D&SDT-Headmaster, LLP

Ohio STNA Mock Skills

Effective September, 2019 | Updated: June 1, 2020

The following errors were found from the 5/1/2020 version and corrected:

Hand Washing: Key step of "Do not recontaminate hands at any time during the procedure" was not bolded and has been fixed.

Emptying a Urinary Drainage Bag: Key step of "Wipe the drain with an antiseptic wipe AFTER the drainage bag is empty." was not bolded and has been corrected.

Making an Occupied Bed: The Key steps of "Raise side rail opposite working side of bed." and "Raise second side rail." were not bolded and have been corrected.

Mouth Care: The Key steps of "Brush resident's teeth, including the inner, outer and chewing surfaces of all upper and lower teeth" has the following verbalization of steps added "while verbalizing the surfaces they are cleaning". 'While verbalizing' was left off and has been added back.

For Testing Effective: 9-1-2019
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HAND WASHING

	Introduce themselves to the resident.	
	Turn on water.	
	Wet all surfaces of hands.	
	Wet wrists.	
	Apply soap to hands.	
	Rub hands together using friction.	
	While hands are not under the water stream, rub hands together for at least 20 seconds.	
	Interlace fingers pointing downward.	
	Wash all surfaces of hands with soap.	
	Wash wrists with soap.	
	Rinse hands thoroughly under running water with fingers pointed downward.	
	Dry hands on clean paper towel(s).	
	Immediately discard paper towel(s) in trash can.	
	Turn off faucet with a clean dry paper towel(s).	
	Discard paper towels into trash container.	
	Do not recontaminate hands at any time during the procedure.	

ABDOMINAL THRUST ON A CONSCIOUS RESIDENT

	Identify two symptoms or signs of choking.	
	Ask resident, “Are you choking?”	
	Bring resident to a standing position while calling for help.	
	Stand behind resident.	
	Wrap arms around resident above the waist.	
	Make a fist with one hand.	
	Place the thumb side of the fist against resident’s abdomen.	
	Position fist slightly above navel and below bottom of sternum.	
	Grasp fist with other hand.	
	Verbalize that you would “press fist and hand into the resident’s abdomen with an inward, upward thrust”.	
	Verbalize you would “thrust at least three times”.	
	Stop and ask resident, “Are you still choking?” **a. Actor will say, “No.”** **b. RN Test Observer will ask “What would you have done if the resident would have indicated that they were still choking?”**	
	At a minimum, state “I would repeat this procedure until it is successful or the resident lost consciousness.”	
	Place resident in recovery position on lateral side.	

AMBULATION USING A GAIT BELT

	Identify that your hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Obtain a correct sized gait belt for the resident.	
	Lock designated bed brake(s) to ensure resident's safety.	
	Lower bed to a position so the resident's feet will rest comfortably flat on the floor when sitting on bed.	
	Bring resident to a sitting position with resident's feet flat on the floor.	
	Place gait belt around resident's waist to stabilize trunk.	
	Tighten gait belt. Check gait belt for tightness by slipping fingers between gait belt and resident.	
	Assist resident to put on non-skid slippers.	
	Bring resident to a standing position using proper body mechanics at all times.	
	Grasp gait belt with one hand with other hand stabilizing resident by holding forearm, shoulder or using other appropriate method to stabilize the resident.	
	Ambulate resident at least 10 steps to the wheelchair.	
	Lock wheelchair brakes to ensure resident's safety.	
	Assist resident to pivot/turn and sit in the wheelchair in a controlled manner ensuring safety at all times.	
	Remove gait belt.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signal device within easy reach of the resident.	
	Identify that hands should be washed.	

AMBULATION WITH A WALKER USING A GAIT BELT

	Identify that your hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Lock designated bed brake(s) to ensure resident's safety.	
	Bring resident to a sitting position with resident's feet flat on the floor.	
	Assist the resident to put on non-skid slippers.	
	Place gait belt around resident's waist to stabilize trunk.	
	Tighten gait belt. Check gait belt for tightness by slipping fingers between gait belt and resident.	
	Position walker.	
	Assists resident to standing position stabilizing walker using hand and/or foot.	
	Position self behind and slightly to the side of the resident.	
	Ambulate resident at least 10 steps to the wheelchair ensuring resident's safety at all times.	
	Lock wheelchair brakes to ensure resident's safety.	
	Assists resident to pivot/turn and sit in the wheelchair using correct body mechanics.	
	Remove gait belt.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signal device within easy reach of the resident.	
	Identify that hands should be washed.	

APPLYING AN ANTI-EMBOLIC STOCKING TO ONE LEG

	Identify that your hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Raise the bed between mid-thigh and waist level.	
	Provide for resident's privacy by only exposing one leg.	
	Provides privacy for resident, pulls privacy curtain.	
	Roll, gather or turn stocking down inside out to the heel.	
	Place stocking over resident's toes, foot and heel.	
	Roll or pull stocking up one leg.	
	Check toes for possible pressure from stocking and adjust as needed.	
	Leave resident with a stocking that is smooth and wrinkle free.	
	Lower bed.	
	Open privacy curtain.	
	Maintains respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

BED-BATH – WHOLE FACE AND ARM, HAND, AND UNDERARM

	Identify that hands should be washed.	
	Explain procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Fill basin with comfortably warm water.	
	Raise bed between mid-thigh and waist level.	
	Cover resident with a bath blanket or clean sheet.	
	Fanfold bed linens down to waist or move linens to opposite side.	
	Remove resident's gown without exposing resident.	
	Dispose of gown in designated container.	
	Wash face WITHOUT SOAP and pat dry.	
	Place towel under arm, exposing one arm.	
	Wash arm, hand and underarm using soap and water.	
	Rinse arm, hand, and underarm.	
	Dry arm, hand and underarm.	
	Assist resident to put on a clean gown.	
	Empty, rinse and dry equipment and return to storage.	
	Dispose of soiled linen in designated container.	
	Lower bed.	
	Open privacy curtain.	
	Maintains respectful, courteous interpersonal interactions at all times.	
	Leaves call light or signaling device and water within easy reach of the resident.	
	Identify that hands should be washed.	

BEDPAN AND OUTPUT

	Identify that your hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Gather supplies.	
	Provide privacy for resident, pull privacy curtain.	
	Put on gloves.	
	Position resident on standard bedpan/fracture pan with pan in correct orientation and using correct body mechanics.	
	Raise head of the bed.	
	Leave tissue within reach of resident.	
	Step away from the resident until the RN Test Observer identifies that the resident is finished.	
	Upon returning, lower the head of the bed and gently remove the bedpan.	
	Hold the bedpan while the RN Test Observer pours fluid into bedpan.	
	Place the graduate on a flat surface for reading output at eye level and pours fluid into graduate.	
	Empty graduate into designated toilet.	
	Rinse and dry bedpan and graduate and return to storage.	
	Wash resident's hands using a wet wash cloth.	
	Dries resident's hands with a dry towel.	
	Dispose of linens in designated container.	
	Remove gloves turning inside out as they are removed and dispose in designated container.	
	Record output on the provided, previously signed recording form.	
	Candidate's recorded output is within 25 cc/ml of RN Test Observer's recorded output.	
	Leave resident in a position of comfort and safety.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signal device within easy reach of the resident.	
	Identify that hands should be washed.	

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CATHETER CARE FOR A FEMALE

	Identify that your hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Raise side rail opposite working side of bed.	
	Raise bed between mid-thigh and waist level.	
	Put on gloves.	
	Fill basin with comfortably warm water.	
	Position a bath blanket or clean sheet over resident to maintain privacy.	
	Turn resident [manikin] (side-to-side) and place waterproof pad under resident [manikin].	
	Verbalize the act of checking, while physically checking, to see that urine can flow unrestricted into the drainage bag.	
	Use soap and water to carefully wash in a circular motion around the drainage tube where it exits the urethra.	
	With one hand holding the catheter near the urethra to prevent tugging on catheter.	
	Cleans at least 3-4 inches from the urethra down the drainage tube with other hand.	
	Clean with strokes only away from the urethra.	
	Use a clean portion of wash cloth for each stroke.	
	Rinse with strokes only away from the urethra.	
	Use a clean portion of wash cloth for each stroke.	
	Pat dry with a clean towel.	
	Do not allow the tube to be pulled at any time during the procedure.	
	Replace top cover over resident.	
	Remove bath blanket or sheet.	
	Remove waterproof pad, without friction, by turning resident [manikin] side-to-side.	
	Dispose of linens in designated container.	
	Empty, rinse, dry and return equipment to storage.	
	Remove gloves turning inside out as they are removed and dispose in designated container.	
	Open privacy curtain.	
	Lower bed and side rail.	
	Leave resident in a position of comfort and safety.	

	CATHETER CARE FOR A FEMALE (CONTINUED)	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signal device within easy reach of the resident.	
	Identify that hands should be washed.	

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CHANGING AN ADULT BRIEF

	Identify that your hands should be washed.	
	Explain the procedure to be performed to the resident [manikin].	
	Provide privacy for resident [manikin], pull privacy curtain.	
	Gather supplies.	
	Raise bed between mid-thigh and waist level.	
	Raise side rail opposite working side of bed.	
	Put on gloves.	
	Place waterproof pad under resident [manikin] by rolling resident [manikin] side to-side.	
	Unfasten wet brief on both sides.	
	Remove soiled brief under resident [manikin] by rolling resident [manikin] side-to-side OR raise buttocks.	
	Discard soiled brief in the designated container.	
	Verbalize that the resident's soiled area would now be washed, rinsed and dried.	
	Verbalize that the brief should be checked every two hours.	
	Apply a new brief by rolling resident [manikin] side-to-side OR raise buttocks.	
	Pull front of brief through ensuring brief is even on both sides of the resident [manikin] and fasten brief securely on both sides.	
	Remove waterproof pad from under buttocks by turning resident [manikin] side-to-side.	
	Dispose of soiled linen in designated container.	
	Lower bed and side rail.	
	Remove gloves turning inside out as they are removed and dispose in designated container.	
	Open privacy curtain.	
	Leave resident in a position of comfort and safety.	
	Place call light or signaling device within easy reach of resident [manikin].	
	Maintain respectful courteous, interpersonal interactions at all times.	
	Identify that hands should be washed.	
	Identify that your hands should be washed.	

DENTURE CARE

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Line bottom of sink with a protective lining that would help prevent damage to the dentures. (Use cloth towel or washcloth, do not use paper towels.)	
	Put on gloves.	
	Remove dentures from cup.	
	Handle dentures carefully to avoid damage being careful to avoid contamination.	
	Apply toothpaste.	
	Thoroughly brush dentures including the inner, outer, and chewing surfaces of upper or lower dentures. (Only one plate is used during testing. Toothettes may be utilized instead of a toothbrush as long as all surfaces listed are cleaned.)	
	Rinse dentures using clean cool water.	
	Place dentures in rinsed denture cup.	
	Add cool clean water to denture cup.	
	Clean and dry equipment and return to storage.	
	Discard protective lining in designated container.	
	Remove gloves turning inside out as they are removed and dispose in designated container.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device and water within easy reach of the resident.	
	Identify that hands should be washed.	

DRESSING A BEDRIDDEN RESIDENT

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Raise bed between mid-thigh and waist level.	
	Keep resident covered while removing gown.	
	Remove gown from unaffected side first.	
	Place used gown in designated container.	
	When dressing the resident in a shirt/blouse, insert your hand through the sleeve of the shirt/ blouse and grasp the hand of the resident.	
	When dressing the resident in a shirt/blouse, always dresses from the affected side first.	
	When dressing the resident in pants, assist the resident to raise their buttocks or turn resident from side-to-side and draw the pants over the buttocks and up to the resident's waist.	
	When dressing the resident in pants, always dress the resident from the affected side first.	
	Apply resident's non-skid slippers while the resident is in bed.	
	Leave the resident comfortably and properly dressed and in a position of safety.	
	Lowers bed.	
	Opens privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device and water within easy reach of the resident.	
	Identify that hands should be washed.	

EMPTYING A URINARY DRAINAGE BAG

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Raise side rails on both sides of the bed	
	Raise bed between mid-thigh and waist level.	
	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 until bag is empty.	
	Avoid touching the graduate with the tip of the tubing.	
	Close the drain.	
	Wipe the drain with an antiseptic wipe AFTER the drainage bag is empty.	
	Replace drain in holder.	
	Lower bed.	
	Lower side rails.	
	Place graduate on level, flat surface.	
	With graduate at eye level, read output.	
	Empty graduate into designated toilet.	
	Rinse, dry and return equipment to storage.	
	Remove gloves, turning inside out as they are removed and dispose in designated container.	
	Leave resident in a position of comfort and safety.	
	Record output on the provided, previously signed recording form.	
	Candidate's measured output reading is within 25 cc/ml of RN Test Observer's output reading.	
	Open privacy curtain.	
	Place call light or signaling device within reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Identify that hands should be washed.	

FEEDING A DEPENDENT RESIDENT

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Verbalize identifying the resident's name against the diet card and verbalize that the resident has received the correct tray while actually checking the diet card and tray.	
	Position the resident in an upright position that is at least 45 degrees.	
	Protect clothing from soiling by using napkin, clothing protector, or towel.	
	Wash and dry resident's hands BEFORE feeding.	
	Discard soiled linen in designated container.	
	Remain at eye level facing the resident while feeding resident.	
	Describe the foods being offered to the resident.	
	Offer each fluid frequently.	
	Offer food in small amounts at a reasonable rate, allowing resident time to chew and swallow.	
	Wipe resident's face during meal at least one time.	
	Leave resident clean and in bed with the head of the bed set up to at least 30 degrees.	
	Record intake in percentage of total solid food eaten on provided, previously signed recording form.	
	Candidate's recorded consumed food intake must be within 25 percentage points of the RN Test Observer's recorded food intake.	
	Record the sum off total fluid consumed in cc/ml on provided, previously signed recording form.	
	Candidate's recorded total consumed fluid intake is within 60 cc/ml of the RN Test Observer's recorded fluid intake.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Place a towel on resident's shoulders.	
	Ask resident how s(he) would like his/her hair styled.	
	Comb/brush/style hair gently and completely.	
	Discard linen in designated container.	
	Leave hair neatly brushed/combed/styled.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

MAKING AN OCCUPIED BED

	Identify that hands should be washed.	
	Gather linen and transport correctly.	
	Place linen on a clean surface. May place linen on the over-bed table, over the back of a chair, on bedside stand or over the foot of the bed.	
	Explain procedure to resident.	
	Provide privacy for resident, pull privacy curtain.	
	Raise side rail opposite working side of bed.	
	Raise bed to between mid-thigh and waist level.	
	Assist resident to roll onto side toward raised side rail	
	Roll or fan fold soiled linen, soiled side inside, to the center of the bed.	
	Place clean bottom sheet along the center of the bed and roll or fan fold linen against resident's back and unfold remaining half.	
	Secure two fitted corners of the clean bottom sheet.	
	Raise second side rail.	
	Assist the resident to roll over the bottom linen, preventing trauma and avoidable pain to resident at all times.	
	Remove soiled linen without shaking.	
	Avoid touching linen to uniform.	
	Dispose of soiled linen in designated container.	
	Pull through and smooth out the clean bottom linen.	
	Secure the other two fitted corners.	
	Place clean top linen and blanket or bed spread over covered resident while removing used linen.	
	Keep resident unexposed at all times.	
	Tuck in top linen and blanket or bedspread at the foot of bed.	
	Make mitered corners at the foot of the bed.	
	Apply clean pillow case, with zippers and/or tags of pillow to inside.	
	Gently lift resident's head while replacing the pillow.	
	Leave bed completely and neatly made without wrinkles.	
	Lower bed.	
	Lower side rails.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

MOUTH CARE – BRUSHING TEETH

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Gather equipment/supplies.	
	Provide privacy for resident, pull privacy curtain.	
	Put on gloves AFTER supplies have been gathered.	
	Drape the chest with towel (cloth or paper) to prevent soiling.	
	Wet toothbrush and apply a small amount of toothpaste to toothbrush. (If available, toothettes may be utilized instead of the toothbrush as long as all of the surfaces listed in steps below are cleaned.)	
	Brush resident's teeth, including the inner, outer, and chewing surfaces of all upper and lower teeth while verbalizing the surfaces they are cleaning..	
	Clean tongue.	
	Assist resident in rinsing mouth.	
	Wipe resident's mouth.	
	Remove soiled chest barrier (cloth or paper) and place in designated container.	
	Empty, rinse and dry emesis basin.	
	Rinse toothbrush.	
	Return equipment to storage.	
	Remove gloves turning inside out as they are removed and dispose gloves in designated container.	
	Leave resident in position of comfort.	
	Open privacy curtain.	
	Leave call light or signaling device within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Identify that hands should be washed.	

NAIL CARE

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Immerse resident's nails in comfortably warm water.	
	Soak nails for at least five minutes. The five minutes may be verbalized by the candidate and acknowledged by the RN Test Observer.	
	Gently push cuticle back with a wet wash cloth.	
	Dry hand thoroughly, making sure to dry carefully between the fingers.	
	Gently clean under the nails with an orange stick.	
	File each fingernail.	
	Empty, rinse, dry and return equipment to storage.	
	Discard soiled linen in designated container.	
	Discard orange stick in the designated container.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

PERINEAL CARE OF A FEMALE

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident [manikin].	
	Provide privacy for resident, pull privacy curtain.	
	Raise side rails on opposite working side of the bed.	
	Fills basin with comfortably warm water.	
	Raise the bed to between mid-thigh and waist level.	
	Place bath blanket or clean sheet on resident [manikin].	
	Put on gloves.	
	Place waterproof pad under resident's [manikin's] buttocks by turning resident [manikin] toward side and place waterproof pad under buttocks.	
	Return resident [manikin] to her back.	
	Expose perineum only.	
	Show separating labia, while verbalizing separating labia.	
	Use water and a soapy wash cloth.	
	Clean both sides and middle of labia from top to bottom with a clean portion of the wash cloth for each stroke.	
	Rinse area from top to bottom with a clean portion of the wash cloth with each stroke.	
	Pat dry the area with a clean portion of the towel each pat.	
	Cover the exposed area with the bath blanket or clean sheet.	
	Assist resident to turn onto side away from the working side of the bed.	
	With a new clean wash cloth with soap and water, clean the rectal area.	
	Clean the rectal area from vagina to rectal area using at least two single strokes with a clean portion of the wash cloth for each single stroke.	
	Rinse the rectal area from vagina to rectal area.	
	Pat dry area from vagina to rectal area.	
	Remove waterproof pad from under buttocks, without friction, by turning resident [manikin] side-to-side and remove waterproof pad from under buttocks.	
	Position resident [manikin] on her back.	
	Dispose of all soiled linen, including the bath blanket or sheet, in the designated container.	
	Empty, rinse, dry and return equipment to storage.	
	Remove gloves, turning inside out as they are removed and dispose in designated container.	
	Lower bed.	
	Lower side rails.	
	Open privacy curtain.	

	PERINEAL CARE OF A FEMALE (CONTINUED)	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

POSITION RESIDENT IN BED ON SIDE

	Identify that hands should be washed.	
	Explain procedure to be performed to the resident.	
	Introduce yourself to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Position bed flat.	
	Raise bed between mid-thigh and waist level.	
	Raise side rail on side of the bed opposite working side of the bed to provide safety.	
	From the working side of the bed, move upper body, hips and legs toward self.	
	Assist/turn resident on his/her side.	
	Ensure that resident's face never becomes obstructed by the pillow.	
	Check to be sure resident is not lying on his/her downside arm.	
	Ensure resident is in correct body alignment.	
	Place support devices under the head, the upside arm, behind the back and between the knees.	
	Leave resident in a position of comfort and safety.	
	Lower side rails.	
	Lower bed.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Identify that hands should be washed.	

RANGE OF MOTION HIP & KNEE

	Identify hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Raise bed between mid-thigh and waist level.	
	Provide privacy for resident, pull privacy curtain.	
	Position resident supine (bed flat).	
	Verbalize resident is in good body alignment as the resident is positioned in good body alignment.	
	Place one hand under the resident's knee and the other hand under the resident's ankle.	
	Move the entire leg away from the body. (abduction)	
	Move the entire leg back 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 resident's knee and the other hand under the resident's ankle.	
	Bend the resident's knee and hip toward the resident's trunk. (flexion of hip and knee at the same time)	
	Straighten the knee and hip. (extension of knee and hip at the same time)	
	Complete flexion and extension of knee and hip at least three times.	
	Do not cause discomfort or pain anytime during ROM.	
	Candidate *must ask* at least once if they are causing any pain or discomfort.	
	Do not force any joint beyond the point of free movement.	
	Leave resident in a comfortable position.	
	Lower bed.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

RANGE OF MOTION FOR SHOULDER

	Identify hands should be washed.	
	Explain the procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Raise bed between mid-thigh and waist level.	
	Position resident supine (bed flat).	
	Verbalize resident is in good body alignment as the resident is positioned in good body alignment.	
	Place one hand under their elbow and the other hand under the resident's wrist.	
	Raise resident's arm up and over the resident's head. (flexion)	
	Bring the resident's arm back down to the resident's side. (extension)	
	Complete flexion and extension of the shoulder at least three times.	
	Continue same supporting for shoulder joint.	
	Move the resident's entire arm out away from the body. (abduction)	
	Return the resident's arm to the resident's side. (adduction)	
	Complete abduction and adduction of the shoulder at least three times.	
	Do not cause discomfort or pain anytime during ROM.	
	Candidate *must ask* at least once if they are causing any pain or discomfort.	
	Do not force any joint beyond the point of free movement.	
	Leave resident in a comfortable position.	
	Lower bed.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

STAND AND PIVOT-TRANSFER RESIDENT FROM BED TO WHEELCHAIR USING A GAIT BELT

	Identify that hands should be washed.	
	Explain the procedure to be performed to the resident and obtain a gait belt.	
	Position wheelchair touching the side of the bed.	
	Lock wheelchair brakes to ensure resident's safety.	
	Lock designated bed brake(s) to ensure resident's safety.	
	Assist resident in putting on non-skid slippers.	
	Assist resident to a sitting position and lower bed so resident's feet are flat on the floor when resident is sitting on the bed.	
	Place a gait belt around the resident's waist to stabilize trunk. Check gait belt for tightness by slipping fingers between gait belt and resident.	
	Face resident and grasp the gait belt with both hands.	
	Bring resident to a standing position using proper body mechanics.	
	Assist resident to pivot and sit in the wheelchair in a controlled manner that ensures safety.	
	Remove gait belt.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

STAND AND PIVOT-TRANSFER RESIDENT FROM WHEELCHAIR TO BED USING A GAIT BELT

	Identify that hands should be washed..	
	Explain the procedure to be performed to the resident and obtain a gait belt.	
	Position wheelchair touching the side of the bed.	
	Lock wheelchair brakes to ensure resident's safety.	
	Lock designated bed brake(s) to ensure resident's safety.	
	Lower bed to a position so the resident's feet will be flat on the floor when the resident is transferred to the bed.	
	Place gait belt around resident's waist to stabilize trunk. Tighten gait belt and check gait belt for tightness by slipping fingers between the gait belt and the resident.	
	Face resident and grasp the gait belt with both hands.	
	Bring resident to a standing position using proper body mechanics.	
	Assist resident to pivot and sit in the wheelchair in a controlled manner that ensures safety.	
	Remove gait belt.	
	Assist resident in removing outer footwear.	
	Assist resident to move to center of bed and lie down, supporting extremities as necessary.	
	Ensure resident is comfortable.	
	Verbalize the resident is in good body alignment as the resident is positioned in good body alignment.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Place call light or signaling device within easy reach of the resident.	
	Identify that hands should be washed.	

VITAL SIGNS – TEMPERATURE, PULSE AND RESPIRATIONS

	Identify that hands should be washed.	
	Explain procedure to be performed to the resident.	
	Provide privacy for resident, pull privacy curtain.	
	Correctly turn on digital oral thermometer.	
	Gently insert bulb end of thermometer in resident's mouth under tongue.	
	Hold thermometer in place for appropriate length of time.	
	Remove thermometer and read and record the temperature reading on provided, previously signed recording form.	
	Candidate's recorded temperature varies no more than 0.1 degrees from the RN Test Observer's recorded temperature.	
	Wipe the thermometer clean with an alcohol pad or discard sheath in the designated container.	
	Locate the radial pulse by placing tips of fingers on thumb side of the resident's wrist.	
	Count pulse for a full 60 seconds and record pulse rate on the provided, previously signed recording form.	
	Candidate's recorded pulse rate is within 4 beats of RN Test Observer's recorded pulse rate for the full 60 seconds.	
	Count respirations for a full 60 seconds and record respirations on provided, previously signed recording form.	
	Candidate's recorded respiratory rate is within 2 breaths of the RN Test Observer's recorded respiratory rate for the full 60 seconds.	
	Open privacy curtain.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Leave call light or signaling device and water within easy reach of the resident.	
	Identify that hands should be washed.	

WEIGHING AN AMBULATORY RESIDENT

	Identify that hands should be washed.	
	Explain procedure to be performed to the resident.	
	Balance (or zero) scale.	
	Lock wheelchair brakes to ensure resident's safety.	
	Assist resident to stand and walk to the scale.	
	Assist resident to step on the scale, checking that resident is centered on scale, has both arms at her/his side and is not holding onto anything that would alter the recording of the weight.	
	Appropriately adjusts weights until scale is in balance OR read the analog scale.	
	Return resident to the wheelchair, assisting resident to sit in the wheelchair.	
	Record weight on the provided, previously signed recording form.	
	Candidate's recorded weight varies no more than 2 lb. from the RN Test Observer's pre-recorded weight.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Leave call light or signal calling device within easy reach of the resident.	
	Identify that hands should be washed.	