OREGON NURSING ASSISTANT CANDIDATE HANDBOOK

(UPDATED January 1, 2014 with changes EFFECTIVE: March 1, 2014)

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

HEADMASTER, LLP …….…….. 8:00 am to 6:00 pm Mon.-Fri. ……. (800) 393-8664
3310 McHugh Lane *(Mountain Time)*
Helena, MT 59604-6609 Fax: …….. (406) 442-3357

Online information and forms available at: www.hdmaster.com

- Candidate Handbook
- Regional Exam Site Schedules
- Verifying an Exam Date
- Rescheduling a Test Date
- Online Test Results
- Online Knowledge 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) …….. 7:30 am to 4:00 pm Mon.-Fri. …… (971) 673-0685
17938 SW Upper Boones Ferry Road *(Pacific Time)*
Portland, OR 97224-7012 Fax: …….. (971) 673-0684

Online information and services available at 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

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INTRODUCTION

In 1987, the Nursing Home Reform Act was adopted by Congress as part of the Omnibus Budget Reconciliation Act (OBRA '87). It was designed to improve the quality of care in long-term health care facilities and to define training and evaluation standards for nursing assistants who work in such facilities. Each state is responsible for following the terms of this federal law. As defined in the OBRA regulations, a nursing assistant competency evaluation program provides specific standards for nursing assistant related knowledge and skills. The purpose of a nursing assistant competency evaluation program is to ensure that candidates who are seeking to be nursing assistants understand these standards and can competently and safely perform the job of an entry-level nursing assistant. This handbook describes the process of taking the nursing assistant competency 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. ***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, 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 (Knowledge and Skill Tests).....$106
Reactivation by Examination (Knowledge and Skill Tests).....$106
If Requesting an Oral Knowledge Exam (tape recording) ..... ***ADDITIONAL*** $35
Retake or Reschedule of both Knowledge and Skill Test.....$70
Retake or Reschedule of Knowledge 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 knowledge 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, 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.

PREFERRED EXAM DATE NOTIFICATION LETTER (continued)

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 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 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 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

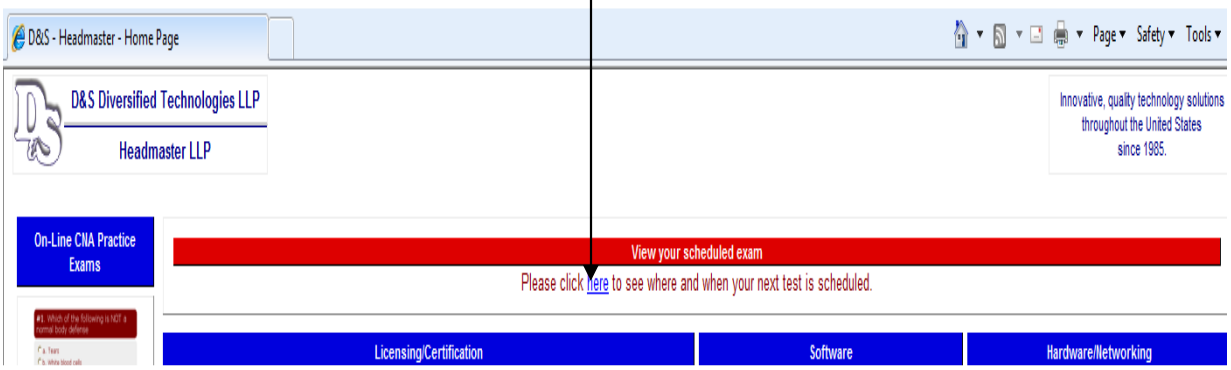
If you must reschedule your exam date, please do so as soon as possible. You may reschedule an exam date up until three business days before your scheduled exam date by calling Headmaster at 800-393-8664. Business days are Monday through Friday excluding official holidays that fall on weekdays. For example, 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, or by calling Headmaster at 800-393-8664 during business hours.

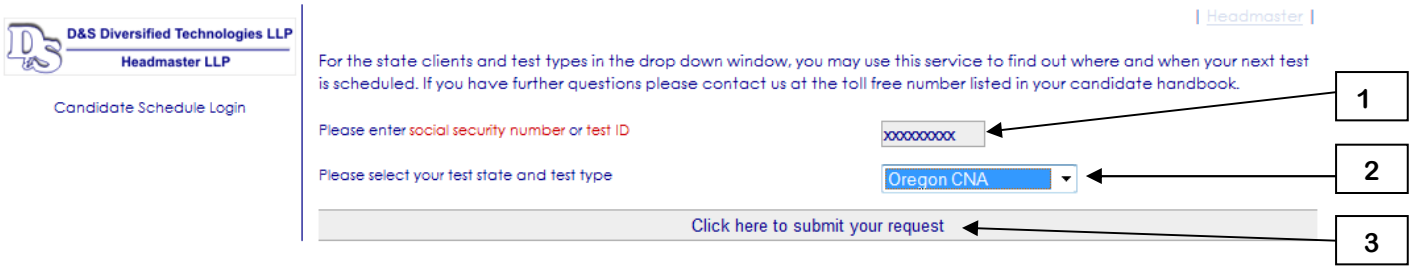
You may reschedule online up until seven (7) days prior to your exam date. To reschedule online go to www.hdmaster.com and click on the "Oregon" button under the Nurse Aide header below the map of the USA then click on the "Reschedule" button under Candidate Forms in the far left-hand column. Complete 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 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 (see below). 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.



1. **Type in your social security number**
2. **Choose Oregon CNA from the drop down box**
3. **Click on "Click here to submit your request"**



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 *(Passport Cards are not acceptable-there is no signature)*
- Alien registration card
- Tribal identification card
- Social Security card
- Credit card or debit card
- 1st 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 knowledge 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 knowledge 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 records 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 knowledge test will be administered to candidates. After candidates finish the knowledge 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 KNOWLEDGE TESTS

Headmaster and OSBN approve exam sites for traditional knowledge 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 (KNOWLEDGE/ORAL) TEST

The knowledge/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 knowledge/oral test is different. No candidates at a test event will have the same knowledge/oral test.

The Knowledge Test Proctor will hand out exam materials and will read the instructions for taking the knowledge test. You will have a maximum of ninety (90) minutes to complete the 77 question knowledge test. You will be told when fifteen (15) minutes are left. You may not ask questions about the content of the knowledge 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 knowledge 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 73% or better to pass the knowledge portion of the test.**

If you want to take the oral version of the knowledge test, you must request it when you submit your application and pay the additional fee. An oral test allows 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 knowledge 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 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

******THE SKILL TASK STEPS INCLUDED IN THIS HANDBOOK ARE OFFERED AS GUIDELINES TO HELP PREPARE CANDIDATES FOR THE OREGON NURSING ASSISTANT SKILL TEST AND THE STEPS INCLUDED HEREIN ARE NOT INTENDED TO BE USED TO PROVIDE COMPLETE CARE THAT WOULD BE ALL INCLUSIVE OF BEST CARE PRACTICED IN AN ACTUAL WORK SETTING******

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 ensures 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.
- Ensure 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 ensures 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.
- 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 IN BED***

- 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.
- Wash and dry client's hands before assisting with meal.
- Sit next to the client while assisting with meal.
- 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. ***ASSISTING A DEPENDENT CLIENT WITH A MEAL IN A CHAIR***

- Knock on door. Wash hands. Explain procedure to the client.
- Look at diet card to check that the client has received the correct tray.
- Wash and dry client's hands before assisting with meal.
- Sit next to the client while assisting with meal.
- 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.

7. ***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.

8. ***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 catheter where it exits the urethra.
- Hold catheter where it exits the urethra.
- With fingers near the urethra, clean 3-4 inches down the catheter 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.
- 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.

9. ***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 denture cleanser 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 denture cup. Place dentures in denture 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.
- Maintain respectful, courteous interpersonal interactions at all times.
- Wash hands. Leave call light or signaling device within easy reach of the client.

10. ***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.

11. ***FINGERNAIL CARE (ONE HAND)***

- Knock on door. Wash hands. Explain procedure to the client.
- Immerse nails in comfortably warm water.
- Verbalize to 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.

12. ***FOOT CARE (ONE FOOT)***

- Knock on door. Wash hands. Explain procedure to the client.
- Fill foot basin with comfortably warm water. Remove sock.
- Immerse foot in comfortably warm water for 5 to 20 minutes (time is to be verbalized).
- Use water and soapy washcloth. Wash entire foot. Wash between toes.
- Rinse entire foot. Rinse between toes.
- Dry foot thoroughly, dry between toes thoroughly.
- Warm lotion by rubbing it between hands. Massage lotion over entire foot, avoiding between the toes.
- 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.

13. ***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 fingernails. 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.
- Does not recontaminate hands at any time during the procedure.

14. ***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.

15. ***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.

16. ***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 to 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.

17. ***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.
- 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.

18. ***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.
- 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.

19. ***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 toothette(s) 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 and dry face around mouth. 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.
- Wash hands.

20. ***PERINEAL CARE FOR A FEMALE CLIENT***

- 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.
- 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 candidate.
- Use water, washcloth and soap. Clean rectal area from front to back with single strokes.
- Use a clean portion of a wash cloth for any cleaning stroke(s).
- 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.
- Lower bed, if it was raised.
- Wash hands. Leave call light or signaling device within easy reach of the client.

21. ***RE-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.
- Ensure 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 the correct side as read to him/her in the scenario.
- 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.

22. ***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

23. ***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 in the same motion - 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.

24. ***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.
- 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.

25. ***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.

26. ***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.

27. ***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.

28. ***TRANSFER FROM BED TO WHEELCHAIR***

- Knock on door. Wash hands. Explain procedure to client.
- Lower bed to same level as wheelchair seat.
- Ensure 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. Ensure 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.

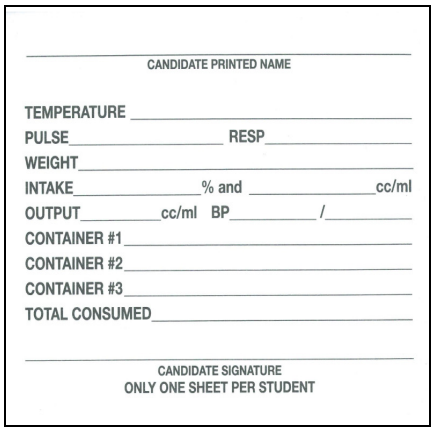
29. ***TRANSFER FROM WHEELCHAIR TO BED***

- 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.
- Ensure 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.
- Ensure 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 knowledge 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. 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 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 online 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 knowledge 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 after 6:00 p.m. Mountain time the day tests are scored by Headmaster. To check for your test results, visit 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 knowledge 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. An attempt means checking in for the competency evaluation and receiving the knowledge test booklet or the skill test instructions including the skills that are to be performed. If a candidate decides to not complete the test after receiving the knowledge test booklet or the skill test instructions, the attempt will be scored as a failure.

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.

- A copy of your test results letter can be securely accessed and printed from www.hdmaster.com any time after your test has been officially scored.

- When your test results letter informs you that you failed the knowledge and/or skill portion of the examination then when you want to apply for a retest:

    1. Check the box for knowledge or skill or both. Check the oral knowledge 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 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 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 knowledge/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

KNOWLEDGE PRACTICE TEST

Headmaster offers a free, ten question knowledge practice test at www.hdmaster.com. In addition, a free knowledge 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 for more details.

VOCABULARY LIST

abdominal thrust
abduction
abduction pillow
abnormal vital signs
absorption
abuse
accidents
activities
acute
adapative equipment
adaptive devices
adduction
ADL
admitting resident
affected side
aging process
agitation
AIDS
alternating pressure mattress
Alzheimer's
ambulation
amputees
anger
angina pectoris
anorexia
anterior
antibacterial
antibiotics
antiembolitic
anxiety
aphasia
apical
appropriate response
arthritis
aspiration
assistive device(s)
atrophy
axillary temperature
back strain
bacteria
bargaining
basic needs

basic skin care
bathing
bathing resident
bed cradle
bed height
bed making
bedpan
bedrest
behavior
behavioral care plan
beliefs
biohazard
bladder training
bleeding
blindness
blood pressure
bodily fluids
body alignment
body language
body mechanics
body temperature
bowel program
breathing
burnout
burns
call light
cancer
cardiac arrest
cardiopulmonary resuscitation
cardiovascular system
care impaired
care plan
cast
cataracts
catheter care
cc's in an ounce
central nervous system
cerebral vascular accident
charge nurse
chemotherapy
chest pain
choking
chronic
circulation
circulatory system
clear liquid diet
clergy
colostomy
combative resident
comfort care
communicable
communication
competency evaluation program
confidentiality
confused resident
congestive heart failure
constipation
contamination
contracture
converting measures
COPD
coughing excessively
cross contamination
cueing
CVA
cyanosis
cyanotic
dangling
death and dying
dehydration
dementia
denial
denture care
dentures
dependability
depression
developmental disability
developmental tasks
diabetes
diabetic
dialysis
diarrhea
diet
digestion
discharging resident
disease
disease process
disinfection
disoriented
disposing of contaminated materials
disrespect
disrespectful treatment
dizziness
DNR
documentation
dressing
droplets
drowsy
dry skin
dying
dysphagia
dyspnea
dysuria
edema
elastic stockings
elevate head
elimination
emesis
emotional abuse
emotional needs
emotional support
empathy
emphysema
end of life care
endocrine system
enema
epilepsy
essential behaviors
ethics
extension
falls
fatigue
fecal impaction
feces
feeding
fire
flatus
flexion
fluid intake
Foley catheter
foot care
Fowler's position
fractures
fraud
free from disease
gait belt
gangrene
gastric feedings
gastrostomy tube
genetic disease
gerontology
gestures
gloves
grieving process
growth
hair care
hallucination
hand care
hand washing
hazardous substance
health-care team
hearing aid
hearing impaired

hearing loss
heart attack
heart muscle
height
helping residents
hemiplegia
hepatitis A
hepatitis B
hip prosthesis
HIPAA
HIV
hospice care
hug
hydration
hyperglycemia
hypertension
hyperventilation
hypoglycemia
ileostomy
immobility
immune
impaction
impairment
incontinence
indwelling catheter
infection
infection control
input and output
in-service programs
insulin
intake
intake and output
integumentary system
interpersonal skills
isolation
IV care
jaundice
job description
laxatives
life support
lift/draw sheet
linen
liquid diet
listening
living will
loose teeth
low sodium diet
making occupied bed
manipulative behavior
Maslow
material safety data sheets
measuring height
measuring temperature
mechanical soft diet
medical asepsis
medical record
memory loss
mental health
mentally impaired
metastasis
microorganisms
middle childhood
military time
minerals
mistreatment
mobility
mouth care
moving
Multiple Sclerosis
muscle spasms
nail care
nasal cannula
needles
neglect
negligence
new resident
non-contagious disease
nonverbal communication
nosocomial
NPO
nursing assistant's role
nutrition
objective
OBRA
ombudsman
oral care
oral hygiene
oral temperature
orientation
osteoporosis
ostomy bag
overbed table
oxygen
pain
paralysis
paranoia
paraphrasing
parenteral nutrition
Parkinson's
passive
pathogens
patience
perineal care
peristalsis
personal care
personal items
pet therapy
phantom pain
phone etiquette
physical change
physical needs
physician's authority
pill-rolling
plate rim
positioning
post mortem care
post-operative pneumonia
post-surgical care
postural hypotension
PPE
precautions
pressure ulcers
preventing falls
prioritizing
privacy
progressive
pronation
prone
prostate gland
prosthesis
psychological needs
psychosocial
pulmonary disease
pulse
quadrant
quadriplegia
radial
ramps
range of motion
regulation
rehabilitation
rejection
reminiscing
reporting
reposition
resident abuse
resident belongings
resident identification
resident independence
resident information
resident unit
resident's chart
resident's environment

resident's rights
respectful treatment
respiration(s)
respiratory symptoms
respiratory system
responding to resident behavior
restorative care
restraints
resuscitation
rights
rotation
safety
seclusion
secretions
seizure
self-actualization
self-esteem
sexual harassment
sexual needs
sexually transmitted diseases
sharps container
shaving
Sims position
skin
skin integrity
skin observation
slander
sleep
smoking
social needs
social worker
soiled linen
specimen
spiritual needs
sputum test
standard precautions
state tested
stereotypes
sterilization
stethoscope
stomach
stress
stroke
strong side
subjective
sundowning
supine
supplemental feedings
suprapubic
survey
swelling
systolic
tachycardia
TED hose
telephone etiquette
terminal illness
threatening resident
tips
toddlerhood
toenails
toileting schedule
trachea
tracheostomy
transfers
transporting food
transporting linens
tub bath
tube feeding
tuberculosis
tubing
twice daily
tympanic
unaffected
unconscious
unsteady
urinary catheter bag
urinary problems
urinary system
urine
validation therapy
vision change
visiting policies
vital signs
vitamins
vomitus
walker
wandering resident
water faucets
water pitcher
weakness
weighing
well-being
wheelchair safety
white blood cells
withdrawn resident

NOTES: