

# OREGON NURSING ASSISTANT CANDIDATE HANDBOOK

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Headmaster is approved by the Oregon State Board of Nursing to administer the Oregon Nursing Assistant Competency Examination

HEADMASTER  
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Helena, MT 59602

8:00 am to 5:00 pm Pacific Time M-F  
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Online information and forms available at: [www.hdmaster.com](http://www.hdmaster.com)

- Candidate Handbook
- Regional Exam Site Schedules
- Verifying an Exam Date
- Rescheduling a Test Date
- Online Test Results
- Online Written NA Practice Tests

Call Headmaster at 800-393-8664 for questions about:

- Exam dates and locations
  - Test scheduling, rescheduling and cancellations
  - Accessing test results
- 

Oregon State Board of Nursing (OSBN)  
17938 SW Upper Boones Ferry Road  
Portland, OR 97224-7012

7:30 am to 4:00 pm Pacific Time M-F  
Phone: (971) 673-0685  
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Online information and services available at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN) :

- Obtaining a Nursing Assistant Application Packet
- Obtaining an ADA Accommodation Form for Testing
- Online License and Certificate Verification System
- Online Renewals for Licenses and Certificates
- A List of Currently Approved Educational Programs for Nursing Assistants

Call OSBN at (971) 673-0685 for information on how to :

- Reactivate CNA1 Certification
  - Update or change your address of record
  - Update or change your legal name
-

## Table of Contents

Introduction.....	2
Certification Process for CNA 1.....	3
Application to Obtain Oregon CNA1 Certification.....	3-4
Exam Fees.....	4
ADA Accommodations.....	4
Scheduling an Exam Date.....	4-5
Rescheduling an Exam Date.....	6
Verifying an Exam Date.....	6
Late Arrivals or Unable to Attend a Scheduled Exam Date.....	6-7
Cancelled Exam Dates.....	7
Exam Check-In (Identification) and Allowed Items.....	7-8
Exam Security.....	8
Testing Method.....	8
Paper or Online Written tests.....	9
The Knowledge (Written/Oral) Test.....	9
The Skill Test.....	10-20
Candidate Feedback – The Exit Survey.....	20
Exam Results.....	21
Retaking the Oregon Nursing Assistant Exam.....	21-22
Sample Questions.....	22
Written Practice test.....	23
Vocabulary List.....	23-27

## Introduction

In 1987, the Nursing Home Reform Act was adopted by Congress as part of the Omnibus Budget Reconciliation Act (OBRA '87). It was designed to improve the quality of care in long-term health care facilities and to define training and evaluation standards for nursing assistants who work in such facilities. Each state is responsible for following the terms of this federal law. As defined in the OBRA regulations, a nursing assistant competency evaluation program provides specific standards for nursing assistant related knowledge and skills. The purpose of a nursing assistant competency evaluation program is to ensure that candidates who are seeking to be nursing assistants understand these standards and can competently and safely perform the job of an entry-level nursing assistant. This handbook describes the process of taking the nursing assistant competency exam in Oregon and is designed to help prepare candidates for testing. There are two parts to the nursing assistant competency exam—a multiple-choice knowledge test and a manual skill test. Candidates must pass both parts of the exam and meet all requirements of the OSBN for certification in Oregon and to have his/her name placed on the Oregon Nursing Assistant Registry.

Oregon has approved HEADMASTER, LLP to provide the certification examination and scoring services for nursing assistant examinations. For questions not answered in this handbook, please contact HEADMASTER toll free at 800-393-8664 or go to [www.hdmaster.com](http://www.hdmaster.com). **This handbook should be kept for future reference.**

# **Certification Process for Oregon CNA1**

## **Nursing Assistant Level 1 Training Program Students**

Complete an Oregon State Board of Nursing (OSBN) approved nursing assistant level-1 training program and pass the competency examination within three attempts and within two years of completing the training. The required Oregon level-1 training program is a minimum of 75 hours of classroom and 75 hours of clinical training. The curriculum includes subjects mandated by the federal government and emphasizes care of the geriatric client/patient. The OSBN also has specified additional content relative to other age groups and settings. Students who successfully finish the required classroom and clinical requirements and pass a training program final examination with a grade of at least 75 percent receive a nursing assistant training program certificate of completion.

Completion of a nursing assistant training program does not imply state certification.

## **Nursing Assistants Previously Certified in Oregon**

If you have held an Oregon CNA certification in the past, please call the OSBN to confirm whether you are eligible to reactivate your Oregon CNA1 certification by taking the competency exam. Please call the OSBN at (971) 673-0685 to clarify whether reactivation by exam is the appropriate process for you at this time.

## **Military Corpsman or Medic Training**

Complete military corpsman or medic training with evidence of at least 400 hours of paid employment, in a nursing-related capacity in the two years immediately preceding application date, and pass the competency examination within three attempts and within two years of application to the OSBN.

## **Nursing Graduates from Outside the United States**

Graduates from a nursing program outside the United States must submit a transcript or other documentation, in English, to the OSBN documenting nursing education with the knowledge and skills necessary to perform CNA1 authorized duties. The OSBN shall determine eligibility to test from the documents submitted.

## **Application to Obtain Oregon CNA1 Certification**

Complete the Oregon State Board of Nursing (OSBN) Nursing Assistant application packet available online from the OSBN website, [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN), or use the one given to you by your nursing assistant training instructor. Send the completed application packet including your certificate of training completion along with the correct fees to the OSBN at the address shown at the top of the application. The name entered on your application must be your current legal name. The two forms of identification you will present at the exam site for admission must match the name entered on your application. Remember to use the same name on the application and all forms, type or print the information clearly, answer all questions, provide written explanations of all YES responses to the background questions, and sign and date the application. Double-check your application for accurate and complete

information before submission. If the application is not signed your application will be returned. Incomplete or illegible applications will delay processing.

Mail the following to the OSBN:

- Completed Fingerprinting Identity Verification Form
- Fingerprint card (Federal Form FD 258), if applicable
- Completed CNA1 Certification by Examination Application
- Training program certificate of completion
- Non-refundable fee for the CNA1 Certification by Examination application
- Non-refundable fee for the fingerprint-based criminal background check processing fee, if applicable

## Exam Fees

Initial Examination (written and skill tests).....	\$106
Reactivation by Examination (written and skill test).....	\$106
If requesting an Oral written Exam (tape recording)..... Additional...	\$ 35
Retake or Reschedule of both written and skill test .....	\$ 70
Retake or Reschedule of written test only .....	\$ 25
Retake or Reschedule of skill test only .....	\$ 45

All fees paid to the Oregon State Board of Nursing are non-refundable.

## Americans with Disabilities Act Compliance

If you have a qualified disability, you may request special accommodations for examination when you apply. Accommodations must be approved by OSBN in advance of examination. The request for ADA Accommodation Form is available on the OSBN website or by calling the OSBN. This form must be submitted with your application packet.

## Scheduling an Exam Date

First time exam candidates will be scheduled to take the written test and skill test on the same day at either an approved Oregon State Board of Nursing (OSBN) regional exam site or at an approved OSBN in-facility exam site.

Upon successful completion of all nursing assistant training requirements, you must choose an exam date. Give your exam date preference to your instructor.

Your exam date preference must be at least 21 days from the date you will mail your examination application packet to the OSBN. Approved exam dates can be obtained:

- from your instructor
- by visiting [www.hdmaster.com](http://www.hdmaster.com), to view the available examination dates in real time
- by calling Headmaster toll free at 800-393-8664 to have an exam schedule faxed, emailed, or mailed to you.

Choose your preferred exam date from the current online exam schedule. Please be sure your exam date preference is at least 21 days from the date you will mail your application packet to the OSBN.

In-facility exam dates are normally arranged by training program instructors. Check with your training program instructor to see if your training site has been approved for in-facility testing. If your training site is an approved in-facility examination site, your training program instructor will tell you the exam date that has been scheduled for you when you complete nursing assistant training.

## **PREFERRED EXAM DATE NOTIFICATION LETTER**

Once you have completed all your training program requirements and have requested an exam date that is at least 21 days from the day your application packet will be mailed to the Oregon State Board of Nursing (OSBN), your training program instructor will give you a nursing assistant training program certificate of completion along with a Preferred Exam Date Notification Letter.

Your Preferred Exam Date Notification Letter will include:

- your preferred exam date
- the exam time
- exam check-in requirements
- a personal identification number (a PIN you need to keep secure)
- examination expectations and
- instructions on how to confirm that your exam date is at the site and on the date you requested

In addition, your Preferred Exam Date Notification Letter will have directions for rescheduling your exam date online at [www.hdmaster.com](http://www.hdmaster.com) or by calling Headmaster at 800-393-8664.

## **EXAMINATION DATE CONFIRMATION LETTER**

You will receive an Examination Date Confirmation Letter from Headmaster by mail or email once you have been approved/released to test by the OSBN.

Your Examination Date Confirmation Letter will include:

- a map to your examination site (if it is a regional exam site)
- your confirmed exam date and time
- examination expectations and
- instructions for verifying your exam date online

If you misplace your Examination Date Confirmation Letter you may verify your exam date at [www.hdmaster.com](http://www.hdmaster.com) or if you need help with exam scheduling please call Headmaster at 800-393-8664. Your Examination Date Confirmation Letter is not required for exam admission, but it is recommended that you have it with you on your exam day.

A few days prior to the requested exam date, you are welcome to visit the Headmaster website at [www.hdmaster.com](http://www.hdmaster.com) and log on using your unique personal identification number (PIN) listed on your Preferred Exam Date Notification Letter. Keep your PIN secure and don't share it with anyone. Your PIN will also allow you to reschedule your exam date, online, if it becomes necessary.

## **Rescheduling an Exam Date**

If you must reschedule your exam date, please do so as soon as possible. You may reschedule an exam date up until three business days before your scheduled exam date by calling Headmaster at 800-393-8664. Business days are Monday through Friday excluding official holidays that fall on weekdays. For example, if you want to reschedule an 8:00 am exam on Monday (and Wednesday, Thursday and Friday aren't holidays) you must have an official reschedule confirmation before 8:00 am Pacific time on Wednesday. To reschedule a 1:00 pm Thursday exam you would need an official reschedule confirmation before 1:00 pm on Monday.

If you attempt to reschedule less than three business days before your requested exam date and time and/or don't show up to take your exam you will be considered a "No Show". You will receive a NO SHOW letter in the mail to complete and mail with correct payment to OSBN. You may reschedule a new exam date and receive official reschedule confirmation by using your pin at [www.hdmaster.com](http://www.hdmaster.com), or by calling Headmaster at 800-393-8664 during business hours.

You may reschedule online up until seven (7) days prior to your exam date. To reschedule online go to [www.hdmaster.com](http://www.hdmaster.com) and click on the "Oregon" button under the Nurse Aide header below the map of the USA then click on the "Reschedule" button under Candidate Forms in the far left-hand column. Complete the requested login information and click the "Submit" button. A current regional exam site schedule will appear. Click on the exam site location and date from the exam schedule drop down window then click the "Submit" button. A printable Preferred Exam Date Notification or Exam Date Confirmation Letter with your rescheduled exam location and date will display along with a new map if you are testing at a regional exam site.

## **Verifying an Exam Date**

You may view your scheduled exam date online at [www.hdmaster.com](http://www.hdmaster.com) by clicking on the link below the red "View your scheduled exam" bar at the top of the Headmaster home page. Complete the requested login information and click the "Submit" button. A printable copy of your examination date information will display with your scheduled exam site location, date, time and exam day information. You may also verify your exam date by calling Headmaster at 800-393-8664.

## **Late Arrivals or Unable to Attend a Scheduled Exam**

You should arrive at the exam site at least 20 to 30 minutes before your scheduled exam start time as indicated on your Examination Date Confirmation Letter. If you are not ready to test (checked-in) by your scheduled exam start time, you will not be allowed to test, will forfeit all exam fees, will have to submit new exam fees, and secure another exam date.

If circumstances beyond your control cause you to be late or prevent you from attending your scheduled exam, you may be allowed to schedule another exam date without having to repay exam fees. You must notify Headmaster no later than the next business day after the missed exam date by calling 800-393-8664 with the reason for your absence. Headmaster

will consider rescheduling your exam based on when Headmaster received initial notice (phone call within one business day) and a signed and dated, documented and verified written explanation of why the exam was missed. Copies of supporting documentation, such as doctor's notes, accident reports, funeral notices, military or court orders along with your explanation letter must be received within ten days of the missed exam date. If you do not provide sufficient notice (phone call within one business day from the missed exam date) and the requested written documentation (within ten days of your missed exam date), you will be considered a "No Show" and you will have to apply to OSBN for another exam date. To apply for new exam date, mail the top portion of your exam results letter, Headmaster Form 1301, along with the correct fees to OSBN. Then select an exam date online from the current regional exam schedule or call Headmaster at 800-393-8664 for assistance. You will receive an Examination Date Confirmation Letter by mail or email once you have been approved (released) to test by OSBN staff.

## Cancelled Exam Dates

If an exam date is cancelled due to weather or other unforeseen circumstances Headmaster staff will make every effort to contact you using the contact information we have on file to reschedule you, for no charge, to a mutually agreed upon new test date. You must, therefore, keep your contact information up to date in case we need to contact you. Call 800-393-8664 during regular business hours any time your contact information changes.

## Exam Check-In (Identification) and Allowed Items

Proper identification is required to test. If you do not bring the required identification with you on the day of your examination, you will not be allowed to test and your examination fees will not be refunded. **Two** forms of original (no photo copies), signature-bearing, current (not expired) proper identification are required to test. At least one of the signature IDs **must** contain your photograph.

The name on your two forms of identification must match the name on your nursing assistant application packet submitted to the OSBN. If you have had a legal name change since submitting your application packet, you must bring an official document proving your legal name has changed such as a marriage certificate or divorce decree.

Examples of accepted identification include a **current (not expired), signature and date bearing**

- Driver's license
- State issued identification card
- Passport
- Alien registration card
- Tribal identification card
- Social Security card
- Credit card or debit card
- 1<sup>st</sup> Aid or CPR card
- Hunting or fishing license
- High School ID for current year with a signature

**Note:** You must notify the OSBN whenever you have a name or address change.

You may **not test** if you have any type of temporary physical limitation that would prevent you from performing duties as a NA or hinder your test. (Examples: Cast, Brace, Crutches, sickness, etc.). Contact Headmaster at least three (3) business days prior to your scheduled test to reschedule a new test date.

It is strongly recommended that you have your Examination Date Confirmation Letter with you; however, it is **not** required for admission to test. Your Examination Date Confirmation Letter includes the exam site location, exam date and time and other important information regarding the examination process.

Bring at least two sharpened No. 2 pencils with good erasers if you are taking a written test at a paper exam site. Bring a watch with a second hand. Wear comfortable, appropriate, clothing and non-skid shoes to your examination. You may wear nursing assistant attire such as scrubs if you wish. You will not be allowed to test if you wear inappropriate or revealing clothing.

No other items may be in your possession during your written or skill test. This restriction includes but is not limited to electronic equipment, cell phones, backpacks, purses, notepaper, books, food or drink. Headmaster and examination sites are not responsible for your personal belongings.

Children, family members, friends and pets are not permitted in examination areas.

## **Exam Security**

If you refuse to follow directions, use abusive language or disrupt the examination environment, you will be dismissed from the exam site, your examination will not be scored, your fees will not be refunded and a report of your behavior will be given to the OSBN. You will not be allowed to retest without OSBN approval.

Anyone who record or tries to remove examination information or material from the exam site will be prosecuted to the full extent of the law. In addition, your exam will be documented as a failure. You will not be allowed to retest without written approval to test from the OSBN. If you give or receive help from anyone during the examination, the exam will be stopped, your exam will not be scored, you will be dismissed from the exam site, and you will forfeit any examination fees paid. You will have a failure status documented as the outcome of your test attempt and your actions will be reported to the OSBN.

## **Examination Method**

The time you are to report to the test site will be noted on your test confirmation letter. Please plan to arrive 20-30 minutes before your scheduled test start time for check in. (On occasion there may be an evening examination group or a modified test event.) You may be at the test site for up to eight hours, so please plan your day accordingly. Please call Headmaster at 800-393-8664, if you have questions.

After check-in and ID verification, the written test will be administered to candidates. After candidates finish the written test they will be assigned a time to take their skill test by the RN test observer. For skill retakes only, the RN test observer will notify you of your test time at check-in.

## Paper or Online Written Tests

Headmaster and OSBN approve exam sites for traditional written paper and pencil testing and/or for electronic testing called WebEtest© using Internet connected computers.

Testing online with WebEtest© allows real time scheduling into examination events and same day transmission of tests for official scoring, eliminating examination material shipping time so test results are available days sooner than with traditional paper and pencil testing.

## The Knowledge (Written/Oral) Test

The written/oral knowledge test is in English. No other language is approved by OSBN for examination. No translation dictionaries or devices are allowed during examination.

Each written/oral test is different. No candidates at a test event will have the same written/oral test.

The Written Test Proctor will hand out exam materials and will read the instructions for taking the written test. You will have a maximum of ninety (90) minutes to complete the 77 question written test. You will be told when fifteen (15) minutes are left. You may not ask questions about the content of the written test (such as "What does this question mean?") For traditional paper and pencil tests fill in only one (1) oval on the answer sheet for each question on a paper written test. **DO NOT** mark in the testing booklet. Marks in the test booklet will not be accepted as answers. Your answers must appear on the separate scan form answer sheet. You must have a score of 65% or better to pass the written portion of the test.

If you want to take the oral version of the written test, you must request it when you submit your application and pay the additional fee. An oral test Allow you to listen to a recording of the test questions through earphones connected to a cassette tape player or computer work station. In addition, you will have a printed copy of the test questions to read while listening to the recording or for WebEtest© exam sites you will see each question displayed on a computer screen while listening to the recording. You mark your answers using a pencil and paper onto a scanform or use a computer keyboard/mouse at WebEtest© exam sites. All paper test materials must be left in the examination room. Anyone who takes or tries to take materials or information from the examination room is subject to prosecution and will be reported to the OSBN.

The written test consists of 77 multiple-choice questions. Questions are selected from subject areas based on the approved Oregon Test Plan and include questions from all the required categories as defined in OBRA regulations. The subject areas and the number of questions from each subject area are as follows:

Safety (10)	Communication (6)
Infection Control (10)	Data Collection (4)
Personal Care (11)	Basic Nursing skills (11)
Mental Health (2)	Role and Responsibility (8)
Care Impaired (2)	Disease Process (3)
Client Rights (8)	Growth & Development across the Ages (2)

## The Skill Test

The purpose of the skill test is to evaluate your nursing assistant skills. Your training program has prepared you for all the skill tasks that you may be asked to demonstrate. Hand washing will always be the first task you will perform. Four (4) additional tasks will be randomly selected from the tasks your training program has prepared you to demonstrate. The steps that are listed in this handbook for each skill task are the *minimum* steps required for a nursing assistant to completely demonstrate the skill task. You must attain a score of 80% on each task without missing any key steps. Key steps have been determined by the OSBN Test Advisory Panel. If you fail a single skill task you will have to take a new skill test with a total of five tasks. At least one of the five tasks on a new skill test will be one that you previously failed.

### What To Expect During the Skill Test

- Each of your five assigned tasks will begin with the reading of a scenario. The scenario for each task will be read to you immediately before you demonstrate each task.
- When you finish each task, tell the RN test observer you are finished and move to the designated “relaxation area.” When the test observer and actor are set up and ready for your next skill task demonstration the test observer will read the scenario for the next task. This allows you to have a few seconds between each task to relax and take a deep breath before the test observer reads the next scenario to you.
- Listen carefully to all instructions given by the RN test observer. You may request to have any of the five scenarios repeated anytime during your skill test.
- Be sure you understand all instructions before you begin your skill test because you may not ask questions once the skill test begins.
- The RN test observer will show you where equipment is located and demonstrate the use of all the equipment you will need for your five skill tasks before starting your skill test.
- You will be allowed a maximum of forty-five (45) minutes to complete the five (5) skill tasks. You must correctly perform all five (5) skill tasks in order to pass the skill test. You will be alerted when fifteen (15) minutes remain for the completion time of your skill test.
- If you believe you made a mistake while performing any task, tell the RN test observer and then repeat the step(s) on the skill task you believe you performed incorrectly. You may repeat any skill step or steps you believe you have performed incorrectly at any time during your allotted 45 minutes or until you tell the RN test observer you are finished with the skill test (all five skill tasks.) Once the skill test begins, the RN test observer may not answer questions, but may re-read the scenario for you anytime, upon your request.

## **SKILL TASK LISTING**

### **1. Ambulation of a Client using a Gait Belt:**

- Knock on door. Wash hands. Explain procedure to be performed to the client.
- Obtain gait belt. Lock bed brakes to ensure client's safety.
- Lower bed so client's feet will be flat on the floor when sitting on the edge of the bed.
- Bring client to sitting position. Assist client to put on shoes.
- Place gait belt around waist. Tighten gait belt.
- Check gait belt by slipping fingers between gait belt and client.
- Stand in front of and face the client.
- Grasp the gait belt on each side of the client with an underhand grip.
- Stabilize the client's legs.
- Bring client to standing position, using proper body mechanics.
- Grasp gait belt with one hand, using under hand grip.
- Stabilize client with other hand by holding forearm, shoulder, or using other appropriate method to stabilize client.
- Ambulate the client and return client to chair.
- Assist client to sit in the chair in a controlled manner that insure safety.
- Remove gait belt. Leave client in position of comfort and safety.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

### **2. Ambulation of a Client with a Walker using a Gait Belt:**

- Knock on door. Wash hands. Explain procedure to client.
- Lock bed brakes to ensure client's safety.
- Lower bed so client's feet will be flat on the floor when sitting on the edge of the bed.
- Bring client to sitting position. Assist client in putting on shoes.
- Assist client to stand. Position walker in front of client.
- Insure client has stabilized walker.
- Position self behind and slightly to side of client.
- Instruct client on proper use of walker.
- Walk to the side a little behind the client.
- Safely ambulate client and return client to the chair.
- Assist client to sit in the chair in a controlled manner that insures safety.
- Remove gait belt. Use correct body mechanics at all times.
- Leave client in position of comfort and safety.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call bell or signal calling device within easy reach of the client.

### **3. Anti-Embolism Elastic Stockings (One Leg):**

- Knock on door. Wash hands. Explain procedure to client.
- Provide for client's privacy by only exposing the (right/left) leg.
- Roll, Gather or Turn stocking down inside out at least to the heel.
- Place stocking over the toes, foot, and heel. Roll or pull stocking up leg.
- Check toes for possible pressure from stocking and adjust as needed.

- Leave client with a stocking that is smooth and wrinkle free.
- Leave client with a stocking that is properly placed. Cover exposed leg.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **4. Assisting a Client to Use a Bedpan:**

- Knock on door. Wash hands. Explain the procedure to the client.
- Provide privacy - pull curtain. Position client on bedpan correctly.
- After placing bedpan, raise head of bed to comfortable level.
- Leave tissue within reach of client. Leave call light within reach of client
- Leave room until called. Put on gloves.
- Gently remove bedpan. Measure output using a graduate.
- Empty graduate into toilet, rinse receptacles and empty rinse water into toilet.
- Remove and dispose of gloves. Wash/Assist client to wash and dry hands.
- Lower bed, if it was raised. Record output on recording sheet.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **5. Assisting a Dependent Client with a Meal:**

- Knock on door. Wash hands. Explain procedure to the client.
- Look at diet card to check that the client has received the correct tray.
- Position the client in an upright position, at least 45 degrees.
- Protect clothing from soiling by using napkin, clothing protector, or towel.
- Wash and dry client's hands before feeding.
- Sit down facing the client while feeding the client or assume other posture so candidate is at eye level with the client.
- Describe the foods being offered to the client. Offer fluid frequently.
- Offer small amounts of food at a reasonable rate.
- Allow client time to chew and swallow.
- Wipe client's hands and face during meal as needed.
- Leave client clean and in a position of comfort. Place soiled linen in hamper.
- Record intake of total solid food eaten as a percentage on I/O pad.
- Record fluid intake in cc/ml on I/O pad.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **6. Bed Bath (Partial - Face, Arm, Hand and Underarm):**

- Knock on door. Wash hands. Explain procedure to the client. Pull privacy curtain.
- Raise bed to appropriate working level. Cover client with a bath blanket or sheet.
- Remove remaining top bed cover. Fold bed cover to bottom of bed or place aside.
- Remove client's gown without exposing client.
- Fill basin with comfortably warm water. Wash face. Dry face.
- Place towel under arm, exposing one arm.
- Using soap: wash arm, hand, and underarm.
- Rinse arm, hand, and underarm. Dry arm, hand, and underarm.
- Assist client to put on a clean gown. Rinse basin. Store basin.
- Dispose of soiled linen in appropriate container. Lower bed if it was raised.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **7. Catheter Care:**

- Knock on door. Wash hands. Explain procedure to client.
- Provide for privacy - pull curtain.
- Put on gloves. Position a bath blanket to maintain privacy.
- Check to see that urine can flow, unrestricted, into the drainage bag
- Use soap and water to carefully wash around the drainage tube where it exits the urethra.
- Hold catheter near the urethra to prevent tugging on catheter.
- Clean 3-4 inches from the urethra down the drainage tube.
- Clean with strokes only away from the urethra.
- Use clean portion of cloth for each stroke. Rinse using strokes only away from the urethra.
- Rinse using clean portion of cloth for each stroke. Pat dry with a clean towel.
- Do not allow the tube to be pulled at any time during the procedure.
- Remove gloves turning inside out. Dispose of gloves.
- Replace top cover over client. Remove bath blanket.
- Leave client in a position of safety and comfort.
- Maintain respectful, courteous interpersonal interactions.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **8. Denture Care of a Dependent Client:**

- Knock on door. Wash hands. Explain procedure to client.
- Line sink (cloth towel or washcloth – No paper towel allowed) with a protective lining or fill with water to prevent damage to the dentures in case they are dropped.
- Put on gloves. Carefully remove dentures from cup.
- Handle dentures carefully to avoid damage. Apply toothpaste to toothbrush.
- Thoroughly brush dentures, including the inner, outer, and chewing surfaces of upper and/or lower dentures.
- Rinse dentures using clean cool running water.
- Rinse cup. Place dentures in rinsed cup.
- Add cool clean water to denture cup. Rinse equipment and return to storage.
- Discard sink's protective lining in an appropriate container, or drain sink.
- Remove gloves turning inside out as they are removed.
- Dispose of gloves in an appropriate container.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **9. Undressing and Dressing a Client:**

- Knock on door. Wash hands. Explain the procedure to the client.
- Provide privacy - pull curtain. Keep client covered while removing gown.
- Remove gown from unaffected side first. Place used gown in laundry hamper.
- During the next two steps, always dress client beginning with the weak side first.
- When dressing the client in a shirt/blouse, insert your hand through the sleeve of the shirt/blouse and grasp the hand of the client.
- When dressing the client in sweat pants assist the client to raise his/her buttocks or rock client side to side and draw the pants over the buttocks and up to the client's waist.
- When putting on the client's socks, draw the socks up the client's foot until they are smooth.

- Leave the client comfortably and properly dressed.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **10. Fingernail Care (One Hand):**

- Knock on door. Wash hands. Explain procedure to the client.
- Immerse nails in comfortably warm water.
- Soak nails for at least five (5) minutes. Dry hand thoroughly.
- Specifically dry between fingers. Gently clean under nails with orange stick.
- Gently push cuticle back with a towel/washcloth or orange stick.
- File each fingernail. Rinse equipment. Return equipment to storage.
- Discard soiled linen in linen hamper or equivalent.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **11. Foot Care (One Foot):**

- Knock on door. Wash hands. Explain procedure to the client.
- Fill foot basin with comfortably warm water. Remove socks.
- Immerse foot in comfortably warm water for 5 to 20 minutes.
- Use water and soapy washcloth. Wash entire foot. Wash between toes.
- Rinse entire foot. Rinse between toes.
- Dry foot thoroughly, being careful to dry between toes.
- Warm lotion by rubbing it between hands. Massage lotion over entire foot.
- If any excess lotion, wipe with a towel. Replace sock on foot.
- Rinse basin. Return basin to storage area.
- Place dirty linen in hamper or equivalent.
- Maintain respectful, courteous interpersonal interactions.
- Leave client in position of safety in proper alignment in the chair.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **12. Hand Washing:**

- Knock on door. Introduce self to the client. Turn on water.
- Thoroughly wet hands. Apply liquid soap to hands.
- Rub hands together for 20 seconds using friction.
- Using friction, rub interlaced fingers together while pointing downward.
- Clean under finger nails. Wash all surfaces of hands and wrist with liquid soap.
- Rinse hands thoroughly under running water with fingers pointed downward.
- Dry hands on clean paper towel(s).
- Turn off faucet with a SECOND (last) clean dry paper towel, or with a dry section of a previously used paper towel.
- Discard paper towels to trash container as used.
- Do not recontaminate hands at any time during the procedure.

#### **13. Making an Occupied Bed:**

- Knock on door. Wash hands. Gather linen. Transport linen away from body.
- Place clean linen on a clean surface. (Bedside stand, chair, or overbed table)
- Explain procedure to client. Provide privacy.
- Raise bed to working height. Client is to remain covered at all times.

- Assist client to roll onto side.
- Roll or fan fold soiled linen, soiled side inside, to the center of the bed.
- Place clean bottom sheet on mattress. Secure two fitted corners.
- Roll or fan fold clean linen against client's back.
- Assist the client to roll over the bottom linen, preventing trauma and avoidable pain to client.
- Remove soiled linen without shaking. Avoid touching linen to uniform.
- Dispose of soiled linen in hamper or equivalent.
- Pull through and smooth out the clean bottom linen.
- Secure the other two fitted corners. Place clean top linen over covered client.
- Place clean blanket or bed spread over covered client.
- Remove used top linen keeping client unexposed at all times.
- Tuck in clean top linen at the foot of bed, while providing room for feet to move.
- Tuck in clean blanket or bedspread at the foot of bed, while providing room or feet to move.
- Apply clean pillowcase without contaminating linen and clothing.
- Gently lift client's head while replacing the pillow. Lower bed if it was raised.
- Return side rails to lowered position, if side rails were used.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

#### **14. Making an Unoccupied Bed:**

- Knock on door. Wash hands. Gather clean linen.
- Transport clean linen away from body.
- Place clean linen on a clean surface. (bedside stand, chair, or overbed table)
- Elevate bed to appropriate working height.
- Remove soiled linen from bed without contaminating uniform.
- Place removed linen in laundry hamper.
- Apply bottom fitted sheet, keeping it straight and centered.
- Make bottom linen smooth and/or tight, free of wrinkles.
- Place clean top linen and blanket or bed spread on the bed.
- Tuck in top linen and blanket or bedspread at the foot of the bed.
- Make mitered corners at the foot of the bed.
- Apply clean pillowcase without contaminating linen and clothing.
- Leave bed completely and neatly made.
- Return bed to lowest position if it was raised. Wash hands.

#### **15. Measure and Record Oral Fluid Intake at Mealtime:**

- Knock on door. Wash hands. Explain procedure to the client.
- Observe dinner tray.
- Use paper, pencil, and/or mental computation calculate grand total cc or ml consumed from three different glasses.
- Record the total cc or ml of fluid consumed.
- Maintain respectful, courteous interpersonal interactions.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **16. Measure and Record Output from a Urinary Drainage Bag:**

- Knock on door. Wash hands. Explain procedure to client. Provide for privacy.
- Put on gloves. Place a barrier on the floor under the drainage bag.
- Place the graduate on the previously placed barrier.
- Open the drain to allow the urine to flow into the graduate.
- Avoid touching the graduate with the tip of the tubing.
- Close the drain. Wipe the drain with antiseptic wipe.
- Replace drain in holder. With graduate at eye level, measure output.
- Record the output in cc/ml. Empty graduate into toilet. Empty rinse water in toilet.
- Return equipment to storage. Turn gloves inside out as they are removed.
- Dispose of gloves. Leave client in a position of safety and comfort.
- Maintain respectful, courteous interpersonal interactions.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **17. Mouth Care:**

- Knock on door. Wash hands. Explain procedure to the client.
- Provide for client's privacy. Drape the chest with towel to prevent soiling.
- Put on gloves. Apply toothpaste to toothbrush/toothette.
- Brush all inner, outer, and chewing surfaces of all upper and lower teeth.
- Clean tongue. Clean gums.
- Assist client in rinsing mouth. Wipe/dry client's mouth.
- Remove soiled linen. Place soiled linen in hamper or equivalent.
- Empty emesis basin. Rinse emesis basin.
- Rinse toothbrush or dispose of toothette.
- Return emesis basin and toothbrush to storage.
- Turn gloves inside out as they are removed.
- Dispose of gloves without contaminating self.
- Leave client in position of comfort and safety.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **18. Mouth Care for a Comatose Client:**

- Knock on door. Introduce self. Wash hands. Provide privacy - pull curtain.
- Turn client to a side lying position to avoid choking or aspiration.
- Drape as needed to protect from soiling.
- Put on gloves. Use toothettes dipped in water.
- Gently and thoroughly clean the inner, outer, and chewing surfaces of all upper and lower teeth.
- Gently and thoroughly clean the gums and tongue.
- Clean, dry face. Return client to position of comfort and safety.
- Rinse equipment. Replace equipment.
- Discard disposable items in waste can. Discard towel and washcloth in linen hamper.
- Remove gloves, turning inside out as they are removed.
- Dispose of gloves properly. Wash hands.

## **19. Perineal Care:**

- Knock on door. Wash hands. Explain procedure to the client (mannequin)
- Provide privacy - pull curtain. Raise the bed to an appropriate working height.
- Fill basin with comfortably warm water. Put on gloves.
- Turn client or raise hips and place water proof pad under buttocks.

- Make sure client is comfortably positioned on back on water proof pad.
- Cover client with bath blanket. Expose perineum only.
- Separate labia. Use water and soapy washcloth.
- Clean one side of labia from top to bottom.
- Use a clean portion of a wash cloth with each stroke for each step.
- Clean other side of labia from top to bottom.
- Clean the vaginal area from top to bottom, rinse the area from top to bottom, pat dry.
- Cover the exposed area with the bath blanket or clean sheet.
- Assist client to turn onto side away from self.
- With a clean portion of wash cloth, clean the rectal area.
- Use water, washcloth and soap. Clean rectal area from front to back with single strokes.
- Rinse area from front to back. Dry area. Position client (mannequin) on her back.
- Turn client or raise hips to remove water proof pad from under buttocks.
- Replace top cover over client, remove bath blanket.
- Dispose of soiled linen in an appropriate container
- Rinse basin, return basin to storage. Turn gloves inside out as they are removed.
- Dispose of gloves in appropriate container. Lower bed, if it was raised.
- Wash hands. Place call light or signaling device within reach of client.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **20. Position Client on Side in Bed:**

- Knock on door.
- Wash hands. Explain procedure to client. Provide privacy - pull curtain.
- Position bed flat. Raise bed to proper working level.
- Insure that the client's face never becomes obstructed by the pillow.
- From the working side of bed - move upper body toward self.
- Move hips toward self. Move legs toward self.
- Assist/turn client onto side.
- Check to be sure client is not lying on his/her arm.
- Maintain client's correct body alignment.
- Place support devices under the client's head and upper arm, behind back, and between knees.
- Lower bed, if it was raised. Lower side rail, if it was used.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **21. Putting on and Removing Gown and Gloves:**

- Wash hands or use hand sanitizer.
- Face the back opening of the gown. Don't shake gown during unfolding
- Place arms through each sleeve. Secure the neck opening
- Secure the waist, making sure that the back flaps completely cover clothing
- Put on gloves. Gloves overlap gown sleeves at the wrist.
- Remove gloves before removing gown
- Remove gloves turning inside out and folding one glove inside the other.
- Do not touch outside of gloves with bare hand at any time
- Dispose of the gloves, without contaminating self, in appropriate container
- Unfasten gown at the neck. Unfasten gown at the waist.
- Remove gown by folding soiled area to soiled area
- Dispose of gown in an appropriate container. Wash hands

## **22. Range of Motion (ROM) Lower Extremities (Hip and Knee):**

- Knock on door. Wash hands.
- Explain procedure to the client. Provide privacy - pull curtain.
- Position client supine. Position client in good body alignment.
- Correctly support joints by placing one hand under the knee and the other hand under the ankle of the leg.
- Move the entire leg away from the body. (abduction)
- Move the entire leg toward the body. (adduction)
- Complete abduction and adduction of the hip at least three times.
- Continue to correctly support joints by placing one hand under the client's knee and the other hand under the client's ankle.
- Bend the client's knee and hip toward the client's trunk. (flexion of hip and knee at the same time - may also do separately)
- Straighten the knee and hip. (extension of knee and hip at the same time - may also do separately)
- Complete flexion and extension of the knee and hip at least three times.
- Ask if causing any discomfort or pain sometime during ROM procedure.
- Do not force any joint beyond the point of free movement.
- Leave client in a comfortable position.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **23. Range of Motion (ROM) Upper Extremities (One Shoulder):**

- Knock on door. Wash hands.
- Explain procedure to the client. Provide privacy - pull curtain.
- Position client on back. Position client in good body alignment.
- Correctly support client's joint by placing one hand under the elbow and the other hand under the client's wrist.
- Raise the client's arm up and over the client's head. (flexion)
- Bring the client's arm back down to the client's side. (extension)
- Complete flexion and extension of shoulder at least three times.
- Ask client if s(he) has any pain. Continue same support for shoulder joint.
- Move the client's entire arm out away from the body. (abduction)
- Return arm to side of the client's body. (adduction)
- Complete abduction and adduction of the shoulder three times.
- Ask if causing any discomfort or pain sometime during ROM procedure.
- Do not force any joint beyond the point of free movement.
- Leave client in a comfortable position.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## **24. Taking & Recording Oral Temperature, Radial Pulse, and Respirations:**

- Knock on door. Wash hands. Explain procedure to client.
- Put sheath on thermometer probe. Correctly turn on digital oral thermometer.
- Gently insert bulb end of thermometer in mouth-under tongue.
- Tell client to hold thermometer in place with lips closed.
- Leave thermometer in place until it beeps. Remove thermometer. Dispose of sheath.
- Read and record the temperature on the recording sheet.
- Wipe the thermometer clean with alcohol pad or discard sheath appropriately.
- Locate the radial pulse by placing tips of fingers on thumb side of the client's wrist.

- Count pulse for 60 seconds. Record reading on the recording sheet
- Count respirations for 60 seconds. Record count on recording sheet.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

### **25. Taking & Recording a Radial Pulse & Respirations:**

- Knock on door. Wash hands. Explain procedure to client. Provide for client's privacy.
- Locate the radial pulse by placing tips of fingers on the thumb side of the client's wrist.
- Count pulse for 60 seconds. Record count on the recording sheet.
- Count respirations for 60 seconds. Record count on the recording sheet.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

### **26. Taking & Recording Blood Pressure (One-Step Procedure):**

- Knock on door. Wash hands. Explain procedure to client.
- Provide privacy - pull curtain.
- Position client with forearm relaxed and supported in a palm-up position, approximately at the level of the heart.
- Roll client's sleeve up about 5 inches above the elbow.
- Apply the appropriate size cuff around the upper arm just above the elbow.
- Correctly align cuff over brachial artery.
- Clean earpieces of stethoscope appropriately and place in ears. Clean diaphragm.
- Locate brachial artery with fingertips. Place stethoscope over brachial artery.
- Hold stethoscope snugly in place. Inflate cuff to 160-180 mm Hg.
- Slowly release air from cuff to disappearance of pulsations. Remove cuff.
- Record blood pressure reading on recording sheet.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

### **27. Transfer from Bed to Wheelchair:**

- Knock on door. Wash hands. Explain procedure to client.
- Lower bed to same level as wheelchair seat.
- Insure client safety by locking wheels on bed.
- Position wheelchair at foot or head of bed with arm of wheelchair almost touching the bed.
- Lock wheelchair brakes. Insure bed is same level as wheelchair seat.
- Bring client to a sitting position using proper body mechanics.
- Apply transfer belt around client's waist.
- Check transfer belt for fit by sliding fingers under belt to determine if it is snug but not too tight.
- Assist client in putting on shoes.
- Bring client to standing position using proper body mechanics.
- Transfer client from bed to wheelchair by assisting client to pivot and sit in a controlled manner that ensures safety.
- Remove transfer belt. Leave client in a position of safety & comfort.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## 28. Transfer from Wheelchair to Bed:

- Knock on door. Wash hands. Explain procedure to client.
- Position wheelchair at foot or head of bed with arm of the wheelchair almost touching the bed.
- Lock wheelchair brakes. Lock bed brakes.
- Insure bed is same level as wheelchair seat. Place gait belt around waist.
- Check gait belt for fit by sliding fingers under belt to determine if it is snug but not too tight.
- Insure client's feet are flat on the floor.
- Instruct client to place hands on wheelchair arm rests. Use legs to stabilize client.
- Assist client to standing position, using an underhand grip on gait belt.
- Assist client to standing position using proper body mechanics.
- Assist client to pivot and sit on bed in a controlled manner that ensures safety.
- Remove gait belt. Remove client's shoes. Assist client to lie down in center of bed.
- Make sure client is comfortable and in good body alignment.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

## Skill Tasks with Recording

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

_____	
CANDIDATE PRINTED NAME	
TEMPERATURE _____	
PULSE _____	RESP _____
WEIGHT _____	
INTAKE _____ % and _____ cc/ml	
OUTPUT _____ cc/ml	BP _____ / _____
CONTAINER #1 _____	
CONTAINER #2 _____	
CONTAINER #3 _____	
TOTAL CONSUMED _____	
_____	
CANDIDATE SIGNATURE	
ONLY ONE SHEET PER STUDENT	

## Candidate Feedback – Exit Survey

Candidates are provided an exit survey after they finish testing. The survey is confidential and will not have any bearing on the outcome of any test. You are encouraged to complete the survey questions regarding the examination process to help improve the process.

## Exam Results

After you have completed both the written test and skill test components and your exam has been officially scored and double-checked in Headmaster's Helena, Montana, office by an official scoring team, Headmaster will send your notification of test results to you by mail or you may securely access your results at [www.hdmaster.com](http://www.hdmaster.com). The OSBN will also receive the results for state record, however, Headmaster and the OSBN cannot release results over the phone. Traditional paper and pencil exam results are normally available online at [www.hdmaster.com](http://www.hdmaster.com) three business days after 6:00 p.m. Mountain time (excluding Saturdays, Sundays and Holidays) after your exam date has passed. WebETest© exam results are normally available online one business day (excluding Saturdays, Sundays and Holidays) after 6:00 p.m. Mountain time after your exam date.

Due to security and confidentiality requirements, test results can not be given out over the telephone. You must wait to receive them in the mail or access them on-line with information known only to you.

When you pass your exam, you may be certified and listed on the Oregon Nursing Assistant Registry **ONLY AFTER** you meet all Board requirements as noted in the CNA1 Certification by Examination Information publication available from the OSBN website. Notice **one** of those requirements includes passing **both** the written and skill test components of the Oregon nursing assistant examination.

If you fail a test component and wish to retake the test(s) that you failed, you must send the top portion of your test results letter marked with the appropriate failed test(s) requested and appropriate retake fee(s) to OSBN. Procedures for retaking the test and detailed test diagnostics are included in any "failed" result letter (Headmaster Form 1301) mailed to your address of record or securely accessed and printed from the web. Passed and failed result letters are posted online the day tests are scored by Headmaster. To check for your test results, visit [www.hdmaster.com](http://www.hdmaster.com), click the "Oregon" button and then click the "On-line Test Results" button under the Candidate Forms column.

You have three attempts to pass the written and skill test portions of the exam within two years from your date of nursing assistant training program completion. If you fail three times, or do not complete testing within two years from completion of training, you must complete a new OSBN approved training program in order to become eligible to further attempt Oregon CNA1 examinations.

## Retaking the Oregon Nursing Assistant Exam

- You will receive a test results letter after your test is officially scored and double-checked by Headmaster. Headmaster sends your notification of test results by mail or you may securely access your results at [www.hdmaster.com](http://www.hdmaster.com).
- A copy of your test results letter can be securely accessed and printed from [www.hdmaster.com](http://www.hdmaster.com) any time after your test has been officially scored.
- When your test results letter informs you that you failed the written and/or skill portion of the examination then when you want to apply for a retest:
  1. Check the box for written or skill or both. Check the oral written test, if desired
  2. Select and include the correct non-refundable fee payment

3. Mail a copy of your test results letter (Headmaster Form 1301) with the correct non-refundable fee to the OSBN. This will be your application to retest.
  4. Request/choose a re-test date that is at least 14 days from the day you mail a copy of your retest application to the OSBN, go to [www.hdmaster.com](http://www.hdmaster.com) or call 800-393-8664 during business hours and ask HEADMASTER to schedule you into a new exam date and site of your choice. Your instructor may also want to schedule you into an exam slot at the next in-facility exam date associated with the facility where you trained.
- If you lose your failure letter (Headmaster Form 1301), you can go online and print another copy.
  - Headmaster will be happy to schedule you over the telephone for your retest, or you may schedule online. You must have mailed the top portion of your test results letter (Headmaster Form 1301) to the OSBN prior to calling Headmaster or going online to schedule a new exam date. The exam date you scheduled must be at least 14 days after you will mail your test results letter to the OSBN.
  - OSBN staff must receive your retest application and non-refundable retake fee in order to make you eligible to test again. Be sure to visit the Headmaster website at [www.hdmaster.com](http://www.hdmaster.com) and log on with your PIN a few days before your new exam date arrives to verify that the OSBN has authorized (released) you to retest.

## Sample Questions

The following questions are samples of the kinds of questions that you will find on the written/oral test. Check your answers to these questions using the answer box below.

**1. Clean linens that touch the floor should be:**

- (A) Picked up quickly and placed back on the clean linen cart
- (B) Used immediately on the next client bed
- (C) Considered dirty and placed in the soiled linen hamper
- (D) Used only in the room with the floor the linen fell on

**2. A soft, synthetic fleece pad placed beneath the client:**

- (A) Takes pressure off the back
- (B) Provide warmth for the client
- (C) Gives the client a sense of security
- (D) Should only be used with bedridden clients

**3. A client's psychological needs:**

- (A) Should be given minor consideration
- (B) Make the client withdrawn and secretive
- (C) Are nurtured by doing everything for the client
- (D) Are nurtured when clients are treated like individuals

Answers: 1C – 2A – 3D

## Written Practice Test

Headmaster Offer a free, ten question written practice test at [www.hdmaster.com](http://www.hdmaster.com). In addition, a free written test question of the day, which changes every day, is available on the website. Candidates and training programs may also purchase complete practice tests online that are randomly generated, based on the Oregon state test plan. Each practice test taken will be unique. A mastery learning testing method is used. This means candidates must get the question they are attempting correct before they may move on to the next question. A first attempt percentage score and vocabulary feedback are supplied upon completion of each practice test. A printable list of vocabulary words to study, based on the questions missed, is provided at the end of each test. Single or group purchase plans are available. Practice test questions may or may not be current to the curriculum in your state. Visit [www.hdmaster.com](http://www.hdmaster.com) for more details.

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### VOCABULARY

#### LIST:

abandonment  
abdominal thrusts  
abduction  
abduction pillow  
abnormal vital signs  
absorption  
abuse  
acceptance  
accidents  
activities  
activity  
acute  
adaptive devices  
adduction  
ADL's  
admission  
admitting client  
affected side  
aging process  
agitation  
alternating pressure mattress  
alternative therapy  
Alzheimer's disease  
Alzheimer's  
environment  
ambulate with assistance  
ambulation  
ambulatory client  
amputees  
anemia

anger  
angina pectoris  
anorexia  
anterior  
antibacterial  
antibiotics  
antiembolus stockings  
anxiety  
aphasia  
apical  
appropriate response  
arteries  
arthritis  
artificial eye  
aseptic  
aspiration  
assistive device  
atherosclerosis  
atrophy  
attitudes  
autism  
axillary temperature  
back strain  
bacteria  
bargaining  
basic human needs  
basic needs  
basic skin care  
bath water temperature  
bathing  
bed bath  
bed cradle  
bed height

bed making  
bed position  
bedfast  
bedpan  
bedrest  
behavior modification  
behavioral care plan  
BID  
biohazard bag  
biohazards  
bladder training  
bleeding  
blindness  
blood pressure  
body alignment  
body fluids  
body language  
body mechanics  
bone loss  
bowel and bladder programs  
bowel movements  
bowel program  
breathing  
brittle bones  
broken equipment  
burnout  
call bell  
call light  
cancer  
cane  
cardiac arrest  
cardiopulmonary resuscitation  
cardiovascular system

care impaired  
care plan  
caring for blind clients  
cast  
cataracts  
catheter care  
cc in an ounce  
central nervous system  
cerebral vascular accident  
charge nurse  
chemical disinfectants  
chemotherapy  
chest pain  
choking  
chronic  
circulation  
circulatory system  
clarification  
cleaning equipment  
cleaning spills  
cleaning stoma  
clear liquid diet  
cold compress  
colostomy  
combative client  
comfort care  
communicable  
communication  
communication with  
    depressed client  
compensation  
competency evaluation  
    program  
compressions  
confidential information  
confidentiality  
confused client  
congestive heart failure  
constipation  
constrict  
contact isolation  
contamination  
contracture  
converting measure  
COPD  
coughing excessively  
CPR  
cross contamination  
cueing  
CVA  
cyanosis

cyanotic  
death and dying  
decubitus ulcer  
deeper tissue  
dehydration  
delusions  
demanding client  
dementia communication  
denial  
denture care  
dentures  
depression  
developmental disability  
diabetes  
diabetic  
dialysis  
diarrhea  
diastolic  
diet  
dietitian  
difficulty talking  
digestion  
digestive system  
discharging client  
disease  
disinfectants  
disinfection  
disoriented client  
disposing of  
    contaminated materials  
disrespectful treatment  
dizziness  
DNR  
documentation  
dressing  
droplet precautions  
drowsy  
dry skin  
dying  
dysphagia  
dyspnea  
dysuria  
edema  
ego-integrity  
elastic stockings  
electrical equipment  
elevate head  
elevating bed  
elimination of wastes  
emesis basin  
emotional lability

emotional needs  
emotional stress  
emotional support  
empathetic  
emphysema  
endocrine system  
enema  
enteral nutrition  
epithelial tissue  
ethical code  
exercise  
extension  
extremity  
eye glasses  
falls  
fecal impaction  
feeding  
feeding tube  
financial abuse  
fire safety  
flatus  
flexed  
flexion  
fluid intake  
Foley catheter  
foot board  
foot care  
foot drop  
Fowler's position  
fracture pan  
fractures  
fraud  
free from disease  
frequent urination  
gait belt  
gastic feedings  
gastrostomy tube  
genetic disease  
geriatrics  
gerontology  
gestures  
glass thermometer  
gloves  
grand mal seizure  
grieving process  
guardian  
hair care  
hallucination  
hand care  
hand tremors  
hand washing

hazardous substances  
health-care team  
hearing aid  
hearing impaired  
hearing loss  
heart attack  
heart muscle  
height  
helping clients  
hemiplegia  
hepatitis A  
hepatitis B  
hereditary  
hip prosthesis  
HIPAA  
HIV  
hospice care  
hydration  
hyperglycemia  
hypertension  
hyperventilation  
hypoglycemia  
ice bag  
identifying clients  
ileostomy  
immobility  
immune system  
impairment  
incident report  
incontinence  
indwelling catheter  
infection  
infection control  
in-house transfer  
initial observations  
input and output  
in-service programs  
insulin  
intake and output  
integumentary system  
interpersonal skills  
intravenous therapy  
isolation  
IV care  
jaundice  
job application  
job description  
kidney failure  
laxatives  
libel  
life support

lift/draw sheet  
linen  
liquid diet  
listening  
living will  
log rolling  
low sodium diet  
macular degeneration  
making occupied bed  
manipulative behavior  
mask  
Maslow  
material safety data sheet  
measuring height  
measuring temperature  
mechanical soft diet  
medical record  
medications  
memory loss  
menopause  
mentally impaired  
microorganisms  
military time  
minerals  
mistreatment  
money  
morning care  
mouth care  
moving a client  
mucous membrane  
multiple sclerosis  
muscle spasms  
musculoskeletal system  
myocardial infarction  
nail care  
nasal cannula  
nausea  
needles  
neglect  
new client  
non-contagious disease  
nonverbal  
communication  
nosocomial infection  
NPO  
nursing assistant's role  
nutrition  
objective  
OBRA  
observation  
occupied bed

ombudsman  
open bed  
oral care  
oral hygiene  
oral temperature  
orientation  
oriented  
orthotic device  
osteoarthritis  
osteoporosis  
ostomy bag  
overbed table  
oxygen administration  
pain  
paralysis  
paranoia  
paraphrasing  
parenteral nutrition  
Parkinson's disease  
partial assistance  
partial bath  
passive  
pathogens  
pathologic process  
patience  
perineal care  
peripheral vascular disease  
peristalsis  
personal belongings  
personal care  
personal choice  
personal protective  
equipment  
personal stress  
pet therapy  
petit mal seizure  
phantom pain  
phone etiquette  
physical change  
physical needs  
physician's authority  
pill-rolling  
plaque  
plate rim  
pleura  
podiatrist  
positioning client  
post mortem care  
post-operative  
pneumonia  
post-surgical care

postural hypotension  
pressure sore  
pressure ulcer  
preventing falls  
preventing injury  
prioritizing  
privacy  
PRN  
progressive illness  
projection  
prone  
prosthesis  
protective equipment  
providing privacy  
psychological needs  
psychosis  
pulmonary disease  
pulse  
quadriplegia  
RACE (acronym)  
radial  
ramps  
range of motion  
rationalization  
reality orientation  
rectal  
reddened/discolored area  
rehabilitation  
religious service  
reminiscing  
reporting observations  
reposition client  
client abuse  
client belongings  
client centered care  
client identification  
client independence  
client information  
client pain  
client rights  
client treatment  
client trust  
client unit  
Client's Bill of Rights  
client's chart  
client's environment  
client's families  
respectful treatment  
respirations  
respiratory condition  
respiratory symptoms

respiratory system  
responding to client behavior  
responsibilities  
restorative care  
restorative dressing  
restorative program  
restraints  
resuscitation  
right to refuse care  
rigidity  
safety and security need  
safety procedures  
scabies  
scale  
secretions  
security  
seizure  
self-actualization  
self-esteem  
semi-prone position  
sensory system  
sexual advances  
sexual harassment  
sexual inappropriateness  
sexual needs  
shampoo tray  
sharing information  
sharps container  
shaving client  
shearing of skin  
shock  
side rails  
simple fracture  
Sims position  
skin integrity  
slander  
sleep  
smoking  
social needs  
social well being  
social worker  
soiled linen  
specimen  
spiritual needs  
sputum test  
stages of grief  
stages of pressure ulcers  
standard precautions  
stealing  
sterilization  
stool specimen

stress  
stroke  
strong side  
subjective  
suicide  
sundowning  
supine  
supplemental feedings  
swelling  
systolic  
tachycardia  
TED hose  
telephone etiquette  
temperature  
tendons  
terminal illness  
thickened liquids  
TIA  
tips  
toileting schedule  
trachea  
tracheostomy  
Transfer  
transport bag  
transporting food  
treating clients with respect  
tub bath  
tube feeding  
tuberculosis  
twice daily  
tympanic temperatures  
unaffected side  
unconscious client  
unethical behavior  
uniform  
unsteady  
urethral  
urinary catheter bag  
urinary problems  
urinary system  
urination  
urine  
urine filter  
urine specimen  
validation therapy  
varicose veins  
vision changes  
visual changes  
visually impaired  
vital signs  
vitamins

vomitus  
walker  
wandering client  
warm and cold applications  
warm application  
water faucets  
water intake  
water temperature  
waterless hand soap  
weak side  
weighing client  
weight  
well balanced meal  
well-being  
wheelchair safety  
white blood cells  
withdrawn client