REGIONAL TESTING CENTER

CANDIDATE HANDBOOK

NURSE ASSISTANT EXAMINATION

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Regional Testing Center (RTC)

Address	15744 Golden West Street Forum I, Room 112A Huntington Beach, CA 92647
Phone Number & Email	(714) 895-8708 rtc@cccd.edu
Hours of Operation	8:00 a.m. - 5:00 p.m. (PST)

The Regional Testing Center can assist the candidate with:

- Registration and Scheduling for the Nurse Assistant Certification Examination
- Cancelling and/or rescheduling an exam
- Facilitate special accommodations examination requests and services
- Provide Scoring and Exam Results

California Department of Public Health (CDPH)

Phone Number	(916) 327-2445
Hours of Operation	8:00 a.m. - 5:00 p.m. (PST)

Website: http://www.cdph.ca.gv

Email: cna@cdph.ca.gov

License Verification Link: https:cvl.cdph.ca.gov/searchpage.aspx

Online submission link with CDPH:

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Online- Submission-Page.aspx

CDPH can assist the candidate with:

- Obtaining information regarding requirements for initial licensing and renewals/reciprocity
- Changing and updating the candidate's current address or name
- Verification of the Nurse Assistant Certification

Regional Testing Center

The Regional Testing Center is an approved testing vendor by the California Department of Public Health (CDPH) located at Golden West College. Established in 1992 with funding from a California Community College Grant managed by the California Community College Chancellor's Office, the center has transitioned to a self-supporting model since the grant concluded in 2022.

The Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), was established to improve the quality of long-term healthcare and to set training and evaluation standards for nurse assistants. Each state is responsible for adhering to this federal law.

The center's objective is to support students in achieving their goal of becoming state-certified nursing assistants in a healthcare setting. The testing center collaborates with educational institutions, professional testing companies, and certification boards to facilitate registration, scheduling, examination and scoring services for the Certified Nurse Examination for the State of California.

This Candidate Handbook is designed for individuals aspiring to become Certified Nurse Assistant in California. It outlines the steps for registering and taking the nurse assistant certification exam. The Nurse Assistant Certification exam consists of two parts: a Written (or Audio) and a Skills Evaluation exam. Candidates must pass both exams to be identified and listed on the California Nursing Assistant Registry.

Mission and Vision

The purpose of the center is to assist students with completing their educational goals of becoming a state Certified Nurse Assistant in a healthcare setting. The Regional Testing Center collaborates with the educational facility and the California Department of Public Health (CDPH) to provide the Certified Nurse Assistant Examination for state certification to practice in the State of California.

Eligibility Requirements

To be eligible for the California Nurse Assistant Examination, the candidate must successfully complete an approved nurse assistant training program by the California Department of Public Health. Upon completion of the training program, the candidate will have two years from the completion date to pass the Nurse Assistant Examination for state licensure.

Should a candidate not pass the examination within the two-year timeframe, the candidate must repeat and complete another training program before the candidate can retake the written and skills exam.

To be placed on the California Nursing Assistant Registry, the candidate must take and pass both the Written (or Audio) Examination and the Skills Evaluation within twenty-four (24) months of the Nurse Assistant training. Your examination results will be sent to CDPH.

If the candidate has not completed a CNA training program but has other relevant training that may qualify for equivalency, please contact the California Department of Public Health at (916) 327-2445 to inquire about your eligibility.

Test Attempts

The candidate is allowed three test (3) attempts to pass the Written (or Audio) and Skills Examination within 2 years from your date of nursing assistant training program completion. Should the candidate be unsuccessful in passing either or both written/written-audio and skills exams with three attempts, the candidate will be required to repeat and successfully complete a state-approved training program to retake the written/written-audio and skills exam.

The Registry

Change of Address or Name

The California Department of Public Health (CDPH) must maintain a current name and address of the licensee for communication regarding your license renewal on the Registry. Failure to update CDPH of a change of name and address may jeopardize your license standing.

Notification Procedure

To update your name and address changes on the Registry account, the candidate must send a written notification of this change to CDPH. Use the Change of Address or Name Form found in the back of this handbook.

Name Changes

Name changes MUST be accompanied by official documentation with the new name, such as a notarized copy of a marriage certificate, divorce decree, or other official supporting document. Your notification must include your previous name, current name, mailing address, phone number, and Social Security number/ Tax Identification number.

Lapsed of Certification

Federal regulations describe the certification and Certification as a Nurse Assistant, becoming invalid after a lapse of twenty-four (24) consecutive months or more in the performance of a paid nursing-related services.

Re-certification

The Nurse Assistant registered with the California Nurse Assistant Registry must renew their state certification through the California Department of Public Health (CDPH) to maintain active status.

Maintaining Work History

It is essential to maintain a personal file of your past work history, which can be verified by your prospective employer.

Requirements for Renewal

Work Experience: The candidate must have worked and received a salary as a nurse assistant performing nursing-related services for at least eight (8) consecutive hours during the twenty-four (24) months before your certification expiration date.

In-Service Training or Continuing Education: The candidate must submit evidence of forty-eight (48) hours of in-service training or education. For more information, please contact the CDPH at (916) 327-2445 or visit www.CDPH.CA.gov.

Certification by Reciprocity

Reciprocity is a process that allows certified nurse assistants from other states to qualify for certification in California. The candidate may be eligible for reciprocity if the candidate is a nurse assistant in another state in accordance with the competency evaluation requirements of OBRA '87 and if the candidate is currently listed on the other state's registry as active and in good standing.

For more information on applying for placement onto the California Nursing Assistant Registry via reciprocity, please contact the CDPH.

Examination Fees

Fees submitted to the Regional Center are **non-refundable** and **non-transferable**. Payment is required at the time of the test date and location booking.

Initial Testing

To schedule your initial or 1st attempt examination, the candidate must schedule for both the Written (or Audio) Examination and the Skills Evaluation.

Forms of Payment Accepted

- Credit Card - Visa, Mastercard, Discover
- Debit Card

Examination		Fees
Written Examination & Skills Evaluation	Initial Examination only	$120
Audio Examination & Skills Evaluation	Initial Examination only	$135
Written Examination ONLY	Re-test	$40
Audio Examination ONLY	Re-test	$55
Skills Evaluation ONLY	Re-test	$80

**A service charge for rebooking is added to reschedule a test.*

Prices subject to change.

Canceling/Rescheduling

To cancel and/or reschedule your Nurse Assistant Examination, go to your RTC account. An administrative fee for **rebooking of $25 in addition to the cost of the exam** will be applied to all rescheduled exams after the cancellation date, canceled, and missed exams (no-shows).

For applicants who had cancelled their testing dates in 2024, you must register using the new RTC registration system including the current fee schedule.

The applicant may cancel and/or select a new test date, time, or location within 3 business days prior to the original test date in the new RTC registration system.

Refunds

All fees are non-refundable after payment is completed.

Absence Policy

If the candidate has registered for the Nurse Assistant Examination and paid the required fee but fails to appear for the test or does not bring the necessary documentation to the test site, the fees are nonrefundable. The candidate will be charged a rescheduling or service charge plus the cost of the examination for the new test date.

A no-show is not considered as an attempt on the Nursing Assistant Exam.

Weather Emergencies

The Nurse Assistant Examination will only be delayed or canceled due to severe weather or natural disasters that deem the test center as inaccessible or unsafe. If an examination is canceled by RTC, the candidate will be rescheduled for the next available testing date and location at no additional charge.

Application Process

- ☑ The applicant will submit an online application found in the Regional Testing Center website. Information collected in the online registration has similar content that is on the Initial Nurse Assistant Application (283B form signed by the RN in charge of their training in Blue Ink) or the Approval Letter from CDPH (932 form).
- ☑ Applicants must upload a completed and signed 283-B or CDPH 932 form with their test registration application.
- ☑ Applicants will declare if the registration is an initial exam or repeat exam #2 and/or #3 on the drop-down menu.
- ☑ Applicants will submit the application to register. RTC will review and approve or deny the application within 3-4 business days.
- ☑ After approval from RTC, the applicant will select a test date, time, and location.
- ☑ Electronic payment will be received via an electronic payment process that accepts most debit and credit cards.
- ☑ Applicants will receive a confirmation email with registration, payment, test date, time, and location information.

Reminder:
The test candidate must submit directly to CDPH a Certified Nursing Assistant (CNA) Initial Application (CDPH 283B). Failure to submit a CDPH 283B to CDPH may cause a delay in receiving certification.

Written or Audio Exam Information

The Written Examination consists of 70 multiple-choice questions. The candidate will have two hours (120 minutes) to complete the exam. A reminder will be given with 15 minutes remaining. **The candidate must score 70% or better to pass the written exam.**

Audio Examination

The candidate has the option of choosing the Audio Examination instead of the Written Examination. During registration, the candidate must select the Written and Audio Examination. There is an additional fee of $15 for a total of $55 for the Written Audio Exam.

Professional Dress Code

The candidate scheduled for the written or audio exam must appear at the test site professionally dress. See dress code under the skills evaluation page 13.

Written (Audio) Examination Content Outline

Category	% of Exam
Physical Care Skills Activities of Daily Living, Basic Nursing Skills, Restorative Skills	64%
Psychosocial Care Skills Emotional and Mental Health Needs, Spiritual and Cultural Needs	10%
Role of a Nurse Assistant Communication, Patient Rights, Legal and Ethical Behavior, Member of the Health Care Team	26%

Skills Evaluation Exam

Important Information

The Skills Evaluation is designed to simulate a real-world healthcare environment. The evaluation area will resemble your workplace and will be equipped with all the necessary equipment for performing the assigned skills. A Nurse Assistant Evaluator will oversee the Skills Evaluation. Prior to the start of the examination, the evaluator will demonstrate the location of the equipment and answer any questions the candidate may have regarding its operation. **See Appendix A for a list of equipment.**

The Skills List outlines the skills a candidate may be asked to demonstrate during the evaluation. Each skill represents a task the candidate will encounter in the role of a nurse assistant and is outlined into a series of steps.

Medical Information:

The candidate has the responsibility to communicate to the test evaluator any limitations in your range of motion, food allergies, latex allergies, and sensitivity to skin soaps and/or lotions.

Infection Control

To maintain infection control, please do not come to the test site with any open wound or sores on your skin. The candidate will be denied testing and will need to reschedule should there is a noticeable presence of an open wound or sores on the skin.

Candidates who are ill and/or appear impaired will be denied at the test site and will need to reschedule. Should special accommodation be required for medical conditions, please inform the RTC office during registration of the appropriate accommodation. *Note: not all test locations may be able to host the accommodation requested.*

Assistance during Test Evaluation

The candidate may not accept assistance from another party during the Skills Evaluation. For questions, the candidate is responsible for requesting accommodation during the registration prior to the start of the evaluation.

Skills Evaluation Exam

Skills Testing Dress Code

- Wear scrubs, if available.
- If scrubs are not available, wear professional dress.
- Wear flat, slip-on, non-skid shoes.
- Socks are required.
- Wear a loose-fitting top with short sleeves that can be rolled up to the shoulder.
- Wear loose-fitting pants that can be rolled up.
- The candidate will be required to put on a gown over your clothing. Undergarments must not be exposed.
- Shorts or garments that may be exposed to the candidate's private parts of the body during the examination are not allowed.

The Patient Role

A volunteer candidate may function as the "patient " during the Skills Evaluation, portraying a weakened elderly person. As the candidate performs the skills, communicate with the patient volunteer as the candidate would with an actual patient in a nurse assistant work setting. Engaging in conversation with the patient volunteer not only demonstrates quality care but can also help the candidate relax while performing the skills.

Candidate Volunteer Requirements

The candidate may be asked to volunteer as a patient for another nurse assistant's Skills Evaluation portraying the role of a nursing home resident. The evaluator will provide verbal instructions on how to act during the evaluation.

Measurement Skills

One of the four randomly selected skills will involve a measurement skill (refer to the Recording A Measurement section for more information).

Skills Evaluation Exam

Skill Selection and Performance

The Nurse Assistant Evaluator will inform the candidate of the five skills the candidate will need to perform during the examination. Handwashing will always be one of the five skills. The remaining four skills will be randomly selected from the complete skills list on pages **26-47.**

Key Steps

A step that is highlighted in bold is referred to as a *Key Step*. These steps are essential and must be performed correctly to pass the skill. If a *Key Step* is either not performed or performed incorrectly, it will result in an automatic failure of the skill. Note that successful completion of only the Key Step does not automatically ensure that the candidate will pass the skill examination. The candidate must also be able to demonstrate sufficient additional steps to meet the required passing standard (or cut score) for each skill. The candidate must pass each skill with a minimum of 70%.

Corrections and Clarifications

If the candidate makes a mistake, inform the evaluator, and indicate the step(s) the candidate wishes to correct. The candidate will be allowed to correct the step(s) without repeating the entire skill. However, there are exceptions:

- **Gloves**
    - Failure to adhere to standard precautions of putting on or taking off gloves when required during a skill will not result in credit for attempting to correct the step.
- **Order-Dependent Steps**
    - If the candidate needs to correct an order-dependent step during the skill performance but fails to specify the correct sequence, the candidate will not receive credit for the correction.

Skills Evaluation Exam

Skill Completion

Once the candidate starts a new skill, the candidate cannot go back to correct a previous skill. The test evaluator will not answer questions during the Skills Evaluation or provide feedback on your performance.

Passing the Skills Evaluation

The candidate must successfully complete five out of the five skills with a minimum of 70% to pass the Skills Evaluation. The candidate will have 30 minutes to demonstrate all five skills.

The skills examination is scored using an online grading rubric accessed by the test evaluator using their unique ID. Each skill examination grading rubric is submitted after the completion of each skill.

Post-Evaluation

At the completion of the Skills Evaluation, the evaluator will direct the candidate to wash their hands. This is required to maintain infection control. This action is not evaluated and not part of your examination results.

Recording of Measurements

The Nurse Assistant Skills Evaluation requires the candidate to perform at least one measurement skill such as blood pressure, radial pulse, respiration, urine output, or weight. The candidate will document your measurements with the appropriate units on the recording sheet in the grading rubric per the evaluator's instruction. The candidate may be asked to record the results of the following measurement skills:

- Measures and Records Blood Pressure
- Measures and Records Weight of Ambulatory Patient
- Measures and Records Urinary Output
- Counts and Records Radial Pulse
- Counts and Records Respiration

Recording Measurements

Recording Sheet for Measurement Skills

Date: _____

Candidate Name: _____

Evaluator Name: _____

Skill Tested: One box next to the skill being tested must be marked.

[] Blood Pressure
[] Radial Pulse
[] Respirations
[] Urine Output
[] Weight (must document the unit of measurement, lb., or kg)

Candidate Result: _____

Evaluator Result: _____

Skills Evaluation Important Tips

Real-World Performance: Perform the skills as the candidate would in a nursing home setting. Use running water when water is required.

Hand Hygiene: All candidates must perform hand hygiene skills. After the first handwashing, the candidate will verbalize to the evaluator when the candidate would wash your hands during subsequent skills instead of washing them.

Skill Demonstration: For all steps except handwashing, the candidate must physically perform the skill to pass the examination. **Verbalization of the skill steps will not result in a passing score.** For example, wash the patient instead of saying the candidate would.

Patient Introduction: After your initial introduction to the patient, the candidate does not need to reintroduce yourself for each skill.

Measurement Skills: To receive full credit for measurement skills, the candidate must accurately perform the measurement and record the results on the Recording Sheet in the grading rubric. The evaluator will provide the sheet at the test site. Familiarize yourself with the sheet before your test date.

Scale Demonstration for Weight: Know how to demonstrate weight measurement on both standing and non-digital bathroom scales, including how to set them to zero.

Equipment: Do not bring your own equipment to the test site (e.g., transfer/gait belt).

Call Signal: Always place the call signal within the patient's reach when leaving their side.

Terminology: The term "patient" refers to the person receiving care.

By following these tips, the candidate can enhance your performance during the Skills Evaluation and increase your chances of successful completion of the Skills Examination.

Americans with Disabilities Act (ADA)

The Regional Testing Center complies with the Americans with Disabilities Act (ADA) and will provide reasonable accommodations to ensures equal access to the Nurse Assistant Examination for individuals with disabilities.

Test accommodation does not guarantee an improved performance or successful completion of the test. Reasonable accommodation will be provided for candidates with a documented disability and the accommodation required.

Test accommodation may include:

1. Separate room for testing.
2. Additional time for testing.
3. A reader and/or recorder for test takers with hearing and vision disability.

If the candidate has a disability, please request the necessary accommodation during the test registration. All requests must be submitted at the time of registration and approved 30 days prior to the exam date.

To file for test accommodation:

- ☐ Request for the test accommodations during the registration.
- ☐ Describe the accommodation requested.
- ☐ Provide supporting documentation from your healthcare provider to confirm your diagnosed disability.

Once the special accommodation request is approved, the Nursing Assistant evaluators administering the Written (or Audio) Examination, and the Skills Evaluation will be notified and prepared to address the needs of nurse assistant candidates with the requested testing accommodations.

Note: Test accommodation may not be available at all testing locations.

Examination Day

IMPORTANT INFORMATION

Students are responsible for their own security and safety and must be aware of the security and safety of others. The Regional Testing Center and Golden West College is not responsible for any student's personal belongings that are lost, stolen, or damaged on the campus and in parking lots of the testing sites. Students should immediately report any medical, criminal, or other emergency occurring at the test site to their Instructor. For any immediate threats or emergency, please contact the 911 emergency services for assistance.

Security and Cheating: Any attempt to provide or receive assistance during the Nurse Assistant Examination will result in immediate termination of the test. The incident will be reported to the California Department of Public Health for review, and the examination will automatically be scored as a failure. Unauthorized distribution or reproduction of any examination content, whether in writing or audibly, is prohibited and may lead to legal action. Individuals who attempt to remove or copy examination materials or information from the test site will be prosecuted.

Electronic Devices: All electronic devices, including cell phones and any other similar devices, must be turned off and stored in a designated area outside of the testing room. Personal belongings, including bags and coats, are not allowed in the testing area, and must be stored in a designated area. Please note that the test center does not provide storage for the candidate's personal items.

Study Aids: Personal belongings including briefcases, large bags, study materials, extra books, or papers are not allowed in the examination room. Any such items brought into the testing area will be collected and returned to the candidate after the candidate has completed the examination.

Prohibited Activities: Eating, drinking, and smoking are prohibited during the Nurse Assistant Examination.

Extenuating emergencies at a Test Location: The test evaluator and/or coordinator reserve the right to postpone or reschedule the test due to extenuating emergency circumstances that may compromise the security and safety of the test event.

Examination Day

Check-in

Please arrive at the testing center 1-hour prior to the scheduled start time. Plan to spend the entire day completing the examination.

Late Arrivals

The candidate who arrived late for their test appointment will not be allowed to sit for the examination. The candidate will need to reschedule their examination. Testing fees are non-refundable. Rebooking service fees are applicable for rescheduling the examination.

Misconduct

Disruptive behavior or unprofessional misconduct at the test site and/or during the Nurse Assistant Examination will result in an immediate dismissal from the test site. The test evaluator will complete an incident report to the Regional Testing Center within 24 hours of the incident.

Prohibited Guests

Guests, visitors, pets, and children are not allowed in the test center.

Required Items for Test Site Admission

The candidate must have the following items on the day of the examination:

- Current government-issued photo identification card with your signature
- A copy of your test confirmation sheet with your test registration number.
- Must wear a watch with a second hand
- Wear non-skid footwear (professional dress required, uniform scrubs preferred)
- Optional Allowances:
    - A paper English translation dictionary with translations only (no definitions) is allowed in the test area to be used during the examination.
    - The evaluator will check the dictionary for notations and security concerns.)

Important Information to Remember

- The candidate will be denied entrance to the testing area if the candidate does not have all the required items on the day of the test.
- All fees are non-refundable.
- The candidate will need to reschedule the examination.
- A rebooking fee and the cost of the test are applicable.
- The exam time length is approximately 4-6 hours. *May vary according to test location.* Please plan accordingly.
- Be prepared to complete and evaluate on five (5) different skills.
    - The "hand washing" skill will be on all exams.

Required Identification

The candidate must present a current and non-expired government-issued photo identification and a copy of their registration confirmation with the application number to be admitted into the testing site. The California Department of Public Health (effective January 2002) meets this requirement.

Photocopies of the identification are not accepted.

Acceptable forms of picture identification include:

- Driver's license
- DMV Identification card Passport or Passport card
- Permanent Resident Visa/Alien Registration card
- U.S. Military ID card
- High School ID

Important Note: The first and last names or any suffixes (e.g., Jr., II, III) on your government-issued photo identification, Social Security card/Tax ID, Nurse Assistant Certification (HS 283b), or CDPH Approval letter must be a match with the name used on your test registration application.

- If the candidate fails to bring proper identification or there are discrepancies in the names on your documents, the candidate will not be allowed to complete the examination.
- All fees are non-refundable.
- All documents presented at the testing site must be current, original, legible, and unaltered.

Exam Results

Exam Results

The Nursing Assistant Evaluator cannot provide information about your Score Report. Exam results will be available to the candidate in your RTC account within 3-4 business days.

To review your Score Report or the examination content, please review your RTC account. Additional questions can be addressed to the Regional Testing Center at rtc@cccd.edu

Written (or Audio) Examination

After completing the Written (or Audio) Examination, the Nursing Assistant Evaluator will submit your results to RTC for scoring validation. The candidate may access your exam results through your RTC account within 3-4 business days after your exam date. The Score Report will indicate whether the candidate has passed or failed the Written (or Written-Audio) and Skills Examinations.

Skills Evaluation

After the Nursing Assistant Test Evaluator reviews your test performance, they will submit the Skills Evaluation grading rubric. The candidate may access your exam results through your RTC account within 3-4 business days after your exam date. The RTC student account will provide a Score Report to indicate whether the candidate has passed or failed the Skills Evaluation.

Delayed Score Reports:

In the event of extenuating circumstances including technical difficulties, the Score Reports may not be available within 3-4 business days. Please contact the Regional Testing Center for further information,

Exam Results

Passing the Examination

Once the candidate has successfully passed both the Written (or Audio) Examination and the Skills Evaluation, your name will be added to the California Nursing Assistant Registry.

Failing the Examination

If the candidate fails the Written (or Audio) Examination or the Skills Evaluation, a new examination fee is required for each retake. To retake either or both exams, the candidate must submit a retake test registration through their RTC account.

State and federal regulations allow for three (3) attempts to pass both the Skills Evaluation and the Written (or Written-Audio) Examinations. If the candidate fails either or both exams on the 3rd attempt, the candidate will be required to retake and successfully complete a state-approved training program to be eligible for a retest. The candidate will not be able to use the prior exams.

Certificate Issuance

After the successful completion of the Skills Evaluation and the Written (or Written-Audio) Examinations, please allow 3-4 weeks for the California Department of Public Health (CDPH) to mail your Nurse Assistant Certificate to the address on file. If the candidate has not received their certificate within 6 weeks of your testing date, please contact CDPH at (916)327-2445 or check the License Verification link at https:cvl.cdph.ca.gov/searchpage.aspx

Certificate Validity:

Your Nurse Assistant Certificate is valid for twenty-four (24) months from the date issued.

Comments/Feedback/Grievances

The candidate has the right to express their feedback regarding the testing process. The Regional Testing Center values our test candidates, and your feedback will assist the RTC to improve our processes and the candidate's experience.

Inquiries are responded to within thirty (30) days of receipt of the written feedback form.

Comments/Feedback/Grievance Process:

- Submit Feedback/Complaint Online
  - All correspondence must be submitted online using the form link on the Regional Testing Center website.
- Provide Detailed Information
  - Candidates must provide complete information and details on the feedback form to address the inquiries.
  - Include test date, time, and location.
- Submit within 30 days of the test date.
  - The feedback form must be submitted to the Regional Testing Center within 30 days of the exam date.

Response from the Regional Testing Center:

A response in writing will be emailed to the candidate within 30 business days from the receipt of the inquiry.

Skills Evaluation List

There are 22 skills that will be included in the evaluation for the Nursing Assistant skill testing.

Critical Steps are in **bold**.

SKILL 1: HAND HYGIENE (HAND WASHING)

The nursing assistant is responsible for caring for a patient who has been admitted for surgery. Before providing care, the nursing assistant should demonstrate proper hand hygiene (hand washing) by correctly completing the eleven (11) steps to ensure safe and clean hands.

	Skills	Met	Not Met
1.	Introduce yourself and identify the patient.		
2.	Turn on the water and adjust the flow so that the water is warm.		
3.	Wet hands thoroughly, keeping hands and forearms lower than elbows. Avoid splashing water on uniform.		
4.	Apply a palm-sized amount of hand soap.		
5.	**Perform hand hygiene using plenty of lather and friction for at least 20 seconds:** **Rub hands palm to palm** **Rub back of right and left hand (fingers interlaced)** **Rub palm to palm with fingers interlaced.** **Perform rotational rubbing of left and right thumbs.** **Rub fingertips against the palm of the opposite hand.** **Rub wrists.** **Repeat sequence at least two times**		
6.	**Keep fingertips pointing downward throughout**		
7.	Clean under fingernails		
8	**Rinse hands with water, keeping fingertips pointing down so water runs off fingertips. Do not shake water from your hands.**		
9.	Dry hands thoroughly from fingers to wrists with a paper towel or air dryer. Dispose of the paper towel(s).		
10.	Use a new paper towel to turn off the water. Dispose of the paper towel.		
11.	Do not lean against the sink or touch the inside of the sink during the hand-washing process.		

Demonstrated Competency: Yes: _____ No_____

SKILL 2: APPLIES ONE KNEE-HIGH COMPRESSION STOCKING (TED HOSE)

The nurse supervisor instructed the nursing assistant to assist the patient in wearing knee-high elastic stockings. The patient has an order for knee-high elastic stockings. The nurse supervisor provided the stockings to the nursing assistant. Demonstrate the eleven (11) steps for correctly applying the knee-high elastic stockings.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene.		
4.	Position the patient in the supine position. Expose only the leg the candidate will be placing the stocking on.		
5.	Gather supplies and turn the stocking inside out to the heel.		
6.	Place the stocking over the patient's toes, foot, and heel.		
7.	Gently pull the stocking up their leg.		
8.	Moves foot and leg gently and naturally, avoiding force and over-extension of limb and joints.		
9.	**Adjust stocking; stocking should be wrinkle-free to the knee.**		
10.	Place the call light or signaling device within reach of the patient. Ensure the bed is low and locked.		
11.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 3: ASSISTS TO AMBULATE USING TRANSFER BELT

The nursing assistant is getting the patient out of bed to ambulate. Demonstrate the eighteen (18) steps for correctly applying a transfer belt on the patient.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene.		
4.	**Place nonskid footwear on the patient**		
5.	Adjust the bed to a safe level.		
6.	Check the brakes of the bed to ensure they are locked.		
7.	**Allow the patient to sit and dangle on the edge of the bed before standing to ambulate**		
8.	Ask the patient if they feel dizzy or light-headed.		
9.	Properly place the gait belt around the patient's waist and check the gait belt for tightness by slipping fingers between the gait belt and the patient.		
10.	Face the patient and place each of the feet in front of the patient's feet to prevent them from slipping.		
11.	Instruct the patient to push up on the bed on the count of three to assist with standing.		
12.	Count to three and assist the patient to a standing position.		
13.	Move to the weak side of the patient, slightly behind them. Hold the gait belt with palms and fingertips pointing upwards.		
14.	Assist the patient in a standing position.		
15.	Walk slightly behind the patient for a distance of 10 feet while safely holding the transfer belt.		
16.	Safely assist the client back to bed and remove the transfer belt.		
17.	Call lights within reach and bed in low position.		
18.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 4: ASSISTS WITH USE OF BEDPAN

The patient's call light is on. The nurse assistant enters the patient's room to see what the patient needs. The patient states, "I need to pee." Demonstrate the twenty-six (26) steps for placing the bedpan correctly underneath the patient.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Lower the head of the bed.		
4.	Perform Hand hygiene		
5.	Put on clean gloves.		
6.	Turn the patient and place a barrier (e.g., a towel, waterproof soaker pad, disposable pad) under their buttocks.		
7.	**Position the patient on the bedpan correctly. The deeper portion of the bedpan should be directed toward their toes, and the patient should be centered on the bedpan**.		
8.	Remove the gloves and perform hand hygiene.		
9.	Raise the head of the bed to a comfortable level.		
10.	Cover the patient with linens or a bath blanket.		
11.	Leave toilet tissue or wipes within reach of the patient.		
12.	Leave the call light within reach of the patient.		
13.	Wait nearby allowing for patient privacy		
14.	When the patient signals, return and assists the patient to perform hand hygiene in bed.		
15.	Perform hand hygiene		
16.	Lower the head of the bed to a comfortable level.		
17.	Put on clean gloves.		
18.	Gently remove the bed pan.		
19.	Discard the soiled linen in the designated laundry hamper.		
20.	Assist with perineal care.		
21.	Empty the bedpan into the toilet.		
22.	Rinse the equipment used and empty the rinse water into the toilet.		
23.	Remove the gloves, turning them inside out.		
24.	Ensure the bed is low and locked.		
25.	Place the call light or signaling device within reach of the patient.		
26.	Perform hand hygiene		

Demonstrated Competency: Yes: _____ No_____

SKILL 5: CLEANS UPPER OR LOWER DENTURE with the patient

The nursing assistant cleans the patient's upper or lower dentures after breakfast. Demonstrate the nineteen (19) steps for properly cleaning the patient's upper or lower dentures.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Perform hand hygiene		
3.	Put on gloves.		
4.	Place all supplies on a barrier.		
5.	Place a clothing protector on the patient.		
6.	Line the sink with a washcloth or paper towel.		
7.	Ask the patient to remove dentures and place them in the cup.		
8.	Handle the dentures carefully to avoid damage or contamination.		
9.	Wet the denture brush and apply denture toothpaste if available. Water alone is acceptable to clean dentures if toothpaste is not available.		
10.	Thoroughly brush the inner, outer, and chewing surfaces of each denture.		
11.	Rinse the dentures using clean, cool water and place them on a clean barrier or in an emesis basin.		
12.	Rinse the denture cup.		
13.	Place the dentures in a rinsed cup.		
14.	Put a denture cleansing tablet in the cup, if desired.		
15.	Rinse the equipment (denture brush and emesis basin).		
16.	Return the equipment to storage.		
17.	Discard the protective lining in an appropriate container.		
18.	Remove the gloves, turning them inside out.		
19.	Perform hand hygiene		

Demonstrated Competency: Yes: _____ No_____

SKILL 6: COUNTS AND RECORDS RADIAL PULSE

The nursing assistant counts the patient's radial pulse and reports and documents the results. Demonstrate the six (6) steps for counting and recording the radial pulse.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Locate the radial pulse by placing the tips of fingers on the side of the patient's wrist.		
3.	Count the pulse for 60 seconds.		
4.	Place the call light or signaling device within reach of the patient.		
5.	Perform hand hygiene.		
6	**Document pulse within plus or minus 4 of the evaluator's result.**		

Demonstrated Competency: Yes: _____ No_____

SKILL 7: COUNTS AND RECORDS RESPIRATIONS

The nursing assistant counts the patient's respiration rate and reports and documents the results. Demonstrate the five (5) steps for counting and recording the radial pulse.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Count respirations for 60 seconds.		
3.	Place the call light or signaling device within reach of the patient.		
4.	Perform hand hygiene.		
5.	**Document respiratory rate within plus or minus 4 of the evaluator's result.**		

Demonstrated Competency: Yes: _____ No_____

SKILL 8: DONNING AND REMOVING PPE (GOWN AND GLOVES)

The nursing assistant is responsible for caring for a patient in isolation. After completing the patient's care, demonstrate the sixteen (16) steps for properly donning and removing the gown and gloves.

	Skills	Met	Not Met
1.	Face the back opening of the gown.		
2.	Unfold the gown.		
3.	Put arms into the sleeves.		
4.	Secure the neck opening at the back of neck.		
5.	Secure the waist, making sure that the back flaps overlap each other and covering clothing as completely as possible.		
6.	Put on gloves.		
7.	Ensure the gloves overlap the gown sleeves at the wrist.		
8.	When the care is complete and before leaving the room, remove the gloves BEFORE removing the gown.		
9.	Remove the gloves, turning them inside out.		
10.	Dispose of the gloves in the appropriate container.		
11.	Perform hand hygiene.		
12.	Unfasten the gown at the neck.		
13.	Unfasten the gown at the waist.		
14.	Remove the gown starting at the top of the shoulders, turning it inside out and folding the soiled area to soiled area.		
15.	Dispose of the gown in an appropriate container.		
16.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 9: DRESSES PATIENT WITH AFFECTED (WEAK) RIGHT ARM

The nursing assistant is supporting a patient who has experienced a stroke and has a right-sided weakness. Demonstrate the fourteen (14) steps for properly assist the patient in putting on their shirt or blouse.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene		
4.	Raise the height of the bed to a safe level.		
5.	Keep the patient covered while removing their gown.		
6.	Remove the gown from the left side first.		
7.	Place the used gown in a designated laundry hamper.		
8.	Ask the patient about their preferences for desired clothing.		
9.	**Start dressing them on their right side first. Insert their hand through the sleeve of their shirt and grasp the hand of the patient to guide it through the sleeve.**		
10.	Place their unaffected arm in the shirt sleeve, grasping the hand of the patient. Finish putting on their shirt by buttoning.		
11.	Return the patient to lying on their back.		
12.	Ensure the bed is low and locked.		
13.	Place the call light or signaling device within reach of the patient.		
14.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 10: FEEDS PATIENT WHO CANNOT FEED SELF

The nursing assistant is responsible for feeding a patient with dementia who is unable to feed themselves. Demonstrate the twenty-two (22) steps for properly feeding the patient.

	Skills	Met	Not Met
1.	Introduce yourself and identify the patient.		
2.	Explain the procedure to the patient.		
3.	Perform hand hygiene.		
4.	Verify the name on the diet card matches the patient.		
5.	Verify the diet, diet texture, and liquid consistency matches the diet card.		
6.	**Position the patient in an upright position, at least 45 degrees.**		
7.	Place a clothing protector on the patient if desired (e.g., a paper or cloth towel or a large napkin).		
8.	Ask the patient if they would like mouth care before eating.		
9	Assist the patient to clean their hands before feeding using sanitizer or soapy and wet washcloths.		
10.	Position self in a chair at eye level facing the patient.		
11.	Describe the foods and fluids being offered to the patient.		
12.	Offer small amounts of food at a reasonable rate.		
13.	Offer fluids frequently.		
14.	Allow the patient time to chew and swallow.		
15.	Wipe the patient's face whenever necessary.		
16.	Continue to alternate foods and fluids until the patient indicates they are full.		
17.	Clean the patient's face and hands.		
18.	Ask the patient if they would like mouth care.		
19.	Leave the patient with their head elevated at least 30 degrees.		
20.	Ensure the bed is low and locked.		
21.	Place the call light or signaling device within reach of the patient.		
22.	Perform hand hygiene		

Demonstrated Competency: Yes: _____ No_____

SKILL 11: PERFORMS MODIFIED BED BATH TO FACE AND ONE ARM, HAND, AND UNDERARM

The nursing assistant is preparing to give a patient with dementia a bed bath. Demonstrate the twenty-eight (28) steps for providing the bath to the patient.

	Skills	Met	Not Met
1.	Introduce self and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene.		
4.	Check water temperature for safety.		
5.	Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the patient check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.		
6.	Raise the height of the bed to safe level.		
7.	Put on clean gloves		
8.	Remove gown patient and place in designated hamper		
9.	Cover patient with bath blanket or towel for privacy.		
10.	**Beginning with eyes, using a damp washcloth without soup, clean the eyes from inner to outer aspect using different sides of the washcloth.**		
11.	**Wash the face using a damp washcloth without soaps using different sides of the washcloth.**		
12.	Pat dry the face.		
13.	Proceed to the arm, expose one arm and place dry towel underneath		
14.	Gather wet washcloth and apply soap.		
15.	Clean the arm and pat dry.		
16.	Wash hands, fingers, and fingernails and pat dry.		
17.	Wash and clean underarm with soap and pat dry.		
18.	Dispose of the gown and used linens into the linen bag or laundry hamper.		
19.	Assist the patient to put on a clean gown		
20.	While wearing gloves, empty the equipment.		
21.	Rinse the equipment.		
22.	Dry the basin.		
23.	Return the equipment to storage.		
24.	Dispose of soiled linen in the designated laundry hamper.		
25.	Remove the gloves, turning them inside out.		
26.	Ensure the bed is low and locked.		
27.	Place the call light or signaling device within reach of the patient.		
28.	Perform hand hygiene		

Demonstrated Competency: Yes: _____ No_____

SKILL 12: MEASURES AND RECORDS URINARY OUTPUT

The patient's call light is on because the patient is finished using the bedpan.
Demonstrate the eleven (11) steps for measuring and recording the patient's urinary output.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure the patient.		
2.	Perform hand hygiene		
3.	Put on clean gloves		
4.	Pour the liquid in the bedpan into a measuring container.		
5.	Rinse the bedpan and empty the water into the toilet.		
6.	Measure the amount of urine at the eye level with the container on flat surface		
7.	Empty the urine into the toilet.		
8.	Rinse the measuring container with water and empty it to the toilet		
9.	Remove gloves		
10.	**Record the volume within plus or minus 25 mL of the actual volume**		
11.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 13: MEASURES AND RECORDS THE WEIGHT OF AMBULATORY PATIENT

The patient is scheduled for the monthly weight. The nursing assistant assisted the patient to the scale. Demonstrate the thirteen (13) steps for measuring and recording the patient's weight.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Perform hand hygiene		
3.	Verify the patient is wearing nonskid footwear.		
4.	Balance (or zero) scale.		
5.	Walk the patient to the scale.		
6.	Assist the patient to step on the scale.		
7.	Check that the patient is centered on the scale.		
8.	Check that the patient has their arms at their side.		
9.	Ensure the patient is not holding on to anything that would alter the reading of the weight.		
10.	Adjust the weights until the scale is in balance or read analog scale.		
11.	Perform hand hygiene.		
12.	**Document weight (plus/minus 2 lbs. or 0.9 kg)**		
13.	Perform hand hygiene		

Demonstrated Competency: Yes: _____ No_____

SKILL 14: PERFORMS MODIFIED PASSIVE RANGE OF MOTION (PROM) FOR ONE HIP AND ONE KNEE

The nursing assistant is responsible for a patient who is confined to bed. Demonstrate the nine (9) steps for performing a modified passive range of motion (PROM).

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene.		
4.	Advise patients to report pain during movement.		
5.	**Abduction/Adduction for Hip:** **Keeping the patient's leg straight, gently move their entire leg away from their body (i.e., abduction).** **Move their legs gently and stop if there is any resistance.** **Ask the patient if they are experiencing any pain during movement.** **Stop the ROM movement if the patient reports pain or displays objective signs of pain.** **Keeping the patient's leg straight, move their entire leg toward their body (i.e., adduction).** **Complete abduction and adduction movements of the hip according to the order in their restorative care plan.** **Continue to correctly support joints by keeping one hand under the patient's knee and the other hand under the patient's ankle.**		
6.	**Flexion/Extension of Knee and Hip:** **Bend the patient's knee and hip up toward the patient's trunk (i.e., flexion of hip and knee at the same time).** **Move the patient's leg gently and stop if there is any resistance.** **Ask the patient if they are experiencing any pain during movement.** **Stop the ROM movement if the patient reports pain or displays objective signs of pain.** **Straighten their knee and hip (i.e., extension of knee and hip at the same time).** **Complete flexion and extension movements of the knee and hip according to the order in the restorative care plan.**		
7.	Ensure the bed is low and locked.		
8.	Place the call light or signaling device within reach of the patient.		
9.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 15: PERFORMS MODIFIED PASSIVE RANGE OF MOTION (PROM) FOR ONE SHOULDER

The nursing assistant is responsible for performing a passive range of motion (PROM) on a patient with generalized weakness. Demonstrate the eighteen (18) steps for performing a passive range of motion (PROM).

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide for privacy.		
3.	Perform hand hygiene.		
4.	Advise patients to report pain during movement.		
5.	Place one of hands under the patient's elbow with palm facing up.		
6.	Place the other hand under the patient's wrist with palm facing up.		
7.	Watch the patient for objective signs of pain during movement.		
8.	Move their arms gently and stop if there is any resistance.		
9.	While keeping the patient's arm straight, raise their arm up and over their head (i.e., flexion).		
10.	**Bring the patient's arm back down to their side (i.e., extension).**		
11.	**Complete flexion and extension movements of the shoulder according to the order in the restorative care plan.**		
12.	Continue to support the elbow and wrist of the patient.		
13.	**Keeping the patient's arm straight, move their entire arm out away from the body (i.e., abduction).**		
14.	Move their arms gently and stop if there is any resistance.		
15.	Return the patient's arm to their side (adduction).		
16.	Ensure the bed is low and locked.		
17.	Place the call light or signaling device within reach of the patient.		
18.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 16: POSITIONS ON THE SIDE (SUPINE TO LATERAL)

The nursing assistant cares for a patient with limited mobility. The patient is on the turn schedule to be turned every two (2) hours. Demonstrate the twenty-four (24) steps for positioning the patient.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene		
4.	Position the bed flat.		
5.	Raise the bed height.		
6.	Raise the side rail on the side of the bed the patient will be facing after repositioning for safety.		
7.	Move to the working side of the bed, which is opposite the side rail that was raised.		
8.	Explain to the patient that the candidate will move them closer to the candidate before turning on the count of three.		
9.	From the working side of the bed count to three and move the patient towards you.		
10.	Instruct the patient to move their arm closest to the raised side rail away from their body. If able, the patient should grasp the side rail with the hand closest to you, reaching across their own body.		
11.	Raise the patient's knee that is closest to the candidate to assist in turning.		
12.	Explain that the candidate will turn the patient towards the side rail on count three.		
13.	Count to three to turn the patient towards the raised side rail.		
14.	Ensure that the patient's face never comes close to the side rail or becomes covered by the pillow.		
15.	Check that the patient is not lying on their bottom arm.		
16.	Place a pillow behind the patient's back, ensuring they will not roll back to the supine position.		
17.	Move to the end of the bed and check that the patient is in correct body alignment.		
18.	Verify that the patient is in the middle of the bed.		
19.	Place a pillow between the patient's top arm and their rib cage or the bed, ensuring the elbow is not directly on their ribs.		
20.	Place a pillow under the top knee, ensuring the knee is not resting directly on the other knee or the ankle is not on top of the other ankle.		
21.	Adjust the pillow under the patient's head for comfort.		
22.	Ensure the bed is low and locked.		
23.	Place the call light or signaling device within reach of the patient.		
24.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 17: PROVIDES CATHETER CARE FOR FEMALE

The nursing assistant cares for a patient who has an indwelling urinary catheter in place and prepares the patient for bed. Demonstrate the thirty-one (31) steps for performing catheter care.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene		
4.	Get water and check water temperature for safety.		
5.	Put on gloves.		
6.	Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the patient check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.		
7.	Raise the bed height to a working height.		
8.	Expose only the urethra and catheter.		
9.	**Follow the tubing from the patient toward the drainage bag, ensuring that the tubing is at a lower level as it goes toward the bag. Be sure no kinks or elevation can cause backflow to the bladder.**		
10.	Turn the patient or raise their hips and place a barrier (e.g., a towel, waterproof soaker pad, or disposable pad) under their buttocks.		
11.	Use the first washcloth with soap and water to carefully wash around the catheter where it exits the urethra.		
12.	Hold the catheter where it exits the urethra with one hand.		
13.	**While holding the catheter, clean 4 inches down the catheter tube.**		
14.	**Clean with strokes moving away from the urethra.**		
15.	Use a clean portion of washcloth for each stroke.		
16.	Put the soiled first washcloth in the linen bag.		
17.	Wet the second washcloth and rinse, using strokes only away from the urethra while continuing to hold the catheter where it exits the urethra.		
18.	Rinse using a clean portion of washcloth for each stroke.		
19.	Put the soiled second washcloth in the linen bag.		
20.	Pat dry with a towel.		
21.	Do not allow the tube to be pulled at any time during the procedure.		
22.	Replace the gown over the patient's perineal area.		
23.	While wearing gloves, empty the basin.		
24.	Rinse the basin.		
25.	Dry the basin.		
26.	Return the equipment to storage.		
27.	Dispose of soiled linen in a designated laundry hamper.		
28.	Remove the gloves, turning them inside out.		
29.	Ensure the bed is low and locked.		
30.	Place the call light or signaling device within reach of the patient.		
31.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 18: PROVIDES FOOT CARE ON ONE FOOT

The nursing assistant performs foot care for the patient. Demonstrate the twenty-four (24) steps for performing foot care.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene		
4.	Get water and check water temperature for safety.		
5.	Put on gloves.		
6.	Fill a foot basin with warm water and place it on a flat surface with a barrier underneath. Have the patient check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.		
7.	Remove their socks.		
8.	Immerse their feet in warm water for 5 to 20 minutes.		
9.	Use water and a soapy washcloth.		
10.	Wash each foot and between the toes.		
11.	Rinse the entire foot with the wet washcloth, including between the toes.		
12.	Dry the foot thoroughly, including between the toes.		
13.	Ask the patient if they would like lotion. If applying lotion, wear gloves.		
14.	Massage the lotion over the foot but avoid applying any lotion between the toes.		
15.	Wipe off any excess lotion with a dry towel.		
16.	Replace the socks or preferred footwear.		
17.	While wearing gloves, empty the equipment.		
18.	Rinse the equipment.		
19.	Dry the basin.		
20.	Dispose of soiled linen in a laundry hamper.		
21.	Remove the gloves, turning them inside out.		
22.	Ensure the bed is low and locked.		
23.	Place the call light or signaling device within reach of the patient.		
24.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 19: PROVIDES MOUTH CARE

The nursing assistant prepares to provide mouth care to a patient before breakfast. Demonstrate the twenty-four (24) steps for performing mouth care.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene		
4.	Place all supplies on a barrier.		
5.	Put on gloves.		
6.	If the patient is in bed, elevate the head of the bed if it is permissible per the care plan.		
7.	Cover the patient's chest with a towel to keep their clothing or gown clean.		
8.	Wet the toothbrush in the sink or in a cup of water.		
9.	Apply a small amount of toothpaste to the toothbrush.		
10.	**Brush the patient's teeth, including the inner, outer, and chewing surfaces of all upper and lower teeth.**		
11.	After each quadrant of the mouth (i.e., lower right, lower left, upper right, or upper left), allow the patient to rinse with water and spit into an emesis basin.		
12.	Clean the patient's tongue, being careful not to cause the patient to gag.		
13.	Assist the patient in rinsing their mouth.		
14.	Wipe the patient's mouth with the towel on their chest.		
15.	Remove the towel and place it in a linen bag.		
16.	Empty the emesis basin.		
17.	Rinse the emesis basin.		
18.	Dry the emesis basin.		
19.	Rinse the toothbrush.		
20.	Remove the gloves, turning them inside out.		
21.	Dispose of the gloves in an appropriate container.		
22.	Ensure the bed is low and locked.		
23.	Place the call light or signaling device within reach of the patient.		
24.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 20: PROVIDES PERINEAL CARE (PERI-CARE) FOR FEMALE

The nursing assistant is gathering the supplies to provide perineal care. Demonstrate the forty-one (41) steps for performing perineal care.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene		
4.	Check water for safe temperature		
5.	Raise one side rail of the bed after checking the patient's mobility and their preferred side to lie on.		
6.	Put on gloves.		
7.	Raise the bed height if needed.		
8.	Fill the basin with warm water and place it on a flat surface with a barrier underneath. Have the patient check the water temperature by placing their hand in the basin or putting a wet washcloth on the back of their hand.		
9.	Turn the patient or raise their hips and place a barrier (a towel, waterproof soaker pad, disposable pad, etc.) under their buttocks.		
10.	Expose their perineum only.		
11.	Separate the labia.		
12.	Use water and a soapy washcloth.		
13.	**Clean one side of the labia from top to bottom.**		
14.	Using a clean portion of the first washcloth, clean the other side of the labia from top to bottom.		
15.	Using a clean portion of the first washcloth, clean the perineal area from top to bottom.		
16.	Put the first washcloth in the linen bag.		
17.	Using the second clean washcloth, rinse one side of the labia from top to bottom.		
18.	Using a clean portion of the second washcloth, rinse the other side of the labia from top to bottom.		
19.	Using a clean portion of the second washcloth, rinse the perineal area from top to bottom.		
20.	Put the second washcloth in the linen bag.		
21.	Pat dry.		
22.	Assist the patient to turn onto their side facing away from the candidate and ask the patient to hold onto the raised side rail.		
23.	Using the third clean washcloth, apply water and soap.		
24.	Using a clean portion of the third washcloth, clean one side of the buttock, wiping away from perineal area.		
25.	**Using a clean portion of the third washcloth, clean the other side of the buttock, wiping away from the perineal area**.		
26.	**Using a clean portion of the third washcloth, clean the rectal area wiping away from the perineal area.**		
27.	Put the third washcloth in the linen bag.		
28.	Using the fourth washcloth, rinse one side of the buttock wiping away from the perineal area.		
29.	Using a clean portion of the fourth washcloth, rinse the other side of the buttock wiping away from the perineal area.		
30.	Using a clean portion of the fourth washcloth, rinse the rectal area wiping away from perineal area.		
31.	Put the fourth washcloth in the linen bag.		
32.	Pat dry.		
33.	Safely remove the waterproof pad from under the buttocks.		
34.	Remove the gloves, turning them inside out.		
35.	Perform hand hygiene.		
36.	Position the patient on her back.		
37.	Put on clean gloves.		
38.	Dispose of soiled linen in the designated laundry hamper.		
39.	Ensure the bed is low and locked.		
40.	Place the call light or signaling device within reach of the patient.		
41.	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 21: TRANSFERS FROM BED TO WHEELCHAIR USING TRANSFER BELT

The nursing assistant is preparing the patient to get out of bed for breakfast and will transfer the patient from the bed to the wheelchair using a transfer belt. Please demonstrate the twenty-two (22) steps involved in the transfer process.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Provide privacy.		
3.	Perform hand hygiene.		
4.	Check the brakes on the bed to ensure they are locked.		
5.	Remove the foot pedals from the wheelchair if needed.		
6.	Assist the patient to a seated position on the side of the bed with their feet on the floor; allow them to dangle their feet for a few minutes.		
7.	**Assist the patient in putting on nonskid footwear.**		
8.	Place the gait belt on the patient.		
9.	Position the wheelchair at the head or foot of the bed so the patient will move towards the wheelchair with the stronger side of their body. The wheelchair should touch the side of the bed.		
10.	**Lock the brakes on the wheelchair.**		
11.	**Ask the patient if they feel dizzy or light-headed.**		
12.	Face the patient and place each of feet in front of the patient's feet to prevent them from slipping.		
13.	Instruct the patient to push up on the bed to aid in standing on the count of three.		
14.	Grasp the gait belt with both hands, with palms and fingertips pointing up.		
15.	Count to three and assist the patient to stand.		
16.	Assist the patient to pivot.		
17.	Instruct the patient to grasp the arms of the wheelchair when they can feel the back of their knees are in contact with the wheelchair seat.		
18.	Assist the patient to a seated position in the wheelchair.		
19.	Remove the gait belt gently to avoid skin injury.		
20.	Release the wheelchair brakes.		
21.	Place the call light or signaling device within reach of the patient.		
22	Perform hand hygiene.		

Demonstrated Competency: Yes: _____ No_____

SKILL 22: MEASURES AND RECORDS MANUAL BLOOD PRESSURE (BP)

The nursing assistant measures and records the patient's blood pressure (BP). Demonstrate the fifteen (14) steps for measuring and recording the patient's manual blood pressure.

	Skills	Met	Not Met
1.	Introduce yourself and explain the procedure to the patient.		
2.	Perform hand hygiene.		
3.	Cleanse the stethoscope and blood pressure cuff prior to placing it on the patient's skin.		
4.	Place the patient in a relaxed reclining or sitting position. The patient should be seated quietly for at least five minutes in a chair prior to blood pressure measurement. Ask the patient which arm they prefer to use. Both feet should be on the floor and the arm should be supported at heart level.		
5.	Remove or rearrange clothing so the cuff and the stethoscope are on bare skin.		
6.	Center the bladder of the blood pressure cuff over the brachial artery with the lower margin 1″ above the antecubital space. Fit the cuff evenly and snugly. Palpate the brachial artery in the antecubital space.		
7.	Inflate the cuff to 160-180 mmHg.		
8.	Deflate the cuff gradually at a constant rate by opening the valve on the bulb (2-3 mm Hg/second) until the first Korotkoff sound is heard. Note the systolic pressure.		
9.	Continue to deflate the cuff slowly at 2 mm Hg/second. Note the point at which Korotkoff sounds disappear completely as the diastolic pressure.		
10.	Deflate the cuff completely and remove the cuff from the patient's arm.		
11.	Inform the patient of the blood pressure reading.		
12.	Cleanse the stethoscope and blood pressure cuff.		
13.	Perform proper hand hygiene.		
14.	**Document both systolic and diastolic pressures each within plus or minus 8 mm hg of the evaluator's reading.**		

Demonstrated Competency: Yes: _____ No_____

Appendix A
Skills List of Equipment

EQUIPMENT
Bed, adjustable bed with *non telescoping side rails (must be working). Head of the bed must go up/down and wheels lock/unlock
Chair
Clock (preferred) or Wristwatch with Second Hand
Linen Receptacle (designated for used/soiled linen)
Mannequin (with female genitalia is required for perineal care]
Privacy curtain, Screen or Door if private room
Scale, calibrated (bathroom/standing) [NO electronic scale, NO digital scale]
Signaling device, movable (must be on cord and attached to bed- can be non-functional)
Sink with running water in room (hot /cold)
Table, bedside
Table, over bed
Toilet/Bedside Commode clearly labeled toilet
Wastebasket with liner
Wheelchair with footrests
Bath towels
Clothing protector (bib or towel)
Gowns (patient)
Clothing Tops (extra-large & XXL shirts or blouses that open in the front, no more than four (4) buttons/snaps -no hospital gowns)
Linens: bottom sheets (fitted or flat)
Linens: pillowcase, top sheet
Pad/Linen Protector (may use towel or drawsheet as pad)
Pillows
Supportive devices (pillows, blanket rolls, wedges)
Washcloth
Basin, bath

Basin, emesis
Bedpan(standard)
Manual Blood Pressure (MBP) Cuff *(standard or extra-large cuffs) and Stethoscope* dual ear- piece *for Manual BP
Denture Brush (toothbrush labeled for denture skill)
Denture cup with lid
Dentures
Knee- high elastic stockings (clean, large or extra-large; must not use older type with loose flap in toe area)
Measuring container
Pen or Pencil
Transfer (gait) belt
Alcohol wipe or Alcohol and cotton ball
Antimicrobial Spray/Wipes- clearly labeled
Drinking cup (disposable)
Food (two varieties that can typically be fed in bite-size portions with a spoon) and beverage water
Gloves, large, disposable non-latex
Gown, Isolation (long sleeves that secure at neck and waist, at back or side, cannot secure in front. Cloth or disposable)
Hand Sanitizer
Hand Wipes (may use washcloth)
Lotion in pump container (hypoallergenic & unscented)
Meal tray with "name" card
Paper plates
Paper towels
Plastic bags (for wastebasket)
Soap, liquid in pump container (hypoallergenic & unscented/no rinseless/no foam soaps)
Spoons (disposable)
Toilet tissue
Toothpaste for denture care

Appendix B
Vocabulary List

Abduction: The movement of a limb away from the body's midline. For example, hip abduction is the movement of the leg away from the midline of the body when getting out of bed.
Active assist range of motion: Movement of a joint by an individual with partial assistance from an outside force.
Active listening: Listening while communicating verbally and nonverbally that we are interested in what the other person is saying and verifying our understanding with the speaker.
Active range of motion: Movement of a joint by the individual with no outside force aiding in the movement.
Activities of daily living (ADLs): Daily basic tasks that are fundamental to everyday functioning (e.g., hygiene, elimination, dressing, eating, ambulating/moving).
Acute pain: Pain with limited duration and associated with a specific cause. It usually causes observable responses such as increased pulse, respirations, and blood pressure. The person may also have diaphoresis.
Adaptive behavior: The skills and abilities to live independently.
Adduction: The movement of a limb towards the midline. For example, if a person has their fingers spread wide apart, bringing them back together is adduction.
Advance directives: Legal documents including the health care power of attorney (POA) and living will.
Agitation: Behaviors that fall along a continuum ranging from verbal threats and motor restlessness to harmful aggressive and destructive behaviors.
Agnosia: The failure to recognize or identify objects despite intact sensory function.
Airborne precautions: Transmission-based precautions used for clients with diagnosed or suspected pathogens spread by very small airborne particles from nasal and oral secretions that can float long distances through the air, such as measles and tuberculosis.
Ambulation: A medical term used for walking.
Angina: Sudden chest pain beneath the sternum (breastbone) associated with a heart attack (myocardial infarction), often radiating down the left arm in male patients.
Anxiety disorder: A condition diagnosed when an individual experiences more than temporary worry or fear that interferes with their daily functioning.
Anxiety: A universal human experience that includes feelings of apprehension, uneasiness, uncertainty, or dread resulting from a real or perceived threat.
Aphasia: A condition with difficulty processing what one is hearing or responding to questions due to dementia, brain injuries, or strokes.
Apraxia: The impaired ability to carry out motor activities despite intact motor function. This means the person can understand instructions and has the ability to complete an action but cannot process the cue to perform the task.
Aspiration: Inadvertently breathing fluid or food into the airway instead of swallowing it.

Assistive devices: Devices such as gait belts and walkers that are used when moving a patient.
Autonomy: Each individual's right to self-determination and decision-making based on their unique values, beliefs, and preferences.
Bariatric lifts: Mechanical lifts that support a client weighing 600 or more pounds.
Belongingness: A human emotional need for interpersonal relationships, connectedness, and being part of a group.
Bipolar disorder: A condition that includes shifts in mood from abnormal highs (called manic episodes) to abnormal lows (i.e., depressive episodes) that cause significant impairment on the person's functioning socially or at work.
Blood-borne pathogens: Infectious microorganisms in blood and body fluids that can cause disease, including hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV).
Body alignment: Good posture principles that prevent musculoskeletal injuries.
Bolus: A slippery mass of partially broken-down food that moves down the digestive tract as you swallow.
Bony prominences: Areas of the body where a bone lies close to the skin's surface, such as the back of the head, shoulders, elbows, heels, ankles, tops of the toes, hips, and coccyx.
Built-up handles: Specialized silverware that allows the use of utensils by individuals with limited functional ability of their fingers (such as severe arthritis) to hold a smaller handle.
Cardiac arrhythmias: Irregularities in a person's heart rate and/or rhythm.
Cardiopulmonary resuscitation (CPR): Emergency treatment provided when a patient's blood flow or breathing stops and may involve chest compressions and mouth-to-mouth breathing, electric shocks to restart the heart, breathing tubes to open the airway, or cardiac medications.
Carrier: An individual who is colonized with an infectious agent.
Cataracts: A vision condition causing clouding of the clear lens of the eye.
Cerebrovascular attack (CVA): The medical term for what is commonly referred to as a "stroke," caused by a lack of blood flow and oxygen to the brain.
Chain of infection: The process of how an infection spreads based on six links of transmission: Infectious Agent, Reservoir, Portal of Exit, Modes of Transmission, Portal of Entry, and Susceptible Host.
Chemical digestion: Digestion of food by enzymes found in saliva that break down food particles into smaller components.
Chemical restraint: A drug used to manage a patient's behavior, restrict the patient's freedom of movement, or impair the patient's ability to appropriately interact with their surroundings, that is not standard treatment or dosage for the patient's condition.
Chronic pain: Ongoing and persistent pain for longer than six months. It typically does not cause a change in vital signs or diaphoresis.
Citation: A problem or discrepancy found during a survey of a facility by the Department of Health Services.
Coagulate: Form a clot.
Coccyx: Tailbone.
Colonization: A condition when a person carries an infectious agent but is not symptomatic or ill.
Colostomy: A surgically placed opening when a client's colon function is impaired. A piece of the colon is diverted to an artificial opening in the abdominal wall called a stoma, and feces is collected in a pouch.

Commode: A movable device with a bucket underneath the seat that is used for elimination when the client has difficulty getting to the bathroom.
Communication: A process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.
Comorbidities: Coexisting health conditions.
Compression stockings: Stockings that apply gentle pressure to a limb to reduce edema; also referred to as thrombo-embolic-deterrent (TED) hose.
Contact precautions: Transmission-based precautions used for clients with known or suspected infections transmitted by touch such as *C-difficile* (C-diff), *methicillin-resistant staphylococcus aureus* (MRSA), *vancomycin resistant enterococcus* (VRE), or *norovirus*.
Cyanosis: Blue coloration around the mouth and in the extremities (i.e., feet and hands) that occurs when there is decreased oxygenated blood flow to the tissues.
Daily weights: Client weight taken at the same time every day, on the same scale, in similar clothing, and before any food or fluids are consumed.
Dangle: Sitting up on the edge of bed for a few minutes before standing to prevent orthostatic hypotension and dizziness.
Delirium: Psychosis caused by medical conditions or substance use that starts suddenly and is reversible by treating the cause of the delirium.
Delusions: Unshakable beliefs in something that isn't true or based on reality.
Dementia: A general term for loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life. There are several types of dementia, including Alzheimer's disease, vascular dementia, Lewy body dementia, and frontotemporal dementia.
Depressive episode: A condition where the person experiences a depressed mood (feeling sad, irritable, or empty) or a loss of pleasure or interest in activities they normally enjoy. Other symptoms may include poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired.
Depth perception: The ability to determine distance between oneself and another object.
Developmental disorders: Disorders caused by impairments in the brain or central nervous system due to problems that occurred during fetal development.
Diaphoresis: Excessive sweating.
Disinfection: The removal of microorganisms. However, disinfection does not destroy all spores and viruses.
Do-Not-Resuscitate (DNR) order: A medical order that instructs health care professionals to not perform cardiopulmonary resuscitation (CPR) if a patient's breathing stops or their heart stops beating. A DNR order is only written with permission by the patient (or the patient's health care power of attorney, if activated).
Documentation: A legal record of patient care completed in a paper chart or electronic health record (EHR).
Droplet precautions: Transmission-based precautions used for clients with a diagnosed or suspected pathogen that is spread in small droplets from sneezing or in oral and nasal secretions, such as influenza or pertussis.
Dysphagia: Difficulty swallowing that can cause aspiration of liquids and food into one's lungs and lead to life-threatening pneumonia.

Edema: Fluid retention causing swelling in the extremities.
Elder abuse: An intentional act, or failure to act, that causes or creates a risk of harm to someone 60 or older. The abuse occurs at the hands of a caregiver or a person the older adult trusts.
Elopement: An event when a resident who is incapable of protecting themselves from harm can successfully leave the facility unsupervised and unnoticed and possibly enter into harm's way.
End-of-life care: Term used to describe care provided when death is imminent, and life expectancy is limited to a short number of hours or days.
Epiglottis: The anatomical flap that covers the trachea and prevents liquids from entering the lungs when swallowing.
Esophagus: The muscular tube from the mouth to the stomach.
Expressive aphasia: A speech disorder where a person understands what other people say but struggles to form words.
Extension: Movement that increases the angle between two bones. For example, extension occurs when doing a bicep curl and the arm is straightened back to starting position, increasing the angle between the elbow joint.
Eye protection: Face shields, visors attached to masks, and goggles that are used to protect the eyes from blood or body fluids.
FAST: An acronym used to remember the early signs of a stroke: Facial drooping, Arm weakness, Slurred speech, and Time (meaning the quicker the response, the better the outcome).
Fever: A temperature of 38 degrees Celsius (100.4 degrees F).
Fine motor skills: Small movements such as those in the wrists and hands.
Flexion: Movement that decreases the angle between two bones. For example, contracting the bicep to lift a weight upwards is flexion.
Foam boots: Specialized soft boots used to support the ankles and keep the heels floated off the bed.
Foot cradle: A device used to keep the sheets and blankets off the tops of a client's toes.
Fowler's position: A position where the client is lying on their back with their head elevated between 30 and 90 degrees.
Friction: Injury caused to skin when it is rubbed by clothing, linens, or another body part.
Glaucoma: A visual condition that occurs due to high pressure on the optic nerve that results in loss of peripheral vision, blind spots, or even blindness across the entire visual field.
Grooming: Maintaining a resident's appearance through shaving, hair, and nail care.
Gross motor skills: Large movements controlled by the legs and trunk of the body.
Hallucinations: A condition where a person senses things such as visions, sounds, or smells that seem real but are not.
Hand hygiene: The process of removing, killing, or destroying microorganisms or visible contaminants from the hands. There are two hand-hygiene techniques: handwashing with soap and water and the use of alcohol-based hand rub (ABHR).
Hand mitt: A large, soft glove that covers a confused patient's hand to prevent them from inadvertently dislodging medical equipment such as a catheter, feeding tube, or intravenous (IV) catheter.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Legislation that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
Heimlich maneuver: A procedure used for someone who is choking that uses abdominal thrusts to clear the airway so they can breathe.
Holistic care: Health care that addresses a patient's physical, emotional, social, and spiritual needs.
Hospice care: Care provided to patients who are terminally ill when a health care provider has determined they are expected to live six months or less. Hospice provides comfort to the client and supports the family, but curative medical treatments are stopped. It is based on the idea that dying is part of the normal life cycle.
Hygiene: Keeping the body clean and reducing pathogens by performing tasks such as bathing and mouthcare.
Hypertension (HTN): Elevated blood pressure.
Hypotension: Low blood pressure.
Impaired skin integrity: Skin that is damaged or not healing normally. An example of impaired skin integrity is a pressure injury (also called a bedsore or pressure ulcer) with damage to the skin and surrounding tissue.
Incontinence briefs or pads: Disposable products used for clients with little to no control over bladder or bowel function.
Incontinence: A lack of voluntary control over urination or defecation.
Infection control: Methods to prevent or stop the spread of infections in health care settings.
Infectious agent: Microorganisms, such as bacteria, viruses, fungi, or parasites that can cause infectious disease.
Inflammation: Redness, warmth, swelling, and tenderness associated with early signs of infection.
Insensible losses: Fluid loss that cannot be measured, such as fluids lost through the respiratory system, sweat, and stool.
Intake and output (I&O): Fluid intake and output measured and documented every shift.
Involuntary muscle: Muscles controlled by the autonomic nervous system, including smooth muscle within the digestive system and respiratory system and the cardiac muscle in the heart that pumps blood throughout the body.
Isolation gowns: Protective garments worn to protect clothing from the splashing or spraying of body fluids and reduce the transmission of microorganisms.
Large intestine: The long, tube-like organ that is connected to the small intestine at one end and the anus at the other.
Lateral (side-lying) position: A position that places the client on their left or right side to relieve pressure on the coccyx or increase blood flow to the fetus in pregnant women.
Living will: A legal document that describes the patient's wishes if they are no longer able to speak for themselves due to injury, illness, or a persistent vegetative state. The living will address issues like ventilator support, feeding tube placement, cardiopulmonary resuscitation, and intubation.
Macronutrients: Carbohydrates, proteins, and fats that make up most of a person's diet and provide energy, as well as essential nutrient intake.

Macular degeneration: A visual condition that causes a blind spot in the center field of vision and is the leading cause of vision loss in people over 50.
Malaise: A feeling of discomfort, illness, or lack of well-being that is often associated with infection.
Mandated reporter: Nursing assistants and other health care professionals are referred to as mandated reporters because they are required by state law to report suspected neglect or abuse of the elderly, vulnerable adults, and children. As a caregiver, you are required to report any signs or symptoms that are suspicious for abuse or neglect to the nurse.
Manic episode: An elevated or irritable mood with abnormally increased energy that lasts at least one week.
Maslow's Hierarchy of Needs: A theory stating that unless basic human needs within a hierarchy are met, humans cannot experience higher levels of psychological and self-fulfillment needs.
Mechanical digestion: Digestion that begins with chewing when teeth crush and grind large food particles into smaller pieces that are easy to swallow.
Medical asepsis: Techniques used to prevent the transfer of microorganisms from one person or object to another but do not eliminate microorganisms.
Military time: A standard for recording time that avoids confusion between daytime and nighttime hours because each hour of the day is represented by a number ranging from 00:00 to 24:59.
Mobility: The ability to move one's body parts, change positions, and function safely within the environment. It is one of the most important factors for remaining independent.
Mode of transmission: The way an infectious agent travels to other people and places.
Modified diet: Any diet altered to include or exclude certain components. For example, a low-salt diet is an example of a modified diet.
Moments of hand hygiene: Appropriate times during patient care to perform hand hygiene, including immediately before touching a patient; before performing an aseptic task; before moving from a soiled body site to a clean body site; after touching a patient or their immediate environment; after contact with blood, body fluids, or contaminated surfaces (with or without glove use); and immediately after glove removal.
Myocardial infarction (MI): The medical term for what is commonly referred to as a "heart attack," caused by a lack of blood flow and oxygen to the heart.
Neglect: Failure to provide care to oneself or to someone for whom you are enlisted to care.
Neurotransmitters: Chemicals in the body used for nerve communication.
Nonskid footwear: Shoes or socks with rubberized soles used to prevent falls.
NPO: A common medical abbreviation referring to "nothing by mouth."
Objective information: Anything that can be observed through sight, touch, hearing, or smell, referred to as "signs." An example of objective information is the client's temperature was 98.6 degrees Fahrenheit.
Obstructive sleep apnea: A condition where one's breathing temporarily stops while sleeping.
Older adults: Adults aged 65 years old or older.
Orthostatic hypotension: A sudden drop in blood pressure that can cause clients to feel dizzy and increase their risk for falls.
Orthotic: A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body.
Osteoarthritis: A medical diagnosis that refers to inflammation of joints due to wear and tear throughout one's life.

Output: Fluids that leave the body, including urine output that is measured.
Oxygen saturation (SpO2): Oxygenation status by a pulse oximeter based on how much of hemoglobin in red blood cells is “saturated” with oxygen.
Pain: An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.
Panic attacks: Sudden periods of intense fear that come on quickly and reach their peak within minutes. Attacks can occur unexpectedly or can be brought on by a trigger, such as a feared object or situation. People experiencing a panic attack may exhibit symptoms such as sweating, trembling, shortness of breath, chest pain, nausea, increased heart rate, or feelings of losing control.
Partial bath: Washing the face, underarms, arms, hands, and perineal area. Partial baths are given daily to maintain hygiene. They preserve skin integrity by not drying out skin with excessive soap and water use.
PASS: An acronym for using a fire extinguisher that stands for the following: P: Pull the pin on the fire extinguisher; A: Aim the extinguisher nozzle at the base of the fire; S: Squeeze or press the handle; S: Sweep from side to side at the base of the flame until the fire appears to be out.
Passive communicator: Individuals who put the rights of others before their own when communicating.
Passive range of motion: When passive range of motion is applied, the joint of an individual receiving the exercise is completely relaxed while the outside force moves the body part.
Perineal: The genital and anal area.
Peristalsis: Contractions that move the bolus through the esophagus, stomach, small intestine, and large intestine.
Perseverating: The act of repeating a task or thought over and over.
Person-centered care: A care approach that considers the whole person, not just their physical and medical needs. It also refers to a person’ autonomy to make decisions about their care, as well as participate in their own care.
Personal care: Care that a client needs to maintain hygiene, well-being, self-esteem, and dignity.
Personal protective equipment (PPE): Specialized clothing or equipment used to prevent the spread of infection, including gloves, gowns, facial protection (masks and eye protection), and respirators.
Personality disorder: A pattern of inner experiences and behaviors that deviates from the expectations of the individual’s culture.
Pharynx: The hollow tube that starts behind the nose and ends at the trachea and esophagus.
Phobia: An intense fear of specific objects or situations (such as flying, heights, spiders, or social events).
Physical therapists: Health specialists who evaluate and treat movement disorders.
Pocketing: The act of keeping food or medications in one’s cheeks and not swallowing it.
Portal of entry: The route by which an infectious agent enters a new host.
Portal of exit: The route by which an infectious agent escapes or leaves the reservoir.
Postmortem care: Care provided after death has occurred through transfer to a morgue or funeral provider.
Presbycusis: Hearing loss that occurs due to the aging process.
Pressure injuries: Localized damage to the skin or underlying soft tissue, usually over a bony prominence, as a result of intense and prolonged pressure and/or shear.
Prone position: A position where the client is placed on their stomach with their head turned to one side.

Prosthetics: An addition or attachment to the body that replicates the function of a lost or dysfunctional limb.
Psychosis: Conditions when a person experiences a loss of contact with reality and has difficulty understanding what is real and what is not real. Symptoms of psychosis include hallucinations and delusions.
Pureed diet: A diet order indicating all food is blended to smooth consistency.
Purulent drainage: Yellow, green, or brown drainage associated with signs of infection.
Quality of life: The degree to which an individual is healthy, comfortable, and able to participate in or enjoy life events.
Receptive aphasia: A speech condition that causes difficulty in understanding conversations.
Rehabilitation: Therapy to help people regain body functions they lost due to medical conditions or injury.
Reservoir: The host in which infectious agents live, grow, and multiply.
Respirator masks: Masks with N95 or higher filtration worn by health care professionals to prevent inhalation of infectious small airborne particles.
Respiratory distress: Problems breathing.
Respiratory hygiene: Methods to prevent the spread of respiratory infections, including coughing/sneezing into the inside of one's elbow or covering one's mouth/nose with a tissue when coughing and promptly disposing of used tissues. Hand hygiene should be immediately performed after contact with one's respiratory secretions. A coughing person should also wear a surgical mask to contain secretions.
Restraints: Devices used in health care settings to prevent patients from causing harm to themselves or others when alternative interventions are not effective.
Routine cares: Personal cares provided to every resident every day, such as assisting them in getting dressed for breakfast.
Scope of practice: Services that a trained health professional is deemed competent to perform and permitted to undertake according to the terms of their professional license.[2]
Seclusion: The confinement of a patient in a locked room from which they cannot exit on their own. It is generally used as a method of discipline, convenience, or coercion.
Seizure: A transient occurrence of signs and/or symptoms due to abnormal neuronal activity in the brain.
Sepsis: Life-threatening infection that has spread throughout the body.
Shear: Injury to skin that occurs when skin moves one way, but the underlying bone and muscle stay fixed or move the opposite direction.
Shortness of breath (SOB): Difficulty breathing or a feeling of not being able to catch one's breath.
Signs: Objective information obtained through the senses of sight, hearing, smell, or touch.
Sims' position: A position similar to the lateral position, but the client is always placed on their left side and their left arm is placed behind their body.
Skeletal muscle: Muscle that produces movement, assists in maintaining posture, protects internal organs, and generates body heat.
Skin breakdown: Damage to the skin due to common preventable causes like immobility and incontinence.
Skin tear: A separation of skin layers caused by shear, friction, and/or blunt force.

Small intestine: A long tube-like organ that connects the stomach and the large intestine where nutrients are absorbed from a food bolus.
Snellen chart: A common tool used for assessing distant vision.
Speech therapists: Therapists who assess, diagnose, and treat communication and swallowing disorders.
Standard precautions: Precautions used by health care workers during client care when contact or potential contact with blood or body fluids may occur based on the principle that all blood, body fluids (except sweat), nonintact skin, and mucous membranes may contain transmissible infectious agents. These precautions reduce the risk of exposure for the health care worker and protect patients from potential transmission of infectious organisms.
Sterilization: A process used on equipment and the environment that destroys all pathogens, including spores and viruses. Sterilization methods include steam, boiling water, dry heat, radiation, and chemicals.
Stoma: A surgically created opening in the abdominal wall where a healthy part of the intestine is attached.
Substance use disorder (SUD): An illness caused by the repeated misuse of substances such as alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, or misuse of other prescription or over-the-counter medications. All these substances taken in excess have a common effect of intensely activating the reward system in the brain so much that normal life activities may be neglected.
Sundowning: Restlessness, agitation, irritability, or confusion that typically begins or worsens as daylight begins to fade and can continue into the night, making it difficult for patients with dementia to sleep.
Supine position: A position where the client is lying flat on their back.
Surgical asepsis: The absence of all microorganisms during any type of invasive procedure; used for equipment used during invasive procedures, as well as the environment.
Susceptible host: A person at elevated risk of developing an infection when exposed to an infectious agent.
Symptoms: Subjective information reported by clients or their family members. Symptoms are documented by using quotes around the exact words expressed by the client or their family member. For example, the client reported, “I have a headache.”
Tendons: Strong bands of dense, regular connective tissue that connect muscles to bones.
Therapeutic communication: A type of professional communication used with patients defined as the purposeful, interpersonal, information-transmitting process through words and behaviors based on both parties’ knowledge, attitudes, and skills that leads to patient understanding and participation.
Timed voiding: Encourages the patient to urinate on a set schedule.
Trachea: The hollow tube, otherwise known as the windpipe, that leads to the lungs.
Transfer status: Assistance the patient requires to be moved from one location to another, such as from the bed to a chair.
Transient ischemic attack (TIA): A medical term for what is commonly referred to as a ministroke. A TIA is a temporary period of symptoms similar to those of a stroke that usually last only a few minutes and don’t cause permanent brain damage.
Transmission-based precautions: Specific types of personal protective equipment (PPE) and practices used with clients with specific types of infectious agents based on the pathogen’s mode of transmission.

Trauma: An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and can have lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being.
Tripod position: A position that people experiencing respiratory distress naturally assume by leaning forward and placing their arms or elbows on their knees or on a bedside table to help improve lung expansion.
Trisomy: A condition of having an extra copy of a chromosome.
Urge incontinence: A condition where as soon as the person feels the need to empty their bladder they have very little time before urine escapes.
Urinary catheter: A device placed into the bladder by a nurse using sterile technique that allows the urine to drain into a collection bag.
Urinary tract infection (UTI): A common infection that occurs when bacteria, typically from the rectum, enter the urethra and infect the bladder or kidneys.
Urostomy: A surgically placed opening to collect urine from a person's ureters when their bladder is diseased or has been removed. Urostomies are typically located on the lower right side of the abdomen, and urine is collected into a drainage bag.
Validation therapy: A technique used when caring with individuals with dementia that involves supporting the reality the person is experiencing.
Vertigo: A sensation that the room is spinning.
Voluntary muscle: Muscle that a person is able to consciously control.
Vulnerable populations: Patients who are children, older adults, minorities, socially disadvantaged, underinsured, or those with certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate health care.[3]
Wandering: The simple act of a person walking around with no purpose due to their confusion regarding their location or environment.
Weighted silverware: Specialized silverware with a weighted handle for individuals with tremors or unsteady hands.
Wet voice: Vocalization with sounds as if food or fluids remain in the mouth or throat.

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