KCTCS NATCEP
ON-SITE COMPLIANCE VISIT

INITIAL ____ ANNUAL ____ REVISIT ____ POC REQUIRED _____

AUDIT PERFORMED BY: _____

Date: ____/____/_____

Program Name: _____ Provider Number: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip _____

Instructor Name: (Last) _____ (First) _____ MI _____

KBN Licensure #: _____

Original Issue Date: _____ Exp Date: _____

REQUIREMENTS:	**MET**	**NOT MET**	**COMMENTS**
1.1 FACULTY CREDENTIALS			
a. Annual TB Testing	_____	_____	_____
b. Hepatitis B Vaccine	_____	_____	_____
c. Other Clinical Facility Requirements?	YES or NO	If YES, List: _____	
f. CPR (if required)	_____	_____	_____
g. MOI	_____	_____	Date: _____
Clinical MOA	_____	_____	_____
1.3 List Clinical Facility/Facilities and Dates Attended:			
1.4 Student Clinical Eval	_____	_____	_____
1.5 Student Faculty Eval	_____	_____	_____
1.6 Textbook (9th ed.)	_____	_____	_____
1.7 Clinical Site Checklist	_____	_____	_____

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REQUIREMENTS: **MET** **NOT MET** **COMMENTS**

2. STUDENT RECORDS

a. ***All in ink*** _____ _____ _____
b. TB **2-Step** annual _____ _____ _____
c. HepB Vaccine _____ _____ _____
c. Other Facility _____ _____ _____
Requirements? _____ _____ _____
d. CPR (if required) _____ _____ _____
e. Statement of Understanding_____ _____ _____
h. Course Card _____ _____ _____
(Each skill checked, dated, and initialed individually yes /no?)

3. REQUIRED DOCUMENTS

3.1 $1/$3 mil Professional _____ _____ _____

Liability Insurance
Carrier Name: _____

Policy Amount: _____ EXP Date: _____

3.2 MOA (KCTCS & Local operated) YES or NO Date: _____

3.3 Student Exams in Record YES or NO

a. Minimum of Three Exams? YES or NO # Exams Given: _____

b. Student Exam Average of 70%* YES or NO
(*Not all exams are required to be 70% or greater for student to pass the course. No extra credit/open book exams allowed. Dual Credit Scores based only on exams)

3.4 Course Hours Documented for:

a. Lecture/Lab YES or NO Meets Required Hours? YES or NO

b. Clinical YES or NO Meets Required hours? YES or NO

3.5 Syllabus _____ _____ _____
3.6 Attendance Policy _____ _____ _____
3.7 Testing Location: _____

REQUIREMENTS: **MET** **NOT MET** **COMMENTS**

4. EQUIPMENT

4.1 Adult briefs _____ _____ _____
4.2 Adult manikin _____ _____ _____
4.3 Audio-visual equipment _____ _____ _____

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4.4	Basins (for bed bath)	_____	_____	_____
4.5	Bedpan	_____	_____	_____
4.6	Catheter supplies	_____	_____	_____
4.7	Denture care supplies			
	• Dentures	_____	_____	_____
	• Denture Cup	_____	_____	_____
4.8	Disposable Gloves	_____	_____	_____
4.9	Elastic Stockings (knee-hi)	_____	_____	_____
4.10	Geriatric Chair ***(optional)***	_____	_____	_____
4.11	Gait/Transfer Belt	_____	_____	_____
4.12	Hair Care Supplies			
	• Shampoo	_____	_____	_____
	• Brush	_____	_____	_____
	• Comb	_____	_____	_____
	• Shampoo Board	_____	_____	_____
4.13	Linens – Flat Sheet	_____	_____	_____
4.14	Linens & Pillows (For Positioning)	_____	_____	_____
4.15	Linen Hamper	_____	_____	_____
4.16	Bathing Supplies			
	• Lotion	_____	_____	_____
	• Soap			_____
	• Deodorant	_____	_____	_____
4.17	Mouth Care Supplies			
	• Lip Balm	_____	_____	_____
	• Toothbrush	_____	_____	_____
	• Toothpaste	_____	_____	_____
	• Emesis	_____	_____	_____
	• Swabs	_____	_____	_____
4.18	Nail Care Supplies			
	• Nail Clippers	_____	_____	_____
	• Emery Boards	_____	_____	_____
	• Orange Sticks	_____	_____	_____
4.19	Obstructed Airway Manikin	_____	_____	_____
4.20	Patient Beds	_____	_____	_____
4.21	Patient Gowns & Clothing for Dress/Undress	_____	_____	_____
	• Socks	_____	_____	_____
	• Slippers	_____	_____	_____
4.22	Personal Protective Equipment Gloves/Gown/Mask	_____	_____	_____
4.23	Restraints/Protective Devices	_____	_____	_____

REQUIREMENTS:		**MET**	**NOT MET**	**COMMENTS**
4.24	Sample Records of Charting			
	• Intake & Output	_____	_____	_____
	• Vital Signs	_____	_____	_____
4.25	Balance Scales for HT/WT	_____	_____	_____

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4.26	Shaving Supplies			
	• Razor	_____	_____	_____
	• Shaving Cream	_____	_____	_____
	• After-Shave Lotion	_____	_____	_____
4.27	Sink with Water	_____	_____	_____
4.28	Sphygmomanometer	_____	_____	_____
4.29	Stethoscope	_____	_____	_____
4.30	Thermometers	_____	_____	_____
4.31	Urinal	_____	_____	_____
4.32	Wheelchair	_____	_____	_____
4.33	Automated BP Arm ***(optional)***	_____	_____	_____
4.34	Other Supplies: Side Rails	_____	_____	_____

5. ADMINISTRATION & HOUSEKEEPING

5.1 Changes to program, classroom, clinical site, and instructor since last audit? YES or NO

_____

_____ IF SO, MAP-414

5.2 Previous Plan of Correction: YES or NO

Progress: _____

_____

_____

5.3 Dual Credit Program YES or NO _____

5.4 KCTCS Updates for Instructors Reviewed and Applied YES or NO _____

http://kctcs.edu/Degrees_Training/Initiatives/Nurse__Aide/Nurse_Aide_Students.aspx

Notes:
Contact local ATC/CTC for dual credit requirements and procedures.

Annual Report

Number Trained: _____ Number Tested: _____ Number Passed on 1st Attempt: _____

Overall Pass/Fail Rate: _____% This information can be found under program results report in TMU under reports. Instructors can use the past year to obtain. Example: enter dates of 07/01/2023 end 06/30/2024

Auditor Signature: _____ Date: _____

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AUDITOR NOTES:
KCTCS NATCEP

Auditor Signature & Date: _____