**ROGUE COMMUNITY COLLEGE**

NA 101/101C

**NURSING ASSISTANT PROGRAM**

**STUDENT HANDBOOK**

###### **SKILLS CHECKLIST**

* **POLICY MANUAL**



**Spring Term**

**2014/2015**

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**Introduction**

This document contains general information about the Nursing Assistant Program, outlines expected behaviors, reinforces course policies and defines the guidelines by which student success is measured. It is to be used as a reference and is binding for the current academic year. This document is reviewed and revised on an annual basis, and as needed.

 **Mission Statement**

The Rogue Community College Nursing Assistant/Health Careers program’s mission is to prepare graduates for the community that are ready to meet the entry level standards for Nursing Assistant care in various settings, e.g. home care, foster care, long-term care, acute care, private duty, and/or entry into other Rogue Community College health-care related programs.

**General Information**

# Affirmative Action

The Nursing Assistant program adheres to the RCC affirmative action policy which does not discriminate on the basis of race, color, religion, gender, age, disability, or national and ethnic origin in the administration of its educational policies, admissions policies, financial aid policies, and athletic and other college-administered programs. In addition, the Nursing Assistant program adheres to the Oregon State Board of Nursing rules which prohibit discrimination in selection and progression of students based on sexual preference or marital status.

# Students Requiring Academic or Testing Modifications

Any student who feels that she or he may need an academic accommodation for any disability should make an appointment with the Support Services Office. Contact the Office of Support Services at 541-956-7337 (Wiseman Center, Grants Pass) or 541-245-7537 (Riverside Center, Medford). Once the Support Services office notifies the Nursing Assistant Director of a requested accommodation, accommodations deemed reasonable, by the director and department head, for the profession and program will be made. These accommodations will not substitute for the basic requirements for entrance or academic and technical standards (essential functions) required for successful completion of the Nursing Assistant class. The notice of accommodation needs to be in place by the first day of class of any given term.

# Academic and Technical Standards (Essential Functions)

*The following standards are a compilation/adaptation from Rogue Community, Chemeketa Community and Portland Community Colleges*)

Nurses must possess the physical and cognitive capacity, emotional stability, and communication skills essential for the delivery of safe, effective nursing care. Students admitted to Nursing Assistant 101, with or without accommodation, must be able to meet the following academic and technical standards (essential functions).

1. **Visual Acuity** sufficient to gather data on clients and their environments and to provide appropriate care. Examples of relevant activities:
	1. Detect changes in skin color or condition
	2. Collect data from recording equipment and measurement devices used in client care
	3. Detect a fire in a client area and initiate emergency action
2. **Hearing Ability** sufficient to gather data on clients and their environments and to provide appropriate care. Examples of relevant activities:
	1. Detect sounds related to bodily functions using a stethoscope
	2. Detect audible alarms e.g. monitors, fire alarms, call bells
	3. Communicate clearly in telephone conversations
	4. Communicate effectively with clients and with other members of the healthcare team in a o variety of settings, including isolation and the operating room where healthcare team members are often wearing masks and there is background noise.
3. **Olfactory Ability** sufficient to gather data on clients and their environments and to provide appropriate care. Examples of relevant activities:
	1. Detect odors of bodily fluids or spoiled foods
	2. Detect smoke from burning materials
4. **Tactile Ability** sufficient to collect data on clients and their environments and to provide appropriate care. Examples of relevant activities:
	1. Detect changes in skin temperature
	2. Detect unsafe temperature levels in heat-producing devices used in client care
5. **Fine Motor Skills** sufficient to perform psychomotor skills integral to client care. Examples of relevant activities:
	1. Accurately place and maintain position of stethoscope for detecting blood pressure sounds
	2. Manipulate small equipment and containers, such as packaged juice, foil pouches, hearing aide batteries

**Strength and mobility** sufficient to perform client care activities and emergency procedures. Examples of relevant activities:

* 1. Safely transfer clients in and out of bed and assist them with ambulation using appropriate devices e.g. a gait belt to prevent client falls
	2. Safely control the fall of a client if it occurs
	3. Lift or move clients or objects, pull or push objects, weighing 35 pounds or more
	4. Turn and position clients as needed to prevent complications due to bed rest
	5. Accurately read the volumes and empty body fluid collection devices hung or placed below bed level
	6. Roll up crank style beds
	7. Reach to shoulder or higher level
	8. Perform cardiopulmonary resuscitation
1. **Physical endurance** sufficient to complete assigned periods of clinical practice (e.g. 8 hour shifts, days, evenings, or weekends) with acceptable speed (an acceptable speed of function is reflected by ability to carry out the usual client care assignment appropriate to a particular point in the course within the allotted clinical time) while caring for 4-6 clients per shift.
2. **Ability to speak, comprehend, read, and write in English** at a level that meets the need for accurate, clear, and effective communication with individuals, families, and groups respecting social, cultural and spiritual diversity. Examples of relevant activities:
	1. Give clear oral reports
	2. Read watches with second hands
	3. Read graphs
	4. Negotiate interpersonal conflict
	5. Read and understand English printed documents
	6. Write legibly in English in client charts
3. **Emotional stability** to function effectively under stress, to adapt to changing situations, to demonstrate honesty and integrity, and to follow through on assigned client care responsibilities. Examples of relevant activities:
	1. Deal with the unexpected e.g. frequently changing client status
	2. Handle strong emotions
	3. Be flexible with changing environments and schedules in both class and clinical settings
4. **Cognitive ability** to collect, analyze, and integrate information and knowledge to make

 clinical judgments (with acceptable speed, as defined in #7 above) that promote client

 outcomes. Examples of relevant activities:

* 1. Respond appropriately in emergency situations with sustained attention
	2. Demonstrate skills of recall using both long and short term memory
1. **Calculation ability** to estimate, add, subtract, multiply, and use fractions without the use of a calculator. Examples of relevant activities:
	1. Demonstrate skill of estimating fluid and solid food intake
	2. Add total amounts of fluid intake (total milliliters) over a period of time
	3. Estimate the fraction/portion of liquid ingested from given containers of known size and multiply the fraction times the total amount to determine intake

**Computer Requirement**

Internet and e-mail access are integral parts of the Nursing Assistant course and access to a computer (at home or at the College) will be required on a daily basis. Required quizzes and assignments completed outside the classroom typically utilize the various tools of Rogue Online (Blackboard), the college’s distance learning platform. The minimum Computing and Internet Access Requirements for Rogue Online (Blackboard Learning) are listed below:

Aside from **a thorough understanding of your computer operating system**, you must meet or exceed the following requirements to succeed in Rogue Online classes:

* **Windows PC**
	+ A Pentium III PC running Windows XP, VISTA, or higher
	+ Firefox 2.0 or higher*(no higher than Firefox 28)*, or Internet Explorer 7.0 or 8, Google Chrome is not supported
* **Macintosh**
	+ OS/X (10.6 or higher, aka Jaguar, Panther or Tiger)
	+ Firefox 4.0 or higher *(no higher than Firefox 28)*
* **General Requirements**
	+ 1gb RAM and at least 50mb of available disk space for assignments
	+ DSL or cable recommended
	+ An Internet service provider (ISP)
	+ A word processing package (Microsoft Word is a RCC standard, but Open Office can substitute; check the Downloads menu

# Faculty/Student Communication

Faculty will meet with students before or after class and as needed to listen to student questions/concerns. The purpose of the meetings are to discuss student concerns, experiences, and obtain feedback from peers and faculty. Faculty may then discuss concerns with the program director or an uninvolved faculty member and will bring decisions back to the students as necessary.

Individual concerns will be dealt with on an individual basis. Students with individual concerns are to discuss them directly with the appropriate faculty, and may request the program director or faculty contact phone numbers will be given on the first day of class. Also, faculty can be emailed through Rogue Online Blackboard or the mail Rogue Community College email system.

# Clinical Facilities Utilized by Students of the Program

The Nursing Assistant program utilizes multiple clinical sites in Jackson County and Josephine County. Students will be assigned to have clinical experiences in these sites and must expect to travel as necessary in their assigned County for clinical experiences. **NOTE:** Students need to be aware that per the OSBN Standards (851-061-0100 2a):

“…for facility-based Nursing Assistant programs, no student who is employed by, or who has received an offer of employment from a facility on the date on which the student begins training will be charged for any portion of the program, including any fees for textbooks or other required course materials in accordance with 42 CFR 483.152(c)(1). DHS Reimbursement for Student Paid NA Training Program Costs in Appendix D.

Clinicals will either be on the day or evening shift.

**Faculty Office Hours**

The Director of the Nursing Assistant program is available during office hours weekly. These hours are posted each term on the Program Director’s office door, TRC 145. Students may make appointments at times other than office hours if the need arises. Classroom and clinical instructors are available during classroom/clinical time as scheduled.

**Eligibility for Clinical and Eligibility for OSBN Certification**

Students must meet the state requirements of 100% of the required classroom hours **and** 100% of the required clinical hours, 40 of which must be completed in the long term care facility. A grade of 75% must be attained on the written and 80% on the Skills Final Exams to attain a grade of “P” (pass) in the classroom phase of this course. A grade of “P” must be attained in the classroom phase **before** a student may begin clinical. A grade of “NP” in the classroom phase will result in denial of admission into clinical. A student may choose to withdraw from the program in lieu of receiving an “NP” as a final grade for the course. Students must complete both classroom and clinical phases in this program with a grade of “P” (Pass vs. No Pass) in order to be eligible to apply to take the Oregon State Board of Nursing written/skills competency exam.

**Underage Students**

Students who are under 18 years of age must meet the requirements listed under “Admission” in the Schedule of Classes. Underage students and their parent/guardian must make an appointment (by calling 541-245-7841) with the Nursing Assistant Program Director and the parent/guardian must sign the “Consent to Attend NA 101,” “Memorandum of Understanding,” and the “Minor Donor Information” (consent for drug testing) forms before the class starts.

**Required Background Check**

In compliance with Oregon State Board of Nursing, all nursing assistant students will have a criminal background check initiated by the time they are admitted to the class. The list of disqualifying crimes will be published and provided to the students in advance of the class, at the Mandatory Orientation as well as in the Handbook section of this handbook/handout packet. This criminal background check is initiated during the required application process at [www.certifiedbackground.com](http://www.certifiedbackground.com) Students may access the DHS current list of potential disqualifying crimes at <http://www.oregon.gov/DHS/>.

During the program, students must self-disclose any warrants, arrests, charges, or convictions that arise while in the Nursing Assistant class. The Nursing Assistant program reserves the right to require additional criminal background checks for cause or if there is an approved interruption in the student’s course of study. Failure to disclose or concealment of a criminal background is grounds for denial of admission or dismissal from the course. The program has the right to deny admission or course continuation to any student whose background poses a threat to an individual, the college, the nursing profession and/or the community. If any college personnel learn of an Allied Health Department Nursing Assistant program student’s arrest for any crime on any of the criminal background check exclusionary lists, the Allied Health Director will obtain any available public records and in consultation with college administration may determine the need to exclude the student from any clinical settings during an investigation and may result in the dismissal of the student from the class. The student *may* be considered for future readmission to the class following the normal application process and criminal background check procedure. Registered NA 101 students who have previously received two Nursing Assistant Criminal Background Check (CBC) denials will be administratively dropped from the course; this now includes drug testing.

If RCC receives notification from Certified Background of a possible disqualification due to the student’s CBC, RCC will review the provided report. If the student’s conviction is on the State of Oregon’s list of disqualifying crimes, the student will be notified of the finding and will be dismissed from the class.

### Requests for Transfer or Reentry

### No student will be allowed to transfer hours from another program.

In the event a student is not able to successfully complete NA101, the student may register for a subsequent course and would be required to complete all course requirements for that course. The NA101 course may only be repeated once. If a student has failed any portion of NA101 twice but registers for a subsequent NA101 course at RCC, the student will be administratively dropped

**Employment While In The Nursing Assistant Program**

Students may not work a shift (i.e. 8 hours) immediately preceding a clinical rotation because of the potential impact on safe client care. Required clinical experiences may be assigned during days and/or evenings during the program. Nursing Assistant classes, labs, and clinicals typically involve 16 - 24 hours of attendance per week. Meeting these requirements may mean that students will need to adjust employment and family responsibilities.

# Application for CNA Examination through the Oregon State Board of Nursing

Satisfactory completion of the entire Nursing Assistant program will provide the student with a reasonable probability of success in passing the Oregon State Board of Nursing written/skills competency exam. The college will supply initial application forms to the student, however, additional application forms may be obtained from the Oregon State Board of Nursing

(971-673-0685).

Submitting the application, a copy of the Nursing Assistant Course Completion Certificate as proof of course completion, **and** application fees are the responsibility of the student. **Scheduling the OSBN Nursing Assistant examination through Headmaster is the responsibility of the student.**

The application for CNA certification will include another criminal background check. Students are directed to call Oregon State Board of Nursing (971) 673-0685 if they have concern about arrests or convictions in their past or have questions about policies for certification.

Students are required to submit fingerprints to OSBN at the time of application for certification as a CNA.

* Students will be given a fingerprint card and envelope at Orientation.
* Students are responsible for obtaining their fingerprints at facilities which provide such services (including Oregon State Police, Sheriff’s Office, etc.).
* There is a fee charged by each facility to get fingerprints done – this fee varies by facility.
* The facility at which the fingerprints are obtained will put the completed fingerprint card in the envelope provided and seal it.
* This envelope must be returned to the NA Program Director or Department Secretary by March 26th, **along with a check or money order for $52 made payable to the OSBN.**
* ***Attach check or money order by paper clip to the fingerprint envelope. Fingerprints received without payment will not be processed. This will not be mailed to or processed by OSBN until after the student has successfully completed the NA101 course***

**Healthcare Provider CPR Card**

The student must have a **Basic Life Support for** **Healthcare Provider** CPR card from the American Heart Association guidelines implemented March 2011 which must conform to the most recent International Liaison Committee on Resuscitation (ILOR) Guidelines for CPR. **The** **CPR course card must show that is still current through the last day of clinical.** These are the only cards that are valid. A student cannot practice in the clinical setting without a current **valid** CPR card. CPR documentation must be submitted before the 1st day of class, with the exception of admitted waitlisted students who must meet the deadline set by the Program Coordinator.

The CPR selected must meet the following criteria:

1. Conform to the most recent International Liaison Committee on Resuscitation (ILOR) or American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care;
2. Include instruction in adult, child, and infant CPR and automated external defibrillator (AED); and
3. Include in-person, hands on skill practice and verification of skill competency of adult, child, and infant CPR and AED by qualified and authorized instructor.

**Policies Relating to Student Health**

**Injury/Illness**

If a student has a fever, diarrhea, open lesions (e.g. “weeping sores, or draining wounds), or a contagious disease, he or she must not attend class or go to the assigned clinical area. If the student is unsure whether or not she/he should attend clinical (due to a cold sore or a cold, etc.), she/he should contact the clinical instructor. In the event a student becomes ill and must leave during a clinical shift, a make-up day may be required. Following an illness, injury, or surgery that could impact the student’s ability to safely perform clinical care, a statement may be required from a physician/primary health care provider stating that it is safe for the student to perform classroom or clinical responsibilities without restriction. The student must share a copy of the course’s “Academic and Technical Standards (Essential Functions)” found on previous pages with the physician/primary health care provider when requesting the release, and must provide the course director or instructor with a copy of the release by the time frame specified by the instructor.

Nursing Assistant students are required to report all injuries sustained in their assigned clinical facility to the instructor immediately. The instructor will assist the student in obtaining treatment, if required, and completing the required forms in accordance with institutional policy and RCC policy. Student injuries in the clinical setting are covered by Worker’s Compensation Insurance.

**Pregnancy**

A pregnant student must understand that the clinical performance expected of her is the same as that expected of any other student. The student should share a copy of the program’s “Technical Standards document with her health care provider, and must notify (via medical release form) the program director if the physician places any restrictions on clinical performance of those functions. Faculty will review the medical release form information provided by the physician/licensed health care provider and determine if the student can continue in clinical experiences.

# Immunizations

Students must obtain a TB test and upload official medical documentation to their account at [www.CertifiedBackground.com](http://www.CertifiedBackground.com). Students will be informed and highly encouraged to obtain and complete the hepatitis B series in the expected time frame. Students must provide documentation of the MMR vaccine which will also be submitted to admissions per RCC Policy. Students will not be admitted to practice in the clinical setting without a completed negative TB test (2 step) or negative chest X-ray within the last year. Students who have a history of a positive PPD will be required to provide documentation of a clear chest X-ray and are required to self-report physical signs and symptoms on the form provided by the program. Influenza vaccines are also highly recommended. Tetanus vaccine/or booster is also required.

**Hazardous Patient Care**

To protect both themselves and their clients, students are required to use universal/standard precautions when caring for all clients. Additional facility-mandated precautions may be required. Students in the clinical facility must follow the facility's procedures for handling bio-hazardous materials. Students may not refuse to provide care to individuals in the clinical setting. To do so will be viewed as a violation of OAR 051-063-0090.

**Conduct Expected of Students**

**Program Standards**

 **In addition to the RCC “Student Code of Responsible Behavior” found in the college catalog, students must abide by the following:**

Graduates from any nursing program are expected to perform in a manner that reflects the standards defined by the Oregon State Board of Nursing and by the nursing profession as a whole. Nursing Assistant students must learn to function in accordance with the accepted standards of practice mandated by the profession. For this reason, the expected conduct, outlined as follows, should be viewed as necessary preparation for the ultimate role that the student will assume when entering the profession. Students must not display conduct unbecoming a Nursing Assistant as defined in OAR 851-063-0090. Interactions in class and clinical are to reflect professionalism and civility as evidenced by caring, fairness, respect, acceptance of responsibility and trustworthiness.  Class should be treated as a work setting. \*

**Behavioral Expectations:**

1. Demonstrate emotional stability to function effectively under stress and adapt to changing environments.
2. Maintain effective, mature, and sensitive relationships with others.
3. Examine and modify one’s own behavior when it interferes with others or the learning environment.
4. Possess attributes that include compassion, empathy, altruism, integrity, honesty, responsibility and tolerance. \*

***Examples of learning activities found in the nursing curriculum and related to industry standards:***

* Exercise judgment, meet acceptable timeframes for client care delivery (acceptable timeframes are reflected by ability to carry out the usual client care assignment for a particular point in the program within the allotted clinical time), work effectively under stress, and adapt to changing client care environments.
* Accept accountability for actions that resulted in client care errors.
* Deal effectively with interpersonal conflict if it arises; maintain effective and harmonious relationships with members of the healthcare team.

*\*Adopted from RCC Associate Degree in Nursing Program*

**Other Expected Student Behaviors**

General Responsibilities

1. All Nursing Assistant students must register for and attend the Nursing Assistant mandatory orientation for the specific term designated. Mandatory orientation is only available to students registered for the orientation or registered waitlisted. Mandatory Orientation is term specific and may not be transferred to a subsequent term. Students submit required documentation by the assigned date given. The registration code to register for the NA101 classes will be emailed out to students who have met the deadline to turn in required documentation, by the Allied Health Department Secretary.

2. Current names, addresses, telephone numbers, city and state of birth must be given to the

program secretary and update information as any change occurs. It is the responsibility of the student to inform his/her instructor of changes immediately.

3. Students are advised not to take valuables into clinical settings.

4. Students are not permitted to take infants or children to class or to the clinical facility.

 Students must NOT be in the clinical facility other than the assigned clinical hours.

5. Cell phones will be turned off while in classroom/lab/clinical settings. No texting is allowed in classroom/lab/clinical. Students may not carry cell phones in the clinical setting. If you need to leave a number where your family can reach you for emergency purposes, they may leave a message for you with the Allied Health Department Secretary at 541-245-7841, or your clinical instructor. If you need to make calls, they can be made during break times only.

**Policy Regarding Cheating and/or Plagiarism**

As stated in the Student Code of Responsible Behavior (RCC Catalog), students are expected to practice academic honesty. The following statements are adapted from policy statements by Professor William Waggner, Mt. San Antonio College, and the Rogue Community College Science Department, and are provided to clarify the meaning and intent of academic honesty.

Instructors have the responsibility of planning and supervising all academic work in order to encourage honest and individual effort and for taking appropriate action if instances of academic dishonesty are discovered.

The term “cheating” includes but is not limited to:

1. having or using unauthorized materials during any test situation.
2. looking at another student’s work during any test situation.
3. changing answers on a returned exam in order to claim there had been a grading error.
4. discussing the content of any test with the individuals who have not yet taken it.
5. turning in work that was generated by other individuals or by the same individual in a prior semester.
6. plagiarism, which is the use of materials authored by another person or obtained from commercial source or the use of passages without proper acknowledgement.
7. obtaining prior or current exams without the instructor’s permission.

Therefore:

1. No dictionaries, electronic devices, notes or other reference materials may be used during any test situation unless authorized by the instructor.
2. No talking, signaling, or sharing materials with other students is allowed during any test situation unless specifically directed by the instructor as part of the requirements for the exam.
3. Only the materials required or authorized for a test should be taken out of the student’s notebook, backpack, or purse. All other materials should be put away as instructed.
4. An act of cheating may result in a grade of “No Pass” for the assignment, exam or course as well as a report filed to the Associate Dean and Dean of Instructional Services and Dean of Student Services.

The Nursing Assistant instructors will follow the college policy/procedure with regard to disciplinary action as outlined in the college catalog.

General Rights

The RCC policy regarding Student Rights, Freedoms, and Responsibilities Statement is available in the nursing program office and on the RCC website. Individual copies may also be obtained from the office of the Dean of Student and Community Services. Students are advised to review the statement to learn about students' freedom to learn, student conduct guidelines, and expectations for student responsibility as expected by members of the college community.

# Dress Code For Lab and Clinical Assignments

Uniform Specifics:

1. For both males and females: wine-colored, professional-appearing scrubs. Typical brand names that carry similar colors include Cherokee, Wonder Winks, Dickies, and Barco.
2. Gait belt
3. White or black socks/hose.
4. A white lab coat may be worn over the uniform in the clinical facility.
5. If a skirt/dress uniform is worn, white or neutral hose are **required** (not socks). Support hose are strongly recommended.
6. Shoes must have closed heels and toes in black or white. Cloth or canvas shoes do not provide adequate protection and are not appropriate.
7. A black, long-sleeved shirt may be worn under the scrub top.
8. RCC Student ID tags are required

**Personal Appearance**

For student and client safety and comfort

1. Jewelry must be worn in a way that does not interfere with client and student safety. *(For example: a ring with a large protruding stone or sharp edges could injure a client; loop or dangling earrings or a necklace could cause personal injury if grabbed by a confused or combative client.)* Nose or tongue rings or other visible body piercing devices are **NOT** acceptable in the lab and clinical setting (exception, may wear one pair of stud-type earrings). All tattoos are to be covered.
2. Personal hygiene must be maintained to promote asepsis and client comfort. Students are advised to be free of the smell of tobacco and fragrances in the clinical setting as it has caused some clients to become nauseated and/or to refuse to have students care for them.
3. Fingernails must be short and clean to promote asepsis and prevent client injury. Nail polish cannot be worn. False nails cannot be worn.
4. Perfumes, oils, after-shaves or strong-smelling talcum may not be used when the student is in the lab and clinical facility.
5. Hair/beards should be worn in such a way that it cannot fall into clean or sterile fields, touch the client’s body or otherwise interfere with client comfort. *(For example: off the collar.)*  Only traditional hair color is acceptable in the clinical setting. Hair must be up and off the collar before entering the facility.
6. Students must comply with facility policies that address a professional personal appearance. *[For example: no gum chewing, hair color, confinement (off the collar), clean and pressed uniform and clean shoes, no more than one ring on each hand (wedding set is one ring).]*
7. Permanent body tattooing must be covered.
8. Many clients are very sensitive to the smell of tobacco and fragrances. Students may not smoke while in clinical uniform and must be free of the smell of tobacco while in the clinical setting.

# Code of Conduct in Clinical Facilities

# Students are required to report all injuries or accidents involving their assigned clients to the instructor immediately. The instructor will assist the student to then follow appropriate course and facility policies.

# Students must communicate changes in client status to their clinical instructor in a timely manner. If a problem develops and a client’s life is not in jeopardy, the student should always call the instructor first. If the problem could be life threatening or result in immediate harm to a client, first locate an RN or LPN to help deal with the problem then notify the instructor.

# For “code” situations, unless the student knows the client’s physician has ordered “Do Not Resuscitate”, when a student finds an unresponsive client, s/he must:

* 1. Yell, “I need help in room \_\_\_\_ NOW”,
	2. Assess for breathing and pulse,
	3. Call a “Code” via the facility’s internal emergency system
	4. Start CPR
	5. When the licensed personnel arrive, the student should allow experienced

personnel to take over but should remain in the area, out of the way, in the event client information is needed.

For long-term care, students must know their assigned resident’s code status and follow the facility’s policy.

1. Students are advised that it is unprofessional and unethical to receive money or gifts from clients, or to continue relationships with clients after clinical hours or after clients have been discharged. Students are not to enter the clinical site during non-clinical hours for any reason as this is a violation of the NA 101 Code of Conduct in Clinical Facilities. Violation of the Code of Conduct in Clinical Facilities will result in dismissal from the Rogue Community College Nursing Assistant Program. If a student leaves personal items in the clinical setting the student should contact the clinical instructor or program director.
2. The following regulations apply to activities in clinical facilities:
	1. Students do not have "privileged" status and must adhere to all visitor regulations applicable to the general public.
	2. Students may not represent themselves as students for the purpose of observing or participating in procedures occurring at times and/or in departments other than those assigned by an instructor.
	3. Students may not be on the floor in uniform before or after clinical.
	4. Students may not use student status to gain access to the records of family or friends who are clients in the health care facility or agency.
	5. Students may not care for relatives or close friends in the clinical setting.
	6. Students may not leave the clinical site (facility) during clinical time without specific permission of the instructor.
	7. Students cannot perform patient care unless a clinical instructor is in the unit.
3. The student is responsible for ensuring that an instructor has checked and co-signed all appropriate forms before leaving the clinical facility. The instructor’s countersignature indicates that the student’s documentation looks appropriate.
4. Students will communicate with faculty, staff and other health care workers in a courteous, assertive, non-aggressive, non-defensive manner, and follow directions from faculty/staff unless it exceeds the students’ authorized duties. Any clinical-related concerns must be communicated to the instructor immediately.
5. Students will conduct themselves in a professional manner when in the clinical setting.
6. Students must always perform within their authorized duties and must follow facility policy/procedures when performing procedures.

**Confidentiality of Information/Social Media/Publication Policy**

Confidentiality is one of the primary responsibilities of every student in a clinical setting. Confidential information is defined as any information, written, spoken or electronically transmitted, whose unauthorized or indiscreet disclosure could be harmful to the interest of a client, employee, physician, the institution, a student or an instructor. Examples of such information include, but are not limited to, personally identifiable medical and social information, professional medical judgments, classroom and post-conference learning activities and discussions.

All information about clients, including names, the nature of the client’s disease, diagnosis and treatment is to be considered protected by applicable state and federal laws and by this policy. Incident reports relating to risk management issues and any other information designated as of a private or sensitive nature is also included in the category of confidential information. These matters should only be discussed in the appropriate school or clinical setting, NOT in public areas such as the cafeteria, break room, or outside of the clinical facility.

This policy applies to information maintained in an electronic fashion by the facility’s computerized information system as well as to written or spoken information and records. Computer or medication dispensing machine passwords are solely for the use of the person to whom they are assigned (unless the facility assigns one password to an instructor for the use of students) and must not be shared in order to prevent unauthorized access to confidential information. Clinical site records are not to be photocopied or removed from the facility.

To prevent a concern that students may gain access to the clinical facilities after completion of the Nursing Assistant course, remove NA ID sticker upon completion of the course. Please remove NA ID sticker from ID badge to receive the certificate of completion.

Students must understand that clinical affiliation agreements state the following: “at no time while a student or in the future shall any student publish or cause to have published any material relative to their learning experience at any clinical facility unless approved by both RCC and the clinical facility.”

Absolutely no reference to a patient, even if all identifying factors have been removed, should ever be shared electronically via any social networking site such as Facebook or via email outside of the password protected Rogue Online mail, and Rogue Online mail communication of any patient information should be only for clinical education purposes. Clinical facility or staff information must never be shared via email or social networking sites. Students must never take pictures of patients whether or not a patient gives permission. Any pictures needed for educational purposes will be taken only by clinical facility or RCC staff following facility and RCC policies with appropriate signed permissions.

Students must request permission before audiotaping or videotaping an instructor, and when they are permitted, such tapes or pictures must only be used for educational purposes within the program unless other express, signed permission is given by the instructor. Educational material (e.g. lesson PowerPoint or outlines) posted on Rogue Online for course student use are not to be posted by students on any other media or site.

Students should understand that negative information about any person posted on any social networking site or other site reflects on the professionalism, integrity and ethical standards of the person posting the information. Employers are known to periodically and randomly search public blog and profile sites.

Violation of this policy will result in the initiation of a disciplinary process and may result in dismissal from the nursing program.

**Policy Regarding Student Suspected of Substance Use**

To maintain the integrity of the nursing program and ensure safe client care, and in accordance with RCC policy, students must abstain from the use of alcohol or drugs/medications which affect safe and appropriate functioning in the following situations:

 a. Before and during nursing class and skills lab.

 b. While in student uniform.

 c. Before and during assigned time in the clinical facility, including the time of client selection.

Students have a responsibility to notify their instructor if they are taking any medications that may have an adverse effect upon their clinical performance. The instructor will then determine if the student’s clinical performance is safe.

Students have a legal and ethical responsibility to report peers who they suspect are substance users.

As stated in the college catalog, “Anyone under the influence of alcohol or controlled substances may be removed, dismissed, or suspended from college functions, classes, activities, or responsibilities. The college will impose disciplinary sanctions on students up to and including expulsion...for violation of these policies.” Referrals to alcohol and drug treatment agencies are available through RCC ACCESS Centers at 956-7191 (Redwood Campus) or 245-7563 (Riverside Campus).

While other medical conditions may cause some of the following, behaviors and signs suggestive of substance use include:

1. slowed thinking processes or very impulsive thinking;
2. immobilization or panic with resulting inability to think or act;
3. wildly unpredictable behavior deviant from usual, acceptable behavior; inappropriate or bizarre response/laughter;
4. irritable, restless manner;
5. complaints of blurred vision; dilated or constricted pupils; bloodshot eyes;
6. slurred speech;
7. emaciated or unusual weight loss;
8. tremors, especially in the hands and early in the morning;
9. complaints of morning headache; abdominal or muscle cramps; diarrhea;
10. diaphoresis;
11. odor of alcohol;
12. poor coordination or unstable gait;
13. threats to kill or harm oneself or another person;
14. possession of a weapon or hazardous object;
15. severe psychological distress;
16. poor judgment regarding safety issues for self, patients, and coworkers;
17. severe physical distress e.g. seizures, chest pain, respiratory distress;
18. possessing, using, or transferring any narcotics, hallucinogen, stimulant, sedative or similar drug other than in accordance with licensed health care provider’s order.

Any Nursing Assistant instructor or immediate supervisor who believes that a student is in a clinical setting while under the influence of alcohol or drugs will remove the student immediately from the client care responsibilities.

In the event of suspected use in the clinical setting, the instructor has the right to confiscate, in the presence of a witness, the substances for identification.

The behaviors and signs observed by the instructor will be documented by the instructor and validated by another nurse (another RCC instructor, nursing supervisor on duty, or nurse manager). The instructor will require the student to, as soon as it can be arranged, submit to body fluid collection and testing performed by a laboratory designated by the Nursing Assistant course. The collection and testing will be performed in a manner which preserves the integrity of the specimen. The student will be escorted to the laboratory by an instructor or other college representative.

The RCC Nursing Assistant course will bear the expense of the course mandated testing unless otherwise specified (e.g. by OSBN stipulation). Following completion of the specimen collection, the Nursing Assistant instructor/college representative will make arrangements for the student’s safe transportation home.

Failure to give written consent, without qualification, to such alcohol or drug testing and/or release of test results to the Director of the Nursing Assistant course, or failure to provide bonafide samples for such testing will be considered implied admission of illegal substance use and grounds for appropriate disciplinary action, including the possibility of immediate dismissal from the Nursing Assistant course.

The student involved in the alleged infraction will be temporarily excluded from the Nursing Assistant course until the test results have been received and reviewed by the Allied Health Department Head and/or Director of the Nursing Assistant course. The program director will follow RCC’s procedure for student dismissal/temporary exclusions.

Students should note that since **medical marijuana** is not a federally approved prescription drug and several clinical facilities have a “no tolerance” policy regarding marijuana, its use during the program as evidenced by a positive urine drug screen will result in dismissal from the program.

Immediately or as soon as reasonably possible after the test has been performed, the Nursing Department Chair Allied Health Department Director will be informed of the drug test.

1. If the results are negative, the student may return to the course activities. Opportunity for make-up will be provided, and the student will be expected to make up missed time and assignments.
2. If the test results are positive, the Director of the program will implement appropriate disciplinary action including the possibility of dismissal from the Nursing Assistant course on the grounds of substance use. The student who disagrees with the decision can utilize the RCC student grievance procedure outlined in the college catalog. The student should also note the “RCC Statement of Student Rights, Freedoms, and Responsibilities” found in the catalog.

Any positive findings will be reported to the Oregon State Board of Nursing.

#### Clinical Skills Supervision/Competency

#### A Nursing Assistant student is assigned a CNA buddy/or Licensed Nurse Preceptor at all times.

#### Students must perform procedures as listed on the “Clinical Skills Checklist Form”

both in the lab and clinical settings to demonstrate 80% competency in the state required skills areas. Only an instructor can "sign" (initial) a student “Competency Checklist”.

Instructors' initials and dates on the form indicate "that the student displayed the requisite

knowledge and satisfactorily passed the check-off evaluation on the specific date noted. There is a duty on the part of students to provide safe and reasonable care in activities they have studied and refrain from any action or intervention that they do not feel adequately prepared to deliver to a patient, and seek help when they are uncertain." (Aiken, T. 1994. Instructor's Guide for Legal, Ethical, and Political Issues in Nursing, F.A. Davis, p. 103.)

A clinical instructor has the responsibility to remove from client care any student they deem to pose a threat to client safety.

**Grading**

#### General Conditions of Grading

#### Grades are issued on a Pass (P) or No Pass (NP) basis.

#### Attendance/Class/Lab Participation

Students who are absent from class/lab are unable to participate in discussion or group

activities. Attendance and participation in class/lab are integral parts of the learning process and are required. A strong work ethic is essential for future employment in the health care field.

Late arrival or early departure for scheduled classroom/lab 15 minutes or more than three

times a term will constitute an absent day and will require a makeup day. A total of 45 minutes missed in class/lab will result in a makeup day. Absence from class/lab for a day will result in a full make-up day. Examples:

1. Student is late 15 minutes twice a term – no makeup day is required.
2. Student is late 45 minutes once – a makeup day is required.
3. Student is late 15 minutes three times a term – a makeup day is required.

An absence day combined with tardiness on other days will result in dismissal from the course.

By OSBN rules, all classroom/skills lab time must be made up. If absences or required makeup exceed the one available makeup day, failure of the course will be the result.

#### Clinical Expectations

#### Breaks: One or two 15 minute breaks and one 30 minute meal break. Reported extended breaks or repeated breaks or lunches may result in a makeup day requirement.

#### Illness: When a student becomes ill or knows s/he is going to be absent on a clinical day, s/he must notify the instructor (always available by phone or beeper) and the assigned clinical area by 0600 or by the specified start designated for the clinical experience. The student must leave a message to notify their instructor or the Program Director at 541-245-7936. Students who are “no call/no show,” i.e. do not attend clinical and do not call the instructor or department office before the start of clinical to explain their absence, should understand that in an employment setting such behavior would likely result in termination. In the NA class, students who are “no call/no show” will receive a clinical evaluation score of NI (Needs Improvement) and may be placed on “Clinical Performance of Concern” or “Clinical Probation” depending on past absences, patterns or clinical performance.

#### Assignments

# Assignments must be received on or before the due date assigned by the instructor. All

Rogue On-Line assignments/quizzes must be completed with an average score of 75% and a didactic final of 75%, to progress to clinical. RCC has multiple computer labs available for student use. If assignment is not completed by due date/time, a “0” will be given for a score. No make-up quizzes will be allowed unless prior arrangements have been made with the instructor.

# Examinations

# Instructors will review exam answers with students and when requested will:

# Verify that grades/scores are correct by going over, test paper or grade book when a student feels that his/her score does not coincide with the instructor’s records.

# Explain (not debate) an answer further if a student is still unclear about the rationale an instructor gave for an answer during the test review session.

# Accept written documentation from the text that a student wishes to present verifying the validity of an answer that is different from the one the instructor has indicated as correct, within one week of the exam in question.

# If a student is absent s/he must be prepared to make-up missed quizzes/exams during the next class or arrangements made with the instructor.

# Basis for Theory/Lab Grading

# At the end of the course, the student's total number of points will be added and divided by

the number of points possible to determine the final percentage. Per OSBN regulations, a score of 75% on the “Written Final” must be obtained. In cases of academic failure, quiz and test grades provide adequate notice of the student's current status. Grades will be awarded using the following scale:

Written Final: The total number of points correct will be added and divided by the number of points possible. A score of 75% must be obtained to progress to clinical. English language translators/dictionaries are not permitted during testing.

Practical Final: A score of 80% must be obtained on the final skills competency exam to progress directly to clinical. Students must accurately perform all critical factors and measurement skills to progress to the clinical phase of the program.

Percent Grade

75 - 100 = Pass On written exam, students may continue on to clinical phase.

80 – 100 = Pass On final skill competencies, students may continue directly to clinical phase.

Below 75 on the final written exam or below 80 on the final skills competency exam = No Pass. Students will be issued a Behavior of Concern and must attend the Skills Lab Review and Make-up to assure readiness for the clinical phase of the program.

**Clinical Assignments**

## Students are required to have criminal history clearance initiated in accordance with OAR

Chapter 411, Division 009 prior to starting clinical. (Fingerprinting will be required at student expense).

Faculty reserve the right (after faculty discussion/agreement) to change a student’s

clinical assignment (e.g. site or unit) after the clinical schedule has been printed and distributed.

A clinical facility has the right, by contractual agreement, to refuse educational access to

its clinical areas to any individual who does not meet the facility’s standards for safety, health, or ethical behavior. A student denied such access will require course status review to determine if course policies have been breached or if clinical requirements and course needs for evaluation can be met with the remaining clinical options.

**Clinical Evaluation**

Student progress evaluations/conferences will be conducted periodically as appropriate. There will be a minimum of two evaluation/conferences. If a student disagrees with anything on the written evaluation, it is the student’s responsibility to document her/his disagreement on the evaluation and discuss it with the instructor. If the student wishes, s/he may request that the involved instructor and another faculty member be present at an evaluation conference.

# Basis for Clinical Grading

# The following designations will be used to evaluate the student’s level of performance each day for each line item. The meaning of each of these designations follows:

E = Exceeds Standard – May be used if the student’s performance exceeds the expected level for that standard of care.

M = Meets Standard – The student’s performance is at the expected level for the standard of care.

NI = Needs Improvement to Meet Standard – Additional learning and attention to detail is required for a particular standard and/or the performance is less than the expected level for that item.

U = Unsatisfactory – The student’s performance is well below the minimum expected level for that standard of care, or is in serious violation of client’s safety as explained under “Safe Clinical Performance and Indicators of Unsafe or Inappropriate Clinical Performance” in the Student Handbook. (One example of a “U” would be a student who transferred any client without the use of a gait belt.)

Three NIs in any STARRED areas or 6 (total) NIs in ANY areas will result in a required clinical make-up day in which the student must demonstrate improvement in performance to pass the course. If there are no make-up days available for the student due to absence, the student will not pass the course. Four NIs in any starred area or 7 (total) NIs in any areas will indicate repeated unsafe or inappropriate performance and result in failure of the course. The student may receive one NI only for each observed incident.

A “U” will be assigned if the student behavior or performance warrants immediate removal from

client care for the day. The instructor will notify the director and a determination will be made as to whether the student will be allowed back into the next scheduled clinical day. If the student is not allowed to return to clinical, it will result in failure of the course.

**\*Note: A “U” will be automatically given to any student attempting to assist a client to transfer or ambulate without the use of a gait belt.** If the student is allowed to return to clinical, a make-up day for demonstration of improvement will be required. If the student was previously scheduled for the only available make-up day, the U will result in failure of the course.

A grade of “P” (Pass) will be assigned to all students who have met the clinical

competency evaluation criteria set forth by the Oregon State Board of Nursing and have satisfactorily demonstrated performance in these required skills in the Clinical setting by providing safe care to two (2) clients within the assigned clinical assignment by the end of the clinical rotation.

A grade of “NP” (No Pass) will be assigned to any student who fails to complete all the

required clinical hours\*, required components of the “Competency Evaluation” form or is unable to meet the standard of caring for two (2) patients safely within the clinical assignment. A grade of No Pass will also be assigned to any student as outlined under the “Code of Conduct in Clinical Facilities” on previous pages, or who causes harm/potential harm to a client through behavior outside the standards of the profession or college.

**\*100% Attendance in this course is mandated by the Oregon State Board of Nursing**. There is one day of clinical make-up for illness and emergencies. Any additional absences will result in a “No Pass” and cannot be made up.

The most common reason for a CNA to lose a job is because of being late to work. Workplace protocol also requires employees to notify their supervisor if they are going to be late or absent from work. During this course, it is important to learn and practice appropriate work ethics. Therefore, students are required to be at clinical at the scheduled pre-conference start time. Late arrival for scheduled clinical time (including pre-conference) of no more than 15 minutes (without instructor notification and/or notation as “excused”) more than three times in the course, or by no more than 45 minutes ONCE in the course will constitute a makeup day. The same time frames apply for students leaving clinical early. Examples:

1. Student is late 15 minutes twice a term – no makeup day is required.
2. Student is late 45 minutes once – a makeup day is required.
3. Student is late 15 minutes three times a term – a makeup day is required.
4. An absence day combined with tardiness on other days will result in dismissal from the course.

When a student becomes ill or knows s/he is going to be absent on a clinical day, s/he must notify the instructor (available by phone) and the assigned clinical area by the specified start time designated for the clinical experience. If unable to reach the instructor by phone, the student must leave a message to notify the program secretary at 541-245-7504. Failure to notify the instructor (or secretary if unable to reach instructor) of absence by the required time will result in review of the situation by the NA 101 Program Director with a possible No Pass.

**Student Performance of Concern Policy**

If a student fails to follow course standards, the student will receive a “Student Performance of Concern” form detailing both the concern and the corrective action needed by the student. Items considered for this form are given below. If the corrective action is not taken by the specified time, the student (after careful consideration by the faculty) may not be allowed to finish the course. Items considered on Performance of Concern include:

1. Classroom performance
2. Dress code for clinical assignments
3. Program requirements such as CPR and immunization records not on file
4. Code of conduct in clinical facilities
5. Skills competency both in lab and clinical
6. Low exam scores
7. Attendance class/lab/clinical
8. Indicators for unsafe clinical performance are addressed
9. Conduct Unbecoming a Nursing Assistant OAR 851-063-0090

**Rogue Community College**

**Nursing Assistant 101 – Classroom/Lab/Clinical**

**Student Performance of Concern**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Classroom Behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dress Code for Clinical Assignment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Program Requirements such as; CPR/Immunization Records (not on file): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Code of Conduct in Clinical Facilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Skills Competency Both in Lab and Clinical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Low Examination Scores: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Attendance Classroom/Lab/Clinical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Indicators for Unsafe Clinical Performance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Conduct Unbecoming a Nursing Assistant OAR 851-063-0090: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Action to be Taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Student Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Instructor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Safe Clinical Performance & Indicators of Unsafe or Inappropriate Clinical Performance\***

Nursing assistant students must safely apply concepts learned in classroom and skills lab in the clinical setting. Students are expected to demonstrate growth in clinical performance through application of knowledge and skills from this course and meet clinical expectations outlined in the clinical evaluation tool. Students are expected to provide safe, competent care. Clinical is the place for demonstration of appropriate behaviors and work ethic.

Nursing assistant students are legally responsible for their own committed or omitted acts and it is therefore necessary for the student and the nursing faculty to conscientiously identify any behavior that is unsafe. The following further defines the asterisked areas on the clinical evaluation tools contained in this handbook.

Unsafe clinical performance includes behavior that places the client or staff or faculty in either physical or emotional/psychological jeopardy. Physical jeopardy is the risk of causing physical harm. Emotional/psychological jeopardy means that the student creates an environment of anxiety or distress that puts the client at risk for emotional or psychological harm or causes the staff or faculty to fear for their safety. Unsafe clinical practice is an occurrence, or pattern of behavior involving unacceptable risk, and unsafe or unprofessional practice may result in a faculty decision to remove the student or bar the student from the clinical area.

*Unsafe clinical behavior* is demonstrated when the student:

1. Compromises the *physical* safety of the client or a co-worker (e.g., neglects use of ordered side rails or other restraints; leaves bed in high position; does not use gait belt when assisting client with transfers or ambulation; leaves call bell out of client reach; inadequately observes/monitors clients at risk).
2. Compromises the *psychological* safety of the client (e.g., speaks inappropriately in front of client and significant others;).
3. Compromises the *microbiological* safety of the client (e.g., comes sick to clinical experience; fails to follow hand hygiene techniques or standard precautions or isolation procedures).
4. Inadequately and/or inaccurately interprets or performs Nursing Assistant authorized duties in assessment/communication/action (e.g. fails to observe and/or report critical changes in client status; makes repeated faulty judgments; fails to follow written and/or verbal instructions/orders from instructor or facility staff; fails to complete care and/or documentation within the specified clinical time frame).
5. Violates previously learned principles/objectives in carrying out basic Nursing Assistant care skills (e.g., does not give enema correctly; does not calculate I & O correctly, fails to observe safety precautions during isolation).
6. Assumes inappropriate independence/dependence in action or decisions (e.g., fails to seek help when situation is out of control or in an emergency; leaves floor without reporting off to appropriate staff/instructor); does not make decisions at appropriate level, (makes inappropriate decisions without consulting an instructor or CNA buddy); does not provide safe Nursing Assistant care.

\*Adapted from Rogue Community College Associate Degree in Nursing Program

**Disciplinary Actions**

Disciplinary actions applied by the college and Nursing Assistant Program in cases of inappropriate student performance or behavior include suspension or immediate dismissal from the course. The involved faculty member(s), in consultation with the Director of the NA Program, the Allied Health Department Head, and/or the appropriate college associate dean, will determine disciplinary actions for each case.

# Grounds for Disciplinary Actions

1. Major or recurrent clinical performance which adversely affects the health, safety, and/or welfare of the public as outlined in the Oregon Administrative Rules 851-063-0090 wherein conduct unbecoming to the standards of Nursing Assistant is defined. This document is included in the handbook. (See addendum on following pages).
2. Failure to comply with program or college policies which results in actual or potential threat to client, student or instructor safety.
3. Sexual harassment, sexual contact, and/or romantic involvement with clients does not conform to the legal and accepted standards for Nursing Assistants. Complaints or incidents involving these behaviors will be investigated and resolved through utilization of RCC’s harassment policy (see the current college catalog).

# Disciplinary Procedure

1. When a violation or repeated performance problems are considered to be serious enough that the student is to be reprimanded, temporarily excluded, or otherwise disciplined including dismissal, the involved instructor will immediately notify the program director/department head and document the performance a behavior of concern, and follow the procedure outlined in the current Handbook. The director will notify the associate dean within one working day. The director will give written notice of the disciplinary action to the student as soon as possible and follow appropriate college procedures.
2. If the student does not accept the decision of the Nursing Assistant faculty, he/she may then pursue the college’s grievance procedure.

**Note: A decision that a student is unable to safely practice in the clinical setting will preclude a student’s completion of the required course work and will *necessitate withdrawal or dismissal from the course.***

**Addendum**

Conduct Unbecoming a Nursing Assistant

851-063-0090

A Nursing Assistant, regardless of job location, responsibilities, or use of the title “CNA,” who, in the performance of nursing related duties, may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a Nursing Assistant. Conduct unbecoming a Nursing Assistant includes but is not limited to:

**(1)** **Conduct related to the client’s safety and integrity:**

1. Leaving a Nursing Assistant assignment without properly notifying appropriate supervisory personnel;
2. Failing to report to proper authorities information regarding incompetent, unethical or illegal practice of any health care provider;
3. Failing to respect client rights and dignity regardless of social or economic status, personal attributes or nature of health problems or disability;
4. Failing to report actual or suspected incidents of client abuse; or
5. Engaging in sexual misconduct related to the client or the workplace.

**(2) Conduct related to other federal or state statutes/rule violations:**

1. Knowingly aiding, abetting or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of health care providers;
2. Violating the rights of privacy, confidentiality of information or knowledge concerning the client, unless required by law to disclose such information;
3. Discriminating against a client on the basis of age, race, religion, sex, sexual preference, national origin or disability;
4. Abusing a client. The definition of abuse includes but is not limited to intentionally causing physical harm or discomfort, striking a client, intimidating, threatening or harassing a client;
5. Neglecting a client. The definition of neglect includes but is not limited to unreasonably allowing a client to be in physical discomfort or be injured;
6. Engaging in other unacceptable behavior or verbal abuse towards or in the presence of a client such as using derogatory names or gestures or profane language;
7. Using the client relationship to exploit the client by gaining property or other items of value from the client either for personal gain or sale, beyond the compensation for services;
8. Possessing, obtaining, attempting to obtain, furnishing or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs; or
9. Removing or attempting to remove drugs, supplies, property or money from the workplace without authorization.

**(3) Conduct related to communication:**

1. Inaccurate recordkeeping in client or agency records;
2. Incomplete record keeping regarding client care; including but not limited to failure to document care given or other information important to the client’s care or documentation which is inconsistent with the care given;
3. Falsifying a client or agency record; including but not limited to filling in someone else’s omissions, signing someone else’s name, recording care not given, fabricating data/values;
4. Altering a client or agency record; including but not limited to changing words/letters/numbers from the original document to mislead the reader of the record, adding to the record after the original time/date without indicating a late entry;
5. Destroying a client or agency record;
6. Failing to maintain client records in a timely manner which accurately reflects management of client care, including failure to make a late entry within a reasonable time period; or
7. Failing to communicate information regarding the client’s status to the supervising nurse or other appropriate person in a timely manner.

**(4) Conduct related to the client’s family:**

1. Failing to respect the rights of the client’s family regardless of social or economic status, race, religion or national origin;
2. Using the NA client relationship to exploit the family for the NA’s personal gain or for any other reason
3. Stealing money, property, services or supplies from the family; or
4. Soliciting or borrowing money, materials or property from the family.

**(5) Conduct related to co-workers: violent, abusive, threatening, harassing or intimidating behavior towards a co-worker which either occurs in the presence of clients or otherwise relates to the delivery of safe care to clients.**

**(6) Conduct related to achieving and maintaining clinical competency:**

1. Failing to competently perform the duties of a Nursing Assistant;
2. Performing acts beyond the authorized duties for which the individual is certified; or
3. Assuming duties and responsibilities of a Nursing Assistant without Nursing Assistant training or when competency has not been established or maintained.

**(7) Conduct related to impaired function:**

1. Using intoxicants, prescription, over the counter or controlled drugs to an extent or in a manner injurious to the Nursing Assistant or others or to the extent that such use impairs the ability to conduct safely the duties of a Nursing Assistant; or
2. Having a physical or mental condition that makes the Nursing Assistant unable to perform safely the duties of a Nursing Assistant.

**(8) Conduct related to certificate violations:**

1. Providing, selling, applying for or attempting to procure a certificate by willful fraud or misrepresentation;
2. Functioning as a medication assistant without current certification as a medication assistant;
3. Altering a certificate of completion of training and/or Nursing Assistant certification issued by the Board;
4. Disclosing contents of the Nursing Assistant competency examination;
5. Allowing another person to use one’s Nursing Assistant certificate for any purpose;
6. Using another’s Nursing Assistant certificate for any purpose; or
7. Representing oneself as a CNA without current, valid CNA certification.

**(9) Conduct related to the certificate holder’s relationship with the Board;**

1. Failing to cooperate with the Board during the course of an investigation. The duty to cooperate does not include waiver of confidentiality privileges, except if a client is harmed. This waiver of confidentiality privileges does not apply to client-attorney privilege.
2. Failing to answer truthfully and completely any question asked by the Board on an application for initial certification, renewal of certification or recertification;
3. Failing to provide the Board with any documents requested by the Board; or
4. Violating the terms and conditions of a Board disciplinary order.

**Nursing Assistant Student**

**Handbook Agreement**

I hereby understand that this course is comprised of two (2) phases. A Theory/Lab portion and a Clinical portion.

I have read the material in the current Nursing Assistant Student Handbook and understand it. As a Rogue Community College Nursing Assistant student, I understand that I must comply with the policies contained in this Nursing Assistant Student Handbook to continue in the course.

I consent to having fellow students perform instructor selected and approved non-invasive procedures on me after appropriate instruction and under instructor supervision.

I understand that all information regarding clients is strictly confidential, whether written in the facility record or coming to my knowledge from being in the health care facility and I will comply with the Confidentiality of Information/Social Media/Publication Policy contained within this handbook. I understand that if I violate this policy, I may be subjected to civil penalties and/or disciplined action. I will not photocopy any clinical site records.

I understand that for purposes of continuity of education and safety of clients, nursing instructors may discuss my clinical performance with other faculty and with me.

I understand that if I request a recommendation for employment purposes from a Nursing Assistant instructor, the request must be in writing. I also understand the recommendation may include information on grades and a performance summary from the other Nursing Assistant instructors.

I agree that for purposes of public safety and health, if I have or develop any type of psychological, medical, drug or alcohol problem that could impair my clinical performance the program may report it to and/or consult with the Oregon State Board of Nursing (OSBN).

I understand that when I am in the clinical setting, if my clinical instructor believes that my ability to perform client care safely is impaired, my instructor will remove me from client care responsibilities and follow the guidelines outlined in the Nursing Assistant Student Handbook.

I am aware of the inherent problems present in the clinical settings regarding lifting clients, communicable diseases that clients may have, the potential for needle stick injuries, exposure to hazardous materials and radiation, etc. I am also aware that these hazards are always present and proper precautions must be taken at all times. I am also aware that I must use "standard precautions" in caring for all clients.

I will adhere to the Oregon Administrative Rules 851-063-0090 where standards of Nursing Assistants’ is defined. This document is located in the handbook.

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(Signature) (Date)

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| **Lesson 1:** |
| * CHC – DHS Review 11-1-11, HB2442

 Crimes Course Overview  | * Oregon Nursing Assistant

Candidate Handbook, 5/1/13 |
| * Introduction to Health Care Agencies
 | * CPR Requirements – AHA, ILOR
 |
| * The Nursing Assistant
 | * Requirements for States and LTC\*

 (Prohibition of Charges) |
| * Ethics and Laws
 | * NA Reimbursement Form
 |
| * Work Ethics
 | * OSBN Nursing Assistants in

Oregon |
| * Understanding the Person
 | * What Certified Nursing Assistants

 Need to Know 4/11 |
| * Mosby’s Textbook for Nursing

Assistants, 8th edition, 2012 | * Rogue On-line Orientation
 |
| * Mosby’s Workbook for Nursing

 Assistants, 8th edition, 2012 (optional) | * NA Lab Orientation
 |

**Lesson Overview:**

The instructor will review the expectations of the student in the Nursing Assistant (NA) course. The student handbook, Oregon Nursing Assistant Candidate Handbook 5/1/13, CHC – DHS Review including HB2442 crimes, *Mosby’s Textbook for Nursing Assistants*, 8th edition, 2012 and optional workbook, equipment, skills lab practice, clinical, and applying for certification to the Oregon State Board of Nursing will be discussed. The roles and responsibilities; legal aspects and limitations of the NA including: authorized duties of the NA including the delegation; the NA’s responsibility for reporting to the nurse; abuse; the client’s rights, including: a) the right to refuse care and b) a description of the role of the federal and state regulatory agencies will be introduced. In addition, there will be a review of effective communication, work ethics, and inter-personal communication skills.

**Learning Objectives:**

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Describe how the Nurse Practice Act affects the CNA. Identify authorized duties of the CNA.
3. Identify legal aspects of working as a CNA in relation to self, health team members, clients, and families.
4. Ethical practice and standards of behavior in relation to self, healthcare team members, clients, families, and employer
5. Responsibility for reporting to facility management and/or the appropriate agency: mistreatment and neglect
6. Providing assistance in resolving grievances and disputes through proper channels.
7. Describe the qualities and characteristics of a successful nursing assistant.
8. Demonstrate the appropriate dress and hygiene for the job.
9. Demonstrate what to do in stressful situations.
10. Demonstrate sensitivity when working with clients of different ages, cultures, or abilities.
11. Working with other health care workers and their roles.
12. List the ways to build productive working relationships with other health care workers.
13. Explain a CNA’s responsibilities when accepting or not accepting a delegated task in settings where RN’s are not regularly scheduled.
14. Explain the difference between an RN, LPN, Nurse Practitioner, and other licensed health care professionals.
15. Who a CNA can accept direction from: LPN, RN, Nurse Practitioner, and other licensed health care professional
16. List three reasons it is important to encourage clients to do as much for themselves as possible and ways to promote client independence.
17. Explain the state certification requirements and process.
18. Explain the accreditation survey processes.
19. Identify signs of abuse and neglect, how to prevent and report abuse and neglect to supervisors.
20. Recognize unacceptable behaviors of conduct unbecoming a CNA in the performance of duties.
21. Explain the difference between verbal and non-verbal communication.
22. Identify barriers to effective communication.
23. Explain the importance of confidentiality.
24. Use communication skills effectively when relating to client’s family and friends.
25. Direct individuals with grievances and disputes through proper channels.
26. Demonstrate how to answer a client’s call signal.
27. Demonstrate effective communication with the angry or potentially violent client.
28. Maintain and improve quality of life for clients by providing a safe, clean, home like environment.
29. Assist client in meeting religious/spiritual needs.
30. Addressing conflict with role and authorized duties.
31. Avoiding factors which block communication.
32. Communicating with others when English is a second language.
33. Communicating with team members including end of shift reporting.
34. Emergency procedures, including CPR, bleeding precautions.
35. Lab orientation

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012, Chapters 1, 2, 3, 4, 8“Oregon Nursing Assistant Candidate Handbook,” 5/1/13“OSBN Nursing Assistants in Oregon – What Certified Nursing Assistants Need to Know” |
| **Review Skills:****# 1-5** | Hand washing/Hand Hygiene; Putting on and Removing Personal Protective Equipment – Gloves, Gown & Mask; Wrist Restraints |
| **Quizzes:** | Chapters 1, 2, 3, 4, 8 |
| **Videos:** | Ethics, Resident Rights, and Dignity; Natural Process of Aging |

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| **Lesson 2:** |
| * Body Structure and Function
 | * Preventing Infection
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| * Safety
 | * Promoting a Restraint Free Environment
 |
| * Environmental Safety and Emergency Procedures
 | * Person-Centered-Care - Protecting Client’s Rights
 |
| * Introduction to Occupational Safety and Health Administration (OSHA)
 | * Standards including, but not limited to: Blood borne Pathogens, Hazard Communication, and OSHA Guidelines for Nursing Homes
 |

**Learning Objectives:**

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Recite the history and the content of the Omnibus Budget Reconciliation Act of 1987.
3. Person-Centered Care
4. Protecting client’s rights including at least:
5. Right to assistance getting to and participating in group and family activities;
6. Right to assistance in resolving grievances and disputes;
7. Right to avoid the need for restraints;
8. Right to care and security of personal possessions;
9. Right to considerate and respectful care;
10. Right to control finances;
11. Right to freedom from physical or psychological abuse, mistreatment, and neglect;
12. Right to have information about the facility’s compliance with regulations, planned changes in living arrangements, and available services including the fees for those services;
13. Right to have information about their diagnosis, treatment, and prognosis;
14. Right to maintenance of confidentiality with personal and medical records: Health Insurance Portability and Accountability Act of 1996 (HIPAA);
15. Right to make healthcare wishes known through advance directives and durable powers of attorney;
16. Right to make personal choices to accommodate their needs and make health care decisions about their plan of care including the right to refuse a recommended treatment;
17. Right to privacy, including privacy while receiving treatments and nursing care, making and receiving telephone calls, sending and receiving mail, and receiving visitors;
18. Right to review the records related to their medical care and have the information explained or interpreted as necessary;
19. Promoting clients’ independence; and
20. Providing holistic care.
21. Explain why hand hygiene is important.
22. Environmental Safety and Emergency Procedures
23. Applying fire safety concepts;
24. Avoiding and managing hazards in the workplace;
25. An introduction to Occupational Safety and Health Administration (OSHA) Standards including, but not limited to: Bloodborne Pathogens, Hazard Communication, and OSHA Guidelines for Nursing Homes;
26. Preventing burns;
27. Preventing falls of residents and staff;
28. Using side rails
29. Demonstrate knowledge of handling and disposing of contaminated materials and hazardous substances.
30. Identify potential hazards in the health care setting and tell how to avoid them including: falls, fire safety, client burns, and safe measures with oxygen use.
31. List OSHA guidelines that relate to working in the healthcare setting.
32. Explain the chain of infection.
33. List signs and symptoms of infection, cellulitis.
34. Identify ways to prevent the spread of communicable and infectious diseases.
35. Explain the cause, transmission, signs/symptoms, and care of clients with AIDS and Hepatitis.
36. Identify restraint alternatives.
37. Demonstrate the proper application of restraints.
38. Using least restrictive form of intervention
39. Dangers and hazards related to use
40. Maintain choice and mobility
41. Demonstrate correct hand washing.
42. Demonstrate correct application and removal of personal protective equipment: gloves, gown, and mask.
43. Follow standard precautions according to the Centers for Disease Control and prevention.
44. Follow guidelines for isolation, including neutropenic precautions.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012, Chapters 9, 14, 15, 12 |
| **Review Skills:****# 6-12** | Vital Signs |
| **Quizzes:** | Chapters 9, 14, 15, 12 |
| **Videos:** | Infection Control, Safety and Restraints |
| **Lab Practice:** | Lab Orientation/Skills 1-5 Hand washing/Hand Hygiene; Putting on and Removing Personal Protective Equipment – Gloves, Gown and Mask; Isolation procedures, including neutropenic precautions.Wrist Restraints; Pre/Post Procedures;The Client Unit; Placing and Answering the Client’s Call Signal |
| **Lesson 3:** |
| * Growth and Development
 | * Basic Anatomy and Physiological Changes
 |
| * Care of the Older person
 | * Across the Life Span
 |
| * Vital Signs
 | * Basic Developmental Tasks Through the Life Cycle including an Awareness of Developmental Tasks Associated with the Aging Process
 |
| * Caring for Mothers and Newborns
 | * Process of Aging including the
* Physiological and Psychological
 |
| * Description of human needs: Cultural/Ethnic Needs, Family Involvement, Safety, Socialization, Individualized Care, Planning, Human Development
 | * How to Organize Client Care for a Group of Clients According to the Clients’ Preferences and the Care Plans
 |

**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Explain why vital signs are measured.
3. List the factors affecting vital signs.
4. Take, record, and recognize the normal ranges of oral, rectal, axillary, and tympanic membrane temperatures.
5. Identify which method of taking a temperature is appropriate in a variety of situations.
6. Locate the sites for and learn to take and record radial and apical pulses.
7. Describe normal respirations.
8. Recognize the normal respiration and pulse ranges for all age groups.
9. Know the factors that affect blood pressure.
10. Recognize the normal blood pressure ranges for all age groups.
11. Demonstrate accurately taking and recording vital signs.
12. Monitor, record, and report pain level using the pain scales.
13. Measuring blood pressures: manual and electronic upper arm, forearm, lower leg, thigh, and orthostatic blood pressure readings
14. Identify the stages of growth and development and the normal age ranges for each stage.
15. Recognize the social and emotional responses across the life span.
16. Describe the changes that occur in the body’s systems during aging and the care required.
17. Describe the functions of the skin, list the age-related changes in the integumentary system, and describe how to assist the client with maintaining skin integrity.
18. Describe special needs and care of both mothers and newborns.
19. Identify signs/symptoms of illness in infants. Describe care and possible complications of circumcisions, cesarean sections, episiotomies, and umbilical cords
20. Cultural Responsiveness: Cultural responsiveness is a process that involves the integration of knowledge, attitudes, and skills that enhance cross-cultural communication and foster meaningful, respectful interactions with others. Two components of cultural responsiveness are:

 (a) Cultural awareness: A conscious learning process in which an individual becomes sensitive and appreciative to other cultures by including but not limited to:

 1. Identifying one’s own cultural background, values, and beliefs; and

 2. Examining one’s own cultural biases toward people whose cultures are different than our own.

 (b) Cultural knowledge: The process of understanding the key aspects of a group’s culture including but not limited to:

 1. Avoiding making assumptions based on cultural background;

 2. Learning basic general information about predominant cultural groups in one’s geographic area;

 3. Reading ethnic newspaper articles and novels; and

 4. Viewing documentaries about cultural groups.

1. Identify and describe the following:
2. Family involvement
3. Safety
4. Socialization
5. Individualized care planning
6. Human development
7. Basic anatomy and physiological changes across the lifespan
8. Basic developmental tasks through the life cycle including an awareness of developmental tasks associated with the aging process
9. Process of aging including the physiological and psychological
10. How to organize client care for a group of clients according to the clients’ preferences and the care plans.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 10, 11, 26, 49 |
| **Review Skills:****# 14-24, 79** | Positioning and Transfers, Mechanical Full Body Lift |
| **Quizzes:** | Chapters 10, 11, 26, 49 |
| **Videos:** |  |
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| **Lesson 4:** |
| * Using Principles of Body Mechanics
 | * Safely Handling, Moving, and Transferring the Person
 |
| * Rehabilitation and Restorative Care
 | * Preventing Falls
 |
| * Sexuality
 | * Preventing Pressure, Friction,and Shearing
 |
| * Mechanical Full Body Lift
 | * Turning and Positioning in Bed and Wheelchair
 |
| * Transporting in Wheelchairs and Specialized Chairs
 | * Using lifts and Safe Resident
 |
| * Restorative Care
* Bedmaking
 | * Handling Devices: Friction-Reducing Devices, Mechanical Lifts Including Site to Stand Lifts, and Bariatric Equipment
 |
| * Approaches to Restoring Independenceat the Client’s Highest Level of Functioning
 | * Assistive Devices for all Ages to

 Include: Care for, Application and  Removal of Prosthetic and Orthotic  Devices and Braces |
| * Promoting Physical Activity
 |  |

**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Perform skills without injury using principles of body mechanics.
3. Demonstrate turning, positioning, and alignment techniques for clients in bed, chair, and wheelchair using safe client handling devices.
4. Move and transfer client safely and comfortably from bed to wheelchair and back.
5. Demonstrate knowledge necessary for transporting clients safely and comfortably in wheelchairs, geriatric chairs, and lifts.
6. Providing for individualized safety needs.
7. Use safe client transfer and handling techniques for lifting and moving (lift equipment, safe client handling devices, seated transfer, etc.) bariatric considerations.
8. Demonstrate respect for a client’s sexuality.
9. Encouragement and training of the client in self care according to the client’s abilities.
10. Position client in good body alignment.
11. Assist a client with ADL programs.
12. Elevate a client’s extremity according to the care plan.
13. Implement cervical, hip, and sternal precautuions
14. Application and care of an established prosthetic device and orthotic device according to the care plan.
15. Assist a client with the use of a self-help device according to the care plan.
16. Correctly place a foot board according to the care plan.
17. Demonstrate use of pillows and other positioning devices for client support according to the care plan.
18. Demonstrate knowledge of placing hand rolls according to the care plan.
19. Use transfer devices according to the care plan.
20. Demonstrate documenting observations using Board-approved abbreviations and procedures (continues through Lesson 10).
21. Demonstrate transfer with mechanical full body lift.
22. Demonstrate transporting in wheelchairs and specialized chairs, and bariatric equipment.
23. Demonstrate turning and positioning in bed and wheelchair, and bariatric equipment.
24. Identify and describe the following:
25. Preventing pressure, friction, and shearing
26. Restorative care:
27. Approaches to restoring independence at the client’s highest level of functioning;
28. Promoting physical activity
29. Assistive devices for all ages to include:
30. Care for, application and removal of prosthetic and orthotic devices and braces
31. Use lifts and safe resident handling devices: friction-reducing devices, mechanical lifts including sit to stand lifts, and bariatric equipment.
32. Bedmaking: Proper linen handling, correct techniques for occupied and unoccupied beds.

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| **Bariatric Equipment****Defining “Bariatric Equipment”** |
| **Equipment considerations****for bariatric care** | * Importance of knowing weight limits for equipment
* How to determine weight limits (equipment labels, consulting supply department, equipment operating manuals, etc.)
* Access to equipment (specially outfitted rooms, rentals, supply department)
* Understanding how to use new equipment (inservices, training manuals, etc.)
 |
| **Commonly needed equipment for** **bariatric residents** | * Wheelchairs
* Shower chairs
* Beds
* Commodes
* Lifts
* Appropriately sized blood pressure cuff
* Appropriately sized linens for alternate beds, possibly gown/clothing for resident
 |
| **Need for altered approaches to transporting bariatric residents** | * Approaches to inclines
* Going over additional assistance
* Enlisting additional assistance
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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 13, 16, 38, 17, 48, 51 |
| **Review Skills:****# 25-32, 79** | Upper and Lower ROMHeight and Weight, and Ambulation |
| **Quizzes:** | Chapters 13, 16, 38, 17, 48 |
| **Videos:** | Resident Transfers the Safe Way; Mechanical Full Body Lift (DVD) |
| **Lab Practice:** | Skills 14-24, 76, 77, 79 Positioning and Transfers; Mechanical Full Body Lift; Transporting in Wheelchairs and Specialized Chairs; Turning and Positioning in Bed and Wheelchair; Using Lifts and Safe Resident Handling Devices: friction-reducing devices, mechanical lifts including sit to stand lifts, and bariatric equipment; Using Principles of Body Mechanics, Occupied and Unoccupied Bedmaking; Hip, Cervical, and Sternal Precautions |

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| **Lesson 5**: |
| * The Persons Unit
 | * Comfort, Rest and Sleep
 |
| * + - Exercise and Activity
 | * Wound Care
 |

**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Caring for the person’s environment.
3. Identify ways in which to assist clients with socialization needs.
4. Explain why family and visitors are important to clients.
5. Describe the physiological changes in the body over the life span.
6. Measure and record accurate height and weight.
7. Explain the importance of client-specific rest/sleep/socialization/activity schedules.
8. Implement measures for preventing pressure sores.
9. Use anti-pressure devices following procedure.
10. Provide care for clients with tubes and special equipment without causing harm to the client.
11. Perform range of motion exercises.
12. Assist a client with ambulation.
13. Use ambulation devices according to care plan.
14. Describe signs/symptoms and causes of pressure ulcers and circulatory ulcers.
15. Identify the pressure points in each body position.
16. Describe observations to make about a wound.
17. Describe how to meet the basic needs of persons with wounds.
18. Describe bed rest, complications of bed rest, and how to prevent complications of bed rest.
19. Explain why pain is a personal experience.
20. List signs/symptoms of pain and nursing measures that relieve pain.
21. Describe factors that affect pain.
22. Use of assistive devices
23. Use of sequential compression devices

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 18, 27, 28, 33, 34 |
| **Review Skills:****# 33-38, 79** | Oral Care, Dentures, Feeding, Calculating Intakes, Measure andRecord Oral Fluid at Meal Times, Assist with Hydration |
| **Quizzes:** | **SKILL LAB QUIZ**Chapters 18, 27, 28, 33 |
| **Videos:** | Preventing and Treating Pressure Ulcers; Ambulating |
| **Lab Practice:** | Skills 25-32, 79 Upper and Lower ROM, Height and Weight, Ambulation with a Walker; Ambulation Using a Cane; Mechanical Full Body Lift; Bariatric Equipment Integrated |
| **Lesson 6**: |
| * Communicating with the Health Team
 | * Assisting with the Nursing Process
 |
| * Interpersonal Communication Skills
 | * Red Flag Reporting – Appendix E, page 13
 |
| * + - Personal Hygiene
 | * Nutrition Support and IV Fluids
 |
| * Nutrition and Fluids**/**Maintenance Hydration
 | * Principles of Documentation
 |
| * + - Preventing Choking and Aspiration
 | * Maintaining optimal independence
 |

**Learning Objectives**: Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Addressing conflict with role and authorized duties.
3. Advocating for self.
4. Avoiding factors which block communication.
5. Asking open-ended, clarifying questions to gain further information and insight.
6. Communication techniques: Active listening, Reflecting, Rephrasing.
7. Coaching and mentoring other nursing assistants.
8. Communicating with others when English is a second language.
9. Communicating with team members including end of shift reporting.
10. Differentiate between appropriate and inappropriate communication.
11. Name the groups in the food pyramid.
12. Recognize different therapeutic diets and when they are used.
13. Position client safely for eating and understand feeding programs.
14. Positioning clients for nutritional and fluid intake
15. Preventing choking and aspiration
16. Demonstrate feeding techniques and assistive eating devices for each individual client
17. Respond to a client’s refusal to eat.
18. Identify measures to prevent dehydration. Recognize signs/symptoms of dehydration.
19. Measure and record intake.
20. Positioning clients for nutritional and fluid intake.
21. Main hydration.
22. Assist a client with oral hygiene following the procedures and reporting/recording observations.
23. Understand observation, reporting, and recording skills:
24. How to observe:
25. Establish normal baseline of the individual client; and
26. Comparison of subsequent observations to previous observations
27. What to observe:
28. Changes in breathing (rapid/decreased)
29. Fever
30. Cough
31. Chills
32. Chest pain
33. Nausea/vomiting
34. Excessive thirst
35. Cyanosis/changes in skin color
36. Pus/drainage
37. Urine/sediment/color/odor/frequency/burning
38. Pain/location/intensity/onset
39. Level of consciousness
40. Mood and behavior
41. Dehydration
42. Edema
43. Changes in appetite, eating habits, and bowel changes
44. Changes in functional ability (e.g. ability to self-transfer)
45. When and how to report observations: principles of documentation
46. Deviations in client conditions that must be reported immediately or deviations that could be reported later
47. Observations requested by licensed nurse
48. How to report observations
49. Who to report observations to
50. Identify information to collect about a client using sight, hearing, touch, and smell.
51. Explain how to report observations promptly, accurately, and objectively to the appropriate person.
52. Demonstrate the principles of documentation using; common medical terminology, chart/flow sheets, good penmanship, knowledge of error correction, signature/title, and ink.
53. Demonstrates how to organize client care in accordance with client’s care plan with regard to symptoms and basic care considerations.
54. Demonstrates ability to assist a client with feeding and knowledge of feeding programs.
55. Assist the client to apply and care for dentures.
56. Assist the client with the use of eating devices according to care plan.
57. Eating assistance and other ADL programs
58. Encouraging and maintaining optimal independence through person-centered care.

a. Reinforcement vs. teaching

b. Motivational techniques

c. Positive vs. negative reinforcement

d. Stressing ability vs. disability

e. Providing a structured environment

f. Reinforcing task segmentation by breaking down tasks into small, doable steps.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 6, 7, 20, 24, 25 |
| **Review Skills:****# 13, 39-44,** **79, 81** | Bathing; Peri/Cath Care; Massage; Changing a Disposable Brief; Assisting with a Shower; Pulse Oximetry; Applying Oxygen Safety Concepts Including Turning Oxygen on and off or Transferring Between Wall and Tank at Pre-established Flow Rate for Stable Clients; Assist with Deep Breathing/coughing |
| **Quizzes:** | Chapters 6, 7, 20, 24, 25 |
| **Videos:** | Oral Care; Bathing Without a Battle |
| **Lab Practice:** | Skills 33-38, 79 Oral Care, Feeding, Calculating Intakes, Measure andRecord Oral Fluid at Meal Times, Mechanical Full Body Lift; Positioning Clients for Nutritional and Fluid Intake; Assist with Hydration |
| **Lesson 7**:  |
| * Personal Hygiene
 | * Respiratory Support
 |
| * The Person Having Surgery
 | * Respiratory System – COPD **and** Pneumonia including Assisting with

Coughing and Deep Breathing |
| * Oxygen Needs
 |

**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.

2. Explain why client cleanliness and grooming is important.

3. Assist a client with bathing including bed, sponge, tub or shower bath following the procedures and reporting/recording observations

4. Describe and perform perineal care thoroughly.

5. Keep clients’ skin clean and dry.

6. Explain special care and needs of a client that is receiving oxygen.

7. Take and record pulse oximetry.

8. Assist with coughing and deep breathing and reinforce use of incentive spirometer.

9. Turn oxygen on and off at pre-established flow rate for a stable client.

10. Apply non-prescription pediculicides.

11. Apply topical barrier creams and ointments for prophylactic skin care.

12. Identify common signs/symptoms of COPD and pneumonia including assisting with coughing and deep breathing.

13. Apply, turn on and off, sequential compression devices

14. Apply warm or cold therapy.

15. Maintain hydration, thicken liquids

16. Utilize techniques for assisting with eating.

17. Understand benefits and management of Caregiver self-care.

18. Understand coaching and mentoring of other nursing assistants.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 21, 22, 25, 32, 35, 36, 37 |
| **Review Skills:****# 47-58,** **79, 80, 82** | Hair/Nail Care, Shaving, Dressing |
| **Quizzes:** | Chapters 21, 32, 36, 37 |
| **Videos:** | Bathing; Peri-Care; Massage |
| **Lab Practice:** | Skills 13, 39-44, 79, 81 Bathing, Peri Care, Cath Care, Back Rub, Changing a Disposable Brief, Pulse Oximetry, Assisting with a Shower; Assist with Coughing and Deep Breathing; Thicken liquids; Applying Non-Prescription Pediculicides; Applying Topical Barrier Creams and Ointments for Prophylactic Skin Care; Applying Oxygen Safety Concepts Including Turning Oxygen on and off or Transferring Between Wall and Tank at Pre-established Flow Rate for Stable Clients, Reinforce use of incentive spirometer, Apply, turn on and off, sequential compression devices, Apply warm or cold therapy, thicken liquids. |
| **Exam:**  | Midterm Examination (55 questions) per Rogue On-line |

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| **Lesson 8**: |
| * Personal Care and Grooming
 | * Nervous System and Musculoskeletal
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| * Hearing and Vision Problems
 | * System: Osteoporosis, Digestive and Endocrine Disorders
 |
| * Basic Emergency Care
 | * Cardiovascular System: Coronary Artery Disease; Hypertension
 |
| * Cancer and Immune System Disorders
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**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Demonstrate effective communication with a visually/hearing/speech impaired client.
3. Assist a client with shampooing and caring for hair following the procedure and reporting/recording observations.
4. Assist a client with dressing/undressing and assistive dressing devices following the procedures and reporting/recording observations.
5. Assist a client in the use and care of antiembolus stockings.
6. Assist a client with grooming and assistive grooming devices following the rules for grooming and reporting/recording observations.
7. Assist a client with nail care including toenails (as acceptable by OSBN rules) following the procedures and reporting/recording observations.
8. Identify the common signs/symptoms of basic care considerations when working with clients with the following illnesses or injuries:
9. Alzheimer’s Disease
10. Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimers and others)
11. Cognitive Impairment:
12. Communicating with cognitively impaired clients
13. Understanding the behavior of cognitively impaired clients
14. Appropriate responses to the behavior of cognitively impaired clients
15. Safe handling and movement of the cognitively impaired client
16. Methods of reducing the effects of cognitive impairments
17. Arthritis
18. Cancer
19. Cardiovascular System: Coronary Artery Disease, Hypertension
20. Cerebrovascular or accident (CVA)
21. Congestive Heart Failure (CHF)
22. Chronic Obstructive Pulmonary Disease (COPD)
23. Diabetes Mellitus
24. Epilepsy/Seizures
25. Fractures
26. Multiple Sclerosis (MS)
27. Musculoskeletal System: Osteoporosis
28. Myocardial Infarction (MI)
29. Parkinson’s Disease
30. Substance Abuse
31. Apply and care for client’s eyeglasses and hearing aids.
32. Assist the client with the use of dressing devices according to the care plan.
33. Demonstrate procedures for preventing choking.
34. Demonstrate the knowledge of administering abdominal thrust (Heimlich Maneuver).
35. Apply TED hose.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 21, 39, 40, 41, 42, 43, 51 |
| **Review Skills:****# 59-69,** **79**  | Fracture and Regular Bed PanMeasuring Output, Enema Emptying Catheters |
| **Quizzes:** | Chapters 21, 39, 40, 41, 42, 43, 51 |
| **Videos:** | Personal Hygiene and Grooming |
| **Lab Practice:** | Skills 47-58, 79, 80, 82 Elastic Stockings, Hair/Nail Care, Foot Care, Shaving, and Undressing/Dressing, Shampooing Hair in Bed, Mechanical Full Body Lift, Heimlich Maneuver, Application of Non-prescriptive Pediculicides |
| **Lab Exam:** | Midterm Skills Exam – Hand washing plus two OSBN testable skills |

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| **Lesson 9**: |
| * Urinary System: Urinary Tract Infections and Urinary Retention
 | * Urinary and Reproductive Disorders
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| * + Urinary Elimination
 | * + The Dying Person – end of Life Care
 |
| * Bowel Elimination
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**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Provide toileting and incontinence care for clients.
3. Provide catheter care including the application of and removal of external urinary catheters.
4. Urinary System: Urinary Tract Infections
5. Demonstrate the changing of a leg bag to a drainage bag.
6. Safely and comfortably administer an enema following correct procedure, understanding the different types of enemas and their use.
7. Safely administer bowel evacuation suppositories available without a prescription.
8. Observation of stool: diarrhea, constipation
9. Keep clients skin clean and dry around ostomy sites.
10. Accurately record measurement of emptying an ostomy bag.
11. Assist a client with bowel/bladder training according to the care plan.
12. Explain how to promote quality of life and comfort care for the dying client.
13. Describe the needs of the family during the dying process including family involvement.
14. Care for the deceased.
15. End of Life Care
16. Role of hospice/palliative care

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 21, 22, 23, 32, 36, 37 |
| **Review Skills:****# 76, 77, 79** | Making an Occupied and Unoccupied Bed |
| **Quizzes:** | Chapters 21, 32, 36, 37 |
| **Videos:** | Normal Elimination; Dealing with Death and Dying |

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| **Lab Practice:** | Skills 59-69, 79 Fracture and Regular Bedpan; Measuring and Recording Urinary Output; Changing a Leg Bag to a Drainage Bag, Changing a Drainage Bag to a Leg Bag; Assist with a Urinal and Commode, Application and Removal of External Urinary Catheter; Change ostomy dressing, appliance, or bag; Assist Client with Use of Toilet; Mechanical Full Body Lift |

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| **Lesson 10:**  |
|  * Mental Health Problems
* Developmental Disabilities
* Confusion and Dementia, Alzheimer’s Poem
 | * Five R’s
* Communicating with the Angry or Violent Client
* De-escalation Techniques
 |

**Learning Objectives:**

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Demonstrate effective communication with the confused or cognitively impaired client.
3. Identify the common signs/symptoms of cognitive impairment and apply basic care considerations when working with a client with cognitive impairment.
4. Communicating with the angry or potentially violent client.
5. Five R’s: remain calm, reassure, redirect, remove yourself, and re-approach
6. De-escalation techniques:
7. With decreasing intensity of event, muscles become more relaxed and serious physical behaviors become less frequent (body seeking baseline);
8. Individual is not yet stable and is vulnerable to re-escalation, especially if trigger events are still a factor;
9. During de-escalation phase, crisis communication should be maintained to ensure that individual does not re-escalate (not time for discussing consequences/intense dialogue);
10. Voluntary quiet and increased personal space is helpful in recovery and;
11. During de-escalation, close personal supervision should be provided.
12. Communicating with the confused or cognitively impaired client.
13. Communicating with the visually/hearing/speech impaired.
14. Giving examples of appropriate/inappropriate communication and how to respond to resident behavior.
15. Modifying behavior in response to client’s behavior.
16. Responding to resident behavior
17. Using the person’s preferred name.
18. Validating the person’s feelings.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 19, 45, 46, 47 |
| **Review Skills:****#** **70-75, 78, 79** | **And also Review for Final Written Exam** |
| **Quizzes:** | Chapters 19, 45, 46, 47 |
| **Videos:** | Bedmaking |
| **Lab Practice:** | Skills 76, 77, 79 Making an Occupied and Unoccupied Bed, Mechanical Full Body Lift |

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| **Lesson 11:**  |
| * Admissions, Transfers and Discharges
 | * Assisting with the Physical Examination
 |
| * Collecting and Testing Specimens
 | * Assisted Living
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**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Admit a client to the nursing unit following the correct procedure.
3. Assist a client with a transfer to another room or unit following the correct procedure.
4. Discharge a client from the nursing unit following the correct procedure.
5. Assist with a physical examination following the correct procedure.
6. Identify the persons at risk for complications from hot and cold applications.
7. Collect stool, clean catch urine, and sputum following procedures including emptying ostomy bags or changing ostomy bags which do not adhere to the skin.
8. Understand the role of a CNA while working in settings where there is not an RN regularly scheduled.

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| **Reading Assignment:** | Mosby’s Textbook for Nursing Assistants, 8th edition, 2012Chapters 29, 30, 31, 34, 35, 50 |
| **Review Skills:****# 70-75,** **78, 79** | Lab Skills **Review All Skills for Skills Final**:  |
| **Quizzes:** | Chapters 29, 30, 31, 34, 35, 50 |
| **Videos:** |  |
| **Lab Practice:** | Review all skills, plus skills 70-75, 78, 79 Mechanical Full Body Lift; Collecting a Clean Catch Urine Specimen; Collecting a Stool Specimen; Clean Ostomy Site for Established, Non-acute Ostomy; Empty Ostomy Bag or Change Ostomy Bag Which does not Adhere to the Skin; Collecting a Sputum Specimen; |
| **Exam**: | Final Written Examination – 176 Questions. A grade of 75% must be obtained on the final written examination to progress to the clinical phase of NA 101. |
| **Videos:** | Teepa Snow, 12 Minutes with Alzheimer’s Disease |

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| **Seminar 1**  |
| * Dementia, Delirium, and Memory
* Dementias and Alzheimer’s: Causes,
* Risk factors, Symptoms
* Alzheimer’s disease: Pathophysiology, Diagnosis, Stages
* Dementias and Alzheimer’s:

Common Behaviors and Aggravators* Losses in Alzheimer’s: Social, Lower

Stress Threshold, Independence, Self-Care* Caring for Clients with Delirium, Dementias, and Alzheimer’s disease
 |   |

**Learning Objectives**:

Upon satisfactory completion of this lesson, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms.
2. Describe two differences between delirium and dementia
3. Describe two changes in the brain that lead to the symptom of Alzheimer’s disease
4. Name 2 areas of the brain that are affected as Alzheimer’s disease progresses, and what the effects of these changes to the person.
5. Name three losses that occur with the progression of Alzheimer’s
6. List two changes that occur in each of the 7 stages of Alzheimer’s disease
7. Demonstrate 2 different techniques that are effective when working with clients with
8. 1) Delirium and 2) mild dementia and 3) Alzheimer’s Disease.

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|  | Teaching Methods 1. Dementia Simulation: Understanding challenges of Alzheimer’s2. Group Activities: - Working with clients with dementia- Communication with clients and family- Recognizing signs of pain or discomfort- Responding to problem behaviors |

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| **Seminar 2**  |
| * Working with the Chronically and Terminally Ill
* “Who am I?” Knowing Yourself
* Vulnerabilities in Nursing: Co-Dependence, Burnout, Unhealthy Lifestyle, Importance of Self-Care
 | * Ethics and Boundaries
* Soft Skills: Multi-Tasking, Good Judgment, Interpersonal Skills, Team Player, Communication Skills, Passion, Empathy, Patience
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**Learning Objectives**:

Upon satisfactory completion of this seminar, the student will be able to demonstrate application of basic nursing by her/his ability to:

1. Define key terms
2. List three characteristics of the chronically or terminally ill client
3. Name 3 characteristics that each individual believes that he or she possesses
4. Name 2 vulnerabilities that each individual believes that he or she may be subject to
5. Identify two ways that our characteristics and vulnerabilities can cause a negative impact on our caregiving behaviors.
6. Identify 2 ways that a caregiver maintains boundaries with the client and/or family
7. Identify 2 ways that a caregiver may violate boundaries with the client and/or family members
8. Name 6 soft skills for caregivers, and demonstrate one characteristic of each.

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| **Teaching Methods**  |
| 2- Instructor Team TeachingInteractive DiscussionActivities: Personal Loss Understanding Boundaries: Their Connection to Ethics  | Recognizing Vulnerabilities: How they Influence our Caregiving Style |

**Course No.:** NA 101 & NA 101C

**Credits:** 9

**Course Title:** Nursing Assistant

**Institution:** Rogue Community College

**Type of Course:** Vocational Preparatory

**Length of Course:** 197 hours/9 credits (7 credits = 118 hours lecture and skills lab, and 2 credits = 79 hours clinical)

**Prerequisites:** MTH60, RD30, WR115 or higher placement test score.

 **Registration and attendance at the mandatory Nursing Assistant Orientation.**

* NA101 Orientation
* Approval of Criminal Background Check (CBC) through [www.certifiedbackground.com](http://www.certifiedbackground.com)
* Immunizations as listed at orientation
* Current CPR Basic Life Support for Healthcare Provider card from American Heart Association (standards as of 3-1-11) or conform to most recent International Liaison Committee on Resuscitation (ILOR) guidelines

**Department Assignment:** Allied Health Department

 Neva Brendmoen, RN NA101 Program Coordinator

 Table Rock Campus (TRC) – Office # 145

 Phone: 541-245-7936

Classroom/Lab Instructors: Classroom and Lab Instructor contact information will be distributed in the first day of class.

Office: Materials can be left with Allied Health Department Nursing Assistant Program Coordinator, Neva Brendmoen @ TRC-145; 541-245-7936; nbrendmoen@roguecc.edu

Office hours: Arrange appointments with instructor before or after class, depending on availability, or through Allied Health Department Secretary, Theresa Leonardo, TRC-108; 541-245-7841; tleonardo@roguecc.edu

**Department Mission Statement**:

The Rogue Community College Nursing Assistant course fulfills part of the Nursing Department’s mission by preparing individuals for the community that are ready to meet the entry level standards for nursing assistant care in various settings, e.g. home care, foster care, long-term care, private duty, and or entry into other Rogue Community College health-care related programs.

**Course Description:**

This course meets requirements of the Oregon State Board of Nursing for students wishing to become Nursing Assistants at training level 1 (i.e. CNA-1). Students who successfully complete the coursework in this program will be able to apply to take the certification exam through the Oregon State Board of Nursing. Students will study patient care, nutrition, safety, legal/ethical issues, physical and mental disease processes, vital signs and infection control, emergency care, and interpersonal skills. Students will be placed in long-term care clinical sites in Josephine or Jackson County to practice their nursing assistant skills during the clinical course (NA101C).

**Testing Policy**:

1. All quizzes/assignments must be completed with an average score of 75%. All quizzes/assignments must be completed to progress to the clinical phase of the program.
2. Quizzes will be given as scheduled. No make-ups are available for missed quizzes unless prior arrangements have been made with the instructor.
3. Students shall practice academic honesty. Cheating is defined as looking on another's test paper, any communication between students, or utilizing notes or any assistance during the test. A student observed cheating will have his/her paper taken away and receive a zero for the exam, resulting in a grade of No Pass for the course. English translators/dictionaries are not permitted.

**Grading Policy**:

Class/lab and clinical grades are issued on a Pass/No Pass basis with ≥75% required to pass final written exam, and ≥80% to pass final skills lab competency exam, plus completion of all classroom and lab hours. To pass clinical all clinical hours must be completed and students must be able to care for at least 2 residents safely.

**Course Outcomes, ILO (Institutional Learning Outcome) Indicators and Assessment:**

On successful completion of this course the student will be able to demonstrate that he/she is ready to meet the entry level standards for nursing assistant care (level 1) in various settings by his/her ability to:

| **Expected Outcomes:** | **ILO Key Indicators:** | **Assessment Methods:** |
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| 1. Utilize safe performance practices in any health care setting. |

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| **AK5 – Demonstrate the ability to adhere to personal and industry safety standards.**  |

 | 1. Instructor evaluation of return demonstration of critical factors, skills lab performance, clinical performance. 75% or better mastery on pertinent quizzes and final written exam. ≥80% on final skills lab competency exam. |
| 2. Demonstrate knowledge of the roles/authorized duties of nursing assistants: e.g. interacting and collaborating with patients, significant others, and members of the health care team.  | **COM3 – Collaborates effectively to achieve course/learning goals.** | 2. Instructor evaluation that return demonstration is consistently satisfactory in clinical setting. |
| 3. Utilize appropriate channels of communication and lines of authority. |

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| **PG 6 - Adhere to a strong work ethic and be able to negotiate and abide by the terms of agreement that defines one’s employment.** |

 | 3. 75% or better mastery on appropriate quizzes and final written exam. Instructor evaluation that return demonstration is consistently satisfactory in clinical setting. |
| 4. Demonstrate therapeutic communication in the clinical care setting with consideration of culture and life-span concerns. |

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| **COM 1 Display understanding, compassion and acceptance; and COM 4 Work respectfully with others by considering opposing view-points and different cultural perspectives.** |

 | 4. Instructor evaluation that return demonstration is consistently satisfactory in clinical setting. |
| 5. Accurately measure and record temperature, pulse, and respiration and deviations that must be reported immediately.  | **AK 4 Use numeracy skills for interpretation, synthesis, and analysis of data.** | 5. Instructor evaluation of satisfactory return demonstration of critical factors, skills lab performance, clinical performance. Appropriate quizzes at 75% or better. |
| 6. List causes of fires, steps to be taken in event of fire, and understand the importance of plans.  | **AK 2 Integrate previous and new learning, along with practical skills, to solve problems.** | 6. Instructor evaluation of return demonstration of clinical performance. 75% or better mastery on appropriate quizzes and final written exam. |
| 7. Identify actions that are unethical or illegal, situations that violate client rights, list ways to prevent theft/loss, discuss role of reporting abuse, neglect or mistreatment, and legal responsibilities of nursing assistant.  | **PG1 Act as a responsible member of a community.** | 7. Instructor evaluation/designation of satisfactory homework completion and exam, group activities, simulated patient care scenarios. |
| 8. List ways to facilitate admission to a long-term care facility, including making client feel at home; list tasks necessary before discharge or transfer.  | **AK1 Demonstrate ability to transfer learning in familiar and unfamiliar contexts in order to complete tasks.** | 8. Instructor evaluation of satisfactory completion of midterm, group activities. |
| 9. Identify phases of grief, stages of dying, guidelines for care of a dying patient, procedures after death.  | **CT1 Recognize own and others’ emotions, assumptions, biases, and cultural contexts.** | 9. 75% or better mastery on appropriate quizzes and final written exam. Instructor evaluation that return demonstration is consistently satisfactory in clinical setting. |
| 10. Identify four signs of infection, describe isolation techniques, list the way HIV and HBV are spread, identify common non-infectious diseases, their symptoms, and procedures associated with hazardous waste disposal.  | **AK1 Demonstrate ability to transfer learning in familiar and unfamiliar contexts in order to complete tasks.** | 10. Completes assignments and passes pertinent quizzes at 75% or better. |
| 11. Describe techniques for working with cognitively impaired clients and identify re-enforcers that are appropriate. Identify tasks associated with responsive observation. | **AL1 Understand and accept responsibility for learning.** | 11. Completes assignments and passes pertinent quizzes at 75% or better. |
| 12. Provide care related to diverse age groups (children, adolescents, etc.)  | **AL3 Internalize and assimilate information into new situations.** | 12. Instructor evaluation of return demonstration of critical factors, skills lab performance, clinical performance. |
| 13. Describe common emergency care procedures, e.g. those for chest pain, respiratory distress, choking, seizures, difficulty swallowing, diabetic emergencies, level of consciousness, falls.  | **CT5 Foresee consequences of actions.** | 13. Instructor evaluation of return demonstration of critical factors, skills lab performance, clinical performance. Pass pertinent quizzes at 75% or better. |
| 14. Identify goals and describe elements of personal health and fitness and why commitment is important.  | **PG2 Balance personal and educational commitments.** | 14. Instructor evaluation/designation of satisfactory performance on group activity, wellness assessment, personal goals. Final exam at 75% or better. |
| 15. Write a short essay regarding a skill experience.  | **COM2 Express ideas clearly in oral, written and visual work.** | 15. Instructor evaluation of assignment. |
| 16. Concisely chart observations on incident and clearly report. | **COM2 Express ideas clearly in oral, written and visual work.** | 16. Instructor evaluation of written documentation in clinical settings. |
| 17. Document accurately in care record, using relevant medical vocabulary. | **COM2 Express ideas clearly in oral, written and visual work.** | 17. Instructor evaluation of written documentation in skills lab and clinical settings. |
| 18. Effectively communicate a resident’s status in a coherent, organized fashion. | **COM2 Express ideas clearly in oral, written and visual work.** | 18. Instructor evaluation that communication of resident information is consistently satisfactory. |
| 19. Demonstrate improvement in documentation over the period of the clinical term. | **COM2 Express ideas clearly in oral, written and visual work.** | 19. Instructor evaluation of written documentation in skills lab and clinical settings. |
| 20. Utilize effective interpersonal skills to communicate constructive criticism to peers during lab skills practice. | **COM 1 Display understanding, compassion and acceptance** | 20. Instructor evaluation that communication skills are consistently satisfactory. |
| 21. Demonstrate recall of previously learned information and skills.  | **AK1 Demonstrate ability to transfer learning in familiar and unfamiliar contexts in order to complete tasks.** | 21. Instructor evaluation that lab and clinical performance are satisfactory. 75% or better mastery on appropriate quizzes and final written exam. ≥80% on final skills lab competency exam. |
| 22. Collect and integrate information from a variety of sources. | **CT3 Locate, organize, analyze, and interpret data.** | 22. Instructor evaluation that assignments, lab and clinical performance are satisfactory. |
| 23. Communicate verbally, and through reading and writing, with individuals from a variety of social, emotional, cultural and educational backgrounds. | **COM4 Work respectfully with others by considering opposing viewpoints and different cultural perspectives.** | 23. Instructor evaluation that assignments, lab and clinical performance are satisfactory. |
| 24. Access learning resources (including Rogue Online) and manage time to complete classroom, lab and clinical assignments on time. | **AL5 Use technological tools to research new information, solve problems, and communicate effectively and PG2 Balance personal and educational commitments.** | 24. Instructor evaluation of satisfactory completion of all quizzes, classroom, lab and clinical performance in scheduled time frame. |

**Typical Required and Recommended Equipment and Text(s):** Sorrentino, Sheila A., Nursing Assistants, 8th edition, 2012, Mosby Lifeline Publishers.

* Wine colored scrubs uniforms
* White or black enclosed comfortable non-canvas shoes
* Watch with second hand
* Gait belt
* Stethoscope/BP cuff

Optional Text: Sorrentino, Sheila A., Nursing Assistants Workbook, 8th edition, 2012, Mosby Lifeline Publishers.

**Expectations for Students**

Expectations for classroom behavior are outlined in the Student Code of Conduct, available in the catalog, schedule, and online. Students may not engage in any activity which the instructor deems disruptive or counterproductive to the goals of the class. Beepers, pagers, and cellular phones can be distracting and are not to be brought into the classroom. Instructors have the right to remove students from class for not following the Code of Conduct or other specified classroom rules.

Students with a documented disability that may require assistance should contact the Disability Services Office for coordination of your academic accommodations prior to the beginning of class. A letter of approved accommodations must be submitted to the instructor before or on the first day of class. The Disability Services Office can be reached by phone at 541-245-7537.

Smoking is not permitted on the premises of Rogue Community College except in designated areas. For more information go to [www.roguecc.edu/TPTF](http://www.roguecc.edu/TPTF)

STUDENT COSTS/SUPPLIES LIST

These items must be completed/purchased prior to or immediately after the first day of class. You will be given further instructions on the remainder of the items once you are in the class.

|  |  |  |
| --- | --- | --- |
| **Supplies:** | **Costs:** | **Suggestions:** |
| RCC Tuition @ $91 a credit, $36 tech fee, and $95 college service fee | $914  | Payment can be made at any RCC campus location or online at [www.roguecc.edu](http://www.roguecc.edu)  |
| Background check | $103 | [www.CertifiedBackground.com](http://www.CertifiedBackground.com)  |
|  Immunizations  | Varies | County Health Dept. or Family Physician |
|  CPR Certification (for the Healthcare Provider) | $40-$70+ | American Heart Association; card must be valid through June 15, 2014 |
| \* Mosby’s Textbook for Nursing Assistants , 8th ed | $47.95 | TRC RCC Bookstore |
| \* Two inch three ring binders | $3+ | RCC Bookstore, Wal-Mart, Fred Meyer, etc. |
|  Watch with sweep second hand | $8+ | Wal-Mart, Fred Meyer, etc. |
| Blood Pressure Cuff , Basic hand pump type, non-digital, regular size | $30+ | Black Oak Pharmacy, Scrub Hub  |
|  Stethoscope | $20+ | Medical supply store or medical uniform shops  |
| Gait belt | $10-$15 | Medical supply store or medical uniform shops  |
| Shoes must be non-skid with closed heels and toes; black or white in color. Nursing leather or tennis/athletic shoes are acceptable; cloth or canvas shoes do not provide adequate protection and are not appropriate. A small amount of color besides white or black is acceptable  | $20-$50 | Various shoe stores |
| 2 pair of wine colored scrub uniforms; suggested brands: Wonder Winks, Cherokee, Dickies, Barco | $25 - $52 each | Scrub Hub, Medford (10% discount for RCC students); may also be purchased elsewhere online |
| Fingerprinting service charges (obtaining inked prints) | $25-$50 | Sheriffs or local Police Departments  |
| Criminal History Background Check Fingerprinting Processing Fee | $52 | Oregon State Board of Nursing |
| OSBN Certification Exam (not included in tuition) | $106 | Exam Fee is sent to OSBN, with certification test application after successful completion of the NA101 course |

*Please note that the costs on this sheet are approximate; actual prices may vary.*

RESIDENT’S BILL OF RIGHTS

This facility presents a Resident’s Bill of Rights with the expectation that observation of these rights will contribute to more effective resident care and greater satisfaction for the resident, his/her physician, and the convalescent center.

This facility enunciates these rights with the commitment that they will be observed and respected by the convalescent center on behalf of its residents, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the resident is essential for the provision of proper medical care. The traditional physician-resident relationship tales on a new dimension when care is rendered within the organized structure of a convalescent center. It is in acknowledgement of these facts that this facility affirms these rights of a resident.

1. Is fully informed, as evidenced by the resident’s written

 acknowledgement, prior to or at the time of admission

 and during stay, of these rights and of all rules and

 regulations governing resident conduct and

 responsibilities;

2. Is fully informed, prior to or at the time of admission

 and during stay, of services available in the facility, and

 of related charges including any charges for services

 not covered under titles XVIII or XIX of the Social

 Security Act, or not covered by the facility’s basic per

 diem rate;

3. Is fully informed, by a physician, of his/her medical

 condition unless medically contraindicated (as

 documented, by a physician, in his/her medical record)

 and is afforded the opportunity to participate in the

 planning of his/her medical treatment and to refuse to

 participate in experimental research;

4. Is transferred or discharged only for medical reasons, or

 for his/her welfare of that of other residents, or for

 nonpayment for his/her stay (except as prohibited by

 titles XVIII or XIX of the Social Security Act), and is

 given reasonable advance notice to ensure orderly

 transfer or discharge, and such actions are documented

 in his/her medical record;

5. Is encouraged and assisted, throughout his/her period

 of stay, to exercise his/her rights as a resident and as a

 citizen, and to this end may voice grievances and

 recommend changes in policies and services to facility

 staff and/or outside representatives of his/her choice,

 free from restraint, interference, coercion,

 discrimination or reprisal;

6. May manage his/her personal financial affairs or be

 given, at least quarterly, an accounting of financial

 transactions made on his/her behalf should the facility

 accept his/her written delegation of this responsibility

 for any period of time, in conformance with state law;

7. Is free from mental and physical abuse, and free from

 chemical and (except in emergencies) physical

 restraints except as authorized in writing by a

 physician for a specified and limited period of time, or

 when necessary to protect the resident from injury to

 himself/herself or to others;

No roster of rights can guarantee for the resident the kind of treatment he/she has a right to expect. A convalescent center has many functions to perform, including the treatment of disease and disabilities, rehabilitation of accompanying conditions, the education of both the resident and his/her family as well as participating in the education of the health professions. All of these activities must be conducted with a primary concern for the resident and the recognition of his dignity as a human being.

8. Is assured confidential treatment of his/her personal

 and medical records, and may approve or refuse their

 release to any individual outside the facility, except, in

 case of his/her transfer to another health care

 institution, or as required by law or third-party

 payment contract;

9. Is treated with consideration, respect, and full

 recognition of his/her dignity and individuality,

 including privacy in treatment and in care of his/her

 personal records;

10. Is not required to perform services for the facility that

 are not included for therapeutic purposes in his/her

 plan of care;

11. May associate and communicate privately with persons

 of his/her choice, and send and receive his/her personal

 mail unopened, unless medically contraindicated (as

 documented by his/her physician in the medical

 record);

12. May meet with, and participate in activities of social,

 religious, and community groups at his discretion,

 unless initially contraindicated (as documented by his

 physician in the medical record);

13. May retain and use his/her personal clothing and

 possessions as space permits, unless to do so would

 infringe upon rights of other residents, and unless

 medically contraindicated (as documented by his/her

 physician in his/her medical record);

14. If married, is assured privacy for visits by his/her

 spouse; if both are residents in the facility, they are

 permitted to share a room, unless medically

 contraindicated (as documented by the attending

 physician in the medical record

RCC Nursing Assistant Program

NA 101C Nursing Assistant

CLINICAL BEHAVIORAL OBJECTIVES

The student will be able to:

1. Care for (2) clients in long-term care nursing facility utilizing safe performance practices.

2. Demonstrate knowledge of the roles and authorized duties of nursing assistants: the delegation process, interacting, collaborating with clients, significant others, and members of the health care team.

3. Demonstrate effective communication and interviewing skills in the clinical care setting with consideration of culture and life-span concerns.

4. Utilize appropriate channels of communicating and lines of authority.

5. Apply theory knowledge base in the clinical setting for:

A. Basic Nursing Assistant Skills

1. Effective and efficient care giving

2. Infection control

3. Safety/emergency procedures

4. Objective data (measuring and recording vital signs), intake and output

5. Therapeutic procedures (providing catheter care)

6. Reporting information

7. Physical environment

B. Basic Restorative Services

1. Prevention (turning client in bed, range-of-motion exercises)

2. Mobility (transferring client from chair to bed)

3. Self-care and independence (encouraging client to use assistive devices)

C. Personal Care Skills

1. Oral hygiene

2. Nutrition and hydration

3. Cleanliness (bathing, peri care, hair, nails)

4. Dressing and grooming

5. Elimination

6. Rest and sleep

D. Mental Health and Social Service Needs

1. Well-being (orienting client to facility and room)

2. Interpersonal Skills/Communication: client, resident, staff, family, therapeutic communication

3. Social function (interacting with client's family)

4. Cognitive impairment (memory-impaired, aphasic, mute due to upper airway devices)

5. Identify caring concepts related to the aging process

6. Demonstrate ability to understand and communicate with the combative client using de-escalation techniques

7. Demonstrate the ability to communicate with clients with speech impairment (i.e. aphasic, dysphasic, and emotional/organic confusion)

8. Demonstrate the ability to communicate with others when English is a second language.

E. Protecting Client Rights

 1. Privacy

2. Confidentiality

3. Promote personal choices

4. Using the person’s preferred name

5. Validating the person’s feelings

F. Self-awareness

1. Identify own feelings related to the aging process

2. Demonstrate understanding of physically impaired clients loneliness to isolation from family and friends

**STUDENT/INSTRUCTOR EVALUATION CONFERENCE**

Instructors will meet with students individually for mid-term and final clinical evaluation conference. It will take approximately 10-15 minutes.

CLINICAL EXPERIENCE

1. Full uniform required including name tag, wine uniform, and white or black shoes.

2. Park in authorized designated area as instructed only.

3. Leave coats, purses, etc. locked in your vehicle. Do not bring valuables or medications into the clinical site.

4. Meet in facility lobby on the first day; meet in designated area thereafter. Students are not to be in the clinical setting other than their scheduled clinical time.

5. Off-site lunches are not appropriate related to 30-minute time frame. Plan to bring or purchase lunch/snacks in facility.

6. Brown bag lunches are permissible during post-conferences.

**CLINICAL ASSIGNMENTS**

1. Find the job description for CNA in each respective facility. Obtain an organization sheet.

2. Check your clinical assignment before you start care for the clients assigned to you. Check the care plan of each patient in your clinical assignment. DO NOT assist any client without checking their care plan. Always perform skills with your assigned CNA buddy or clinical instructor until checked off to perform skills independently by clinical instructor.

3. Get report on your clients from the off-going charge nurse or CNA assigned to that client.

4. Provide safe, therapeutic environment clients and provide care and assist clients with the following tasks related to the activities of daily living.

 a. Personal Care

 (1) Bathing

 (2) Dressing

 (3) Grooming

 (4) Shaving

 (5) Shampooing and caring for hair

 (6) Providing and assisting with oral hygiene and denture care

 (7) Caring for the skin

 (8) Caring for the nails

 (9) Providing peri care

 (10) Bedmaking and handling linen

 (11) Maintaining environmental cleanliness

 (12) Applying non-prescription pediculicides

 (13) Applying topical, non-prescription barrier creams and ointments for

 prophylactic skin care

 (14) Turning oxygen on and off or transferring between wall and tank at pre-

 established flow rate for stable clients

 b. Maintaining Mobility

 (1) Ambulating

 (2) Transferring

 (3) Transporting

 (4) Positioning

 (5) Turning

 (6) Lifting

 (7) Elevating extremities

 (8) Performing range of motion exercises

 (9) Maintaining alignment

 c. Nutrition and Hydration

 (1) Feeding and assisting client with eating

 (2) Assisting client with drinking

 d. Elimination

 (1) Toileting

 (2) Assisting with use of bed pan and urinal

 (3) Providing catheter care, including the application of and removal of

 external urinary catheters

 (4) Administering enemas

 (5) Collecting specimens, sputum, stool, and urine including clean catch urine

 specimens

 (6) Cleaning ostomy site ojn established, healthy ostomy and emptying

 ostomy bags or changing ostomy bags which do not adhere to the skin

 (7) Inserting bowel evacuation suppositories available without a prescription

 e. Assistive Devices

 (1) Caring for dentures, eyeglasses, and hearing aids

 (2) Caring for, applying and removing

 (a) Antiembolus stockings

 (b) Prosthetic devices

 (c) Orthotic devices

 (d) Braces

 (3) Assisting with wheelchairs, walkers, or crutches

 (4) Using footboards

 (5) Assisting with and encouraging the use of self-help devices for eating,

 grooming, and other personal care tasks

 (6) Utilizing and assisting clients with devices for transferring, ambulation,

 and alignment

 f. Data gathering, Recording, and Reporting

 (1) Measuring temperature, pulse, respiration and blood pressure (manual and

 electronic-upper arm only, and orthostatic blood pressure readings)

 (2) Measuring height and weight

 (3) Measuring and recording oral intake

 (4) Measuring and recording urinary output, both voided and from urinary

 drainage systems

 (5) Measuring and recording emesis

 (6) Measuring and recording liquid stool

 (7) Measuring and recording pulse oximetry

 (8) Collect responses to pain using a facility approved pain scale

**ACCEPTABLE CPR CARD TYPES**

**for**

**NURSING ASSISTANT CLASSES**

**NO EXCEPTIONS!**

|  |  |
| --- | --- |
| **American Heart Association** | Basic Life Support for Health Care Providers(must conform to new CPR standards as of 3-1-11) |
| **ILOR** | CPR which conforms to the most recent International Liaison Committee on Resuscitation (ILOR) guidelines |
| **Rogue Community College** | RCC’s HE 261 Class |

**14 TIPS FOR TAKING THE CNA EXAM**

1. Relax and stay calm; candidates perform better when they are less anxious.

2. Read the candidate handbook found at [www.hdmaster.com/testing/cnatesting/oregon/orformpages/ORCandidateHandbook.pdf](http://www.hdmaster.com/testing/cnatesting/oregon/orformpages/ORCandidateHandbook.pdf).

3. Become familiar with the test instructions found at [www.hdmaster.com/testing/cnatesting/oregon/orformpages/SkillTestInstructions.pdf](http://www.hdmaster.com/testing/cnatesting/oregon/orformpages/SkillTestInstructions.pdf).

4. Do the beginning and ending steps for every skill. Candidates frequently forget to state they would wash their hands at the beginning and end of every skill.

5. Note that if the candidate washes something in a skill, they will most likely need to rinse and dry it too.

6. Remember, if there are italicized words on the skill procedure sheet, it indicates that there is another skill embedded in the procedure. For example, *Use of a Gait/Transfer Belt* is embedded in the ambulation and transfer skills.

7. Make sure the bedpan is correctly placed; either a regular bedpan or a fracture pan may be used during testing.

8. Record all measurements on the form provided. A sample of this form is found at [www.hdmaster.com/testing/cnatesting/oregon/orformpages/RecordingFormInstructors.pdf](http://www.hdmaster.com/testing/cnatesting/oregon/orformpages/RecordingFormInstructors.pdf).

9. Perform the steps. The RN Test Observer will not give credit unless the step is **actually performed**. Sometimes candidates state they would do something, but never actually do the action. The only exception to this is that after handwashing is performed as the first skill, the candidate will get credit for just saying they would wash their hands in the following skills.

10. Preserve privacy throughout the skill; keep the actor covered. Pay attention to the use of bath blankets in the skill.

11. Maintain safety throughout the skills. Use side rails as needed or ask the RN Test Observer to move into place to keep the actor safe when you are turning and positioning the actor. If a side rail is put up during the procedure, put it back down at the end of the skill.

12. Be thorough, but gentle, when doing mouth care. Make sure that all areas are cleaned.

13. Watch the placement of hands when doing range of motion and do all movements for the minimum amount of repeats.

14. Take time to review the skill steps and opening and closing procedures; make any needed corrections before stating that you have completed.

**OSBN TEST SKILLS TASK LIST**

Ambulation of a Client using a Gait Belt

Ambulation of a Client with a Walker using a Gait Belt

Assisting a Client to Use a Bedpan

Assisting a Dependent Client with a Meal in Bed

Assisting a Dependent Client with a Meal in a Chair

Anti-Embolism Elastic Stockings

Bed Bath (Partial – Face, Arm, Hand and Underarm)

Catheter Care

Denture Care of a Dependent Client

Undressing and Dressing a Client

Fingernail Care (One Hand)

Foot Care (One Foot)

Hand Washing

Making an Occupied Bed

Making an Unoccupied Bed

Measure and Record Oral Fluid Intake at Mealtime

Measure and Record Output from a Urinary Drainage Bag

Mouth Care

Mouth Care for a Comatose Client

Perineal Care

Position Client on Side in Bed

Putting on and Removing Gown and Gloves

Range of Motion (ROM) Lower Extremities (Hip and Knee)

Range of Motion (ROM) Upper Extremities (One Shoulder)

Taking & Recording Digital Oral Temperature, Radial Pulse, and Respirations

Taking & Recording a Radial Pulse & Respirations

Taking & Recording Blood Pressure (One-Step Procedure)

Transfer from Bed to Wheelchair

Transfer from Wheelchair to Bed

**PRE AND POST PROCEDURE ACTIONS**

|  |  |
| --- | --- |
| Step | PRE PROCEDURE |
| 1 | Knock on door. |
| 2 | Wash hands (before gathering clean linen or before client care). |
| 3 | Introduce self by name and title. |
| 4 | Identify the client by checking the ID bracelet and addressing the client byname. |
| 5 | Explain the procedure to the client. (On longer procedures such as a bath, allow the client time to use the bathroom or to make a phone call.) Speakclearly, slowly and directly, maintaining face to face contactwheneverpossible.  |
| 6 | Collect supplies and arrange them on the barrieron the overbed table. |
| 7 | Position client/bed/bedside table for body mechanics. (Bedside table must be over bed if client is assisting or at your arms’ reach.) |
| 8 | Provide for privacy. |
| 9 | Check/lock bed wheels or wheelchair brakes.  |
| 10 | Encourage client to assist with ADLs as tolerated to promote independence and self esteem. |
| **Step** | POST PROCEDURE |
| 1 | Tidy the room. (Clean and replace equipment. Discard disposable items.)Follow agency policy for dirty linen. |
| 2 | Leave client in position of safety and comfort.a. Place bed in the lowest position.b. Placement of rails is always per the care plan.c. Place call light and bedside table within client’s reach. |
| 3 | Unscreen client. (Thanked client for their assistance.) Explain that you willreturn within one hour unless they call sooner. |
| 4 | Wash hands |
| 5 | Report/record Record measurements on your pocket notepad (Procedure, how client tolerated procedure, unusual or abnormal observations) |

|  |
| --- |
| **Important Factors to Consider with Client Care** |
| 1. Get help if needed. |
| 2. Maintain standard precautions at all times. |
| 3. Maintain client dignity. |
| 4. Communicate with courtesy throughout the procedure. |
| 5. Maintain privacy and confidentiality. |
| 6. Follow up with client hourly. |
| 7. Place bed in the lowest position at any time you cannot visualize your client. |
| 8. Maintain client right to choose/refuse care. |
| 9. Apply gloves as needed for universal precautions |

\*Skill 1: Handwashing

Step # Description

1 **Knock on door**.

2 **Introduce self by name and title**.

3 Identify and address the client by name.

4 Assemble equipment: liquid soap, paper towels, sink with warm running water, and waste container.

5 Remove or push wristwatch up to mid-forearm.

6 Stand away from the sink so that your clothes do not touch the sink. Stand so that the soap and faucet are easy to reach.

7 **Turn on the water at sink and adjust to warm temperature**.

8 **Thoroughly wet hands and wrists thoroughly with fingertips pointed down**.

9 Apply liquid soap to hands.

10 Lather all surfaces of fingers and hands including above the wrists: Keep hands lower than elbows. Rub hands together using friction, interlacing fingers pointing downward, washing all surfaces of hands and wrists, and underneath wedding ring if wearing one.

11 **Rub hands together for at 20 seconds using friction.**

12 **Clean under fingernails by rubbing fingertips against palms of the opposite hand**.

13 **Wash all surfaces of hands and wrist with liquid soap**.

14 If you have touched any dirty objects, repeat steps 8 through 13.

15 **Rinse all surfaces of hands**, wrists and fingers **thoroughly under running water** keeping hands **lower** than the elbows and **fingers pointed downward** without contaminating hands.

16 **Dry all surfaces of hands, wrists, and fingers with clean, dry paper towel** and discard paper towel without contaminating hands.

17 **Turn off faucet with a second (last) clean dry paper towel or with a dry section of a previously used paper towel.**

18 **Discard paper towel into trash container as used.**

19 **Do not recontaminate hands at any time during the procedure**.

20 Avoid touching dirty object(s) after hands are clean, e.g., crumpling up the paper towel used to turn off the faucet with both hands before discarding it.

 \* Dry hands from fingertips to wrist (clean to dirty). Discard paper towel with each stroke.

**\*Skills 2 & 3: Putting on and Removing Personal Protective Equipment: Gown and Gloves**

**Step # Description**

1 ***Wash hands or use hand sanitizer***.

2 Assemble equipment: disposable gloves and gown.

3 Hold a clean gown out in front of you and let it unfold. **(Do not shake gown during unfolding.)**

4 **Put arms through the each sleeve**.

5 Make sure gown covers you from your neck down to your knees, and covers your arms to the end of your wrists.

6 **Secure the neck opening**.

7 **Secure the waist, making sure that the back flaps completely cover clothing.**

8 **Put on *gloves*.**

9 **Gloves overlap gown sleeves at the wrist.**

10 Provide client care.

**Removing a Gown**

1 **Remove *gloves* before removing gown.**

2 **Remove gloves turning inside out and folding one glove inside the other.**

3 **Do not touch outside of gloves with bare hand at any time.**

4 **Dispose of gloves without contaminating self in appropriate container.**

5 Wash hands.

6 **Unfasten gown at the neck. Unfasten gown at the waist. Do not touch the front of the gown.**

7 **Remove gown by folding soiled area to soiled area.**

8 Hold and roll up the gown away from you. Keep it inside out.

9 **Dispose the gown in an appropriate container.**

10 *Wash hands*.

**\*Skill 6: Taking & Recording Oral Temperature with Digital Thermometer, Radial Pulse, and Respirations**

**Step # Description**

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Ask the client if he/she has recently had hot or cold fluids or been smoking. If the answer is yes, wait 10 minutes before taking an oral temperature.

7 Assemble equipment: protective barrier, disposable sheath/probe cover, disposable gloves (Gloves should be worn if the client has draining wounds, non-intact skin, or you have contact with blood or body fluids including mucous.), paper, pen, thermometer, and watch with a second hand.

8 Pull curtains; provide for privacy throughout procedure.

9 Assemble equipment on bedside table using protective barrier.

10 Make sure the client is in a comfortable, relaxed position.

11 Put on clean *gloves* if indicated.

12 **Put sheath/probe cover over the stem of the thermometer probe**.

13 **Correctly turn on digital oral thermometer**.

14 **Gently insert bulb end of thermometer into mouth, under tongue, and to one side. Remind client not to bite down on the thermometer.**

15 **Tell client to hold oral thermometer in place in mouth with lips closed**. Assist as necessary.

16 **Leave thermometer in place until it beeps**.

17 **Dispose of sheath**.

18 Read and record temperature on the recording sheet.

19 **Wipe the thermometer clean with alcohol pad or discard sheath appropriately**.

20 Remove and dispose of *gloves* into waste container without contaminating self.

21 **Locate radial pulse by placing tips of fingers on thumb side of client’s wrist**. (Do not use your thumb to take pulse because it contains a pulse that may be confused with the client’s pulse.) Press lightly until you feel the beat.

22 **Count pulse beats for 60 seconds**, noting the rhythm and force.

23 **Record reading on the recording sheet**. Note the strength of the pulse and if it is regular or irregular.

24 **Count respirations for 60 seconds. Record count on recording sheet**.

25 Lower the height of the bed to the lowest position.

26 Open the privacy curtains.

27 **Maintain respectful, courteous interpersonal interactions at all times.**

**28 *Wash hands*. Leave call light or signaling device within easy reach of the client.**

29 Report any abnormal vital signs to the licensed nurse.

\*Skill 10: Taking and Recording Manual Blood Pressure (One-Step Procedure)

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: alcohol wipes, paper, pen, stethoscope and sphygmomanometer with appropriate size cuff.

7 **Provide for privacy - pull curtain**.

8 Make sure the client is in a comfortable, relaxed position, with back and arms supported and with legs not crossed.

9 Expose client’s upper arm.

10 **Position client with forearm relaxed and supported in a palm-up position approximately at the level of the heart**.

11 **Roll client’s sleeve up about 5 inches above elbow**.

12 Before putting the cuff on the arm, open the valve and squeeze all the air out of the cuff. Make sure needle is on zero.

13 **Apply the appropriate size cuff around the upper arm just above the elbow. Wrap the cuff around the arm snugly and smoothly so that the bladder presses evenly against the arm. Correctly align cuff over the brachial artery**.

14 **Clean earpieces of stethoscope appropriately and place in ears. Clean diaphragm**.

15 **Locate brachial artery with fingertips. Place stethoscope over brachial artery and hold snugly in place.**

16 **Hold stethoscope snugly in place**.

17 **Inflate cuff to 160-180 mm Hg**.

18 **Slowly release air from cuff to disappearance of pulsations**. The reading when you first hear the pulse sound is the systolic pressure. Remember this number and go on. The reading when the pulse sound stops is the diastolic pressure. Remember this number and quickly let all of the air out of the cuff. (If reading is not noted the first time, wait one minute before trying again. Never try more than twice on one arm, e.g., you will need to inflate the cuff higher if you hear palpations immediately upon releasing air.)

 \* Check the cuff for excess air and that the dial has returned to 0. If not, you must remove the cuff and repeat Step 12.

19 **Remove cuff**.

20 **Record blood pressure reading on recording sheet and give recording sheet to the rater**.

21 Clean and replace equipment.

22 Open the privacy curtains.

23 **Maintain respectful, courteous interpersonal interactions at all times**.

24 ***Wash hands*. Leave call light or signaling device within easy reach of the client.**

\*Skill 16: Position Client on Side in Bed

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client** **(even a mannequin)**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: at least four pillows.

7 Provide for privacy – pull curtain.

8 Lock wheels on bed.

9 Position bed flat. Raise the bed to a comfortable working height.

10 Reposition pillow under client’s head. Ensure that client’s face never becomes obstructed by the pillow.

11 Fanfold linens to bottom of bed. Maintain privacy by only exposing body parts as necessary.

12 Cross the client's arms over the client's chest.

13 **From the working side of bed**, move upper body towards you (Place your arm under the client's shoulders then place other arm under mid-back, move the upper part of the client's body towards you using proper body mechanics.) **Move the upper body toward self**.

14 **Move hips toward self.** (Place one arm under client's waist & one under client's thighs.)

15 **Move legs toward self.** (Place one arm under client's thighs and one under client's calves.)

16 Cross client’s arm over their chest. Move arm out of the way on side toward which client is being turned.

17 If the client has not had hip surgery, cross client’s leg nearest you over the other leg at the ankles or bend client's knees if possible.

18 **Slowly assist/turn client onto side** (facing away from you while supporting the client’s body).

19 **Check to make sure client is not lying on his/her arm**.

20 **Maintain client‘s correct body alignment.**

21 Place support devices under the client’s head and upper arm, behind back, and

 between knees

22 To relieve pressure on the hip and shoulder. Face client and place hands under hip and adjust one to two inches toward you and repeat at shoulder area.

23 Cover client with top linen.

24 **Lower the height of the bed to the lowest position if it was raised**. **Lower side rail if it was used.**

25 **Maintain respectful, courteous interpersonal interactions at all times.**

26 Open the privacy curtains.

27 ***Wash hands*. Leave call light or signaling device within easy reach of the client.**

\*Skill 22: Transfer from Bed to Wheelchair

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: wheelchair with pressure relieving cushion or protective covering, non-skid footwear, and transfer belt as indicated. Use of a transfer belt may not be appropriate for some clients.

7 Pull curtains; provide for privacy throughout the procedure.

8 Always transfer client to strong side.

9 Remove or position wheelchair footrests out of the way.

10 **Lock wheels on wheelchair and bed**.

11 **Lower bed to same level as the wheelchair seat. Lock wheelchair brakes**.

12 **Position wheelchair close to bed with arm of the wheelchair almost touching the bed**.

13 **Bring client to sitting position with feet flat on the floor using proper body mechanics**.

14 ***Apply transfer belt* around client’s waist over clothing. Check transfer belt for fit by sliding fingers under belt to determine if it is snug but not too tight. Hold *transfer belt* using underhand grip**.

15 **Assist client in putting on shoes**.

16 Use your legs to stabilize the client’s legs.

17 Tell client on the count of three to use hands (if able) to press into the mattress, to straighten elbows and knees, and to come to a **standing position** **using good body mechanics**.

18 Assist client to pivot to wheelchair with back of client’s legs against wheelchair seat. Have client reach back and hold arm rests as you assist the client to sit in a **controlled manner that ensures safety**.

19 Position the client with hips touching the back of the wheelchair.

20 **Remove *transfer belt***.

21 Position client’s feet on footrests if appropriate.

22 Unlock wheelchair brakes.

23 Lower the height of the bed to the lowest position.

24 Leave client in position of safety and comfort.

25 **Maintain respectful, courteous interpersonal interactions at all times**.

26 Open the privacy curtains.

27 ***Wash hands***. **Leave call light or signaling device within easy reach of the client.**

\*Skill 23: Transfer from Wheelchair to Bed

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: Transfer belt as indicated. Use of a transfer belt may not be appropriate for some clients.

7 Pull curtains; provide for privacy throughout the procedure.

8 Always transfer client to strong side.

9 Position wheelchair close to bed with arm of the wheelchair almost touching the bed.

10 Remove or position wheelchair footrests out of the way.

11 **Lock wheelchair brakes**.

12 **Ensure bed is the same level as the wheelchair seat**.

13 **Place gait *belt* around client’s waist over clothing**. **Check gait belt for fit by sliding fingers under belt to determine if it is snug but not too tight.**

14 Hold *gait belt* using underhand grip.

15 Have client move hips forward to front of wheelchair seat. **Ensure client’s feet are flat on the floor**. With stronger foot slightly in back of weaker foot.

16 **Instruct client to place hands on the wheelchair arm rests**.

17 **Use legs to stabilize the client**. If the client has a weak extremity use the knee and foot of one leg to block the client’s weak leg or foot.

18 On the count of three gradually **assist client to standing position using an underhand grip on gait belt, using good body mechanics**. Allow client to remain standing for a time to stabilize position.

19 **Assist client to pivot and sit on bed in a controlled manner that ensures safety**. Have client reach back to assist to lower onto bed mattress.

20 **Remove *gait belt***. **Remove clients shoes**.

21 **Assist client to lie down in center of bed**. Cover with bed linens.

22 **Make sure client is comfortable and in good body alignment**.

23 **Maintain respectful, courteous interpersonal interactions at all times.**

24 **Open the privacy curtains**.

25 ***Wash hands*. Leave call light or signaling device within easy reach of the client.**

\*Skill 25: Ambulation of a Client using a Gait Belt

Step # Description

1 **Knock on door**.

2 ***Wash hands****.*

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure** to client, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: ***gait belt*** unless contraindicated. (Use of a *gait belt* may not be appropriate for some clients.)

7 Pull curtains; provide for privacy throughout the procedure.

8 **Lock wheels on** wheelchair and **bed**.

9 If client is in bed, **lower the height of the bed to a position so that the client can sit on the edge of the bed with his/her feet flat on the floor**.

10 **Make sure client has on sturdy, properly fastened non-skid footwear**.

11 **Help the client to a sitting position**. Stay with the client and give him/her time to sit on the side of the bed for approximately 2 minutes. If the client becomes dizzy, sweaty, short of breath, or is in any pain, lie him/her back down and report to the licensed nurse.

12 **Apply *gait belt* around client’s waist over clothing**, **tighten gait belt**. **Check gait belt by slipping fingers between gait belt and client.**

13 **Stand in front of and facing the client, grasp the gait belt at each side with an underhand grip and stabilize the client's legs**.

14 **Bring client to standing position using proper body mechanics**.

15 Stand slightly behind the client's side while he/she gains balance. Do not let go of the gait belt.

16 Encourage client to stand erect with head up and back straight.

17 **Walk on the weaker side if applicable and a little behind the client, while holding onto the *gait belt* and the client’s forearm or shoulder to stabilize the client**.

18 Encourage the client to walk normally, looking ahead. Discourage shuffling, sliding, or walking on tiptoes.

19 **Walk the required distance and do not rush the client**.

20 **Assist client to return to bed or sit in chair using proper body mechanics**.

21 **Remove the *gait belt***.

22 Lower the height of the bed to the lowest position.

23 **Leave client in position of safety and comfort with call bell in reach**.

24 Open the privacy curtains.

25 **Maintain respectful, courteous interpersonal interactions at all times.**

26 ***Wash hands***.

\*Skill 28: Ambulation of Client with a Walker using a Gait Belt

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: Walker (check for good working order), *gait belt* unless contraindicated. (Use of a *gait belt* may not be appropriate for some clients.)

7 Pull curtains; provide for privacy throughout the procedure.

8 **Lock wheels on wheelchair and bed**.

9 **If client is in bed, lower the height of the bed to a position so that the client can sit on the edge of the bed with his/her feet flat on the floor.**

10 **Make sure client has on sturdy, properly fastened non-skid footwear**.

11 **Help the client to a sitting position**. Stay with the client and give him/her time to sit on the side of the bed for approximately 2 minutes. If the client becomes dizzy, sweaty, short of breath, or is in any pain, lay him/her back down and report to the licensed nurse.

12 Apply *gait belt* around client’s waist over clothing.

13 Stand in front of and facing the client, grasp the gait belt at each side with an underhand grip and stabilize the client's knees.

14 **Bring client to standing position using proper body mechanics**.

15 Stand slightly behind the client's side while he/she gains balance. Do not let go of the gait belt.

16 Encourage client to stand erect with head up and back straight.

17 **Position walker 6 to 12 inches in front of client**.

18 Ask client to hold on to walker. **Make sure that client and walker are stabilized before client starts ambulation**.

19 Instruct client to pick up/roll the walker. Have client place the walker 6 to 12 inches in front of him/her. Make sure that all 4 feet or wheels of the walker are on the ground before the client steps forward to the walker. Have client move one foot and leg up to the walker, then have the client move the other foot and leg up to the walker. The walker should not be moved again until the client has moved both feet forward and is steady. The client should never put his feet ahead of walker. Discourage shuffling, sliding, or walking on tiptoes.

20 **Walk on the weaker side if applicable and a little behind and slightly to side of the client, while holding onto the gait belt**.

21 Walk the required distance and do not rush the client.

22 **Assist client to return to bed or sit in chair using proper body mechanics and in a controlled manner that ensures safety.**

23 **Remove the *gait belt*. Use correct body mechanics at all times.**

24 Lower the height of the bed to the lowest position.

25 **Leave client in position of safety and comfort with call bell in reach**.

26 Open the privacy curtains.

27 **Maintain respectful, courteous interpersonal interactions at all times.**

28 ***Wash hands***.

\*Skill 29: Range of Motion (ROM) Upper Extremities

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client the name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 **Pull curtains**; provide for privacy by exposing only the extremity you are working on throughout the entire procedure.

7 Lock wheels on bed.

8 Raise the bed to a comfortable working height and lower the head of the bed.

9 **Position the client on back (supine) and in good body alignment**.

10 Provide support for each individual joint while range of motion is being performed on it (e.g. support client’s arm at elbow by placing one hand under the elbow and at the wrist by placing one hand under the wrist while performing range of motion for the shoulder).

11 Repeat full range of motion at least three times or as stated in the care plan .

12 While supporting the limb, move joint gently, slowly, and smoothly through the range of motion to the point of resistance. Stop if pain occurs. Monitor non-verbal cues.

13 **Correctly support client’s joint by placing one hand under the elbow and the other hand under the client’s wrist.**

**A) Raise the client’s arm up and over the client’s head. (flexion)**

 **Bring the client’s arm back down to the client’s side. (extension)**

 **Complete flexion and extension of shoulder at least three times.**

 **Ask client if s(he) has any pain. Continue same support for shoulder**

 **joint.**

 **B) 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.**

 **Do not cause discomfort or pain at any time during ROM.**

 **Do not force any joint beyond the point of free movement.**

14 Provide support for the ELBOW JOINT. Grasp wrist with one hand and the elbow with the other.

A) Flexion/Extension: Bend the arm at the elbow, so that the hand touches the

 shoulder on the same side. Straighten the arm.

 B) Exercise the forearm by moving it so palm faces downward (pronation) and

 then upward (supination)

 15 Provide support for the WRIST JOINT. Grasp wrist with one hand & the client's fingers with the other,

A) Flexion/Extension/Hyperextension: Move the hand downward, straighten the

 wrist, move the hand back.

B) Abduction/Adduction: Turn the hand toward the little finger, turn the hand

 toward the thumb.

16 Provide support for the THUMB JOINT: Hold the client's hand with one hand and the client's thumb with the other.

A) Flexion/Extension: Bend the thumb into the hand, move the thumb out to the

 side of the fingers.

B) Abduction/Adduction: Move the thumb out from the inner part of the index

 finger, move the thumb back next to the index finger.

C) Opposition: Touch each fingertip with the thumb and open hand fully between

 each movement.

17 Provide support for the FINGER JOINTS. Hold the client's hand with one hand and the client's fingers with the other.

 A) Flexion/Extension: Make a fist, straighten the fist by extending the fingers,

 one at a time.

 B) Abduction/Adduction: Spread each finger and thumb apart, bring the fingers

 and thumb together.

18 Lower the height of the bed to the lowest position.

19 Leave client in a comfortable position. Open privacy curtains.

20 Maintain respectful, courteous interpersonal interactions at all times.

21 Wash hands. Leave call light or signaling device within easy reach of the client.

**\*Skill 30: Range of Motion (ROM) Lower Extremities**

**Step # Description**

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 **Pull curtains; provide for privacy** by exposing only the extremity you are working on throughout the entire procedure.

7 Lock wheels on bed.

8 Raise the bed to a comfortable working height and lower the head of the bed.

9 **Position client supine. Position client in good body alignment**.

10 **Provide support for each individual joint while range of motion is being performed. Correctly support joints by placing one hand under the knee and one hand under the ankle of the leg.**

11 Repeat full range of motion at least 3 times.

12 While supporting the limb, move joint gently, slowly, and smoothly through the range of motion to the point of resistance. Stop if pain occurs. Monitor nonverbal cues.

13 Provide support for the **HIP JOINT**. Put one hand under the client's bent knee and the other under the client's ankle.

 A) Flexion/Extension: Raise the leg by bending the knee and moving leg toward

 head, straighten the leg.

 B) **Move the entire leg away from the body (abduction), move the entire**

 **leg toward the body (adduction).**

 Continue to correctly support joints by placing one hand under the client’s

 knee and the other hand under the client’s leg.

 C) Internal/External Rotation: Turn the leg inward, turn the leg outward.

14 Provide support for the **KNEE JOINT**. Put one hand under the client's bent knee and the other under the client's ankle with foot flat on bed Flexion/Extension: Straighten the knee and bend the lower leg back to bed at least 3 times.

 Do not cause discomfort or pain any time during ROM.

 Do not force any joint beyond the point of free movement.

15 Provide support to the ANKLE JOINT. Keep foot close to bed. Put one hand under the client's ankle and grasp his/her foot with your other hand.

A) Dorsiflexion/Plantar flexion: Push the foot forward toward the client's head,

 point the foot downward away from the client's head.

B) Supination/Pronation: Turn the inside of the foot inward towards the body;

 turn the sole of the foot away from the body.

C) Rotation- rotate ankle in circle.

16 Provide full range of motion of TOE JOINTS: Put one hand under the client's foot and the other on the top of their foot over the toes.

A) Flexion/Extension: Curl toes downward, straighten the toes.

B) Abduction/Adduction: Spread the toes apart one by one, bring toes back

 together.

17 Lower the height of the bed to the lowest position.

18 Leave client in a comfortable position.

19 Maintain respectful, courteous interpersonal interactions at all times.

20 *Wash hands*. Leave call light or signaling device within easy reach of the client.

\*Skill 33: Mouth Care

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: emesis basin, glass of water, disposable gloves, toothbrush/toothettes, toothpaste, mouth wash solution (mix 4 parts of water with 1 part of mouthwash in disposable cup), protective barrier and towel.

7 **Pull curtains; provide for privacy**.

8 If client is in bed, lock wheels on bed and raise the bed to a comfortable working height.

9 Ensure client is in an upright sitting position.

10 Position the over-bed table so you can reach it with ease. Place protective barrier on table.

11 **Drape the chest with towel to prevent soiling**.

12 **Put on *gloves***.

13 Moisten toothbrush or toothette.

14 **Apply toothpaste to the toothbrush or toothette**.

15 **Brush all inner, outer and chewing surfaces of all upper and lower teeth**.

16 **Clean tongue. Clean gums**.

17 **Assist client in rinsing mouth.** Offer mouthwash solution.

18 Hold emesis basin to client’s chin.

19 **Wipe/dry client’s mouth. Remove soiled linen**.

20 **Empty emesis basin. Rinse emesis basin**.

21 **Rinse toothbrush or dispose of toothette**.

22 Return emesis basin and toothbrush to storage.

23 Lower the height of the bed to the lowest position.

24 **Remove and dispose of *gloves* without contaminating self**.

25 **Leave client in position of safety and comfort**.

26 **Maintain respectful, courteous interpersonal interactions at all times**.

27 Open the privacy curtains.

28 ***Wash hands*. Leave call light or signaling device within easy reach of the client**.

29 Report any problems to the licensed nurse (swollen gums, irritations, etc.).

\*Skill 34: Denture Care for Dependent Client

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: client's dentures and denture cup, disposable gloves, **washcloth**, toothpaste or denture cleaner, and towel.

7 Pull curtains; provide for privacy throughout the procedure.

8 **Put on clean *gloves***.

9 **Before handling dentures**, protect dentures from possible breakage by **lining sink** **with a cloth towel/washcloth(NO Paper towel allowed) as a protective lining or fill with water to prevent damage to the dentures in case they are dropped!**

10 Sit client upright if dentures need to be removed from oral cavity. Avoid putting fingers between teeth.

11 Remove upper denture first, using a washcloth for grip if needed. A slight downward pull will be required to break suction

12 Turn upper denture at an angle to take out. Place denture in denture cup.

13 Remove the lower denture using a wash cloth for grip if needed. Place denture in denture cup.

14 Take dentures in cup to sink. Maintain clean technique with placement of dentures and toothbrush throughout procedure. **Carefully remove dentures from cup**.

15 Handle dentures carefully to avoid damage.

16 Rinse dentures using clean, cool water before brushing them.

17 Apply toothpaste or denture cleanser to toothbrush.

18 **Thoroughly brush all surfaces of dentures (inner, outer, and chewing) of upper and/or lower dentures**.

19 **Rinse all surfaces of dentures using clean, cool running water**.

20 **Rinse denture cup. Place clean dentures in rinsed cup**.

21 **Add cool clean water to denture cup**.

22 **Rinse equipment and return to proper storage** (e.g. bedside stand).

23 Clean and replace equipment.

24 **Discard sink’s protective lining in appropriate container or drain sink**.

25 **Remove *gloves* turning inside out as they are removed**.

26 Dispose of gloves in an appropriate container.

27 **Maintain respectful, courteous interpersonal interactions at all times.**

28 **Leave client in position of safety and comfort with call light or signaling device within easy reach of the client**.

29 Open the privacy curtains.

30 ***Wash hands***.

31 Report any problems to the licensed nurse (swollen gums, irritations, etc.).

**\*Skill 35: Mouth Care for a Comatose Client**

**Step # Description**

1 **Knock on door.**

2 **Introduce self by name and title.**

3 ***Wash hands*.**

4 Identify and address the client by name.

5 Explain procedure to client, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: disposable gloves, emesis basin, glass of water, toothettes, and towels.

7 **Pull curtains; provide for privacy**.

8 Lock wheels on bed.

9 Raise the bed to a comfortable working height.

10 **Turn client to a side lying position to avoid choking or aspiration**. Turn client on side facing you (head to one side and slightly forward so any excess fluid will not run down throat).

11 Position the over-bed table so you can reach it with ease.

12 **Drape as needed to protect from soiling**.

13 **Put on *gloves*. Use toothettes dipped in water**.

14 Gently pull down on chin to open mouth.

15 **Gently and thoroughly clean the inner, outer, and chewing surfaces of all upper and lower teeth**.

16 Clean mouth gently making sure that your fingers are never in the client’s mouth.

17 Put used toothettes into the emesis basin.

18 Dip un-used toothettes into clean water and swab mouth to rinse. Remove excess water from toothette before putting into client’s mouth.

19 **Clean and dry face. Return client to a position of comfort and safety**.

20 Lower the height of the bed to the lowest position.

21 **Clean and rinse equipment. Replace equipment**.

22 **Discard disposable items in waste can**.

23 **Discard towel and washcloth in linen hamper**.

24 **Remove gloves, turning inside out as they are removed**.

25 **Dispose of gloves properly**.

26 Open the privacy curtains.

27 ***Wash hands***.

28 Report any problems to the licensed nurse (swollen gums, irritations, etc.).

**\*Skill 36a: Assisting a Dependent**

**Client with a Meal in a Bed**

**Step # Description**

1. **Knock on door.**
2. ***Wash hands.***
3. Introduce self by name and title
4. Identify and address the client by name.
5. **Explain procedure to client,** speaking clearly, slowly, and

 directly, and maintaining face-to-face contact whenever possible.

1. Offer client the opportunity to use bathroom or bedpan.
2. Oral/Denture care as needed.
3. Clear away anything that is unpleasant such as emesis basin or bedpan and clean the over-bed table eating surface.
4. Assemble equipment: client’s meal tray, clothing protector, washcloth, and towel.
5. **Position client in upright position must be at least 45 degrees.**
6. **Look at diet card to check that client has received the correct tray.** Verify food tray with client’s identity. Then check diet texture and fluid consistency.
7. Wash and dry client’s face and hands or assist client with washing and drying face and hands before feeding client.
8. **Assist client with putting on clothing protector, napkin, or towel.**
9. **Sit down in a chair** at eye level facing client while assisting the client or assume other position so caregiver is at eye level with the client.
10. Identify food on tray for client, cutting into bite-sized pieces. Prepare food/drink per client’s preferences and needs. Re-heat as necessary.
11. Verbalize temperature of food prior to assisting client.
12. **Using a spoon, and according to client preferences, offer both solid and liquid foods in small amounts frequently.**
13. **Allow client time to chew and swallow**. **Cue client to swallow as necessary.**
14. Make sure the client’s mouth is empty before next bite of food or drink of beverage.
15. **Wipe client’s hands and face during meal as needed**.
16. Carry on a pleasant conversation with client during meal.
17. Wash and dry client’s face and hands or assist client with washing and drying face and hands.
18. Remove clothing protector and dispose in proper receptacle.
19. Remove food tray and determine oral fluid intake and percentage of meal consumed.
20. **Leave client clean and in upright position (at least 45 degrees) of safety and comfort for at least 30 minutes with call bell in reach.**
21. Place soiled linen in hamper and remove tray.
22. *Wash hands.*
23. Maintain respectful, courteous interpersonal interactions at all times.
24. Make certain call light or signaling device is within easy reach of the client.

**\*Skill 36b: Assisting a Dependent**

**Client with a Meal in a Chair**

**Step # Description**

1. **Knock on door.**
2. ***Wash hands.***
3. Introduce self by name and title
4. Identify and address the client by name.
5. **Explain procedure to client,** speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.
6. Offer client the opportunity to use bathroom or bedpan.
7. Oral/Denture care as needed.
8. Clear away anything that is unpleasant such as emesis basin or bedpan and clean the over-bed table eating surface.
9. Assemble equipment: client’s meal tray, clothing protector, washcloth, and towel.
10. **Look at diet card to check that client has received the correct tray.** Verify food tray with client’s identity. Then check diet texture and fluid consistency.
11. Wash and dry client’s face and hands or assist client with washing and drying face and hands before assisting with meal.
12. **Assist client with putting on clothing protector, napkin, or towel.**
13. **Sit down in a chair** at eye level facing client while assisting the client or assume other position so caregiver is at eye level with the client.
14. Identify food on tray for client, cutting into bite-sized pieces. Prepare food/drink per client’s preferences and needs. Re-heat as necessary.
15. Verbalize temperature of food prior to assisting client.
16. **Using a spoon, and according to client preferences, offer both solid and liquid foods in small amounts frequently.**
17. **Allow client time to chew and swallow**. **Cue client to swallow as necessary.**
18. Make sure the client’s mouth is empty before next bite of food or drink of beverage.
19. **Wipe client’s hands and face during meal as needed**.
20. Carry on a pleasant conversation with client during meal.
21. Wash and dry client’s face and hands or assist client with washing and drying face and hands.
22. Remove clothing protector and dispose in proper receptacle.
23. Determine and **record intake of total solid food eaten** as a percentage.
24. Determine and **record oral fluid intake** in cc/ml.
25. Place soiled linen in hamper and remove tray.
26. *Wash hands.*
27. Maintain respectful, courteous interpersonal interactions at all times.
28. Make certain call light or signaling device is within easy reach of the client.

\*Skill 38: Measure and Record Oral Fluid Intake at Mealtimes

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: I & O record sheet, pen & paper.

7 **Observe dinner tray**.

8 **Use paper, pencil, and/or mental computation, calculate grand total cc or ml consumer from three different glasses**.

9 Determine original amount of liquid.

10 Subtract the remaining amount from the full serving amount to determine the estimated oral intake.

11 **Record the total cc or ml of fluid consumed on measurement recording sheet.**

12 Remove food tray.

13 **Maintain respectful, courteous interpersonal interactions**.

14 *Wash hands*.

15 **Leave client in position of safety and comfort with call light or signaling device within easy reach of the client**.

\*Skill 39: Bed Bath

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: bath basin, bath blanket, bath towels, bed linens, disposable gloves (Gloves should be worn if the client has draining wounds, non-intact skin, or you have contact with blood or body fluids including mucous.), gown or clothing as appropriate, laundry receptacle, lotion, protective barrier, soap, and washcloths. Arrange items on over-bed table using a protective barrier. Place clean linens on clean surface in order of use. Place laundry receptacle nearby.

7 Close doors and windows to prevent drafts.

8 Pull curtains; provide for privacy throughout the procedure.

9 Offer a bedpan or urinal before starting procedure.

10 Lock wheels on bed.

11 **Raise the bed to a comfortable working height**.

12 If side rails are ordered or in use: lower the side rail on the working side only. Side rail is to remain up at all times on the side you are not working on. Adjust as necessary to maintain safety throughout bed bath.

13 Position client close to working side of bed.

14 **Cover client with bath blanket or sheet. Remove remaining top bed cover. Fold bed cover to bottom of bed or place aside.**

15 **Remove client's gown without exposing client.**

16 **Fill basin two-thirds full with comfortably warm water. Change water whenever it gets too cold or soapy**.

17 Test water temperature and ensure it is safe and comfortable before bathing client. Adjust if necessary.

18 If indicated, use *gloves* and change as necessary throughout the bed bath.

19 Make a mitt of the washcloth.

20 Wash the client's eyes with water only (no soap) by gently wiping from the inner to the outer corner of the eye with a corner of the mitt. Clean the far eye first and repeat this step for the near eye with a clean corner of the mitt. Use a different area of the washcloth for each eye. **Wash the client's face, neck, and ears with water only (no soap)**.

21 **Dry client's face, neck, and ears thoroughly**.

22 Expose only part of body being bathed.

23 Move client’s body gently and naturally, avoid force and over-extension of limbs and supporting joints throughout the procedure.

24 Wash arms: **Place a bath towel lengthwise under far arm exposing one arm**. Support the arm with your palm under the client's elbow, his/her forearm rests on your forearm. **Wash the exposed arm, hand, shoulder, and underarm with long, firm, strokes using soap.**

25 **Rinse arm, hand, shoulder and underarm. Dry arm, hand, and underarm**.

26 Place the basin on the towel. If possible, put the client's hand into the water and wash it well. (*Fingernail care* can be done at this time.)

27 Remove the basin and dry the hand well. Cover the arm with the bath blanket and remove the bath towel. Repeat the above steps for the near arm.

28 Wash chest: Place a bath towel over chest horizontally. Hold the towel in place while removing the bath blanket from underneath down to the client's waist. Lift the towel slightly and wash the chest without exposing the client.

29 Rinse and dry chest especially under breasts.

30 Leave bath towel in place over chest as you lower bath blanket down to pubic area.

31 Wash, rinse and dry abdomen.

32 Pull bath blanket up to shoulders covering both arms and then remove the bath towel.

33 Wash leg: Uncover the far leg. Do not expose the genital area. Place a towel lengthwise under the foot and leg. Bend the knee and support the leg with your arm. Wash the leg with long, firm, strokes.

34 Rinse and dry leg.

35 Repeat the above steps for the near leg.

36 Place the basin on the bath towel. If possible, put the client's feet into the basin of water. Wash and rinse the feet. (Foot care and toenail care can be done at this time.)

37 Remove the basin and dry the feet well including between client's toes. Cover the leg with the bath blanket and remove the bath towel.

38 Change the water.

39 Turn the client onto his/her side facing away from you. Keep him/her covered with the bath blanket.

40 Wash back and buttocks: Uncover the back and buttocks. Place a towel lengthwise on the bed along the back. Wash the back working from the back of the neck to the lower end of the buttocks. Use long, firm, continuous strokes.

41 Rinse and dry back and buttocks.

42 Give client a back rub with lotion if indicated.

43 Turn the client onto his/her back.

44 Change the water.

45 Set up equipment and allow client to do own perineal care if indicated. Otherwise perform perineal care. Leave call bell within reach of client and ask the client to signal when done.

46 Remove and dispose of *gloves* into waste container without contaminating self.

47 *Wash hands*.

48 Apply lotion as needed after bed bath.

49 Assist client to put on a clean gown while maintaining privacy. Remove bath blanket and cover client if indicated with bed covers.

50 Comb and brush hair.

51 Lower the height of the bed to the lowest position.

52 **Rinse and store basin in proper storage.**

53 **Dispose of soiled linen in laundry receptacle. Avoid contact between your clothing and soiled linens.**

54 Maintain respectful, courteous interpersonal interactions at all times.

55 ***Wash hands*.**

56 Open the privacy curtains.

57 **Leave client in position of safety and comfort with call light or signaling device within easy reach.**

**Partial Bed Bath (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.

\*Guideline for Oregon NA Skill test, not intended to be used to provide complete care in an

 actual work setting

\*Skill 42: Perineal Care

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client** **(mannequin for testing)**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: wash cloths or wipes, bath blanket, disposable gloves, soap, towel, washbasin, protective barrier and one incontinence pad.

7 **Provide for privacy** – pull curtain.

8 Lock wheels on bed.

9 Offer client *bedpan/urinal.*

10 **Raise the bed to an appropriate working height**.

11 Arrange items on over-bed table on protective barrier.

12 **Fill basin with comfortably warm water**

13 **Put on *gloves* before contact with linen, incontinence pad, and/or client**.

14 **Turn client to side or raise hips and place clean pad under the buttocks**.

15 **Make sure client is comfortably positioned on back on water proof pad**.

16 Position client in supine position.

17 **Cover client with a bath blanket. Expose perineum only**.

18 Help the client flex knees and spread legs. If the client cannot flex knees, help the client spread legs as much as possible with knees straight.

19 Put on clean *gloves*.

20 Wet and apply soap to washcloth or wipes. Squeeze excess water out of washcloth before using.

21 **Female: 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.**

22 Male: Gently grasp the penis and retract the foreskin if the client is uncircumcised. Clean and rinse the tip of the penis using a circular motion. Start at the urethral opening and work outward. Repeat this step as necessary using a clean area of the washcloth or clean washcloth for each stroke. Use more than one washcloth if needed. Rinse and dry entire perineal area. Return foreskin to its natural position.

23 **Cover the exposed area with the bath blanket or clean sheet**.

24 **Assist client to turn onto side away from self**.

25 **With a clean portion of wash cloth, clean the rectal area**.

26 **Use water, washcloth and soap. Clean rectal area from front to back with single strokes.**

27 **Rinse area from front to back. Dry area. Position client (mannequin) on her back**.

28 **Turn client or raise hips to remove waterproof pad from under buttocks.**

29 Change *gloves*.

30 **Replace top cover over client, remove bath blanket**.

31 **Dispose of soiled linen in an appropriate container**.

32 Avoid contact between your clothing and the soiled linens/pads throughout the procedure.

33 **Empty, rinse, and wipe basin, return to storage**.

34 **Turn gloves inside out as they are removed**.

35 **Dispose of gloves in appropriate container. Lower bed, if it was raised**.

36 **Maintain respectful, courteous interpersonal interactions at all times.**

37 ***Wash hands*. Leave call light or signaling device within easy reach of the client**.

38 Report to the licensed nurse if redness or irritation is noted.

\*Skill 43: Catheter Care

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: at least 4 wash cloths, bath blanket, disposable gloves, paper towels, soap, towel, washbasin, and one bed protector. Arrange items on over-bed table using bed protective barrier.

7 **Pull curtains; provide for privacy**.

8 Lock wheels on bed.

9 Raise bed to a comfortable working height.

10 Put on clean *gloves* **before** contact with linen, bed protector, and/or client.

11 Position client in supine position.

12 Turn client to side or raise hips and place bed protector under buttocks

13 Drape the client for catheter care by positioning a bath blanket to maintain client privacy.

14 **Check to make sure that urine can flow, unrestricted, into the drainage bag!**

15 Fill washbasin with comfortably warm water. Test water temperature and ensure it is safe and comfortable, adjust if necessary.

16 Place the filled washbasin on the over-bed table on top of the protective barrier.

17 Fold back the bath blanket between the legs to expose the genital area only.

18 Perform *perineal care* if indicated*.*

19 Separate the labia for a female client or retract the foreskin for an uncircumcised male client. Check for crusts, abnormal drainage, or secretions. Report any abnormalities to your licensed nurse.

20 Return the foreskin to its natural position.

21 **Use soap and water to wash around the drainage tube where it exits the urethra.**

22 **Hold catheter near urethra to prevent tugging on the catheter**.

23 **Clean 3-4 inches from the urethra down the drainage tube moving in only one direction, away from urethra. Use a clean area of the washcloth for each stroke. Repeat if necessary with a clean washcloth. Rinse using strokes only away from the urethra**.

24 **Pat dry with a clean towel**.

25 **Do not allow the tube to be pulled at any time during the procedure**.

26 Check to be sure tubing is coiled without kinks on bed and hangs straight down into drainage container.

27 Remove bed protector.

28 **Remove gloves turning inside out. Dispose of gloves. Replace top cover over client. Remove the bath blanket.**

29 Dispose of soiled linen in laundry receptacle.

30 Lower the height of the bed to the lowest position.

31 Empty, rinse, and wipe basin.

32 Return basin to proper storage.

33 **Leave client in position of safety and comfort.**

34 **Maintain respectful, courteous interpersonal interactions.**

35 Open the privacy curtains.

36 ***Wash hands*. Leave call light or signaling device within easy reach of the client.**

37 Report to the licensed nurse if redness or irritation is noted.

\*Skill 47: Anti-Embolism Elastic Stockings

Step # Description

1 **Knock on door.**

2 ***Wash hands*.**

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: anti-embolus elastic stockings.

7 Pull curtains; provide for privacy throughout the procedure.

8 Lock wheels on bed.

9 Position the client in a supine position for at least 30 minutes before application of stocking.

10 Raise the bed to a comfortable working height.

11 **Expose only the leg to which the stocking is being applied**.

12 **Roll, gather or turn stocking down inside out at least to the heel**.

13 Place foot of stocking over toes, foot, and heel.

14 **Roll or pull top of stocking over foot, heel, and leg**.

15 Move client’s foot and leg gently and naturally, avoid force and over-extension of limb and joints throughout the procedure.

16 **Ensure that anti-embolus stocking has no twists, is wrinkle free, and that the stocking is properly placed.**

17 **Check toes for possible pressure from stocking; adjust as needed.**

18 Return bed linens to cover client.

19 Lower the height of the bed to the lowest position.

20 **Leave client in position of safety and comfort with call bell in reach**.

21 Open the privacy curtains.

22 Maintain respectful, courteous interpersonal interactions at all times.

23 *Wash hands*.

\*Skill 55: Fingernail Care

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: disposable gloves, nail clipper, orangewood stick-blunt end, emery board, lotion, basin, bath towel, paper towels, protective barrier and washcloth.

7 Pull curtains; provide for privacy throughout the procedure.

8 Elevate head of bed, if permitted, and adjust the over-bed table in front of client. If client is allowed out of bed, assist client to transfer to a chair and position over-bed table waist-high across lap.

9 **Fill basin with comfortably warm water**. Place on over-bed table on top of protective barrier.

10 Test water temperature and ensures it is safe and comfortable before immersing client’s fingers in water. Adjust if necessary.

11 Put on clean ***gloves*** before cleaning under fingernails.

12 **Soak nails for at least five (5) minutes**. Make sure the basin is placed at a comfortable level for the client.

13 **Dry hands thoroughly. Specifically dry between fingers**.

14 **Gently clean under nails with orangewood stick**.

15 Wipe orangewood stick on towel after each nail.

16 **Gently push back client’s cuticles with towel/washcloth or blunt end of orange stick**.

17 Cut fingernails as necessary: Use nail clippers to cut fingernails straight across. Do not cut below tips of fingers. Keep nail clippings on paper towel until discarded.

18 **File each fingernail with emery board.**

19 Check to make sure nails are smooth and free of rough edges.

20 Remove and dispose of *gloves* into waste container without contaminating self.

21 Put lotion in hand.

22 Warm lotion by rubbing hands together.

23 Apply lotion onto both hands. Remove any excess lotion (if any) with a towel.

24 **Empty, rinse, and wipe out basin**.

25 Return equipment to proper storage.

26 Clean and replace equipment.

27 **Discard soiled linen in linen hamper or equivalent**.

28 **Maintain respectful, courteous interpersonal interactions.**

29 Leave client in position of safety and comfort with call light or signaling device within easy reach of the client.

30 Open the privacy curtains.

31 ***Wash hands***.

**\*Skill 56: Foot Care**

**Step # Description**

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: basin, bath towel, disposable gloves, protective barrier, lotion, soap, and washcloth.

7 Pull curtains; provide for privacy throughout the procedure.

8 If client is able to be out of bed, assist client to transfer to a chair.

9 Place protective barrier on floor in front of client.

10 **Fill basin with comfortably warm water and place on protective barrier**.

11 Test water temperature and ensure that it is safe and comfortable before placing client’s foot in the water. Adjust if necessary.

12 Put on clean *gloves* before washing feet.

13 **Remove socks. Completely submerge feet in warm water 5-20 minutes**.

14 **Use water and soapy washcloth. Wash entire foot. Wash between toes**.

15 **Rinse entire foot. Rinse between the toes**.

16 **Dry foot thoroughly, being careful to dry between toes**.

17 Observe the toenails and the skin on the foot and between the toes for general appearance and condition. Look especially for redness and cracking of the skin.

18 Repeat steps 13-17 with other foot.

19 Remove and dispose of *gloves* into waste container without contaminating self. (May use new *gloves* to apply lotion.)

20 Put lotion in hand.

21 **Warm lotion by rubbing it between hands**.

22 **Massage lotion over entire feet (top and bottom except between toes). Remove any excess lotion, wipe with a towel**.

23 **Replace socks on feet**.

24 Support foot and ankle properly throughout procedure.

25 **Empty, rinse, and wipe out basin**.

26 Return the basin to proper storage.

27 **Place dirty linen in hamper or equivalent**.

28 Remove and dispose of *gloves* into waste container without contaminating self.

29 Make sure bed is in lowest position.

30 **Maintain respectful, courteous interpersonal interactions**.

30 **Leave client in position of safety in proper alignment in the chair**.

31 Open the privacy curtains.

32 ***Wash hands*. Leave call light or signaling device within easy reach of the client**.

33 Report to the licensed nurse if redness or irritation is noted.

**\*Skill 57 & 58: Undressing and Dressing a Client**

**Step # Description**

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: client's choice of clothing.

7 **Provide for privacy – pull curtain**.

8 Lock wheels on bed.

9 Raise bed to a comfortable working height.

10 Ask client which outfit he/she would like to wear and dress client in outfit of choice. Position client as suitable for dressing while allowing client to dress self as able.

11 **Keep client covered while removing gown**.

12 **Remove gown from unaffected side first. Place gown in laundry hamper**.

13 **During the next two steps, always dress client beginning with the weak side first**.

14 While putting on items, move client’s body gently and naturally, supporting joints at all times.

15 **When dressing the client in a shirt/blouse, insert your hand through sleeve of the shirt/blouse and grasp client’s hand**. Draw sleeve over your hand and client's, adjust sleeve at shoulder, assist client to move forward, arrange clothing across back, gather sleeve on opposite side by slipping your hand in from outside, grasp client's wrist and pull sleeve of garment over your hand and client's hand, adjust shirt at shoulder, and button, zip or snap garment. Smooth back of garment to remove any wrinkles.

16 **When dressing the client inn sweat pants, dress client's weak side first**. For pants: Gather client's pants from waist to leg hole, slip pants over one foot at a time, pull pants up legs as high as possible, **assist client to raise buttocks or rock client side to side and draw the pants over the buttocks and up to the client’s waist.** Adjust garment until it is comfortable. Fasten garment if required. Smooth back of garment to remove any wrinkles.

17 Place bed at a safe and appropriate level for client.

18 **When putting on the client’s socks, draw the socks up the client’s foot until they are smooth**. Put on shoes before assisting client to a standing position.

19 Check to make sure client is dressed appropriately (e.g. clothing right side out, zippers/buttons fastened, etc.).

20 Dispose of soiled linen in laundry receptacle.

21 **Leave client comfortably and properly dressed**.

22 **Maintain respectful, courteous interpersonal interactions at all times**.

23 Open the privacy curtains.

24 ***Wash hands*. Leave call light or signaling device within easy reach of the client.**

\*Skill 59: Assisting a Client to Use a Regular Bedpan

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 Assemble equipment: bedpan, cover with plastic cover, paper cover or paper towels, protective barrier, disposable gloves, towel, toilet paper, and washcloth and incontinence pad.

7 Pull curtains; provide for privacy throughout the procedure.

8 Lock wheels on bed.

9 Put on clean gloves before handling bedpan.

10 Remove bedpan from cover and place on top of protective barrier either at the foot of the bed or on a chair.

11 Lower head of bed before placing bedpan.

12 Remove covers by fan fold at end of bed leaving sheet to cover client.

13 **Position client on bedpan**: Ask the client to bend the knees with feet flat on the bed and raise the hips. Assist if needed with your hand under the client's lower back. Place incontinence pad and bedpan. If the client is unable to raise the hips, roll him or her to the side, place the incontinence pad under buttocks, place the bedpan on the incontinence pad, and roll the person onto the bedpan. Position bedpan so wider end of pan is aligned with client’s buttocks.

14 **Raise the head of the bed after placing bedpan and the knee rest if client can tolerate so that the client is in a comfortable, sitting position and cover with a sheet.**

15 **Put roll of toilet tissue within reach of client**.

16 Remove and dispose of *gloves* into waste container without contaminating self.

17 *Wash hands*.

18 Leave call bell within reach of client and ask the client to signal when done.

19 **Leave room or provide for privacy**. Never leave a client on a bedpan for more than ten minutes without checking to see if the client needs assistance.

20 Return when the client signals. Knock before entering the room.

21 *Wash hands.*

22 Lower head of bed before removing bedpan.

23 **Put on clean gloves before removing bedpan**.

24 Remove unused toilet tissue roll and put in bedside stand.

25 **Remove bedpan gently so contents don't spill and cover immediately**. Place on top of protective barrier either at the foot of the bed or on a chair.

26 **Wash client's hands or assist client with washing and drying hands**.

27 Provide perineal care if necessary.

28 Remove the incontinence pad and dispose per facility policy.

29 Cover client with sheet.

30 Dispose of soiled linen in laundry receptacle.

31 Take the bedpan to the bathroom or dirty utility room.

32 Observe contents and *measure output* **if using a graduate.**

33 **Empty graduate into toilet**.

34 **Rinse bedpan and graduate until clean and pour rinse water into toilet**.

35 Cover bedpan and change cover if soiled.

36 **Remove and dispose of *gloves* into waste container without contaminating self**.

37 *Wash hands*.

38 Put on clean gloves.

39 Return bedpan to proper storage.

40 **Remove and dispose of *gloves* into waste container without contaminating self**.

41 **Lower the height of the bed to the lowest position**.

42 Open the privacy curtains.

43 ***Record output* on recording sheet and document abnormalities to the licensed nurse**.

44 **Maintain respectful, courteous interpersonal interactions at all times.**

45 ***Wash hands***. **Leave client in position of safety and comfort with call bell or signaling device within easy reach of client**.

\*Skill 65: Measure and Record Output from a Urinary Drainage Bag

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.

6 Assemble equipment: antiseptic wipe, calibrated graduate or urinal, disposable gloves, and paper towels.

7 **Pull curtains; provide for privacy**.

8 **Put on *gloves***.

9 **Place a barrier/paper towel on the floor under the drainage bag. Place the graduate on the previously placed barrier**.

10 **Open the drain to allow the urine to drain into the graduate. Avoid touching the graduate with the tip of the tubing**.

11 **Close the drain. Wipe the drain with antiseptic wipe. Replace the drain in holder**.

12 Cover and take the graduate/urinal to the bathroom or dirty utility room.

13 **With graduate at eye level, measure output**. Check the contents carefully for any abnormal or unusual appearance. If anything unusual is observed save the urine for the licensed nurse's inspection.

14 **Record the output in cc/ml**.

15 **Empty graduate into toilet**.

16 **Empty rinse water into toilet**.

17 **Return equipment to storage**.

18 **Turn gloves inside out as they are removed**.

19 **Dispose of *gloves*** into waste container without contaminating self.

20 Leave client in position of safety and comfort.

21 Open the privacy curtains.

22 **Maintain respectful, courteous interpersonal interactions**.

23 ***Wash hands*. Leave call light or signaling device within easy reach of the client.**

\*Skill 76: Making an Unoccupied Bed

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title if client is present.

4 Identify and address the client by name if present.

5 Explain procedure to client, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible (if present).

6 Assemble equipment: Gather clean linen - two clean flat sheets or one fitted and one flat sheet, bedspread and blanket as needed, pillowcase, and disposable gloves. (Gloves should be worn if the client has draining wounds, non-intact skin, or you have contact with blood or body fluids including mucous.)

7 **Transport clean linen away from body**.

8 **Place clean linen on clean surface within your reach (e.g., bedside stand, chair, or over-bed table). Avoid contamination of clean linen throughout procedure.**

9 Flatten bed.

10 Lock wheels on bed.

11 **Elevate bed to appropriate working height**.

12 Avoid touching linen to uniform.

13 Put on ***gloves*** and carefully check bed and linens for foreign articles such as eyeglasses, dentures and hearing aids.

14 **Remove soiled linen** and roll up linen individually **from bed without shaking linen, without contamination uniform place in laundry receptacle.**

15 Remove and dispose of *gloves* into waste container without contaminating self.

16 Wash hands.

17 Complete making one side of the bed before moving to the other side by: **Apply clean bottom fitted sheet**, **keeping it straight and centered**. **Make bottom linen smooth and/or tight, free of wrinkles**. Fold the bottom sheet lengthwise and place on the bed. The stitching should be downward. Place the center fold of the sheet in the center of mattress from head to foot, open the sheet. Fanfold ½ of the bottom sheet to center of bed, Place hem even with bottom end of mattress. Tuck the bottom sheet under head of mattress. Make a mitered (square) corner if using a flat sheet. Tuck entire hanging portion of the sheet under the mattress on the side you are working on.

18 **Place clean top linen**: fold the top sheet lengthwise and place it on the bed, place the center fold on the center of the bed from the head to foot, put the hem at the head of the bed even with the top edge of the mattress, open the sheet with the hem stitching to the outside, fan-folding ½ to the center of the bed. Do not tuck in at the side of the bed.

19 **Apply blanket** if necessary over the top sheet: fold the blanket lengthwise and place on bed, place the center fold of the blanket in the center of the bed from head to foot, place the upper hem approximately 6 inches from the top edge from the top edge of the mattress, and open the blanket. Do not tuck in at the sides of the bed.

20 **OR** **Apply bedspread** on the bed over the blanket: fold the bedspread lengthwise and place it on the bed, place the center fold in the center of the bed from head to foot, place the upper hem even with the head edge of the mattress and open the bedspread. Do not tuck in at the sides of the bed.

21 **Tuck in top linen and blanket, or bed spread, at foot of the bed. Make mitered) corners at the foot end of the bed.**

22 Now go to the other side of the bed.

23 Pull the bottom sheet tight to get rid of all wrinkles and place over top of mattress. For flat sheet, miter the top corner, and then tuck entire hanging portion of sheet under the mattress on the side you are working.

24 Go up to the head of the bed to fold the top hem of the bedspread over the top hem of the blanket, fold the top hem of the sheet back over the edge of the spread and the blanket to make a cuff. The hemmed side of the sheet must be on the underside so that it does not come in contact with the client.

25 **Apply clean pillow case without contaminating linen and clothing.**

26 **Leave bed complete and neatly made.**

27 **Lower the height of the bed to the lowest position, if it was raised**.

28 Leave the call light within reach.

29 *Wash hands*.

\*Skill 77: Making an Occupied Bed

Step # Description

1 **Knock on door**.

2 ***Wash hands***.

3 Introduce self by name and title.

4 Identify and address the client by name.

5 **Explain procedure to client**, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.

6 **Assemble equipment**: bath blanket, bedspread and blanket as needed, disposable gloves (Gloves should be worn if the client has draining wounds, non-intact skin, or you have contact with blood or body fluids including mucous.), two clean flat sheets or one fitted and one flat sheet, and pillowcase.

7 **Transport linen away from body**.

8 **Place clean linen on clean surface (e.g., bedside stand, chair, or over-bed table)**. Avoid contamination of clean linen throughout procedure.

9 **Pull curtains; provide for privacy**.

10 Lower the head of bed before moving client.

11 Lock wheels on bed.

12 **Raise bed to working height**.

13 Take the bedspread and blanket off the bed, fold them and put on a clean surface if they are to be re-used. Place soiled linen in laundry receptacle. Carefully check linen for foreign articles such as eyeglasses, dentures or hearing aids. Leave the client covered with the top sheet.

14 Unfold bath blanket over the top sheet and remove top sheet. **Client is to remain covered at all times**.

15 Raise side rail, if present, or have second person to stand on opposite side of bed for safety.

16 Slowly **assist client to roll onto side** towards raised rail or second person. Adjust positioning and support body parts as needed.

17 Move pillow so that it is under client's head and adjust so that client is comfortable.

18 Loosen bottom soiled linen on the side you are working.

19 **Roll or fan fold soiled linen, soiled side inside, to the center of the bed**.

20 Remove and dispose of *gloves* into waste container without contaminating self, if worn.

21 Wash hands.

22 **Place clean bottom sheet on the mattress side you are working**. **Secure two fitted corners.**

23 **Roll or fan fold clean linen against client’s back**.

24 **Assist client to roll over the bottom linen, preventing trauma and avoidable pain to client**.

25 Move to other side of bed.

26 **Remove soiled linen by rolling the edges inward and without shaking. Avoid touching linen to uniform**.

27 **Dispose of soiled linen in hamper or equivalent**.

28 Remove and dispose of *gloves* into waste container without contaminating self.

29 Wash hands.

30 **Pull through and smooth out the bottom linen. Secure the other two fitted corners.**

31 Assist client turn onto back in center of the bed.

32 **Remove used top linen keeping client unexposed at all times**.

33 **Place clean top linen over covered client**: Put the top sheet on the bed, unfold it lengthwise, make sure the crease is in the middle, the hem is to be even with the top of the mattress and the hemstitching is on the outside. Ask the client to hold onto the top sheet or tuck in under their shoulders so that you can remove the bath blanket.

34 **Apply clean blanket if necessary over the top sheet**: Fold the blanket lengthwise and place on bed, place the center fold of the blanket in the center of the bed from head to foot, place the upper hem approximately 6 inches from the top edge of the mattress, open the blanket which should be high enough to cover the client's shoulders. Do not tuck in at the sides of the bed.

35 **OR Apply clean bedspread on the bed over the blanket**: Fold the bedspread lengthwise and place it on the bed, place the center fold in the center of the bed from head to foot, place the upper hem even with the head edge of the mattress, and open the bedspread, Do not tuck in at the sides of the bed.

36 Using the top sheet, blanket and bedspread, tuck under foot of mattress altogether, and make a mitered (square) corner at the foot end of the bed.

37 Make toe pleat or provide room for feet by grasping the top linens over the toes and pulling straight up. This reduces pressure on the toes.

38 **Apply clean pillowcase without contaminating linen and clothing**.

39 **Gently lift client’s head while replacing pillow**.

40 **Lower the height of the bed to the lowest position if it was raised**.

41 **Return side rails to lowered position, if side rails were used**.

42 Dispose of soiled linen in laundry receptacle.

43 Avoid contact between your clothing and soiled linen throughout procedure.

44 Remove and dispose of *gloves* into waste container without contaminating self.

45 Maintain respectful, courteous interpersonal interactions at all times.

46 Leave client in position of safety and comfort with call light or signaling device within easy reach.

47 Open the privacy curtains.

48 *Wash hands*.

**Program Name –NA Lab/Clinical Skills Checklist**

**Student Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lab:** This practice must be under the supervision of a Board-approved instructor/preceptor in the skills lab on a mannequin or another person**. Skills must be done in lab before giving direct patient care in Clinical.**

**Clinical**: The student must successfully demonstrate the skills, to a Board approved clinical instructor/preceptor, on a client, patient, or resident in the clinical setting.

 **Bolded skills should be done in lab and clinical**

|  **Skills** | **Date** Demonstrated | **Date** Return Demonstrated in Lab | **Signature/****Initial**Nurse Evaluator | **Date**Return Demonstrated in Clinical | **Signature/****Initial**Nurse Evaluator |
| --- | --- | --- | --- | --- | --- |
| **Communications** |  |  |  |  |  |
| **Infection Control and Standard Precautions:** |  |  |  |  |  |
| **Wash hands/hand hygiene** |  |  |  |  |  |
| **Follow standard precautions according to the Centers for Disease Control and Prevention** |  |  |  |  |  |
| Assist with coughing and deep breathing |  |  |  |  |  |
| **Handle linen** |  |  |  |  |  |
| **Make an occupied bed** |  |  |  |  |  |
| **Make an unoccupied bed** |  |  |  |  |  |
| **Put on and removing personal protective equipment: gloves** |  |  |  |  |  |
| Put on and removing personal protective equipment: gown |  |  |  |  |  |
| Put on and removing personal protective equipment: mask |  |  |  |  |  |
| Collect a clean catch urine specimen |  |  |  |  |  |
| Collect a sputum specimen |  |  |  |  |  |
| Collect a stool specimen |  |  |  |  |  |
| **Safety/Emergency Procedures:** |  |  |  |  |  |
| Administer abdominal thrust (Heimlich Maneuver) |  |  |  |  |  |
| **Ambulate using a gait belt** |  |  |  |  |  |
| Ambulate with a cane |  |  |  |  |  |
| **Ambulate with a walker** |  |  |  |  |  |
| Apply a wrist restraint |  |  |  |  |  |
| **Apply position/alignment techniques for clients in bed using safe client handling devices** |  |  |  |  |  |
| **Position/alignment techniques for clients in chairs and wheelchairs using safe client handling devices** |  |  |  |  |  |
| **Transfer client from bed to wheelchair** |  |  |  |  |  |
| **Transfer client from wheelchair to bed** |  |  |  |  |  |
| Turn oxygen on and off at pre-established flow rate for stable client |  |  |  |  |  |
| **Use safe client transfer and handling techniques with lift equipment** |  |  |  |  |  |
| Use safe client transfer and handling techniques with seated transfers |  |  |  |  |  |
| **Nutrition and Hydration:** |  |  |  |  |  |
| **Assist with a meal** |  |  |  |  |  |
| **Assist with hydration** |  |  |  |  |  |
| **Elimination:** |  |  |  |  |  |
| **Assist with the use of a fracture pan** |  |  |  |  |  |
| **Assist with the use of a regular bedpan** |  |  |  |  |  |
| **Assist with use of a toilet** |  |  |  |  |  |
| Assist with use of a urinal |  |  |  |  |  |
| **Change of a disposable brief** |  |  |  |  |  |
| Change from a drainage bag to a leg bag |  |  |  |  |  |
| Change from a leg bag to a drainage bag |  |  |  |  |  |
| Clean ostomy site for established, non-acute ostomy |  |  |  |  |  |
| Empty ostomy bag or change ostomy bag which does not adhere to the skin |  |  |  |  |  |
| Give an enema |  |  |  |  |  |
| Insert a bowel evacuation suppository |  |  |  |  |  |
| Provide catheter care including the application of and removal of external urinary catheters |  |  |  |  |  |
| **Personal Care:** |  |  |  |  |  |
| **Put on and care for eyeglasses** |  |  |  |  |  |
| **Put in and care for hearing aids** |  |  |  |  |  |
| Apply anti-embolism elastic stockings |  |  |  |  |  |
| Apply non-prescription pediculicides |  |  |  |  |  |
| **Apply topical, non-prescription barrier creams & ointments**  **for prophylactic skin care** |  |  |  |  |  |
| Assist with hair care/shampoo |  |  |  |  |  |
| **Dress/undress** |  |  |  |  |  |
| **Give a bed bath** |  |  |  |  |  |
| **Give shower bath** |  |  |  |  |  |
| **Provide denture care** |  |  |  |  |  |
| **Provide fingernail care** |  |  |  |  |  |
| **Provide foot care** |  |  |  |  |  |
| **Provide mouth care** |  |  |  |  |  |
| Provide mouth care for a comatose client |  |  |  |  |  |
| **Provide perineal/incontinence care** |  |  |  |  |  |
| **Provide skin care** |  |  |  |  |  |
| Shave face with electric razor |  |  |  |  |  |
| Shave face with safety razor |  |  |  |  |  |
| **Restorative Care:** |  |  |  |  |  |
| **Assist with lower extremity range of motion** |  |  |  |  |  |
| **Assist with upper extremity range of motion** |  |  |  |  |  |
| **Measure and Record:** |  |  |  |  |  |
| Height |  |  |  |  |  |
| **Weight** |  |  |  |  |  |
| **Input** |  |  |  |  |  |
| **Output** |  |  |  |  |  |
| **Pain level** |  |  |  |  |  |
| **Temperature** |  |  |  |  |  |
| Apical pulse |  |  |  |  |  |
| **Radial pulse** |  |  |  |  |  |
| **Respirations** |  |  |  |  |  |
| Electronic blood pressure |  |  |  |  |  |
| **Manual blood pressure** |  |  |  |  |  |
| Orthostatic blood pressure readings |  |  |  |  |  |
| **Pulse oximetry** |  |  |  |  |  |

**Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Instructor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###  Rogue Community College Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Nursing Assistant 101C Term/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Final Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Nursing Assistant Clinical Evaluation Tool

Key: E = Exceeds Standard U = Unsatisfactory behavior or performance

 = Meets Standard = Not observed

 NI = Needs Improvement

Three NIs in any STARRED areas or six (total) NIs in ANY areas will result in a required clinical make-up day in which the student must demonstrate improvement in performance to pass the course. If there is no make-up day available for the student due to absence, the student will not pass the course. Four NIs in any starred area or seven (total) in non-starred areas will indicate repeated unsafe or inappropriate performance and result in failure of the course.

A U will be assigned if the student behavior or performance warrants immediate removal from client care. The instructor will notify the director and a determination will be made as to whether the student will be allowed back into the clinical. If the student is not allowed to return to the clinical, it will result in failure of the course. (One example of a U would be a student who is found not using a gait belt with a hands-on transfer)

 Attendance:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Standard: Clinical Date: |  |  |  |  |  |  |  |  |  |  |  |  |  | Comments: |
| **Client Interaction:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. \* Safety  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. Maintains Client rights, dignity and privacy |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Maintains confidentiality. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. \*Maintains standard precautions at all times. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. Provides for Client comfort and demonstrates compassion and caring. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. Promotes Client independence. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. \*Communicates clearly with courtesy throughout procedures. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Health Care Team Interaction:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8. \*Communicates effectively in a non-aggressive, non-defensive manner with care team. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9. Demonstrates a positive attitude |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. \*Demonstrates honesty and integrity. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. \*Gets help when needed. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. Seeks learning opportunities. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13. Assists other care team members as time allows. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. Consistently demonstrates increasing awareness or knowledge base/comfortable, confident and organized with skills. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. Notifies instructor, in a timely manner, of skills to be performed. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  **Professionalism:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. Accepts constructive criticism. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. Adheres to RCC policies. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. Adapts to facility policies. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19. \*Demonstrates appropriate appearance, communication and behavior. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. Arrives to clinical on time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Hours: (79 Possible) |  |  |  |  |  |  |  |  |  |  |  |  |  | Total Hrs. \_\_\_\_\_\_\_ |

**Classroom/Lab Instructor Comments/Final Skills Summary:**

####  P=Pass NP=No Pass

|  |  |  |  |
| --- | --- | --- | --- |
| DATE: |  | Skill |  |
|  |  | Handwashing: |  |
|  |  | B/P |  |
|  |  |  |  |
|  |  |  |  |

### CLASSROOM/LAB FINAL GRADE: PASS NO PASS

### Comments:

**The student meets the standard in the classroom/Lab. section of the course and is ready to progress into the clinical facility. YES □ NO □**

Student Comments:

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Midterm Summary:**

Strengths:

Areas to work on:

Comments:

(Students are encouraged to comment. Please attach comments to this form.)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Final Evaluation:**

Strengths:

0

Areas to work on:

Comments:

(Students are encouraged to comment. Please attach comments to this form.)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Instructor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rogue Community College**

**NA 101 Nursing Assistant**

**Clinical Facility Orientation “Tour”**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| I have been oriented to the location of the following areas and/or procedures: | I have been oriented to the location/function of the following: |
| * Nurse’s station
* CNA Care Plans
* Report procedure
* Patient/CNA assignment
* Location of emergency “crash cart” and back boards
* Clean utility area
* Dirty utility area
* Supplies
* Clean linen supplies
* Dirty linen procedures, supplies
* Cafeteria and/or break rooms
* Water fountain, public telephone and staff restrooms
* Pre and post-conference meeting areas
* Parking
 | * Patient’s rooms
* Bed and controls
* Patient’s bathroom
* Call light and how to cancel
* How clients are ID’d
	+ - * Bracelets
			* Picture ID
			* Diabetics
* Where ID is recorded
* Where BPs are recorded
* Where weights are recorded
* CNA/patient “charts”
* Shower/Schedule bath
 |

Write in the location of the following:

1. Policy manual, procedure book, and elopement book\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Fire pulls stations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Fire extinguishers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. My responsibility in the event of: Fire \_\_\_\_\_\_\_\_\_\_\_\_ Cardiac/Respiratory Arrest \_\_\_\_\_

 Safety/Security \_\_\_\_\_\_\_\_\_\_\_\_\_ Bomb threat \_\_\_\_\_\_\_\_\_\_\_\_\_

 External Disaster \_\_\_\_\_\_\_\_\_\_\_\_\_

* I have reviewed the policy regarding blood/fluid exposure.
* I have reviewed the policy regarding pain and pain management.
* I have reviewed the policy regarding restraints.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**101 Nursing Assistant**

**Rogue Community College** Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Term/Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Student Evaluation of Clinical Facility

In an effort to evaluate the effectiveness of the facilities used for the clinical component of your education, please take a moment to give us your opinion of the facility in the following areas. Your input is instrumental to success of the program. Thank you.

On a scale of 1-5, 1 being (very poor), 2 (below average), 5 (excellent) rate the facility. Circle the number the best represents your opinion. Space is provided for additional comments.

1) Availability of opportunities to complete objectives/skills checklist. 1 2 3 4 5

 Comment:

2) Communication between nursing staff and students. 1 2 3 4 5

 Comment:

3) Nursing staff/CNA buddy’s effectiveness as role models. 1 2 3 4 5

 Comment:

4) Nursing staff/CNA buddy’s encouragement of questions. 1 2 3 4 5

 Comment:

5) Adequacy of area for student/instructor conferences. 1 2 3 4 5

 Comment:

6) Rate the adequacy of the overall clinical environment. 1 2 3 4 5

 Comment:

7) Rate the overall clinical experience at this facility. 1 2 3 4 5

 Comment:

8) We encourage positive feedback of staff that were especially helpful to you.

Comment:

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