CABINET FOR HEALTH AND FAMILY SERVICES
**Department for Medicaid Services**

**Ernie Fletcher**
Governor

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**Mark D. Birdwhistell**
Secretary

**Shawn M. Crouch**
Commissioner

October 23, 2007

**TO: Nursing Facility (12) Providers**
**Provider Letter: A-228**

**RE: Revisions to Nurse Aide Training Program Manuals**

Dear *KyHealth Choices Provider*:

Please see enclosed the following updated items regarding revisions to the Nurse Aide Training Program Manuals:

- Revised Kentucky Medicaid Nurse Aide Testing Procedures Manual and Study Guide, October 19, 2007 edition.
- Attachment 1: List of changes in the 2007 Testing Procedures Manual and Study Guide
- Attachment 2: New Coarse Card which includes:
  Part A: Student information and attendance record
  Part B: Nurse Aide Task List

Implementation of the updated Medicaid Nurse Aide Testing Procedures Manual and Study Guide is February 1, 2008.

Please continue to teach all skills appropriately. Should you have questions, you may contact Vicki Barber, R.N. at (502) 564-5707, Division of Long Term Care and Community Alternatives, Long Term Care Branch, Monday through Friday, 8:00 a.m. until 4:30 p.m. (eastern-time).

Sincerely,

Shawn M. Crouch
Commissioner

Enclosure(s)

Xc: Nursing Facility (12) Provider Letter A-228

SMC/CB/amd00350

**Kentucky Community & Technical College System (KCTCS)**
**Kentucky Medicaid Nurse Aide**
**Testing Procedures Manual and Study Guide**

The KCTCS Medicaid Nurse Aide Testing Procedures Manual and Study Guide have been updated. This study guide will be used for competency testing starting February 1, 2008.

Changes from the May 31, 2007 Testing Procedures Manual and Study Guide include:

Page 5: Test takers with an allergy may request non-latex gloves two (2) weeks prior to the test date.
Page 7 – 8: Task list has been updated to reflect the corresponding textbook chapters.
Page 11: Information added concerning bedrails and definitions of restraints.
Page 11: The following information was added: "Resident's care plan indicates side rails are not to be used. Side rails will be raised when the bed is raised. Side rails will be lowered when the bed is lowered."

Skills removed from testing rotation:

Emptying a Urinary Drainage Bag.

**All** skills need to be reviewed for changes.
**Special attention** needs to be paid to skills that require the use of side rails.

The nurse aide training website,
https://unity.kctcs.edu/docushare/dsweb/View/Collection-1264, has been updates to reflect the following:

- New study guide with a notation it will go into testing rotation on 2/1/08. The current version of the study guide, May 31, 2007, will be utilized until the new one becomes effective on February 1, 2008.
- Course card – an easy way to document each nurse aide's training.
- Link update to the Elsevier required textbook/workbook, Mosby's Long Term Care Assistants, 5th Edition by Sorrentino and Gorek.

| | | | | | |
|---|---|---|---|---|---|
| Name | Last First Middle | | Course Number | | |
| Address | | | Course Instructor | | |
| City, State, Zip Code | | | Date Started | | |
| Social Security Number | | | Last Date Attended | | |
| Date of Birth | | | Hours Present/ Hours Absent | | |
| Telephone Numbers with AREA CODE | Home | Work | Final Grade Theory / Clinical | | |

| | | | |
|---|---|---|---|
| Circle Highest formal grade completed | 1 2 3 4 5 6 7 8 9 10 11 12 or GED | College 1 2 3 4 5 More | Technical College/School 1 2 |
| Employer | | Present Occupation | |
| Employer's Address Include Street, City, and State | | | |
| Please sign this form to provide a sample of your signature so that future inquires with your signature can be verified with this sample of your signature. Providing this signature sample is requested to protect your good name. | | | |

| Grades/Date | T1 | T2 | T3 | WB |
|---|---|---|---|---|

Notes:

1) An asterisk in the T column indicates one or more skills test items are taken from this task.
2) Chapters are from Sorrentino's LTCNA 5th by Mosby/Elsevier.
3) D is the date the student demonstrates the task. I is the instructor's initial.

Attendance Data

| Date | S | M | T | W | Th | F | S | NOTES |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | L = Classroom & Lab<br>C = Clinical Hours |
| | | | | | | | | Record hours present above the diagonal lines and the type of hours below the diagonal line |
| | | | | | | | | Enter the date of the Sunday beginning each week in the space under the column labeled DATE |
| | | | | | | | | Clinical Site: |
| | | | | | | | | |
| | | | | | | | | Clinical Instructor: |
| | | | | | | | | |

Tuberculosis Test Results:

Hepatitis B Vaccine or Waiver Data: 1) 2) 3)

Abuse Registry Verification

REMARKS:

**Attachment 2 Part A**

## Nurse Aide Task List (10/4/07)

| T | Task | C | D | I |
|---|---|---|---|---|
| | 1. Practice good personal hygiene | 3 | | |
| | 2. Maintain good personal health | 3 | | |
| | 3. Exhibit acceptable behavior | 3 | | |
| | 4. Work cooperatively with others | 3 | | |
| | 5. Maintain confidentiality | 3 | | |
| | 6. Observe the Resident's Rights | 1 | | |
| | 7. Identify and report abuse or neglect to appropriate person | 2 | | |
| | 8. Use plan of care to meet resident's needs | 5 | | |
| | 9. Communicate with resident, family, and staff | 4 | | |
| | 10. Assist resident in use of intercom/call system/telephone | 16 | | |
| | 11. Report observations/information to appropriate personnel | 4 & 5 | | |
| | 12. Recognize health problems related to the aging process | 35 | | |
| | 13. Recognize needs of the resident with cognitive impairment | 37 | | |
| | 14. Assist with providing diversionary activities for the resident | 24 | | |
| | 15. Assist with giving postmortem care | 41 | | |
| | 16. Follow standard precautions & bloodborne pathogens standard | 13 | | |
| * | 17. Wash hands aseptically | 13 | | |
| | 18. Provide for environmental safety | 10-15 | | |
| | 19. Adjust bed and side rails | 16 | | |
| | 20. Assist with application of protective devices | 12 | | |
| | 21. Report unsafe conditions to appropriate person | 10 | | |
| | 22. Assist with care of resident with oxygen | 26 | | |
| | 23. Follow fire and disaster plan | 10 | | |
| | 24. Assist resident who has fallen | 11 | | |
| | 25. Assist resident who has fainted | 40 | | |
| | 26. Assist resident who is having a seizure | 40 | | |
| * | 27. Clear the obstructed airway - the conscious adult | 40 | | |
| | 28. Use elevation, direct pressure, and pressure points to control bleeding | 40 | | |
| | 29. Serve meals and collect trays | 22 | | |
| | 30. Recognize diet modifications/restrictions | 22 | | |
| | 31. Check food tray against diet list (or diet card) | 22 | | |
| | 32. Feed or assist resident in eating | 22 | | |
| | 33. Administer after meal care | 18<br>20 | | |
| | 34. Record and report intake and output | 22 | | |
| * | 35. Give bed bath | 18 | | |
| * | 36. Give partial bath | 18 | | |
| | 37. Assist resident with tub bath | 18 | | |
| | 38. Assist resident with shower | 17 | | |
| * | 39. Make unoccupied (closed) bed | 17 | | |
| * | 40. Make occupied bed | 18 | | |
| * | 41. Perform or assist in performing oral hygiene for the conscious/unconscious resident | 19 | | |
| | 42. Assist with or shave resident | 18 | | |
| | 43. Give backrub | 18 | | |
| * | 44. Give perineal care | 19 | | |
| | 45. Shampoo/groom hair | 19 | | |
| * | 46. Give nail care | 19 | | |
| * | 47. Assist resident with dressing and undressing | 20 | | |
| * | 48. Provide urinary catheter care | 20 | | |
| | 49. Provide care for the incontinent resident | 20 | | |
| | 50. Assist resident in bladder and bowel retraining | 20 | | |
| * | 51. Assist resident in using bedpan/urinal | 21 | | |
| | 52. Assist with enema administration | 30 | | |
| | 53. Collect routine/clean catch urine specimen | 30 | | |
| | 54. Collect stool specimen | 30 | | |
| | 55. Collect sputum specimen | 14 | | |
| | 56. Use good body mechanics | 24 | | |
| * | 57. Perform or assist with range of motion exercises | 15 | | |
| * | 58. Turn and position the resident in bed | 15 | | |
| * | 59. Transfer resident to and from bed/chair | 15 | | |
| | 60. Use a mechanical lift to transfer resident | 15 | | |
| * | 61. Apply and use gait belt | 15 | | |
| * | 62. Assist resident with standing/walking | 24 | | |
| | 63. Assist resident in using cane/walker | 10 | | |
| | 64. Transport resident by wheelchair | 39 | | |
| | 65. Move resident between stretcher and bed | 31 | | |
| | 66. Assist with admission, in-house transfer, and discharge of resident | 28 | | |
| | 67. Measure and record resident temperature using by oral, auxiliary, rectal and tympanic routes using non-mercury glass/electronic thermometer | 28 | | |
| * | 68. Measure and record radial pulse | 28 | | |
| * | 69. Measure and record respiration | 28 | | |
| * | 70. Measure and record blood pressure | 28 | | |
| * | 71. Measure and record resident height/weight | 28 | | |
| | 72. Assist in prevention of pressure/circulatory ulcers | 32 | | |
| * | 73. Apply elastic stockings | 32 | | |
| | | | | |

**Attachment 2 Part B**

# KENTUCKY MEDICAID NURSE AIDE

# Testing Procedures Manual and Study Guide

2007

**KCTCS**

Kentucky Community and Technical College System

10/19/2007 version

The color of this cover is not an indicator of the version.

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## INTRODUCTION

This handbook is designed to provide nurse aide test candidates and nurse aide educators with general information about Kentucky's Nurse Aide Testing Program (KNAT). Any questions relating to the information in this handbook may be addressed to your local Medicaid Nurse Aide Coordinator.

The approved text for the nurse aide training program is Mosby's Textbook for Long-Term Care Assistants in its most recent edition. The competency evaluation is based on this text. Each nurse aide trainee shall acquire an individual copy of the Mosby's text and workbook and shall not be changed for any portion of the costs incurred in **facility** based training, including books.

## NURSE AIDE WEBSITE

The nurse aide website is located at http://unity.kctcs.edu/docushare/dsweb/View/Collection-1264. This website contains valuable information for nurse aide students, test candidates, instructors, and facilities. This web address may be freely distributed

The website contains, but is not limited to, such information as:

Nurse Aide Study Guide
Updates from the Publisher to the Textbook
Medicaid Services Manual
Contact Information for the KNAT Regional Coordinators

Content is updated on a regular basis. **Nurse Aide trainers are mandated to provide each student a copy of the most current version of the study guide at no charge. The study guide becomes the property of the nurse aide student.**

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## MEDICAID NURSE AIDE TRAINING

### OBRA

The nursing home reform provisions of the Omnibus Budget Reconciliation Act (OBRA) (42USC139 6 R) of 1987 established a requirement for a nurse aide training and competency evaluation program for nurse aides who are employed by nursing facilities. Cabinet for Health and Family Services, Department for Medicaid Services is the appointed regulatory authority.

A nurse aide is defined as any individual including a nursing student, medication aide and one employed through a nursing pool, providing nursing or nursing related services to facility residents, who is not a licensed health professional or volunteer. There is a requirement for a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation. The registry shall be established and shall be maintained by the Kentucky Board of Nursing.

In addition to the names of individuals having satisfactorily completed the nurse aide training and competency evaluation program, the registry shall include information addressing any State findings concerning any individual resident abuse or neglect or misappropriation of resident's property, and a brief statement (if any) by the aide disputing the findings.

### COMPETENCY EVALUATION

The Kentucky Community and Technical College System (KCTCS) has responsibility for the final written or oral examination and the skills demonstration aspect of the competency evaluation. The test questions are developed based on the State-approved curriculum with input from members of the Nurse Aide Training Advisory Committee. The test is validated by KCTCS to ensure its reflection of the material presented in the training. KCTCS also has responsibility to maintain the integrity of the test and the individual examinations.

The oral examination may be substituted for the written examination for persons with a documented limitation of literacy skills.

The skills-demonstration aspect of the examination must consist of a minimum performance of five (5) skills. These five (5) skills are randomly selected from a pool of evaluation items.

If a student has a disability, an alternate form of the test may be administered. The alternate form of the test must be requested by the nurse test candidate. This request must be submitted on the appropriate form obtained from your regional KNAT coordinator at least 2 weeks prior to the test date.

**LATEX ALLERGY**: If a student has a latex allergy, non-latex gloves may be requested by the nurse aide test candidate. This request must be submitted to the KNAT coordinator at least 2 weeks prior to the test date.

## MEDICAID NURSE AIDE TRAINING

### COMPETENCY EVALUATION (continued)

To satisfactorily complete the evaluation, the student must:

1. Make a score of at least 70% (raw score of 52 or higher) on the 75 multiple-choice written examination; and

2. Must successfully demonstrate at least five (5) procedures under the observation of an examiner, with 70% accuracy. Some steps on some of the procedures are considered critical. These steps must be performed with 100% accuracy. An asterisk has denoted these steps.

A test candidate, who fails either part of the examination, may reschedule to take the exam at the next available test date. If the test candidate fails the written test but passes the performance test, the candidate must repeat the written test only. If the test candidate fails the performance test but passes the written test, the test candidate is required to repeat the performance test including all 5 skills. An employed individual has only three (3) opportunities to pass the test within the initial four (4) month employment period. An individual not currently employed in long-term care has three (3) opportunities to successfully complete the competency evaluation and be placed on the registry within one year of completion of training. (This includes nursing students, also.)

To apply for the competency evaluation program (CEP) a candidate must contact the health care facility administrator, who will then contact the Medicaid nurse aide test coordinator at the nearest test site. Nursing students and unemployed individuals with documentation of approved training (i.e. transcript of fundamentals, letter from training program which includes verification of clinical training component, etc.) may apply for the CEP by contacting a Medicaid nurse aide test coordinator listed on pages 4 – 5 of this study guide. Health Science students may apply for the CEP after successfully completing the Medicaid nurse aide curriculum in an approved training site.

### RECORDS

Within thirty (30) days of satisfactory completion of the competency evaluation, KCTCS shall forward to the Kentucky Nurse Aide Registry, the name and social security number, address and test date of students who have successfully completed the competency evaluation.

The student, the nursing facility administrator, the training instructor, and the test coordinator will be advised in writing by KCTCS, of the competency evaluation (test) results.

The Kentucky Board of Nursing shall maintain, on the registry, the name of each student who has successfully completed the competency evaluation.

Registry toll free – Nurse Aides: 888-530-1919
Online verification: http://kbn.ky.gov/knar/verifications.htm
Registry (toll) - 502-429-3347

The Kentucky Medicaid Nurse Aide Test consists of seventy-five (75) written multiple-choice test items, which are taken from the following task list.

## TASK LIST FOR MEDICAID NURSE AIDE

| Task | Chapter |
|---|---|
| 1. Practice good personal hygiene | 2 |
| 2. Maintain good personal health | 2 |
| 3. Exhibit acceptable behavior | 2 |
| 4. Work cooperatively with others | 2,4 |
| 5. Maintain confidentiality | 3 |
| 6. Observe the Resident's Rights | 2 |
| 7. Identify and report abuse or neglect to appropriate person | 2 |
| 8. Use plan of care to meet resident's needs | 4 |
| 9. Communicate with resident, family, and staff | 4 |
| 10. Assist resident in use of intercom/call system/telephone | 16 |
| 11. Report observations/information to appropriate personnel | 4 |
| 12. Recognize health problems related to the aging process | 35 |
| 13. Recognize needs of the resident with cognitive impairment | 37 |
| 14. Assist with providing diversionary activities for the resident | 24 |
| 15. Assist with giving postmortem care | 41 |
| 16. Follow standard precautions & bloodborne pathogens standard | 13 |
| 17. Wash hands aseptically | 13 |
| 18. Provide for environmental safety | 10-15 |
| 19. Adjust bed and side rails | 17 |
| 20. Assist with application of protective devices | 12 |
| 21. Report unsafe conditions to appropriate person | 10 |
| 22. Assist with care of resident with oxygen | 26 |
| 23. Follow fire and disaster plan | 10 |
| 24. Assist resident who has fallen | 11 |
| 25. Assist resident who has fainted | 40 |
| 26. Assist resident who is having a seizure | 40 |
| 27. Clear the obstructed airway - the conscious adult | 10 |
| 28. Using elevation, direct pressure, and pressure points to control bleeding | 40 |
| 29. Serve meals and collect trays | 22 |
| 30. Recognize diet modifications/restrictions | 22 |
| 31. Check food tray against diet list | 22 |
| 32. Feed or assist resident in eating | 22 |
| 33. Administer after meal care | 18,20 |
| 34. Record and report intake and output | 22 |
| 35. Give bed bath | 18 |
| 36. Give partial bath | 18 |
| 37. Assist resident with tub bath | 18 |
| 38. Assist resident with shower | 18 |
| 39. Make unoccupied (closed) bed | 17 |
| 40. Make occupied bed | 17 |
| 41. Perform or assist in performing oral hygiene for the conscious/unconscious resident | 18 |
| 42. Assist with or shave resident | 19 |
| 43. Give backrub | 18 |
| 44. Give perineal care | 18 |
| 45. Shampoo/groom hair | 19 |
| 46. Give nail care | 19 |
| 47. Assist resident with dressing and undressing | 19 |
| 48. Provide urinary catheter care | 20 |

**TASK LIST FOR MEDICAID NURSE AIDE** (Continued)

| Task | Chapter |
|---|---|
| 49. Provide care for the incontinent resident | 20 |
| 50. Assist resident in bladder and bowel retraining | 20,21 |
| 51. Assist resident in using bedpan/urinal | 20 |
| 52. Assist with enema administration | 21 |
| 53. Collect routine/clean catch urine specimen | 30 |
| 54. Collect stool specimen | 30 |
| 55. Collect sputum specimen | 30 |
| 56. Use good body mechanics | 14 |
| 57. Perform or assist with range of motion exercises | 24 |
| 58. Turn and position the resident in bed | 15 |
| 59. Transfer resident to and from bed/chair | 15 |
| 60. Use a mechanical lift to transfer resident | 15 |
| 61. Apply and use gait belt | 15 |
| 62. Assist resident with standing/walking | 24 |
| 63. Assist resident in using cane/walker | 24 |
| 64. Transport resident by wheelchair | 15 |
| 65. Move resident between stretcher and bed | 15 |
| 66. Assist with admission, in-house transfer, and discharge of resident | 31 |
| 67. Measure and record resident temperature by using oral, auxiliary, rectal and tympanic routes using non-mercury glass/electronic thermometer | 28 |
| 68. Measure and record radial pulse | 28 |
| 69. Measure and record respiration | 28 |
| 70. Measure and record blood pressure | 28 |
| 71. Measure and record resident height/weight | 31 |
| 72. Assist in prevention of pressure/circulatory ulcers | 32 |
| 73. Apply elastic stockings | 32 |

## TIPS FOR THE WRITTEN TEST

There are a number of skills that may help you improve your ability to take a test. Here are some tips that are strongly recommended:

Get a good night's rest before the test.

Be familiar with the test directions. If anything in the directions is not clear, ask the test administrator to clarify. You will have a few minutes to ask questions before the test begins.

Think through each question. Read each question word for word. Consider all of the answer choices. Do not choose the first answer that seems reasonable. Read and evaluate all choices to find the best answer to the question. Give careful consideration before going on to the next question, but do not spend too much time on any one question.

When selecting the best answer to a question, do not re ad too much into the questions. The questions are written to be clear and straightforward. They are not intended to be tricky or misleading.

If, after considering all answer choices, the correct answer is not clear, eliminate the choices you know are incorrect and choose from the remaining answers. You may want to review the questions after you have completed the rest of the test.

Always guess even if you cannot eliminate any of the possible responses. Every question will be scored right or wrong. Your test score is based on the number of questions answered correctly. You **do not lose** points for incorrect answers, so you will not be penalized for guessing.

After you have finished the test, review your answers. If possible, check all responses. Do not be afraid to change your answer. However, before changing your answer, consider the reason for your original answer.

Check all answers to be sure that they are correctly recorded on the answer sheet. Be sure that your answers are recorded next to the number on the answer sheet corresponding to the question number.

**Facilities and test candidates are encouraged to schedule the test so they do not work 12 hours prior to the competency evaluation.**

## SAMPLE WRITTEN TEST ITEMS

Test Item:

1. A specimen collected by having the resident cough up a substance from the lungs and bronchial tubes is called

A. saliva
B. mucus
C. sputum
D. spit

2. Your see bruises on a resident's face. You should notify

A. a state agency responsible for abuse
B. the charge nurse
C. the family
D. the physician

Bubble in the response for the sample written test items above

**1.** **A B C D E**

1 2 3 4 5

**2.** **A B C D E**

1 2 3 4 5

Correct Answers: 1. C 2. B

## TIPS FOR THE SKILLS TEST

The skills demonstration aspect of the examination must consist of a minimum performance of 5 randomly selected skills

The following skills will be used for test purposes. At least 70% of the steps must be performed correctly in each skill. Some of the steps within a skill are considered critical and must be performed at 100% accuracy. An asterisk (*) identifies the critical steps.

A critical step is defined as a step within a task that relates to physical safety of the resident **or nurse aide** or medical asepsis (infection control).

Sequencing of steps will not be considered critical unless it becomes a physical safety or medical asepsis violation as defined above.

The skills test is not designed to teach. The skills test is designed to measure competency. No help will be given.

All test candidates are expected to complete the skills in a timely manner. At the evaluator's discretion, you may be given a 5 minute warning to finish the current skill.

For clarification of procedures, test candidates are encouraged to refer to the procedure checklist in your workbook.

Promoting Safety and Comfort: Bed Rails - page 156 of the approved text
Safety
You raise the bed to give care. Follow these safety measures to prevent the person from falling:

- For a person who uses bed rails – Always raise the far bed rail if you are working alone. Raise both bed rails if you need to leave the bedside for any reason.
- For the person who does not use bed rails – Ask a co-worker to help you. The co-worker stands on the far side of the bed. This protects the person from falling.
- Never leave the person alone when the bed is raised.
- Always lower the bed to its lowest position when you are finished giving care.

Comfort
The person has to reach over raised bed rails to access items on the bedside stand and overbed table. Such items include the water pitcher and cup, tissues, phone, and TV and light controls. Adjust the overbed table so it is within the person's reach. Ask if the person wants other items nearby. Place them on the overbed table too. Always make sure needed items, including the signal light, are within the person's reach.

For the purpose of testing, the resident's care plan indicates side rails are not to be used. Side rails will be raised when the bed is raised. Side rails will be lowered when the bed is lowered.

42 C.F.R 483.13(a) provides that "the resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience, and not required to treat the resident's medical symptom." Centers for Medicare & Medicaid Services (CMS) defines "physical restraints" in the State Operations Manual (SOM), Appendix PP as, "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts movement or normal access to one's body."

You will be expected to perform the skills as you would in a nursing home setting. When water is required, you must use water. All candidates will be required to perform the Wash Hands Aseptically skill. The evaluator will inform you after you have washed your hands for the first time that you should tell him or her when you would wash your hands during your performance of the rest of the skills rather than actually washing them for each skill. No other steps will give you credit for simply verbalizing to the evaluator what you would do, or for simulating the step, unless noted in this study guide next to that particular step within a skill. To receive credit for all other steps, you must actually demonstrate the step.
The test will consist of 5 of the 26 skills, which follow:

## APPLYING KNEE HIGH ELASTIC STOCKINGS

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
*2. Raise bed rails. Raise bed to best level for good body mechanics.
3. Lower side rail on the side you are working. Place in supine position.
4. Expose the leg while providing for privacy
5. Turn the stocking inside out down to the heel.
6. Slip the foot of the stocking over the toes, foot, and heel.
7. Grasp the stocking top. Slip it over the foot and heel. Pull it up the leg. The stocking turns right side out as it is pulled up. The stocking is even and snug.
8. Remove twists, creases, or wrinkles.
*9. Raise the side rail.
10. Go to the other side and lower the side rail.
11. Repeat steps 5 through 8 for the other leg (May verbalize this step)
*12. Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach.
13. Wash hands and report & record observations.

*** Denotes Critical Step**

**ASSIST WITH DRESSING AND UNDRESSING (Hemi-technique) Dependent Resident**

| | |
|---|---|
| 1 | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise bed rails. Raise bed to best level for good body mechanics. |
| 3. | Lower side rail on resident's weak side. Place in supine position. |
| 4. | Cover resident with bath blanket. Fanfold linens to foot of bed without exposing resident. |
| 5. | Raise resident's head and shoulders or turn onto side away from nurse aide. |
| 6. | Unfasten buttons, snaps, zippers, or ties in back of garment. |
| 7. | Bring sides of garment to the resident's sides, or if in side-lying position, tuck far side under resident and fold near side onto chest |
| 8. | Place resident in supine position. |
| 9. | Slide garment off shoulder on resident's strong side. Remove garment from the arm. Repeat for weak side. |
| 10. | Put on garments that open in the front: slide garment onto arm and shoulder of weak side. |
| 11. | Raise head and shoulders. Bring side of garment around the back. Lower resident to supine position. |
| 12. | Slide garment onto the arm and shoulder of the strong arm. |
| 13. | Fasten buttons, snaps, zippers, or ties. |
| 14. | Put on pants or slacks. Slide pants over feet and up the legs. |
| 15. | Turn onto the strong side and pull pants over buttocks and hip of weak side. |
| 16. | Turn resident to the weak side and pull pants over buttocks and hip of strong side. |
| 17. | Place resident in supine position and fasten buttons, snaps, zippers, ties, and/or belt buckle. |
| 18. | Remove bath blanket. |
| 19. | Put socks and shoes or slippers on resident. |
| *20. | Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach. |
| 21. | Wash hands and report & record observations. |

*** Denotes Critical Step**

**BED BATH - FULL**

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
2. Fill bath basin 2/3 full of warm water.
*3. Raise bed rails. Raise the bed to best level for good body mechanics.
4. Lower bed rail and position resident in supine position.
5. Cover the resident with a bath blanket and remove top linens.
6. Lower bed rail and place towel across resident's chest.
7. Make mitten of washcloth and wet with water; squeeze out excess.
8. Wash eyes first. Start at inner corner and work out. Use different area of mitten for each eye.
9. Wash, rinse, and dry the face.
10. Wash, rinse, and dry the ears and then neck.
11. Remove the gown without exposing the resident.
12. Expose arm farthest from the side. Place bath towel under arm up to axilla.
13. Place basin of water on bed and immerse resident's hand in water and wash. Remove the basin and dry hand well.
14. Wash and rinse shoulders, axillae and arms.
15. Repeat steps 12, 13, & 14, using nearest arm. (May Verbalize This Step)
16. Place towel across chest and fold bath blanket to waist.
17. Wash, rinse, and dry chest while lifting towel.
18. Dry the skin thoroughly.
19. Fold bath blanket to pubic area; keep chest covered with towel
20. Wash, rinse and dry abdomen. Remove the towel and cover with bath blanket.
*21. Raise the side rail before leaving the bedside. Change bath water in basin.
22. Lower bed rail.

* **Denotes Critical Step**

**See Next Page**

23. Expose the far leg; flex leg and place bath towel lengthwise under the leg up to the buttocks.

24. Place basin on towel and put foot into it. Support leg at knee joint with hand.

25. Wash and rinse leg and foot.

26. Remove basin of water and dry leg, foot, and between toes.

27. Repeat steps #23 - #26 for near leg. (May verbalize this step)

*28. Raise the side rail before leaving the bedside. Change bath water in basin.

29. Lower bed rail and assist resident to turn on side with back facing the aide.

30. Fold the bath blanket over resident's side to expose back and buttocks; place towel parallel to resident's back.

31. Wash, rinse and dry back and buttocks.

32. Give back rub and remove towel and turn resident onto back; place towel under buttocks.

*33. Raise the bedrail before leaving the bedside. Change the water for perineal care.

34. Lower bed rail.

*35. Put on disposable gloves.

36. Wash, rinse, and dry the perineum. (may verbalize, perineal care tested on separate skill) Remove towel under buttocks.

*37. Remove and discard gloves. Wash your hands. Raise the bedrail before leaving the bedside

38. Apply lotion and deodorant.

39. Without exposing the resident, dress him/her in a clean gown.

*40. Raise the bedrails. Lower bed. Lower bedrails. Attach signal light within resident's reach.

41. Wash hands and report & record observations.

* **Denotes Critical Step**

**PARTIAL BED BATH**

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
2. Cover the resident with a bath blanket and remove top linens.
3. Fill the washbasin 2/3 full with warm water.
4. Place the basin on the over-bed table.
5. Raise the head of the bed so resident can bathe comfortably.
6. Help the resident remove the gown or pajamas.
7. Position the over-bed table so the resident can easily reach the basin and supplies.
8. Ask resident to wash easy-to-reach body parts. Explain that you will wash the back and those areas that cannot be reached.

*9. Attach signal light within resident's reach.

10. Return to resident's room when signal light is on. Wash hands. (may verbalize)
11. Change the bath water.

*12. Raise the side rails. Raise the bed to the best level for good body mechanics. Lower side rail nearest you.

13. Assist resident to wash areas that could not be reached. (may verbalize, including the use of gloves if needed.)
14. Apply deodorant and lotion.
15. Help resident put on clean clothes, a gown, or pajamas.

*16. Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach.

17. Empty, clean, and store the supplies appropriately.
18. Wash hands and report & record observations.

* **Denotes Critical Step**

**BED MAKING - OCCUPIED**

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.

*2. Raise bed rails. Raise bed to best level for good body mechanics.

3. Lower side rail nearest you.

4. Wear gloves if linens are soiled. (may verbalize)

5. Loosen the top bedding at foot of bed. Remove spread and/or blanket.

6. Place bath blanket over top sheet. Remove top sheet without exposing resident.

7. Keep pillow under resident's head and turn resident to side of bed not being made.

8. Loosen bottom bedding; free bottom linen and roll each piece separately to the resident's back.

9. Place bottom sheet lengthwise with fold in center and lower edge of sheet even with foot of mattress. Face hem stitching downward.

10. Tuck sheet under head of mattress: miter corners; tuck well under side of mattress.

11. Fanfold surplus sheet close to resident's back.

12. Place draw sheet on middle 1/3 of mattress; fanfold 1/2 to resident's back and tuck in excess material.

*13. Raise side rail of bed.

14. Go to opposite side of bed; lower bedside rail.

15. Move resident to clean side of bed and then place pillow under resident's head.

16. Pull through all bottom linen. Roll, remove, and discard soiled linen in laundry hamper or bag. Hold soiled linen away from own uniform.

17. Pull clean bottom sheet toward the edge of bed. Tuck it under the mattress at the head of the bed and make a mitered corner, tuck it well under the side of the mattress.

18. Pull the sheet toward foot of bed and remove all wrinkles. Pull the draw sheet; tighten, and tuck excess under the mattress.

19. Assist resident to center of bed.

20. Place top sheet over bath blanket: ask resident to hold or tuck under resident's shoulders. Remove bath blanket. Replace blanket/spread.

21. Tuck sheet, blanket, and bedspread at foot of bed under mattress and miter corners on each side, allowing for movement of resident's feet.

* **Denotes Critical Step**

**See Next Page**

| | |
|---|---|
| 22. | Change pillowcase and place pillow under resident's head |
| *23. | Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach. |
| 24. | Recess bed cranks (if necessary). |
| 25. | Wash hands and report & record observations. |

* **Denotes Critical Step**

## BED MAKING – UNOCCUPIED / CLOSED

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise bed to best level for good body mechanics. |
| 3. | Remove linens from bed, rolling linen away from you so that the surface that touched the resident is inside the roll. |
| 4. | Place the bottom sheet on the mattress.<br>Unfold it lengthwise.<br>Place the center crease in the middle of the bed.<br>Position the lower edge evenly with the bottom of the mattress.<br>Face hem stitching downward |
| 5. | Pick the sheet up from the side to open it. Fanfold it toward the other side of the bed. |
| 6. | Go to the head of the bed. Tuck the top of the sheet under the mattress. Make sure the sheet is tight and smooth. Make a mitered corner. |
| 7. | Place the draw sheet on the middle 1/3 of the mattress. |
| 8. | Open the draw sheet and fanfold to the other side of the bed. |
| 9. | Tuck draw sheet and go to other side of the bed. |
| 10. | Miter the top corner of the bottom sheet. |
| 11. | Pull the bottom sheet tightly to smooth out wrinkles. Tuck well under side of mattress. |
| 12. | Pull the draw sheet tightly and tuck in the sheet. |
| 13. | Go to other side of bed. |
| 14. | Place the top sheet on the bed.<br>Unfold it lengthwise.<br>Place the center crease in the middle.<br>Place the sheet evenly with the top of the mattress.<br>Open the sheet and fanfold the extra toward the other side.<br>Face hem stitching outward. |
| 15. | Place the bedspread on the bed with the upper hem even with the top of the mattress. Open and fanfold extra to the other side. |
| 16. | Make sure the bedspread facing the door is even and covers all the top linens. |

* **Denotes Critical Step**

**See Next Page**

| | |
|---|---|
| 17. | Tuck in the linens together at the foot of the bed. Make a mitered corner. |
| 18. | Go to other side of bed. Straighten all top linen, tucking in top linens. Make a mitered corner. |
| 29. | Put pillowcase on pillow and place on bed with open end away from the door. |
| *20. | Lower bed. Attach signal light within resident's reach. |
| 21. | Wash hands and report & record observations. |

*** Denotes Critical Step**

## CATHETER CARE

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.

*2. Raise side rails. Raise bed to the best level for good body mechanics.

3. Lower side rail nearest you, place resident in supine position, and drape resident. Fanfold linens to foot of bed.

*4. Put on disposable gloves.

5. Place bed protector on bed under buttocks.

6. Expose perineal area.

7. Separate the labia of the female or retract the foreskin (uncircumcised male) and check for any crusts, abnormal drainage, or secretions.

*8. Gently wash around the opening of the urethra with soap and water.

*9. Holding the catheter near the meatus, clean the catheter from the meatus down the catheter about 4 inches, using soap, water and a clean washcloth. Clean downward away from the meatus with one stroke. Repeat as needed with a clean area on the washcloth each time. Rinse and pat dry.

10. Secure catheter properly. Coil and secure tubing to the bed.

11. Remove the bed protector.

12. Remove and discard the gloves.

13. Cover resident and remove bath blanket.

14. Make sure the resident is comfortable.

*15. Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach.

16. Wash hands and report & record observations.

* **Denotes Critical Step**

## CLEARING THE OBSTRUCTED AIRWAY - THE CONSCIOUS ADULT

| | |
|---|---|
| 1. | Ask the victim if they are choking. |
| *2. | Determine if the victim can cough or speak. |
| *3. | Stand behind the victim. |
| *4. | Wrap your arms around the victim's waist. |
| *5. | Make a fist with one hand. Place the thumb side of the fist against the abdomen. The fist is in the middle above the navel and below the end of the sternum. |
| *6. | Grasp your fist with your other hand. |
| *7. | Press your fist and hand into the victim's abdomen with a quick, upward thrust. |
| *8. | Repeat the abdominal thrust until the object has been expelled or the victim loses consciousness. |

* **Denotes Critical Step**

**DENTURE CARE**

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.

2. Raise the head of the bed. Position the resident for resident for oral hygiene. Place towel over the resident's chest.

*3. Put on disposable gloves.

4. Ask the resident to remove dentures or remove resident's dentures using gauze if the resident cannot do so.

5. Grasp the upper denture with the thumb and index finger of one hand. Move the denture up and down slightly to break the seal. Gently remove the denture and place in kidney/emesis basin or denture cup.

6. Remove the lower denture by grasping it with your thumb and index finger. Turn it slightly, and lift it out of the mouth. Place the denture in kidney/emesis basin or denture cup.

7. Line the sink with a towel and fill with water.

8. Take dentures and equipment to the sink and rinse each denture under warm running water. Return to denture cup.

*9. Apply denture cleaner or toothpaste to the brush and brush and rinse dentures. Place in denture cup. Fill it with cool water.

10. Clean kidney/emesis basin. Bring basin and denture cup to bedside.

11. Position the resident for oral hygiene.

12. Ask the resident to rinse his/her mouth with mouthwash. Hold the kidney/emesis basin under the resident's chin.

13. Ask resident to insert dentures. Insert the dentures if the resident cannot.

14. Grasp the upper denture with thumb and index finger. Raise the upper lip with the other hand and insert denture. Use index fingers to press gently on upper denture to make sure that it is secure.

15. Grasp the lower denture securely with thumb and index finger. Pull down slightly on the lower lip and insert the denture.

16. Put denture cup in the top drawer of the bedside stand.

*17. Remove and discard gloves.

*18. Attach signal light within resident's reach.

19. Wash hands and report & record observations.

*** Denotes Critical Step**

**GIVING NAIL CARE**

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
2. Position the over bed table in front of the seated resident. It should be low and close to the resident.
3. Fill the kidney basin with warm water.
4. Place the kidney basin on the over bed table on top of the paper towels.
5. Put the resident's fingers into the basin. Position the arms so that he or she is comfortable.
6. Let the fingernails soak for 15 to 20 minutes (may verbalize without waiting). Re-warm the water as needed.
7. Clean under the fingernails with the orange stick.
8. Remove the kidney basin. Dry fingers thoroughly.
9. Clip fingernails straight across with nail clippers.
10. Shape nails with an emery board or nail file.
11. Push cuticles back with a washcloth or orange stick.
12. Clean and return equipment and supplies to their proper places. Discard disposable supplies.

*13. Attach signal light within resident's reach.

14. Wash hands and report & record observations.

*** Denotes Critical Step**

## GIVING FEMALE PERINEAL CARE

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
2. Fill the wash basin with warm water.
*3. Raise side rails. Raise bed to the best level for good body mechanics.
4. Lower side rail nearest you. Position the resident on her back, drape with a bath blanket and remove top linen.
*5. Put on disposable gloves.
6. Place a waterproof pad under buttocks.
7. Assist the resident to flex knees and spread legs, if able. Otherwise, help the resident to spread legs as much as possible with knees straight.
8. Apply soap to a washcloth.
*9. Separate the labia. Clean downward from front to back with one stroke.
10. Repeat steps 7 & 8 until the area is clean. Use a clean part of the washcloth for each stroke. Use more than one washcloth if needed.
*11. Rinse the perineum with a washcloth. Separate the labia. Stroke downward from front to back.
12. Pat the area dry with the towel.
13. Assist the resident to lower the legs and turn onto the side, away from you.
*14. Wash from the vagina to the anus with one stroke. Rinse and pat dry.
15. Remove waterproof pad.
*16. Remove and discard the gloves.
17. Cover the resident with top linen and remove the bath blanket.
*18. Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach.
19. Wash hands and report & record observations.

*** Denotes Critical Step**

## GIVING MALE PERINEAL CARE

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
2. Fill the wash basin with warm water.
*3. Raise side rails. Raise bed to the best level for good body mechanics.
4. Lower the side rail nearest you. Position the resident on his back, drape with a bath blanket and remove top linen.
*5. Put on disposable gloves.
6. Place a waterproof pad under buttocks.
7. Retract the foreskin if the person is uncircumcised.
8. Grasp the penis.
9. Clean the tip. Use a circular motion. Start at the urethra, and work outward. Repeat as needed. Use a clean part of the washcloth each time.
10. Rinse the area with another washcloth.
11. Return the foreskin to its natural position.
12. Clean the shaft of the penis. Use firm downward strokes away from the urinary meatus. Rinse the area.
13. Help the person flex his knees and spread his legs. Or help him spread his legs as much as possible with knees straight.
14. Clean the scrotum. Rinse well. Observe for redness and irritation in the skin folds.
15. Pat the penis and scrotum dry.
16. Help him lower his legs, cover him, and turn him onto his side away from you. Fold the bath blanket back between his legs.
17. Wash, rinse, and pat dry the anal area. Wash from the scrotum to the anus with 1 stroke.
18. Remove the waterproof pad.
*19. Remove and discard gloves.
20. Cover the resident with top linen and remove bath blanket.
*21. Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach.
22. Wash hands and report and record observations.

*** Denotes Critical Step**

## GIVING THE BEDPAN

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.

*2. Raise side rails. Raise bed to the best level for good body mechanics.

3. Lower the side rail nearest you. Position the resident in supine position.

*4. Put on disposable gloves.

5. Turn the resident onto his/her side away from you and correctly place the bedpan firmly against the buttocks.

6. Push the bedpan down and toward the resident.

7. Hold the bedpan securely. Turn the resident onto his/her back. Center the bedpan under the resident. Remove gloves.

8. Raise the head of the bed so the resident is in a sitting position.

*9. Place the signal light within resident's reach. Raise side rail. Lower bed. Lower side rail.

10. Place the toilet tissue within reach of the resident. Ask the resident to signal when through or when assistance is needed.

11. Wash your hands. Leave the room and close door. (may verbalize)

12. Return when the resident signals. (may verbalize)

*13. Raise side rails. Raise the bed to the best level for good body mechanics. Lower the side rail nearest you and head of the bed.

*14. Put on disposable gloves.

15. Remove the bedpan. You need to hold the bedpan securely and turn him or her onto the side away from you.

*16. Clean the perineal area. Clean from front to back with toilet tissue. Provide perineal care if necessary.

*17. Cover the bedpan. Raise side rail. Lower the bed. Lower side rails. Take bedpan to the bathroom.

18. Measure urine if the resident is on intake and output. Collect a urine specimen if needed. Empty, clean & rinse bedpan. Remove gloves. Wash hands.

19. Put on clean gloves (may verbalize), and store the bedpan. Remove and discard gloves.

20. Help the resident wash hands.

21. Wash your hands. (may verbalize).

*22. Attach signal light within resident's reach.

23. Report & record observations.

* **Denotes Critical Step**

## HELPING THE PERSON TO WALK

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.

*2. Adjust bed to lowest position and lock bed wheels.

3. Fanfold top linens to the foot of the bed. Put on shoes or non-skid footwear.

4. Raise the head of the bed up (Fowler's position), help the person to dangle.

*5. Apply the transfer belt.

6. Help the person to stand. Grasp the transfer belt on each side.

7. Stand at the person's side while they gain balance. Hold the belt at the side and back.

8. Encourage the person to stand erect with the head up and back straight.

9. Help the person walk. Walk to the side and slightly behind the person. Provide support with the transfer belt.

10. Encourage the person to walk normally. The heel strikes the floor first. Discourage shuffling, sliding or walking on tiptoes.

11. Walk the required distance without rushing the person.

12. Help the person return to bed. Remove the transfer belt.

13. Lower the head of the bed. Help the person to the center of the bed.

14. Remove footwear and cover the resident.

*15. Attach signal light within the resident's reach.

16. Wash hands and report & record observations

* Denotes Critical Step

## MEASURE AND RECORD HEIGHT AND WEIGHT

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| 2. | Raise height-measuring rod and adjust scale to ***zero.*** |
| 3. | Place paper towel on the scale platform. |
| 4. | Ask resident to remove slippers/shoes (assist if necessary). |
| 5. | Assist resident onto scale. |
| 6. | Move the weights until the balance point is in the middle. |
| *7. | Read and record the weight within 1 lb. |
| 8. | Ask resident to stand erect. |
| 9. | Adjust height meter to top of head and note height. |
| 10. | Assist resident off platform and adjust weights to *zero.* |
| 11. | Assist resident in putting on slippers/shoes. Assist to his/her bed or chair. |
| *12. | Record the height within 1 inch. |
| *13. | Attach signal light to within the resident's reach. |
| 14. | Wash hands and report & record observations. |

* Denotes **Critical Step**

## MEASURE AND RECORD PULSE, RESPIRATION AND BLOOD PRESSURE

1. Knock before entering the room. Identify and greet resident. Explain procedure to resident. Wash your hands. Provide privacy.
2. Position the resident seated/reclining.
3. Find the resident's radial pulse by placing your middle two or three fingers on palm side of resident's wrist on thumb side, next to bone.
4. Count for 30 seconds, times 2 if regular (count for 1 minute if irregular).
5. Continue to hold the resident's wrist and begin counting when you see the chest rise; count respiration for 30 seconds, times 2 if regular (count for 1 minute if irregular).

*6. Recount respiration if unsure. Record respiration on paper. Recorded respiration must be within 5 of that obtained by the evaluator.

*7. Record pulse. Recorded pulse must be within 5 pulse counts of that obtained by the evaluator.

8. With the resident seated/reclining with the entire lower arm on a flat surface.
9. Expose the arm as much as possible. Squeeze the cuff to expel any remaining air and turn the valve clockwise on the bulb to close it.
10. Wrap cuff snugly around the upper arm--at least one inch above the elbow.
11. Clean earpieces and diaphragm of the stethoscope with alcohol sponge.
12. Locate the brachial artery at the inner aspect of the elbow.
13. Place the earpieces of the stethoscope in your ears.
14. Place the diaphragm of the stethoscope over the brachial artery.
15. Inflate the cuff.
16. Loosen valve and deflate the cuff slowly noting the systolic and diastolic reading.
17. Deflate the cuff completely and remove from the resident's arm.
18. Record blood pressure on paper.

*19. Recorded reading must be within 6 mm of that obtained by the evaluator.

20. Wash your hands and record and report observations to the nurse.

* **Denotes Critical Step**

**RESIDENT POSITIONING AND ALIGNMENT – FOWLER'S (This procedure begins in supine position)**

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise the head of the bed to a 45-60 degree angle. |
| 3. | Keep the spine straight. |
| 4. | Support the head with a pillow. |
| 5. | Support the arms with pillows. |
| *6. | Attach signal light within the resident's reach. |
| 7. | Wash hands and report & record observations. |

*** Denotes Critical Step**

**RESIDENT POSITIONING AND ALIGNMENT – LATERAL / SIDE**
**(This procedure begins in supine position)**

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise bed rails. Raise the bed to best level for good body mechanics. |
| 3. | Lower rail on side where you are working. |
| 4. | Place a pillow under the resident's head and neck. |
| 5. | Roll resident to side away from you. |
| 6. | Place the upper leg in front of the lower leg. |
| 7. | Support the upper leg and thigh with pillows. |
| 8. | Place a pillow against the resident's back. |
| 9. | Place a small pillow under the upper hand and arm. |
| *10. | Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach. |
| 11. | Wash hands and report & record observations. |

* **Denotes Critical Step**

**RESIDENT POSITIONING AND ALIGNMENT – SUPINE (This procedure begins in lateral position)**

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise bed rails. Raise the bed to best level for good body mechanics. |
| 3. | Lower rail on side where you are working. |
| 4. | Place a pillow under the resident's head and shoulders. |
| 5. | Roll resident into supine position. |
| 6. | Position arms comfortably at each side. |
| *7. | Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach. |
| 8. | Wash hands and report & record observations. |

*** Denotes Critical Step**

## PROVIDING MOUTH CARE – THE UNCONSCIOUS RESIDENT

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise bed rails. Raise the bed to best level for good body mechanics. |
| 3. | Lower the bed rail nearest you. |
| *4. | Put on disposable gloves. Position the resident in the side lying position, facing you. Turn resident's head well to the side. |
| 5. | Place the towel under the resident's face. Place kidney/emesis basin under the chin. |
| 6. | Clean the chewing and inner surfaces of the teeth using appropriate supplies. |
| 7. | Swab the roof of the mouth, inside of the cheeks, and the lips using appropriate supplies. |
| 8. | Swab the tongue using appropriate supplies. |
| 9. | Moisten a clean sponge swab with water, and swab the mouth to rinse. |
| 10. | Apply moisturizer to the resident's lips. |
| 11. | Remove and discard the gloves. |
| 12. | Reposition the resident. |
| *13. | Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach. |
| 14. | Wash hands and report & record observations. |

*** Denotes Critical Step**

## RANGE OF MOTION EXERCISES - ELBOW

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise bed rail. Raise the bed to the best level for good body mechanics. |
| 3. | Lower the side rail. |
| 4. | Position the resident supine and in good alignment. |
| 5. | Support the resident's wrist with one hand and the elbow with the other. |
| 6. | Flexion: bend the arm so that the same-side shoulder is touched. |
| 7. | Extension. straighten the arm. |
| 8. | Repeat flexion and extension 5 to 6 times. |
| *9. | Raise the side rail. |
| 10. | Go to the other side and lower the side rail. |
| 11. | Repeat steps for exercising the elbow. (may verbalize this step) |
| 12. | Make sure the resident is comfortable. |
| *13. | Raise side rail. Lower bed. Lower side rail Attach signal light within resident's reach. |
| 14. | Wash hands and report & record observations. |

*** Denotes Critical Step**

## RANGE OF MOTION EXERCISES - WRIST

1. Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy.
* 2. Raise bed rail. Raise the bed to the best level for good body mechanics.
3. Lower the side rail on the side you are working.
4. Position the resident supine and in good alignment.
5. Support the resident's wrist with both of your hands.
6. Flexion: bend the hand down.
7. Extension: straighten the hand.
8. Hyperextension. bend the hand back.
9. Radial flexion: turn the hand toward the thumb.
10. Ulnar flexion: turn the hand toward the little finger.
11. Repeat flexion, extension, hyperextension, and radial and ulnar flexion 5 to 6 times.
*12. Raise the side rail.
13. Go to the other side and lower the side rail.
14. Repeat steps for exercising the wrist. (may verbalize this step)
15. Make sure the resident is comfortable.
*16. Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach.
17. Wash hands and report & record observations.

*** Denotes Critical Step**

**RANGE OF MOTION EXERCISES – HIP**

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| *2. | Raise the bed rail. Raise the bed to the best level for good body mechanics. |
| 3. | Lower the side rail on the side you are working. |
| 4. | Position the resident supine and in good alignment. Cover resident with a bath blanket and remove top linens. |
| 5. | Place one hand under the resident's knee and the other hand under the ankle to support the leg. |
| 6. | Flexion: raise the leg. |
| 7. | Extension: straighten the leg. |
| 8. | Abduction: move the leg away from the body. |
| 9. | Adduction: move the leg toward the other leg. |
| 10. | Internal rotation: turn the leg inward. |
| 11. | External rotation: turn the leg outward. |
| 12. | Repeat flexion, extension, abduction, adduction, and inward and outward rotation 5 to 6 times. |
| 13. | Cover the resident. |
| *14. | Raise the side rail. |
| 15. | Go to the other side and lower the side rail. |
| 16. | Repeat steps for exercising the hip. (may verbalize) |
| 17. | Make sure the resident is comfortable. |
| 18. | Cover the resident with top linens. Remove the bath blanket. |
| *19. | Raise side rail. Lower bed. Lower side rail. Attach signal light within resident's reach. |
| 20. | Wash hands and report & record observations. |

* **Denotes Critical Step**

## TRANSFERRING A RESIDENT TO A WHEELCHAIR

| | |
|---|---|
| 1. | Knock before entering the room. Identify and greet resident. Explain procedure. Wash your hands. Provide for privacy. |
| 2. | Place chair parallel to or at a 45-degree angle to bed. |
| 3. | Cover chair with bath blanket or protective pad. |
| *4. | Lock the wheels of the wheelchair. |
| 5. | Remove or lift foot rests out of the way. |
| *6. | Adjust bed to lowest position, lock bed wheels, and raise head of bed (Fowler's position). |
| 7. | Fanfold top linens to the foot of bed. |
| 8. | Put shoes on the resident and apply transfer belt. |
| *9. | Turn resident as a unit from Fowler's to dangling position. |
| 10. | Stand in front of resident. |
| 11. | Grasp the transfer belt at each side. |
| 12. | Position your feet and legs to provide stability for the resident and prevent the resident from falling or sliding. |
| 13. | On the count of three, pull resident into a standing position as you straighten your knees. |
| 14. | Support the resident in the standing position. |
| 15. | Turn to lower the resident into the wheelchair as you bend your hips and knees. Position feet on footrests. |
| 16. | Remove transfer belt. Cover the resident with bath blanket or lap robe. |
| 17. | Unlock the wheels of the wheelchair. |
| *18. | Attach signal light within the resident's reach. |
| 19. | Wash hands and report & record observations. |

*** Denotes Critical Step**

## WASH HANDS ASEPTICALLY

1. Remove watch and bracelets or push up 4 to 5 inches above hand. Remove all rings except a smooth wedding band.
2. Stand away from sink so clothes do not touch the sink.
3. Turn on the faucet and adjust the water to a warm, comfortable temperature.
4. Wet hands thoroughly, including three to four inches above wrists.
5. Hold hands with wrists lower than elbows during hand washing procedure.
6. Apply a generous amount of soap to hands.
7. If bar soap is used, rinse it well before lathering and before returning it to the dish.
8. Rub palms together to work up a good lather for at least 15 seconds.
9. Steps 10 – 13 should last at least 20 seconds. Wash using friction and rotating motion.
10. Wash the palms and back of hands.
11. Wash fingers and between fingers.
12. Wash wrists and lower arms.
13. Clean well under fingernails by rubbing fingers against palms. Use nail file or orange stick to clean under fingernails.
14. Rinse well from arms to hands.
15. With a clean dry paper towel or towels, pat dry starting at fingertips working to wrist. Discard towel or towels.
16. Repeat step on wet hand with clean dry towel or towels. Discard towel or towels.

*17. Turn off faucet with clean, dry paper towel and discard in wastebasket.

*** Denotes Critical Step**

## TEST ADMINISTRATION PROCEDURES

1. Each candidate is to be at the test location and ready to begin the test by the starting time. A candidate arriving late may be considered a "no-show".

2. Only the candidates who are on the official roster will be allowed to take the written and/or performance test(s).

3. When arriving at the test site, candidates will be required to provide the following documents at every test appointment:
   - An unexpired state or federal issued photo identification
   - A United States Social Security card that is not laminated; and
   - If the Social Security Cards states "Not Valid for employment without Immigration and Customs enforcement authorization" or contains a similar statement a final examination candidate shall present an Employment Authorization Document issued by the US Department of Homeland Security
   - A test candidate's identity documents presented to the competency evaluation program proctor shall identify the candidate's same full name to include middle initial.

   This does not mean that a middle initial or middle name is required, but if a middle initial or middle name is listed on one document, it must be present and match by the first letter of the middle initial or middle name on all. For example: Jane Doe on a Social Security card and Jane A. Doe on a Driver's License are not the same and will not be accepted. However, Jane A Doe on a Driver's License and Jane Ann Doe on Social Security card will be accepted.

**Multiple Middle Names on Social Security Card**

If the social security card has multiple middle names, but the driver's license (DL) or state issued identification card (I.D.) has only a middle initial or one middle name, a letter from the Circuit Clerk's office, on official letterhead, is required. The Circuit Clerk, in the test candidate's home county, is the entity responsible for issuing driver's license and state issued I.D. cards. The letter must contain at a minimum the following information:

* Candidates name on DL or state issued I.D. card

* Candidates full name that matches the full name and name order on the SS card

* DL # or state issued I.D. card # of the candidate to verify the identification in question

* Signature of the Circuit Clerk or Circuit Clerk's designee

The order of the names, initials, and spelling must match, in both the letter and on the identification cards.

**Acceptable Example:**

Jane A Doe on Drivers License
Jane Ann Smith Doe on SS Card
Letter containing references to these names in the same order

**Unacceptable Example:**

Jane S Doe on Drivers License
Jane Ann Smith Doe on SS Card

To correct this situation, the test candidate must get a new DL or State Issued ID card with the middle initial "A" and the corresponding letter referencing the names in the same order.

A test candidate with multiple middle names on the social security card who fails to provide the identity documentation above will not be allowed to take the state test until the documentation is received or identification is presented that meets acceptable criteria.

Please note that a letter from a Social Security Administration field office stating a test candidate applied for a replacement social security card will **not** be accepted as proof of the candidate's social security number or identity.

Candidate's identity documents including the social security card must be in good condition. Good condition is defined as: A condition that allows the test proctor to establish the candidate's identity and validity of the document. Condition of the documents is to be determined by the test proctor and is at their total discretion.

Candidates that arrive at the test site without the proper ID's will **not** be allowed to test and will be required to reschedule their assessment and will forfeit all testing fees.

Candidates that present fraudulent identification documents for testing will forfeit all testing fees and may be reported to the proper authorities.

4. Test related materials that are needed will be supplied. Candidates will not be allowed to bring reference materials, etc. into the test room or use any notes, or other types of references during the test.

5. No test materials, documents, or notes of any kind may be removed from the examination room.

6. Any candidate observed giving or receiving assistance of any kind during the test will be dismissed and his/her test results will be declared null and void.

7. The test monitor will orient the candidates as a group prior to testing.

8. At the end of time for each section of the test, the candidate will turn in all test materials to the monitor.

9. Payments for nurse aide testing that returned and not honored, the assessment(s) will not be graded and you must pay in full within 30 days of your test date. If you bring your account in good standing within 30 days, your test will be graded. If you fail to bring your account in good standing within 30 days of your test date, your test will be shredded. You will be required to reschedule your assessment and repay your test fee.

10. If you have an account that is not in good financial standing with any KCTCS college regardless of your training site, you will not be allowed to test until your account is brought into good financial standing.

11. This information is current as of the date it as printed. Regional Coordinators and Test administrators will follow the information contained in the current version of the document. The current version is available on the nurse aide website http://unity.kctcs.edu/docushare/dsweb/View/Collection-1264.

## NOTIFICATION OF TEST SCORES

Each candidate will receive test scores via postal mail. The Medicaid nurse aide test coordinator, the nursing facility, and the training facility will receive a printout of the candidates test scores. If the candidate has successfully completed both the written and the performance tests of the Medicaid Nurse Aide Competency Evaluation, their name will be forwarded to the Kentucky Nurse Aide Registry at the Kentucky Board of Nursing. If any test retakes are necessary, information will be provided to the candidate. No other agency or individual will be provided individual test scores without the expressed written request of the test candidate. Please allow thirty (30) days for test processing.

## RENEWAL OF REGISTRATION

The Kentucky Board of Nursing shall renew a nurse aide's registration at least once every two (2) years. The nurse aide will be notified when their renewal of registration is pending. In order for that office to locate a nurse aide, it is important that whenever the nurse aide has a change of name and/or address, the aide should contact that office immediately. The address for the Kentucky Nurse Aide Registry is 312 Whittington Parkway, Suite 300-A, Louisville, KY 40222-5172.

## NURSE AIDE STATE-REGISTERED CARD

State Registered Nurse Aide cards will no longer be issued or replaced, according to Kentucky Administrative Regulations (907 KAR 1:450). For more information, consult your training provider.

The Kentucky Community and Technical College System does not discriminate on the basis of race, color, national origin, sex, disability, age, religion or marital status in training, activities or employment practices in accordance with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, Title VII of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1991.