D&S Diversified Technologies LLP

Headmaster LLP

North Dakota Nursing Assistant Candidate Handbook

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Contact Information

Questions regarding testing process, test scheduling and eligibility to test: (800) 393-8664

Questions about Nursing Assistant certification, renewals or Registry: (701) 328-2353

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North Dakota Department of Health (NDDOH) *Division of Health Facilities* *600 East Boulevard Avenue, Dept. 301* *Bismarck, ND 58505-0200* *Email: naregistry@nd.gov* *Web Site: https://www.health.nd.gov/nar*	*Monday through Friday* *8:00 AM – 5:00 PM*	Phone #: (701) 328-2353

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Introduction

In 1987, the Nursing Home Reform Act was adopted by Congress as part of the Omnibus Budget Reconciliation Act (OBRA '87). It was designed to improve the quality of care in long-term health care facilities and to define training and evaluation standards for Nursing Assistants who work in such facilities. Each state is responsible for following the terms of this federal law.

As defined in the OBRA regulations, a Nursing Assistant competency evaluation program provides specific standards for Nursing Assistant related knowledge and skills. The purpose of a Nursing Assistant competency evaluation program is to ensure that candidates who are seeking to be Nursing Assistants understand these standards and can competently and safely perform the job of an entry-level Nursing Assistant.

This handbook describes the process of taking the Nursing Assistant competency examination and is designed to help prepare candidates for testing. There are two parts to the Nursing Assistant competency examination—a multiple-choice knowledge test and a skill test. All candidates must be registered, complete approved training, pass both parts of the exam and meet all other requirements of the North Dakota Department of Health Services for certification in North Dakota.

The North Dakota Department of Health (NDDOH) has approved D&S Diversified Technologies (D&SDT)-Headmaster LLP to provide tests and scoring services for Nursing Assistant Testing. For questions not answered in this handbook please contact Headmaster at (800)393-8664 or go to http://hdmaster.com/testing/cnatesting/ndakota/ND_CNA_Home.htm. The information in this handbook will help you prepare for your examination.

The Registry

The North Dakota Department of Health maintains information regarding the certification of nurse aides in North Dakota and operates according to federal and state requirements and guidelines. Anyone may contact the North Dakota Department of Health to inquire about his or her status as a nurse aide and to inquire about lapsed certification and transfer of certification to or from another state.

CNA certificates will be renewed approximately every two years. Initial certification is two years. After the initial two years, the expiration date is based on the last date worked, plus two years. Renewal notices will be mailed 60 days before renewal date to the last known address on file with the Registry.

The North Dakota Department of Health must be kept informed of your current address. If your address or name changes at any time after you are placed on the Registry, you may call the North Dakota Department of Health, Nurse Aide Registry at (701)328-2353 or go to their website at: https://www.health.nd.gov/nar.

Americans with Disabilities Act (ADA)

ADA Compliance

If you have a qualified disability, you may request special accommodations for examination. Accommodations must be approved by the North Dakota Department of Health (NDDOH) in advance of examination. The request for ADA Accommodation Form 1404ND is available on D&SDT-Headmaster's North Dakota webpage under the Candidate Forms column at:

http://hdmaster.com/testing/cnatesting/ndakota/ND_CNA_Home.htm.

This form must be submitted to Headmaster with the required documentation listed on the second page of the ADA application in order to be reviewed for a special accommodation.

The North Dakota Nurse Aide Competency Exam

Schedule an Exam

In order to schedule an examination date, candidates must have successfully completed nursing assistant (NA) training with a nursing assistant program approved by the North Dakota Department of Health or the candidate can challenge the exam. In addition, all nursing assistant certification exam candidates must be registered with D&SDT-Headmaster by their training program. Your registration information will be transmitted to the North Dakota Department of Health upon passing both portions of the CNA exam.

Exam Check-In

You should arrive at your confirmed test site between twenty and thirty (20-30) minutes before your exam is scheduled to start. (*For example*: if your test start time is 8:00AM – you need to be at the test site for check-in no later than 7:30 to 7:40AM)

Identification

You must bring a **PHOTO-BEARING FORM OF IDENTIFICATION**. Some examples of the forms of photo ID's that are acceptable are:

- Driver's License
- State issued Identification Card
- Passport
- Military Identification
- Alien Registration Card
- Tribal Identification Card
- Work Authorization Card
- School ID (with photo)

Please note: *A driver's license or state-issued ID card that has a hole punched in it is NOT VALID and will not be accepted as a valid form of ID. You will not be admitted for testing and you will be considered a NO SHOW. You will forfeit your testing fees and have to pay for another exam date.*

The **FIRST** and **LAST** names listed on the ID presented to the RN Test Observer during sign-in at your test event ***MUST EXACTLY MATCH*** the FIRST and LAST names that were entered in the ND nurse aide database by your training program. You may call D&SDT-Headmaster at (800)393-8664 to confirm that your name of record matches your photo-bearing ID.

Please note: You will not be admitted for testing if you do not bring proper ID, your ID is invalid (*see note above) or if your FIRST and LAST printed names on your photo ID do not match your current name of record. You will be considered a NO SHOW. You will forfeit your testing fees and have to pay for another exam date.

You will be required to re-present your ID when you enter the skills lab for your skills exam. Please keep your ID with you during the entire exam day.

Instructions for the Knowledge and Skill Tests

Test instructions for the knowledge and skill tests will be provided in written and oral format in the waiting area when you sign-in for your test. Oral and PDF versions are also available anytime from your smart phone via the link on D&SDT-Headmaster's North Dakota website. These instructions detail the process and what you can expect during your exams. Please read through the instructions (or listen to them on your smart phone) ***before*** entering the knowledge test room or skill demonstration lab. The instructions will be left in the waiting area during testing for you to refer to throughout your time at the test site. The RN Test Observer and/or Knowledge Test Proctor will ask you questions about the instructions you read when you enter the knowledge test room and/or skill test lab.

Testing Policies

The following policies are observed at each test site—

- If you arrive late for your confirmed exam (you need to be at the test site to check in at least 20-30 minutes before your scheduled start time – if your test start time is 8:00AM, you need to be at the test site by 7:40AM at the latest), you will not be admitted to the exam and any exam fees paid *will NOT be refunded*.
- If you do not bring a photo ID, you will not be admitted to the exam.
- If the FIRST and LAST printed names on your ID do not match your current name of record, you will not be admitted to the exam.
- Cell phones, smart watches, fitness monitors, electronic recording devices and personal items (such as briefcases, large bags, study materials, extra books, or papers) are not permitted to be on or near you in either testing room. You will be informed by the testing team of the designated area to place your personal items and electronic devices in the designated area and you are to collect these items when you complete your test(s). All electronic devices must be **turned off**. Any smart watches or fitness monitors must be removed from your wrist.
- Anyone caught using any type of electronic recording device during testing will be dismissed from the exam, your test will be scored as a failed attempt, you will forfeit all testing fees, you will not be permitted to test for six (6) months and you will be reported to your training program and the North Dakota Department of Health. You may, however, use personal devices during your free time in the waiting area.

- You are encouraged to bring a jacket, snack, drink or study material to have while waiting to test.
- You may bring a basic calculator. You may not use the calculator on your cell phone or any other electronic device.
- You are not permitted to eat, drink, smoke or vape during the exam.
- You are not allowed to leave the testing room (knowledge test room or skills lab) once the exam has begun ***for any reason***. If you do leave during your test event, you will not be allowed back into the testing room to finish your exam.
- You may not take any notes or other materials from the testing room.
- If you are discovered causing a disturbance of any kind, engaging in any kind of misconduct or try to take any notes or testing materials from the testing room, you will be dismissed from the exam, your test will be scored as a failed attempt, you will forfeit all testing fees, you will not be permitted to test for six (6) months and you will be reported to your training program and the North Dakota Department of Health.
- No visitors, guests, pets (including companion animals) or children are allowed.
- For a paper test event, bring several sharpened No. 2 pencils with erasers. The test sites usually do not supply pencils to test candidates.
- You may not test if you have any type of physical limitation (excluding pre-arranged ADA's) that would prevent you from performing your duties as a nursing assistant. (Examples: cast, arm/leg braces, crutches, etc.) Call D&SDT-Headmaster immediately if you are on doctor's orders. You must fax a doctor's order **within 3 business days** of your scheduled exam day to qualify for a free reschedule.
- Latex/Powder Allergies: If you have an allergic reaction to latex or the powder in latex gloves, please bring latex/powder free gloves with you to the test site to use during your skill exam.
- **Please refer to this Candidate Handbook for any updates to testing.**

Rescheduling

Tests may be rescheduled at the discretion of the RN Test Observer.

- You will need to make appropriate arrangements with the RN Test Observer if you need to reschedule your scheduled test event date.

Security

If you refuse to follow directions, use abusive language or disrupt the examination environment, your test will be stopped and scored as a failure. You will be dismissed from the testing room and will forfeit any testing fees paid and a report of your behavior will be given to the North Dakota Department of Health (NDDOH). You will not be allowed to retest for a minimum period of six (6) months.

Anyone who removes or tries to remove test material or takes notes or information from the test site will be reported to NDDOH and is subject to prosecution to the full extent of the law. Your test will be scored as a test failure and you will forfeit any testing fees paid. You will not be allowed to retest for a minimum period of six (6) months. You will need to obtain permission from NDDOH in order to be eligible to test again.

If you give or receive help from anyone during testing (which also includes the use of any electronic recording devices such as cell phones, smart watches, etc.), your test will be stopped and scored as a failure. You will be dismissed from the testing room and will forfeit any testing fees paid. You will be reported to NDDOH and you may need to obtain permission from NDDOH in order to be eligible to test again.

Test Results

After you have completed both the Knowledge Test and Skill Test components of the competency exam, your test results will be officially scored and double checked. Official test results are available to you after 6:00PM Mountain Standard time the day tests are scored. You will be able to access your test results online at:

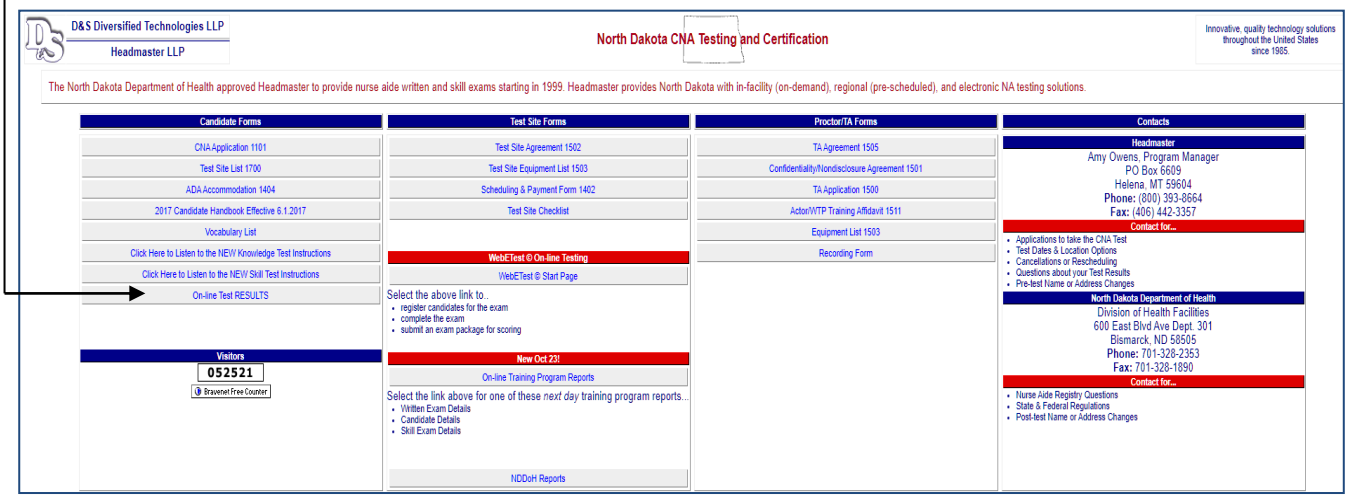
https://www.dandsdiversifiedtech.com/ND/NDCNA_LoginResults.html.

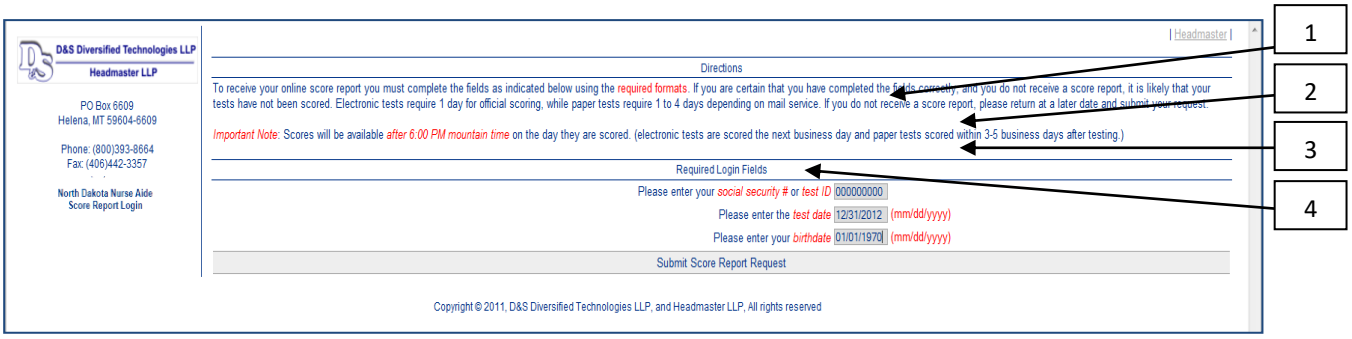
You will be emailed your test results to the email in your record and/or a copy of your test results can be printed from D&SDT-Headmaster's website any time after your test has been officially scored. Your device must have an RTF reader to open emailed test results.

Your test results are submitted electronically to the North Dakota Department of Health the day your test is scored. Your results are not official until they are received and processed by the ND Department of Health.

D&SDT-HEADMASTER does not send postal mail test result letters to candidates.

To check your test results on-line, go to http://hdmaster.com/testing/cnatesting/ndakota/ND_CNA_Home.htm, click on On-Line Test Results:





1) Type in your social security number
2) Type in your test date
3) Type in your birth date
4) Click on Submit Score Report Request

Test Attempts

A candidate who has completed training with an approved training program is allowed **six (6) months of testing eligibility, and three (3) attempts**, to pass both portions of the exam from completion of training date. If a candidate fails three attempts, written, skills or both, the candidate would have to go through an approved nurse aide training program again.

A candidate can challenge the nursing assistant exam without training. These candidates are allowed three (3) attempts within six (6) months of testing eligibility to pass both portions of the exam from completion of their first test attempt. If a candidate fails three attempts, written, skills or both, the candidate would have to go through an approved training program.

Checking your North Dakota Nurse Aide Certificate on the North Dakota Registry

After you have successfully passed both the Knowledge Test and Skill Test components of the nursing assistant exam, your test results will be sent electronically to the North Dakota Department of Health by Headmaster. You will be certified by the North Dakota Department of Health only after you meet all NDDOH requirements (see the additional requirements needed to apply for licensure at the North Dakota Department of Health website).

To check on your nurse aide certificate, go to NDDOH's website at: https://services.ndnar.org/ and under Registration Verifications, click on "Verify a Registration" (or go to https://www.health.nd.gov and click "Regulations and Licensure" then click on "Nurse Aide Registry and CNA", then on "Nurse Aide Registry On-Line Services" and under Registration Verifications, click on "Verify a Registration").

Retaking the Nursing Assistant Test

In the event that your test results inform you that you failed the knowledge and/or skill portion of the examination and when you want to apply for a retest, you will need to repay for the portion that you failed before you can schedule an exam date.

To schedule a test or re-test, contact your training facility where you previously tested or contact a regional testing facility listed on the Test Site List 1700 on D&SDT-Headmaster's North Dakota website.

The regional testing facility contact person and phone number is listed on the Test Site List Form 1700ND.

Test Review Requests

You may request a review of your test results or dispute any other condition of your testing. **There is a $25 test review deposit fee.** To request a review, you must submit the PDF fillable Test Review Request and Payment Form 1403 available on D&SDT-Headmaster's main webpage at www.hdmaster.com (before you get to the North Dakota NA webpage). Submit the Test Review Fee of $25 (MasterCard, Visa or debit card) and a detailed explanation of why you feel your dispute is valid (upload with Form 1403) via the PDF fillable Test Review Request and Payment Form 1403 **within three (3) business days** from official scoring of your test (excluding Saturdays, Sundays and Holidays). Late requests will be returned and will not be considered.

Since one qualification for certification as a nursing assistant in North Dakota is demonstration by examination of minimum nursing assistant knowledge and skills, the likely outcome of your review will determine who pays for your re-test. If the results of the review are in your favor, D&SDT-Headmaster will pay for your re-test fee and refund your review fee. D&SDT-Headmaster will review your detailed recollection, your knowledge test markings and any skill task measurements you recorded at the time of your test, in addition to reviewing markings, notations and measurements recorded by the RN Test Observer at the time of your test. D&SDT-Headmaster will re-check the scoring of your test and may contact you and/or the RN Test Observer for any additional recollection of your test(s). After a candidate reaches the age of 18, D&SDT-Headmaster will only discuss test results or test disputes with the candidate or the candidate's training program. D&SDT-Headmaster will not review test results or disputes with family members or anyone else on behalf of the candidate once the candidate is 18 years of age. D&SDT-Headmaster will complete your review request within 10 business days of the receipt of your timely review request and will email or mail the review results to your email address or physical address of record and to the North Dakota Department of Health.

The Knowledge/Oral Test

The RN Test Observer/Knowledge Test Proctor will hand out materials and give instructions for taking the Knowledge Test. You will have a maximum of ninety (90) minutes to complete the 72 question Knowledge Test. You will be told when fifteen (15) minutes remain. You may not ask questions about the content of the Knowledge Test (such as "What does this question mean?") For paper tests, fill in only one (1) oval on the answer sheet for each question. Do not mark in the testing booklet. Marks in the test booklet will not be accepted as answers. Your answers must appear on the separate scan form answer sheet. **You must have a score of 75% or better to pass the knowledge portion of the exam.**

- For paper knowledge tests, you must bring several sharpened Number 2 pencils with erasers. Do not bring or use ink pens.

Electronic testing called WebEtest© using Internet connected computers is utilized at several sites in North Dakota. For electronic tests, the knowledge test portion of your exam will be displayed on a computer screen for you to read and key in your answers. Testing online with WebEtest© allows

next business day scoring of tests and eliminates examination material shipping time so test results are available days sooner than with traditional paper and pencil testing.

An audio (Oral) version of the knowledge test is available. However, you must request an Oral test before you submit your testing fee payment. There is an additional charge for an Oral Test. The questions are read to you, in a neutral manner, from an MP3 player, with control buttons for play, rewind, pause, etc., in addition to having the knowledge test and scan form for the paper test. For WebETest© you will hear the questions on the computer headphones and have control buttons on the computer screen (play, rewind, pause etc.).

Per the North Dakota Department of Health, translation dictionaries are not allowed during testing.

All test materials must be left in the testing room. Anyone who takes or tries to take materials, notes or information from the testing room is subject to prosecution and will be reported to the North Dakota Department of Health.

Knowledge Test Content

The Knowledge Test consists of 72 multiple-choice questions. Questions are selected from subject areas based on the NDDOH approved North Dakota test plan and include questions from all the required categories as defined in OBRA regulations. The subject areas are as follows:

Subject Area	# of Questions
Basic Nursing Skills	11
Care Impaired	5
Communication and Interpersonal Skills	6
Data Collection	3
Disease Process	5
Growth & Development Across the Ages	2
Infection Control	5
Mental Health	4
Personal Care	6
Resident Rights	6
Role and Responsibility	11
Safety	8

Subject Area Information

Questions regarding the following subject areas would involve or include:

Basic Nursing Skills: Broad subject area including any act or activity that would be considered a basic skill necessary to perform the job of a CNA: includes data acquisition, handling and routing.

Care Impaired: Questions dealing with residents that are limited either physically or mentally from receiving "standard" care. CNA's must perform more extensively or differently to accommodate these residents.

Communication and Interpersonal Skills: Any type of communication, both verbal and non-verbal, written and spoken; any communication related to hearing, seeing, feeling, tasting or smelling.

Data Collection: Questions relating to date acquisition, handling and routing.

Disease Process: Questions dealing with the stages of disease(s) and/or the theory of disease(s) and the detection, prevention or treatment of disease(s).

Growth and Development Across the Ages: Process and progression of humans becoming what they will be as they move along the time line of their lives.

Infection Control: Relating to the nature of infections; causes and prevention, correct methods and procedures for dealing with infection.

Mental Health: Mental processes of residents, signs and stages of mental states of residents both normal and care impaired; mental well-being and interaction of a CNA and co-workers.

Personal Care: Activities or acts performed by a CNA for or to residents that are personal in nature; accommodations necessary for care impaired residents; stages and/or the theory of diseases, detection, prevention and treatment.

Resident Rights: Rights residents are legally entitled to; facility and CNA roles in ensuring those rights.

Role and Responsibility: A broad subject area including any act or activity that would be considered part of the basic role or responsibility of a CNA in the workplace.

Safety: Safety of residents, CNAs, facility safety issues and safety of facility personnel in general.

Knowledge Practice Test

D&SDT-Headmaster offers a free knowledge test question of the day and a ten question on-line static practice test available on our web site at www.hdmaster.com. Candidates may also purchase complete practice tests that are randomly generated, based on the state test plan. A mastery learning method is used and each practice test taken will be unique. This means candidates must get the question they are attempting correct before they may move onto the next question. A first attempt percentage score and vocabulary feedback are supplied upon completion of the practice test. A list of vocabulary words to study is provided at the end of each test. Single or group purchase plans are available.

The following are a sample of the kinds of questions that you will find on the Knowledge/Oral test.

1. Clean linens that touch the floor should be:
(A) Picked up quickly and placed back on the clean linen cart
(B) Used immediately on the next resident bed
(C) Considered dirty and placed in the soiled linen hamper
(D) Used only in the room with the floor the linen fell on

2. A soft, synthetic fleece pad placed beneath the resident:
(A) Takes pressure off the back
(B) Provides warmth for the resident
(C) Gives the resident a sense of security
(D) Should only be used with bedridden residents

3. A resident's psychological needs:
(A) Should be given minor consideration
(B) Make the resident withdrawn and secretive
(C) Are nurtured by doing everything for the resident
(D) Are nurtured when residents are treated like individuals

ANSWERS: 1-C |2-A |3-D

The Manual Skill Test

- The purpose of the Skill Test is to evaluate your performance when demonstrating North Dakota approved nursing assistant skill tasks. You will find a complete list of skill tasks in this handbook.

- You will be asked to re-present your ID that you showed the RN Test Observer at sign-in.

- Be sure you understand all instructions you read while in the waiting area before you begin your skill task demonstrations. You may not ask questions once the Skill Test begins and the timer starts. Once the Skill Test begins, the RN Test Observer may not answer questions.

- Each of your randomly selected three (3) or four (4) tasks will have scenarios associated with them. The scenarios will be read to you by the RN Test Observer immediately before you are asked to do each task.

- You will be allowed a maximum of **thirty (30) minutes** to complete your three (3) or four (4) tasks. After 15 minutes have elapsed, you will be alerted that 15 minutes remain.

- Listen carefully to all instructions given by the RN Test Observer. You may request to have any of the scenarios repeated **at any time** during your Skill Test up until you run out of time or you tell the RN Test Observer that you are finished with your skill task demonstrations.

- You must correctly perform all of the **key** steps (in bold font) and 80% of all non-key steps on each task assigned in order to pass the Skill Test.

- You may repeat or correct **any step** or **steps** on any task you believe you have performed incorrectly at **any time** during your allotted thirty (30) minutes or until you tell the RN Test Observer you are finished with the Skill Test.

- If you believe you made a mistake while performing a task, say so. You will need to demonstrate the step or steps on the task you believe you performed incorrectly for the correction to be noted for the step.

- At any time during any skill, you may direct the RN Test Observer to move anywhere needed to assist in providing safety for the resident.

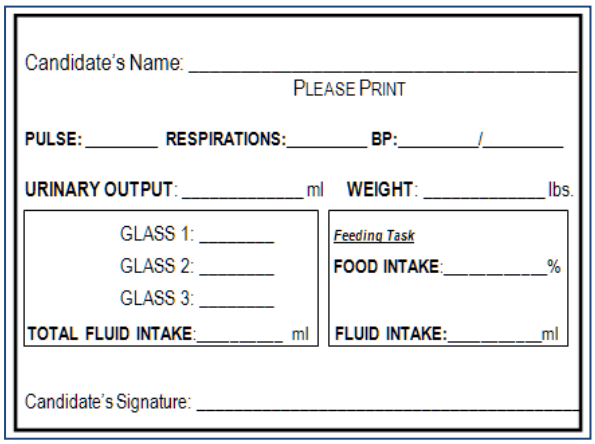
- The skill task steps are generally not order dependent, unless the words BEFORE or AFTER are used in a step.

- When you finish each task, verbally tell the RN Test Observer you are finished and move to the designated "relaxation area." When the RN Test Observer and actor have set up and are ready for your next skill task demonstration, the RN Test Observer will read the scenario for your next task.

- **All steps must actually be demonstrated. Steps that are only verbalized WILL NOT COUNT.**

Skill Test Recording Form

The RN test observer will provide a recording form similar to the one displayed below if your skill test includes a skill task which requires recording a count or measurement.



Candidate's Name: _____
PLEASE PRINT

PULSE:_____ **RESPIRATIONS:**_____ **BP:**_____/_____

URINARY OUTPUT: _____ml **WEIGHT**: _____lbs.

GLASS 1: _____
GLASS 2: _____
GLASS 3: _____
TOTAL FLUID INTAKE:_____ ml

Feeding Task
FOOD INTAKE:_____%
FLUID INTAKE:_____ml

Candidate's Signature: _____

Skill Test Mandatory First Tasks

You will be assigned **one** of the following mandatory tasks as your first task:

- Bedpan and Output with Hand Washing
- Donning an Isolation Gown and Gloves then Emptying a Urinary Drainage Bag with Hand Washing
- Perineal Care of a Female with Hand Washing

Please note: Hand washing is embedded in each of the mandatory tasks and must be demonstrated at the end of each mandatory task.

You will also receive an additional two (2) or three (3) randomly selected tasks from the Skill Task Listing below. These selected tasks will make up your personalized and unique skill test. Each skill test randomly assigned by the WebETest© skill test assignment algorithm will be comparable in overall difficulty. That is why some skill tests will have a differing number of tasks.

Skill Tasks Listing

Every step must actually be performed and demonstrated during your skill test demonstration in order to receive credit.

The steps that are listed for each task are the steps required for a nursing assistant candidate to successfully demonstrate minimum proficiency of the skill task for the RN Test Observer. The steps will be performed on a live resident actor for most of the tasks (the perineal care tasks will be done on a manikin). You will be scored only on the steps listed. You must have a score of 80% on each task without missing any key steps (the Bolded steps) to pass the skill component of your competency evaluation. If you fail the Skill Test, one of the tasks on your retest will be a task you previously failed. There will always be only one of the three mandatory tasks to start each Skill Test. The other tasks included on your Skill Test are randomly chosen so that every Skill Test is comparable in difficulty and average length of time to complete. The RN Test Observer will observe your demonstrations of your skill tasks and record what she/he sees you do. D&SDT-Headmaster scoring teams will officially score and double check your test.

Please note: The skill task steps included in this handbook are offered as guidelines to help prepare candidates for the North Dakota nursing assistant skill test and the steps included herein are not intended to be used to provide complete care that would be all inclusive of best care practiced in an actual work setting.

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Bedpan and Output with Hand Washing

(One of the possible mandatory first tasks)

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident – pull curtain.
6) Put on gloves.
7) Raise the bed height.
8) Position resident on bedpan/fracture pan correctly. (Pan not upside down, is centered, etc.)
9) Position resident on bedpan/fracture pan using correct body mechanics.
10) Raise head of bed to comfortable level.
11) Leave tissue within reach of resident.
12) Leave call light or signal calling device within easy reach of the resident.
13) Move to an area of the room away from the Actor.
14) When the RN Test Observer indicates, candidate returns.

15) Wash/assist resident to wash hands. (Using a wet washcloth or a disposable wipe.)
16) Discard soiled linen in designated laundry hamper, or dispose of wipe.
17) Lower head of the bed, if it was raised.
18) Gently remove bedpan/fracture pan.
19) Hold the bedpan/fracture pan for the RN Test Observer while liquid is poured into bedpan/fracture pan.
20) Place graduate on level, flat surface.
21) With graduate at eye level, read output.
22) Record output on the previously signed recording form.
23) Candidate's recorded output measurement is within 25ml's of the RN Test Observer's pre-measured output amount.
24) Lower bed, if it was raised.
25) Empty equipment used into designated toilet.
26) Rinse equipment used and empty rinse water into designated toilet.
27) Dry equipment used.
28) Remove gloves turning inside out.
29) Properly dispose of gloves.
30) Place call light or signal calling device within easy reach of the resident.
31) Maintain respectful, courteous interpersonal interactions at all times.
32) Wash hands: Turn on water.
33) Wash hands: Begin by wetting hands.
34) Wash hands: Apply soap to hands.
35) Wash hands: Rub hands together using friction.
36) Wash hands: Rub hands together for at least twenty (20) seconds.
37) Wash hands: Using friction, rub interlaced fingers together while pointing downward.
38) Wash hands: Wash all surfaces of hands with soap.
39) Wash hands: Wash wrists with soap.
40) Wash hands: Rinse hands thoroughly under running water with fingers pointed downward.
41) Wash hands: Dry hands on clean paper towel(s).
42) Wash hands: Turn off faucet with a paper towel.
43) Wash hands: Discard paper towel(s) to trash container as used.
44) Wash hands: Does not re-contaminate hands by touching faucet or sink at any time during/after the hand washing procedure.

Donning an Isolation Gown and Gloves then Emptying a Urinary Drainage Bag with Hand Washing

(One of the possible mandatory first tasks)

1) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
2) Face the back opening of the gown.
3) Unfold the gown.
4) Place arms through each sleeve.
5) Secure the neck opening.
6) Secure the waist, making sure that the back flaps cover clothing as completely as possible.

7) Put on gloves.
8) Gloves overlap gown sleeves at the wrist.
9) Knock on the door.
10) Introduce yourself to resident.
11) Explain the procedure to the resident.
12) Provide privacy for resident – pull curtain.
13) Place a barrier on the floor under the drainage bag.
14) Place the graduate on the previously placed barrier.
15) Open the drain to allow the urine to flow into the graduate.
16) Avoid touching the graduate with the tip of the tubing.
17) Close the drain.
18) Replace drain in holder.
19) Place graduate on level, flat surface.
20) With graduate at eye level, read output.
21) Empty graduate into designated toilet.
22) Rinse equipment emptying into designated toilet.
23) Return equipment to storage.
24) Leave resident in a position of comfort and safety.
25) Record the output in ml's on previously signed recording form.
26) Candidate's recorded output measurement is within 25ml's of the RN Test Observer's pre-measured output amount.
27) Place call light or signal calling device within easy reach of the resident.
28) Maintain respectful, courteous interpersonal interactions at all times.
29) Remove gloves, turning inside out.
30) Dispose of the gloves in appropriate container.
31) Unfasten gown at the neck.
32) Unfasten gown at the waist.
33) Remove gown by folding soiled area to soiled area.
34) Bare hands never touch soiled surface of the gown.
35) Dispose of gown in garbage can or designated container.
36) Wash hands: Turn on water.
37) Wash hands: Begin by wetting hands.
38) Wash hands: Apply soap to hands.
39) Wash hands: Rub hands together using friction.
40) Wash hands: Rub hands together for at least twenty (20) seconds.
41) Wash hands: Using friction, rub interlaced fingers together while pointing downward.
42) Wash hands: Wash all surfaces of hands with soap.
43) Wash hands: Wash wrists with soap.
44) Wash hands: Rinse hands thoroughly under running water with fingers pointed downward.
45) Wash hands: Dry hands on clean paper towel(s).
46) Wash hands: Turn off faucet with a paper towel.
47) Wash hands: Discard paper towel(s) to trash container as used.
48) Wash hands: Does not re-contaminate hands by touching faucet or sink at any time during/after the hand washing procedure.

Perineal Care of a Female with Hand Washing

(One of the possible mandatory first tasks)

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident. (manikin)
5) Provide privacy for resident – pull curtain.
6) Fill basin with warm water.
7) Raise the bed height.
8) Put on gloves.
9) Direct RN Test Observer to stand on opposite side of the bed or raise side rail on opposite side of bed.
10) Turn resident or raise hips and place barrier under buttocks. (Candidate will choose barrier such as a towel, water proof pad, chux pad, etc.)
11) Expose perineum only.
12) Separate labia.
13) Use water and soapy washcloth.
14) Clean one side of labia from top to bottom.
15) Use a clean portion of a washcloth, clean other side of labia from top to bottom.
16) Use a clean portion of a washcloth; clean the vaginal area from top to bottom.
17) Use a clean washcloth, rinse one side of labia from top to bottom.
18) Use a clean portion of a washcloth; rinse other side of labia from top to bottom.
19) Use a clean portion of a washcloth; rinse the vaginal area from top to bottom.
20) Pat dry.
21) Cover the exposed area with the bath blanket or gown, or combination of both.
22) Assist resident to turn onto side away from the candidate.
23) Use a clean washcloth.
24) Use water, washcloth and soap.
25) Clean only from vagina to rectal area.
26) Use a clean portion of a washcloth with any stroke.
27) Use a clean washcloth, rinse from vagina to rectal area.
28) Use a clean portion of a washcloth with any stroke.
29) Pat dry.
30) Safely remove barrier from under buttocks, if placed.
31) Position resident (manikin) on her back.
32) Lower bed, if it was raised.
33) Dispose of soiled linen in designated laundry hamper.
34) Empty equipment in designated sink or toilet.
35) Rinse equipment.
36) Dry equipment.
37) Return equipment to storage.
38) Remove gloves, turning inside out.
39) Dispose of gloves in appropriate container.

40) Place call light or signal calling device within easy reach of the resident.
41) Maintain respectful, courteous interpersonal interactions at all times.
42) Wash hands: Turn on water.
43) Wash hands: Begin by wetting hands.
44) Wash hands: Apply soap to hands.
45) Wash hands: Rub hands together using friction.
46) Wash hands: Rub hands together for at least twenty (20) seconds.
47) Wash hands: Using friction, rub interlaced fingers together while pointing downward.
48) Wash hands: Wash all surfaces of hands with soap.
49) Wash hands: Wash wrists with soap.
50) Wash hands: Rinse hands thoroughly under running water with fingers pointed downward.
51) Wash hands: Dry hands on clean paper towel(s).
52) Wash hands: Turn off faucet with a paper towel.
53) Wash hands: Discard paper towel(s) to trash container as used.
54) Wash hands: Does not re-contaminate hands by touching faucet or sink at any time during/after the hand washing procedure.

Abdominal Thrust

1) Candidate is able to identify symptoms of choking. Evaluate choking by asking resident "Are you choking?"
2) Candidate verbalizes they would call for help.
3) Stand behind resident and wrap arms around resident's waist.
4) Make a fist with one hand.
5) Place the thumb side of the fist against the resident's abdomen.
6) Position fist slightly above navel and below the xiphoid process.
7) Grasp fist with other hand, press fist and hand into the resident's abdomen with an inward, upward thrust 6-10 times. Must demonstrate at least one time and then can verbalize the rest of the upward thrusts.
8) Stop, asks resident "Are you still choking?" If resident indicates yes –
9) Candidate should indicate that they would repeat this procedure until it is successful or until victim loses consciousness.
10) Candidate verbalizes they would notify the nurse.

Ambulation with a Gait Belt

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Obtain gait belt for the resident.
6) Lock bed brakes to ensure resident's safety.
7) Position bed so the resident's feet will rest comfortably flat on the floor when sitting on the bed.
8) Bring resident to sitting position.

9) Properly place gait belt around resident's waist to stabilize.
10) Tighten gait belt.
11) Check gait belt for tightness by slipping fingers between gait belt and resident.
12) Assist resident to put on non-skid footwear.
13) Stand in front of and face the resident.
14) Grasp the gait belt on each side of the resident with an underhand grip.
15) Ensure resident is stable.
16) Bring resident to standing position.
17) Use proper body mechanics at all times.
18) Grasp gait belt with one hand, using underhand grip.
19) Stabilizing resident with other hand by holding forearm, shoulder or other appropriate method to stabilize resident.
20) Ambulate resident at least 10 steps and return resident to chair.
21) Assist resident to sit in the chair in a controlled manner that ensures safety.
22) Remove gait belt, if it was placed on resident.
23) Leave resident in position of comfort and safety.
24) Place call light or signal calling device within easy reach of the resident.
25) Maintain respectful, courteous interpersonal interactions at all times.
26) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Ambulation with a Walker

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene
    a. Cover all surfaces of hands with hand sanitizer
    b. Rub hands together until hands are completely dry.
4) Explain procedure to resident.
5) Obtain a gait belt that fits the resident.
6) **Lock bed brakes to ensure resident's safety.**
7) Lower bed so resident's feet will be flat on the floor when sitting on the edge of the bed.
8) Bring resident to sitting position with resident's feet flat on the floor.
9) Properly place gait belt around resident's waist to stabilize.
10) Tighten gait belt.
11) Check gait belt for tightness by slipping fingers between gait belt and resident.
12) Assist resident to put on non-skid footwear BEFORE standing.
13) Stand in front of and face the resident.
14) Grasp the gait belt on each side of the resident with an underhand grip.
15) Bring the resident to a standing position.
16) Ensure the resident is stable.
17) Position walker in front of resident.
18) Ensure resident has stabilized walker.
19) Position self behind and slightly to side of resident.
20) Instruct resident on proper use of walker.

21) Candidate walks to the side a little behind the resident.
22) Safely ambulate resident 10 steps and return resident to the chair.
23) Assist resident to sit in the chair in a controlled manner that ensures safety.
24) Candidate uses correct body mechanics at all times.
25) Remove gait belt.
26) Leave resident in position of comfort and safety.
27) Perform hand hygiene
    a. Cover all surfaces of hands with hand sanitizer
    b. Rub hands together until hands are completely dry.
28) Maintain respectful, courteous interpersonal interactions at all times.
29) Place call light or signal calling device within easy reach of the resident.

Applying an Anti-Embolic Stocking to One Leg

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident by only exposing one leg.
6) Roll, gather or turn stocking down inside out to the heel.
7) Place stocking over the resident's toes, foot, and heel.
8) Roll or pull stocking up the leg.
9) Check toes for possible pressure from stocking and adjust as needed.
10) Leave resident with stocking that is smooth and wrinkle free.
11) Leave resident with stocking that is properly placed without restriction.
12) Cover exposed leg.
13) Place call light or signal calling device within easy reach of the resident.
14) Maintain respectful, courteous interpersonal interactions at all times.
15) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Bed Bath- Whole Face and One Arm, Hand and Underarm

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident – pull curtain.
6) Raise bed height.
7) Cover resident with a bath blanket.
8) Remove remaining top linens. (Fold top linens to bottom of bed or place aside.)
9) Remove resident's gown without exposing resident.

10) Dispose of gown in designated laundry hamper.
11) Fill basin with warm water.
12) Wash face WITHOUT SOAP.
13) Use a clean portion of the washcloth with each wipe.
14) Pat dry face.
15) Exposes one arm.
16) Place towel under arm, exposing one arm.
17) Wash arm with soap.
18) Wash hand with soap.
19) Wash underarm with soap.
20) Rinse arm.
21) Rinse hand.
22) Rinse underarm.
23) Pat dry arm.
24) Pat dry hand.
25) Pat dry underarm.
26) Assist resident to put on a clean gown.
27) Lower bed, if raised.
28) Empty equipment in designated sink or toilet.
29) Rinse equipment.
30) Dry equipment.
31) Return equipment to storage.
32) Dispose of soiled linen in designated laundry hamper.
33) Place call light or signal calling device within easy reach of the resident.
34) Maintain respectful, courteous interpersonal interactions at all times.
35) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Blood Pressure

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain procedure to resident.
5) Position resident with forearm supported in a palm-up position.
6) Position resident with forearm approximately at the level of the heart.
7) Roll resident's sleeve up about 5 inches above the elbow, if resident is wearing a top with sleeves.
8) Apply the appropriate size cuff around the upper arm just above the elbow.
9) Line cuff arrows up with brachial artery.
10) Clean earpieces of stethoscope appropriately and place in ears.
11) Clean diaphragm of the stethoscope.
12) Place stethoscope earpieces in ears.

13) Locate brachial artery with fingertips.
14) Place stethoscope diaphragm over brachial artery and hold snugly in place.
15) Inflate cuff to 160-180mmHg or 30mmHg above where pulse was last heard or felt.
16) Inflate the blood pressure cuff no more than two times per arm.
17) Slowly release air from cuff to disappearance of pulsations. Remove cuff.
18) Place call light or signal calling device within easy reach of the resident.
19) Maintain respectful, courteous interpersonal interactions at all times.
20) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
21) Record reading on the previously signed recording form.
22) Candidate's recorded systolic blood pressure is within 4mmHG beats of the RN Test Observer's systolic blood pressure recording.
23) Candidate's recorded diastolic blood pressure is within 4mmHG beats of the RN Test Observer's diastolic blood pressure recording.

Denture Care

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Line bottom of the sink with a protective lining (towel, washcloth or paper towel) or fills the sink with water to prevent damage to the dentures in case they are dropped.
6) Put on gloves.
7) Carefully remove dentures from cup.
8) Handle dentures carefully to avoid damage.
9) Rinse denture cup.
10) Never put dentures in/on a contaminated surface.
11) Apply denture cleanser/cream to denture brush/toothbrush.
12) Thoroughly brush denture inner surfaces of upper or lower dentures.
13) Thoroughly brush denture outer surfaces of upper or lower dentures.
14) Thoroughly brush denture chewing surfaces of upper or lower dentures.
15) Thoroughly brush denture groove or plate that touches gum surface.
16) Rinse denture using clean cool running water.
17) Place denture in rinsed denture cup.
18) Add cool clean water to denture cup.
19) Rinse equipment.
20) Dry equipment.
21) Return equipment to storage.
22) Discard sink protective lining in an appropriate container, or drain the sink.
23) Remove gloves, turning inside out.
24) Dispose of gloves in an appropriate container.
25) Place call light or signal calling device within easy reach of the resident.

26) Maintain respectful, courteous interpersonal interactions at all times.
27) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Dressing a Bedridden Resident

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident – pull curtain.
6) Keep resident covered while removing gown.
7) Remove gown from unaffected (strong) side first.
8) Place soiled gown in designated laundry hamper.
9) Dress the resident in a button-up shirt. Insert hand through the sleeve of the shirt and grasp the hand of the resident.
10) When dressing the resident in a button-up shirt, always dress from the affected (weak) side first.
11) Assist the resident to raise his/her buttocks or turn the resident from side to side and draw the pants over the buttocks and up to the resident's waist.
12) When dressing the resident in pants, always dress the affected (weak) side leg first.
13) Put on the resident's socks. Draw the socks up the resident's foot until they are smooth.
14) Leave the resident in correct body alignment.
15) Leave the resident properly dressed.
16) Place call light or signal calling device within easy reach of the resident.
17) Maintain respectful, courteous interpersonal interactions at all times.
18) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Feeding a Dependent Resident

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Look at the diet card to check that the resident has received the correct tray.
6) Position the resident in an upright position, at least 90 degrees.
7) Protect clothing from soiling by using an appropriate clothing protector.
8) Wash resident's hands BEFORE feeding. (May use a wet washcloth or disposable wipe.)
9) Discard soiled linen in designated laundry hamper or dispose of wipe.
10) Sit next to the resident while assisting with feeding.

11) Describe the foods being offered to the resident.
12) Offer fluid frequently.
13) Offer small amounts of food at a reasonable rate.
14) Allow resident time to chew and swallow.
15) Wipe resident's hands and face during meal as needed.
16) Leave resident clean and in a position of comfort.
17) Place call light or signal calling device within easy reach of the resident.
18) Maintain respectful, courteous interpersonal interactions at all times.
19) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
20) Record intake as a percentage of total solid food eaten on the previously signed recording form.
21) Candidate's calculation must be within 25 percentage points of the RN Test Observer's.
22) Record sum of estimated fluid intake in ml's on the previously signed recording form.
23) Candidate's calculation must be within 30ml's of the RN Test Observer's.

Fluid Intake

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain procedure to the resident.
5) Observe dinner tray.
6) Uses paper, pencil, and/or mental computation to arrive at the number of ml's consumed.
7) Decide on ml's of fluid consumed from each container.
8) Candidate obtains total fluid consumed in ml's.
9) Place call light or signal calling device within easy reach of the resident.
10) Maintain respectful, courteous interpersonal interactions.
11) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
12) Record the total ml's consumed from the tray on the previously signed recording form.
13) Pre-measured total and Candidate calculated total are within required range.

Mouth Care—Brushing Teeth

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident – pull curtain.
6) Drape resident's chest with a towel to prevent soiling.

7) Put on gloves.
8) Apply toothpaste to resident's toothbrush or toothette.
9) Brush resident's teeth, including the inner surfaces of all upper and lower teeth.
10) Brush resident's teeth, including the outer surfaces of all upper and lower teeth.
11) Brush resident's teeth, including chewing surfaces of all upper and lower teeth.
12) Clean resident's tongue.
13) Assist the resident in rinsing mouth.
14) Wipe resident's mouth.
15) Remove soiled linen.
16) Place soiled linen in the designated linen hamper.
17) Empty emesis basin.
18) Rinse emesis basin.
19) Dry emesis basin.
20) Rinse toothbrush or discard toothette.
21) Return equipment to storage.
22) Remove gloves turning inside out.
23) Dispose of gloves in appropriate container.
24) Leave resident in position of comfort.
25) Place call light or signal calling device within easy reach of the resident.
26) Maintain respectful, courteous interpersonal interactions at all times.
27) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Making an Occupied Bed

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain procedure to resident.
5) Gather linen.
6) Transport linen away from body.
7) Place clean linen on a clean surface (bedside stand, chair or over-bed table).
8) Provide privacy for resident – pull curtain.
9) Direct RN Test Observer to stand on the opposite side of the bed, or raises side rail opposite working side of bed.
10) Raise the bed height.
11) Resident is to remain covered with sheet or blanket at all times.
12) Assist resident to roll onto side toward RN Test Observer or side rail.
13) Roll or fan fold linen, dirty side inside, to the center of the bed.
14) Place clean bottom sheet along the center of the bed and roll or fan fold linen against resident's back and unfold remaining half.
15) Secure two fitted corners.

16) Direct the RN Test Observer to the opposite side of the bed, or raise side rail opposite working side of bed.
17) Assist the resident to roll over the bottom linen, preventing trauma and avoidable pain to resident.
18) Remove dirty linen without shaking.
19) Avoid placing dirty linen on the over-bed table, chair or floor.
20) Avoid touching linen to uniform.
21) Dispose of dirty linen in designated laundry hamper.
22) Pull through and smooth out the clean bottom linen.
23) Secure the other two fitted corners.
24) Make sure resident's body never touches the bare mattress.
25) Place clean top linen over covered resident. Remove dirty linen while keeping resident unexposed at all times.
26) Tuck in top linen at the foot of the bed.
27) Make mitered corners at the foot of the bed.
28) Apply clean pillow case, with zippers and/or tags to inside, gently lifting resident's head to replace the pillow.
29) Lower bed, if it was raised.
30) Lower side rails, if they were used.
31) Place call light or signal calling device within easy reach of the resident.
32) Maintain respectful, courteous interpersonal interactions at all times.
33) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Nail Care

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain procedure to the resident.
5) Immerse nails in comfortably warm, soapy water and soak for at least five (5) minutes. The five minutes may be verbalized.
6) Gently clean under nails with file or nailbrush. Nails may be cleaned as they soak.
7) Dry hands thoroughly being careful to dry between fingers.
8) Gently push cuticle back with towel or washcloth.
9) Offer to cut resident's nails.
10) Clean equipment and return to storage. Discard dirty linen in designated laundry hamper.
11) Place call light or signal calling device within easy reach of the resident.
12) Maintain respectful, courteous interpersonal interactions at all times.
13) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Passing Fresh Water

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Scoop ice (or marbles) into water pitcher.
5) **Properly use ice scoop.**
    a. Do not allow ice to touch hand and fall back into container.
    b. Or use ice dispenser without contaminating water.
6) Properly store ice scoop after use.
    a. Scoop placed in appropriate receptacle after each use.
7) Add water to pitcher.
8) Return pitcher to resident.
9) Pour glass of water for resident.
10) Leave pitcher and glass at the bedside.
11) Place call light or signal calling device within easy reach of the resident.
12) Maintain respectful, courteous interpersonal interactions at all times.
13) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
14) Place call light or signal calling device within easy reach of the resident.

Position Resident on Side

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to resident.
5) Provide privacy for resident – pull curtain.
6) Position bed flat.
7) Raise bed height.
8) Ensure that the resident's face never becomes obstructed by the pillow.
9) Direct RN Test Observer to stand in position opposite working side of bed to provide safety, or use side rail, or always turn resident towards self.
10) From the working side of the bed - move resident's upper body toward self.
11) From the working side of the bed - move resident's hips toward self.
12) From the working side of the bed - move resident's legs toward self.
13) Move to opposite side of the bed, if RN Test Observer wasn't directed or side rail not used, and turn resident toward self. Otherwise, may remain on the working side of the bed and turn resident toward the RN Test Observer or raised side rail.
14) **Assist/turn resident on his/her left/right side. (Turned to correct side read to candidate by RN Test Observer.)**
15) Check to be sure resident is not lying on down side arm.

16) Maintain correct body alignment with the head of the bed flat.
17) Ensure/place support device(s) under the resident's head.
18) Place support device(s) under the resident's up side arm.
19) Place support device(s) behind back.
20) Place support device(s) between knees.
21) Lower bed, if it was raised.
22) Lower side rail, if it was used.
23) Place call light or signal calling device within easy reach of the resident.
24) Maintain respectful, courteous interpersonal interactions at all times.
25) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Range of Motion for Hip and Knee

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident – pull curtain.
6) Raise bed height.
7) **Position resident supine (bed flat).**
8) Position resident in good body alignment.
9) Provide privacy for resident – pull curtain.
10) **Support leg joints (knee and ankle) with one hand under the knee and one hand under the ankle at all times.**
11) Move the entire leg away from the body. (abduction)
12) Move the entire leg toward the body. (adduction)
13) Complete abduction and adduction of the hip at least three times.
14) Continue to correctly support joints by placing one hand under the resident's knee and the other hand under the resident's ankle.
15) Bend the resident's knee and hip toward the resident's trunk. (flexion of hip and knee at the same time)
16) Straighten the knee and hip. (extension of knee and hip at the same time)
17) Complete flexion and extension of the knee and hip at least three times.
18) Do not force any joint beyond the point of free movement.
19) **Candidate must ask at least once during the ROM exercise if there is/was any discomfort/pain.**
20) Leave resident in a comfortable position.
21) Place call light or signal calling device within easy reach of the resident.
22) Maintain respectful, courteous interpersonal interactions at all times.
23) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Range of Motion for Shoulder

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Provide privacy for resident – pull curtain.
6) **Support arm joints (elbow and wrist) with one hand under the elbow and one hand under the wrist at all times.**
7) Raise the resident's arm up and over the resident's head. (flexion)
8) Bring the resident's arm back down to the resident's side. (extension)
9) Complete flexion and extension of shoulder at least three times.
10) Continue same support for shoulder joint.
11) Move the resident's entire arm out away from the body. (abduction)
12) Return arm to side of the resident's side. (adduction)
13) Complete abduction and adduction of the shoulder at least three times.
14) Do not force any joint beyond the point of free movement.
15) **Candidate must ask at least once during the ROM exercise if there is/was any discomfort/pain.**
16) Leave resident sitting in the wheelchair.
17) Place call light or signal calling device within easy reach of the resident.
18) Maintain respectful, courteous interpersonal interactions at all times.
19) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Stand and Pivot-Transfer a Weight Bearing Resident from Bed to Wheelchair using a Gait Belt

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Obtain a gait belt.
6) Position wheelchair arm/wheel touching the side of the bed.
7) **Lock wheelchair brakes to ensure resident's safety.**
8) **Lock bed brakes to ensure resident's safety.**
9) Bring resident to a sitting position using proper body mechanics with bed placed at a height such that the resident's feet are naturally flat on the floor.
10) Assist resident in putting on non-skid footwear.
11) Place gait belt around the resident's waist to stabilize trunk.
12) Tighten gait belt.

13) Check gait belt for tightness by slipping fingers between gait belt and resident.
14) Grasp gait belt in underhand grip with both hands to stabilize the resident.
15) Ensure resident is stable.
16) Bring resident to standing position using proper body mechanics.
17) Do not ambulate resident.
18) Assist resident to pivot and sit in wheelchair in a controlled manner that ensures safety.
19) Remove gait belt.
20) Leave resident in a position of safety and comfort.
21) Place call light or signal calling device within easy reach of the resident.
22) Maintain respectful, courteous interpersonal interactions at all times.
23) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Stand and Pivot-Transfer a Weight Bearing Resident from Wheelchair to Bed using a Gait Belt

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to the resident.
5) Obtain a gait belt.
6) Position wheelchair arm/wheel touching the side of the bed.
7) Wheelchair placed at a slight angle to the bed.
8) Raise bed to same level as wheelchair seat.
9) Lock wheelchair brakes to ensure resident's safety.
10) Lock bed brakes to ensure resident's safety.
11) Place gait belt at the resident's waist.
12) Check gait belt for tightness by slipping fingers between gait belt and resident.
13) Ensure resident's feet are flat on the floor.
14) Instruct resident to place hands on wheelchair arm rests.
15) Ensure resident is stable.
16) Grasp the gait belt in underhand grip with both hands to stabilize resident.
17) Bring resident to standing position using proper body mechanics.
18) Do not ambulate resident.
19) Assist resident to pivot and sit on bed in a controlled manner that ensures safety.
20) Remove gait belt.
21) Remove resident's footwear.
22) Assist resident to lie down in the center of the bed, supporting extremities as necessary.
23) Make sure resident is comfortable and in good body alignment.
24) Place call light or signal calling device within easy reach of the resident.

25) Maintain respectful, courteous interpersonal interactions at all times.
26) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.

Pulse and Respirations

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to resident.
5) Locate the radial pulse by placing tips of fingers on thumb side of the resident's wrist.
6) Count pulse for 60 seconds.
    a. Tell the RN Test Observer when you start counting and tell him/her when you stop counting.
7) Count respirations for 60 seconds.
    a. Tell the RN Test Observer when you start counting and tell him/her when you stop counting.
8) Place call light or signal calling device within easy reach of the resident.
9) Maintain respectful, courteous interpersonal interactions at all times.
10) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
11) Record your pulse reading on the previously signed recording form.
12) Candidate's recorded pulse rate is within 4 beats of RN Test Observer's recorded rate.
13) Record your respirations reading on the previously signed recording form.
14) Candidate's recorded respiratory rate is within 2 breaths of the RN Test Observer's recorded rate.

Weighing an Ambulatory Resident

1) Knock on the door.
2) Introduce yourself to the resident.
3) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
4) Explain the procedure to resident.
5) Balance (or zero) scale.
6) Assist resident to stand.
7) Walk resident to the scale.
8) Assist resident to step on scale.
9) Check that resident is centered on scale.
10) Check that resident has arms at side.
11) Check that resident is not holding on to anything that would alter reading of the weight.
12) Appropriately adjust weights until scale is in balance.

13) Return resident to the chair.
14) Assist resident to sit in chair.
15) Place call light or signal calling device within easy reach of the resident.
16) Maintain respectful, courteous interpersonal interactions at all times.
17) Perform hand hygiene.
    a. Cover all surfaces of hands with hand sanitizer.
    b. Rub hands together until hands are completely dry.
18) Record weight on previously signed recording form.
19) **Candidate's recorded weight varies no more than 2 lb. from RN Test Observer's recorded weight.**

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Knowledge Test Vocabulary List

ABANDONMENT
abdominal thrusts
abduction
abductor wedge
abnormal vital signs
absorption
abuse
accidents
activities
acute
adaptive
adaptive devices
adaptive equipment
adduction
ADL
admission
admitting residents
advance directives
afebrile
affected side
aggressive residents
aging process
agitation
AIDS
alternating pressure mattress
Alzheimer's
Alzheimer's care
Alzheimer's disease
ambulation

amputees
anatomy
anger
angina
antibiotics
antiembolic stocking(s)
anxiety
aphasia
apical pulse
apnea
appropriate response
arteries
arthritis
aseptic
aspiration
assault
assistive device
atrophy
attitudes
authorized duty
axillary temperature
bacteria
bargaining
basic human needs
basic needs
basic nursing skills
basic skin care
bath water temperature
bathing
bed cradle

bed making
bed position
bedrails
bedrest
bedsore
behavior
behavioral
behavioral care plan
beliefs
biohazard
bladder training
blindness
blood pressure
body alignment
body fluid
body mechanics
body system
body temperature
bowel and bladder programs
bowel program
BP
bradycardia
breathing
burnout
burns
call light
cancer
cardiac arrest
cardiopulmonary resuscitation

cardiovascular system
care impaired
care plan
care planning
cast
cataract
catheter
catheter care
cc's in an ounce
central nervous system
cerebral vascular accident
chain of command
charge nurse
chemical restraint
chemical safety
chemotherapy
CHF
choking
chronic
circulation
circulatory system
clarification
cleaning
cleaning spills
clear liquid diet
clergy
cognitively impaired
cold application
cold compress
colostomy bag
colostomy care
coma
comatose resident
combative resident
comfort care
communicable
communication
compensation
compression
conduct
confidentiality

conflict resolution
confused resident
congestive heart failure
constipation
constrict
contact isolation
contamination
contracture
converting measures
COPD
coughing excessively
CPR
cueing
CVA
cyanotic
data collection
death
death and dying
decubitus ulcer
deeper tissue
defamation
dehydration
delegation
delirium
dementia
denial
denture care
dentures
depression
development
developmental disability
diabetes
diabetes mellitus
diabetic
dialysis
diastolic
diet
digestion
dilate
discharging resident
disease

disease process
disinfection
disoriented
disoriented resident
disposing of contaminated materials
disrespect
disrespectful treatment
dizziness
DNR
documentation
domestic abuse
dressing
droplets
drowsy
drug tolerance
dry skin
dying
dysphagia
dyspnea
dysuria
edema
elastic stockings
elderly
elevate head
elimination
emergency situation
emesis
emesis basin
emotional abuse
emotional needs
emotional stress
emotional support
empathy
emphysema
end of life care
enema
epilepsy
ethics
evacuation
eye glasses

falls
false imprisonment
fasting
fecal impaction
feces
feeding
feeding resident
financial abuse
fire
fire safety
first aid
flatus
flexed
flexion
fluid intake
Foley catheter
foot care
Fowler's
Fowler's position
fractures
fraud
frayed cord
free from disease
frequent urination
gait belt
gastric feedings
gastrostomy tube
geriatrics
germ transmission
gerontology
gestures
gifts
gloves
grand mal seizure
grieving process
group settings
HAI
hair care
hallucination
hand tremors
hand washing

hazardous substance
health-care team
hearing
hearing aid
hearing impaired
hearing loss
heart muscle
heat application
height
hemiplegia
HIPAA
HIV
hormones
hospice
hospice care
hydration
hyperglycemia
hypertension
hyperventilation
hypoglycemia
I&O
immobility
immune
impaired
impairment
incontinence
indwelling catheter
infection
infection control
infection prevention
infectious disease
in-house transfer
initial observations
input and output
in-service programs
insomnia
insulin
intake
intake and output
integumentary system
interpersonal skills

isolation
isolation precautions
jaundice
job description
kidney failure
life support
lift/draw sheet
linen
listening
living will
log roll
logrolling
loose teeth
low sodium diet
manipulative behavior
Maslow
Maslow's
masturbation
material safety data sheets
MDS
measuring height
measuring temperature
mechanical lift
mechanical soft diet
medical asepsis
medical record
medications
memory loss
mental health
mentally impaired
metastasis
microorganism
microorganisms
milliliters
minerals
misappropriation
mobility
mouth care
moving
MSDS
mucous membrane

multiple sclerosis
musculoskeletal
musculoskeletal system
myocardial infarction
nail care
neglect
negligence
new resident
non-contagious disease
non-verbal communication
nosocomial
nosocomial infection
NPO
nurse's station
nursing assistant behavior
nursing assistant's role
nutrition
objective
objective data
OBRA
observation
official records
ombudsman
open-ended questions
oral care
oral hygiene
oral temperature
orientation
oriented
osteoporosis
ostomy bag
output
overbed table
oxygen
pain
palliative care
paralysis
paranoia
Parkinson's
partial assistance
passive

passive range of motion
pathogen
pathogens
patience
pediculosis
perineal care
personal belongings
personal care
personal items
personal protective equipment
personal stress
personal values
pet therapy
phantom pain
phone etiquette
physical needs
physician's authority
plaque
podiatrist
policy book
positioning
positioning resident
postmortem care
postural supports
PPE
pressure ulcer
pressure ulcers
preventing falls
preventing injury
privacy
professional boundaries
progressive
projection
pronation
prone
prostate gland
prosthesis
prosthetic
psychological needs
psychosis

psychosocial
pulse
QID
quadriplegia
quality of life
radial
ramps
range of motion
rationalization
reality orientation
receptive aphasia
rectal
refusal
regulation
rehabilitation
religious service
reminiscence therapy
reminiscing
renewal
reporting
reporting abnormal changes
reporting abuse
reporting observations
reposition
resident abuse
resident belongings
resident centered care
resident identification
resident independence
resident pain
resident pictures
resident right
resident rights
resident treatment
resident unit
Resident's Bill of Rights
resident's chart
resident's environment
resident's families
respectful treatment

respiration
respiratory symptoms
respiratory system
responding to resident behavior
responsibility
restorative
restorative care
restraint
restraints
resuscitation
right to refuse care
rights
rigidity
risk factor
rotation
safety
scabies
scale
seclusion
security
seizure
self-esteem
semi Fowlers
sensory system
sexual harassment
sexual needs
sexuality
sharps container
shaving
shearing
side rails
Sim's position
skilled care facility
skin integrity
slander
smoking
social needs
social worker
soiled linen
specimen

spills
spiritual needs
sputum test
standard precautions
standard/universal precautions
STAT
stealing
sterile
sterilization
stethoscope
stomach
stress
stroke
strong side
subjective
subjective data
substance abuse
suicide
sundowning
supine
suprapubic
survey
swallowing
swelling
systolic
tachycardia
TED hose
telephone etiquette
temperature
tendons
terminal illness
thickened liquids
threatening resident
tips
toenails
toileting schedule
trachea
transferring
transfers
transporting

transporting food
tub bath
tube feeding
tubing
twice daily
tympanic
tympanic temperature
unaffected
unconscious
undressing
urethral
urinary catheter bag
urinary drainage bag
urinary elimination
urinary problems
urinary system
urinary tract
urination
urine
urine filter
validation
validation therapy
violent behavior
vision change
visually impaired
vital signs
vitamins
vocabulary
vomitus
walker
wandering resident
water faucets
water intake
water temperature
weak side
weakness
weighing
weight
well balanced meal
well-being
wheelchair safety

white blood cells
withdrawn resident

workplace violence

Notes:
