinician with experience in geriatric care. Each month, the GAST will contact facilities in its county and offer training services, which facilities may accept or decline. Training topics range from specific mental illnesses, to crisis

j 10A NCAC 27G .0104 (1)
k 10A NCAC 27G .0104(15)
l 10A NCAC 27G .0202 (g)
m 10A NCAC 27G .0203
n Caregivers for a person over the age of 65 years can also receive training if they are caring for an individual with a mental illness who is at imminent risk for psychiatric hospitalization.

prevention and response, to medication side effects. In addition, a GAST can also develop specific training modules to meet needs of staff of a given facility, within the scope of mental health and substance abuse topics.[8]

GASTs provide a cost-effective means of educating large numbers of ACH staff and administrators on issues tailored to their needs. The Task Force noted that GAST teams are a valuable but underutilized tool for improving the care for individuals with disabilities living in ACHs. GASTs could be used to provide basic training around working with individuals with mental health needs to large numbers of staff working in ACHs. GASTs could provide training around the kind of "person-centered" approach to caregiving recommended for those providing care to individuals with mental health needs, intellectual and developmental disabilities, and those with Alzheimer disease/dementia.[9] A person-centered approach to care has developed from the belief that caregiving should be based on a concern for the quality of care *and* quality of life for patients.[9,10] For an adult care facility, this means that staff would be trained to treat residents as family or peers in a home-like environment.[10] Emphasis should be placed on treating residents with respect and personal integrity, despite their age or level of infirmity. Thus, any care that was offered would take into account the opinions, values, and preferences of individual residents in addition to a medical standard of care.[7] For direct care workers who work with patients with mental illness, GAST training would instruct caregivers to use respectful and supportive communication to encourage rather than to force compliance with a task. Training on using a patient-centered approach to caregiving focuses on encouraging workers to establish a connection with patients before working toward task completion and teaches that successful connections between caregivers and patients may be established through supportive and calm communication and through the use of visual, verbal, and tactical cues. In addition, caregivers should try to identify the level and type of care for each patient on the basis of the perceived level of the patient's functioning and his or her level of need.[7]

**Geriatric/adult mental health specialty teams provide a cost-effective means of educating large numbers of ACH staff and administrators on issues tailored to their needs.**

Although GAST training aims to teach direct care workers about handling the majority of care for ACH residents with disabilities, direct care workers still may not have the specialized expertise to deal with crisis or emergency situations. In these cases, ACHs can elicit support from NC START teams or Mobile Crisis Teams that offer specialized care. NC START is targeted to adults with developmental disabilities and provides 24/7 crisis response, consultation, and crisis planning for each of three regions across North Carolina.[11] Mobile Crisis Teams offer services to individuals with mental health problems, intellectual and developmental disabilities, or substance abuse by professionals and medical practitioners experienced in crisis management.[12]

The Task Force supports the current work of GASTs and believes they could provide additional value by training staff in all ACHs. GASTs, NC START teams, and Mobile Crisis Teams all provide valuable support to ACHs that house individuals with disabilities. Therefore, the Task Force recommends:

## Recommendation 5.1: Use Geriatric/Adult Mental Health Specialty Teams to Provide Training in all ACHs

**a) The North Carolina General Assembly should enact legislation to require all adult and family care homes (ACH) to receive geriatric/adult mental health specialty team (GAST) training at least three times per year. The training should be tailored to the needs of the specific ACH but should, at a minimum, cover person-centered thinking and de-escalation skills. Staff on all three shifts (including supervisors, administrators, personal care assistants, medication aides, and any other workers who have direct hands-on contact with residents) should receive this training at least once per year.**

**b) The North Carolina Department of Health and Human Services should evaluate and report back to appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by fall 2012 information on whether there are enough GAST resources to meet the new training requirements and whether there are sufficient mobile crisis teams and START crisis teams to meet the needs of ACHs in the event of behavioral health crises.**

### Overall Behavioral Health Training for Staff

As mentioned in Chapter 2, a majority of residents living in ACHs have a mental illness, intellectual and other developmental disabilities, or Alzheimer disease/dementia (64% in 2009).[1] Although not all individuals with these diagnoses manifest inappropriate behaviors, many of them do exhibit aggressive or combative behaviors. Such behavioral problems can often be safely managed by well-trained staff. Direct care workers and other staff in ACHs are not required to receive specific training in crisis prevention and must rely on the support of NC START and Mobile Crisis Teams (as described above) after the individual's situation escalates to full crisis. This lack of formal training for staff contributes to the safety risks associated with co-locating older individuals with personal care needs with individuals who manifest aggressive or combative behaviors. In order to better prevent crises and to ensure the safety of caregivers and residents, caregivers should receive training in crisis prevention.[2] For all service delivery, including crisis prevention, direct care workers should employ patient-centered thinking and approach to care. Therefore, the Task Force recommends:

## Recommendation 5.2: Require Adult and Family Care Home Staff to Be Trained and to Exhibit Competency in Person-Centered Thinking and Crisis Prevention

**The North Carolina General Assembly should require all adult and family care home direct care workers, personal care aides, medication aides, and supervisors to be trained and to have passed the competency exam for state-approved crisis intervention training by June 2013.**

In September 2010, North Carolina was awarded a three year federal Personal and Home Care Aide State Training Program (PHCAST) grant to develop, to pilot test, to implement, and to evaluate the impact of a comprehensive training and competency program for direct care workers. Although the grant focuses on training for home care aides, one type of direct care worker, training modules will be developed also for personal care aides working in adult care homes. The training curriculum developed as part of the PHCAST grant will be available both as a full training curriculum that can be taken from start to finish and as modules that can be used for in-service training programs—thus allowing both students and current workers access to the curriculum. The goal is to develop and to pilot test this curriculum and then to implement it statewide. When fully implemented, the new training and competency program will add new modules and competencies to the current requirements for personal care aides working in adult care homes. The major content areas for which training and competencies will be developed are as follows:

- addressing consumer-specific needs training pertaining to specific care populations, such as the elderly, children, and individuals with disabilities;
- consumers' rights, ethics, and confidentiality;
- interpersonal skills;
- safety and emergency training; and
- dementia and patient abuse prevention training.
- The Task Force believes the PHCAST grant provides an excellent opportunity to develop new training and competency requirements for direct care workers in adult care homes. As part of this process, the Task Force recommends:

**In September 2010, North Carolina was awarded a three year federal Personal and Home Care Aide State Training Program grant to develop, to pilot test, to implement, and to evaluate the impact of a comprehensive training and competency program for direct care workers.**

## Recommendation 5.3: Pilot New Behavioral Health Training and Competency Examination Requirements for New Direct Care Workers

**a) The North Carolina Division of Health Service Regulation (DHSR), in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program (PHCAST) grant. The core training should include, but not be limited to, the following:**

**1) Knowledge and understanding of the people being served, including the impact of aging on different populations.**

**2) Recognizing and interpreting human behavior.**

**3) Recognizing the effect of internal and external stressors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.**

**4) Strategies for building positive relationships with persons with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders and for recognizing cultural, environmental, and organizational factors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.**

**5) Recognizing the importance of and assisting in the person's involvement in making decisions about his or her life.**

**6) Skills in assessing individual risk for escalating behavior.**

**7) Communication strategies for defusing and de-escalating potentially dangerous behaviors.**

**8) Positive behavioral supports providing means for people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders to choose activities that directly oppose or replace behaviors that are unsafe.**

**9) Information on alternatives to the use of restrictive interventions.**

10) **Guidelines on when to intervene (understanding imminent danger to self and others).**

11) **Emphasis on safety and respect for the rights and dignity of all persons involved, including least restrictive interventions and incremental steps in an intervention.**

12) **Knowledge of prohibited procedures, including but not limited to abuse, neglect, and exploitation.**

13) **Debriefing strategies, including their importance and purpose, particularly after resident deaths.**

14) **Documentation methods/procedures.**

**The competency test developed should include both written and skills-based evaluation of training related to working with individuals with disabilities.**

b) **To encourage retention of qualified staff, staff who undergo additional training and who demonstrate additional competencies should be rewarded with higher salaries.**

c) **The DHSR should evaluate and make recommendations about whether this training should be mandatory for all direct care workers. DHSR should report its findings to the appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by the end of the three-year PHCAST pilot.**

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