Arizona Mock Skills

For Testing Effective: February 1, 2025

Please note: The skill task steps included in this document are offered as guidelines to help prepare candidates for the Arizona nursing assistant skill test. The steps included herein are not intended to be used to provide complete care that would be all-inclusive of best care practiced in an actual work setting.

D&S Diversifed Technologies (D&SDT), LLP – Headmaster, LLP

Ambulating Resident with a Walker using a Gait Belt

(Assisting resident to ambulate at least 10 steps with a walker using a gait belt)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Lock bed brakes to ensure resident's safety.	
	Lock wheelchair brakes to ensure resident's safety.	
	Bring the resident to a sitting position.	
	Place a gait belt around the resident, below the rib cage and above the waist, to stabilize the trunk.	
	Tighten the gait belt.	
	Check the gait belt by slipping fingers between the gait belt and the resident.	
	Assist the resident in putting on non-skid slippers/shoes. *(No non-skid socks.)*	
	Ensure the resident's feet are flat on the floor. *(If needed, assist the resident in scooting to the edge of the bed.)*	
	Position the walker in front of the resident.	
	Assist the resident in standing and ensure the resident has a stabilized walker.	
	Position yourself behind and slightly to the side of the resident.	
	Ambulate the resident at least 10 steps to the wheelchair.	
	Assist resident in turning and sitting in the wheelchair, using correct body mechanics.	
	Remove the gait belt.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place resident within easy reach of the call light or signaling device and water.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Apply Resident's Anti-embolic Stocking to One Leg

(APPLYING A KNEE-HIGH ANTI-EMBOLIC STOCKING TO ONE OF THE RESIDENT'S LEGS)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provide for resident's privacy by only exposing one leg.	
	Gather or turn the stocking down inside out to the heel.	
	Place stocking over the toes, foot, and heel and roll OR pull up the leg.	
	Check toes for possible pressure from stocking and adjust as needed. (*)	
	Leave the resident with a stocking that is smooth and wrinkle-free. (*)	
	Leave the resident with a stocking that is properly placed without restriction.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place the call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Bed Bath for Resident- Face and One Arm, Hand and Axilla

(Providing a modified bed bath to the resident's face, one arm, hand, and axilla)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provides privacy for the resident, pull the privacy curtain.	
	Raise the bed to a comfortable working height.	
	Prepare the resident for a complete bath, even though will be demonstrating a partial bed bath.	
	Cover the resident with a bath blanket.	
	Remove the top bed linens to the foot of the bed.	
	Remove the resident's gown without exposing the resident.	
	Fill a basin with comfortably warm water.	
	Wash and dry the resident's face WITHOUT SOAP.	
	Use a clean portion of the washcloth and gently wipe the resident's eyes from the inner to the outer using a clean portion with each stroke.	
	Place a towel under the resident's arm; only expose one arm.	
	Wash arm, hand, and axilla using soap and water.	
	Rinse arm, hand and axilla.	
	Dry arm, hand and axilla.	
	Assist the resident in putting on a clean gown.	
	Lower bed.	
	Empty, rinse and dry (with a clean, dry paper towel) the equipment and return to storage.	
	Place soiled linen in a designated laundry hamper.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Denture Care - Cleaning Upper or Lower Denture

(Cleaning only one denture plate, upper or lower)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Line the sink with a protective lining to help prevent damage to the denture. (Use a cloth towel or washcloth; *do not use paper towels.)*	
	Put on gloves.	
	Remove the denture from the cup.	
	Handle the denture carefully to avoid damage.	
	Never place the denture in/on a contaminated surface.	
	Rinse the denture cup.	
	Apply denture cleanser.	
	Thoroughly brush the denture, including the inner, outer, and chewing surfaces, as well as the denture groove and/or plate that will touch any gum surface. *(Only one plate is used during testing.)*	
	Rinse the denture using clean, cool water.	
	Place the denture in the denture cup.	
	Add cool, clean water to the denture cup.	
	Empty, rinse and dry (with a clean, dry paper towel) equipment and return to storage.	
	Discard the protective lining in an appropriate container.	
	Remove gloves and dispose of gloves in an appropriate container.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Catheter Care for a Resident, Empty a Urinary Drainage Bag, Measure and Record Output with Hand Washing

(One of the possible mandatory first tasks) [DEMONSTRATED ON A MANIKIN]

(PERFORMING CATHETER CARE FOR RESIDENT/MANIKIN, EMPTYING A URINARY DRAINAGE BAG AND MEASURING AND RECORDING URINE OUTPUT)

	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Greet the resident by name.	
	Introduce yourself by name.	
	Explain the procedure to the resident (manikin).	
	Provide privacy for the resident; pull the privacy curtain.	
	Put on gloves.	
	Lift the resident's gown to expose the catheter area.	
	Check to see that urine can flow unrestricted into the drainage bag. *(It would be helpful to verbalize checking while looking for kinks in tubing, etc.)*	
	Use a washcloth with soap and water to carefully wash ***around the catheter*** where it exits the urethra.	
	Hold the catheter where it exits the urethra with one hand.	
	While holding the catheter tubing with fingers where it exits the urethra, clean 3-4 inches down the catheter tube.	
	Clean with stroke(s) only away from the urethra.	
	Use a clean portion of a washcloth for any strokes.	
	Rinse using stroke(s) only away from the urethra.	
	Rinse using a clean portion of a washcloth for any strokes.	
	Pat dry.	
	Do not allow the tube to be pulled at any time during the procedure.	
	Replace the top cover over the resident.	
	Leave the resident in a position of comfort.	
	Place a barrier on the floor under the drainage bag.	
	Place the graduate on the previously placed barrier.	
	Open the drain to allow the urine to flow into the graduate.	
	Completely empty drainage bag.	
	Avoid touching the graduate with any part of the tubing.	
	Close the drain.	
	Wipe the drain with an alcohol wipe AFTER emptying the drainage bag.	
	Replace the drain in the holder.	
	Place the graduate on a level, flat surface	
	With the graduate at eye level, read the output.	

	Empty, rinse and dry (with a clean, dry paper towel) equipment.	
	Return equipment to storage.	
	Record output on the previously signed recording form.	
	The candidate's recorded output measurement is within 30 ml of the RN Test Observer's output reading.	
	Remove gloves, turning inside out, and dispose of gloves in the designated container (trash can).	
	Wash hands: Begin by wetting your hands.	
	Apply soap to hands.	
	Rub hands together using friction with soap.	
	Rub hands together for at least twenty (20) seconds with soap.	
	Interlace fingers pointing downward with soap.	
	Lather all surfaces of your hands with soap.	
	Lathers wrists with soap.	
	Rinse hands thoroughly under running water with fingers pointed downward.	
	Dry hands with a clean paper towel(s).	
	Turn off the faucet with a clean, dry paper towel.	
	Discard paper towels to the trash container.	
	Do not re-contaminate hands at any point by touching the faucet or sink during/after the procedure.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Donn an Isolation Gown and Gloves, Assist Resident with a Bedpan, Measure and Record Output, Remove Gown and Gloves with Hand Washing

(One of the possible mandatory first tasks)

(Placing resident on a bedpan, removing bedpan. Measuring and recording urine output and removing gown and gloves.)

	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Face the back opening of the gown.	
	Unfold the gown.	
	Place arms through each sleeve.	
	Fasten the neck opening.	
	Fasten the waist, making sure that the back flaps cover the clothing as completely as possible.	
	Put on gloves.	
	Glove overlap gown sleeves at the wrist.	
	Greet the resident by name.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provide privacy for the resident; pull the privacy curtain.	
	Position resident on bedpan correctly using correct body mechanics.	
	Raise the head of the bed to a comfortable level.	
	Leave call light and tissue within easy reach of the resident.	
	Step away to a private area of the room away from the resident.	
	When signaled by the RN Test Observer, the candidate returns.	
	Obtain a wet washcloth with soap and provide the washcloth with soap for the resident to wash their hands.	
	Provide a wet washcloth for the resident to rinse their hands.	
	Provide a towel or dry washcloth for the resident to dry their hands.	
	Lower the head of the bed.	
	Place soiled linen in a designated laundry hamper.	
	Gently remove the bedpan and hold while the RN Test Observer adds a known quantity of fluid.	
	Measure output.	
	Empty, rinse and dry (with a clean, dry paper towel) equipment and return to storage.	
	Record output on the previously signed recording form.	
	The candidate's recorded output is within 30mls of the RN Test Observer's recorded output.	

	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	
	Remove gloves, turning inside out.	
	Remove gloves BEFORE removing the gown.	
	Dispose of the gloves in the designated container (trash can).	
	Unfasten the gown at the waist.	
	Unfasten the gown at the neck.	
	Remove the gown by slipping your hands underneath the gown at the neck and shoulder.	
	Remove the gown by folding/rolling soiled area to soiled area.	
	Dispose of the gown in the designated container (trash can).	
	Wash Hands: Begin by wetting your hands.	
	Apply soap to hands.	
	Rub hands together using friction for at least 20 seconds with soap.	
	Interlace fingers pointing downward with soap.	
	Lather all surfaces of hands and wrists with soap.	
	Rinse hands thoroughly under running water with fingers pointed downward.	
	Dry hands with a clean paper towel(s).	
	Turn off the faucet with a clean, dry paper towel(s).	
	Discard paper towels into a trash container.	
	Do not re-contaminate hands at any point by touching the faucet or sink during/after the procedure.	

Dressing a Bedridden Resident with an Affected (Weak) Side

(Dressing a bedridden resident with an affected side in a button-up shirt, pants/shorts, and socks)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provide privacy for the resident; pull the privacy curtain.	
	Keep the resident covered while removing the gown.	
	The resident always remains lying in bed.	
	Remove the gown from the unaffected side first. (*)	
	Place the soiled gown in a designated laundry hamper.	
	From the affected (weak) side first, dress the resident in a button-up shirt or blouse. The candidate inserts their hand through the sleeve of the shirt or blouse and grasps the affected hand of the resident. (*) *(Candidate is free to position resident in a manner acceptable to dress the resident but never sits the resident on the side of the bed.)*	
	From the affected (weak) side first, dress the resident in pants. The candidate assists the resident in raising their buttocks or turns the resident from side to side and draws the pants over the buttocks and up to the resident's waist. (*)	
	When putting on the resident's socks, the candidate draws the socks up the resident's foot until they are smooth.	
	Leave the resident in correct body alignment and properly dressed. *(Pants pulled up to the waist, shirt buttoned and not bunched up in front or back.)*	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Feeding a Dependent Resident

(Feeding a dependent resident food from a single-serve food item and offering fluid from two glasses, measuring and recording the percentage of total food consumed and the sum total of fluid consumed in ml)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Look at (pick up) the diet card and indicate that the resident has received the correct tray.	
	Position the resident in an upright position. *At least 45 degrees*.	
	Provide hand hygiene for the resident BEFORE feeding. *(You may use hand sanitizer on the resident covering all surfaces of the resident's hands and rubbing the sanitizer in until dry –or wash and dry the resident's hands using a wet washcloth with soap.)*	
	Protect clothing from soiling by using a napkin, clothing protector, or towel.	
	Place soiled linen in a designated laundry hamper.	
	Remain at eye level or below while feeding the resident.	
	Describe the foods being offered to the resident.	
	Offer fluid frequently from each glass.	
	Offer food in small amounts at a reasonable rate, allowing the resident to chew and swallow.	
	Wipe the resident's hands and face during the meal as needed.	
	Leave the resident clean and in a position of comfort.	
	Record intake in the percentage of total solid food eaten on the previously signed recording form.	
	Record total fluid intake consumed in ml on the previously signed recording form.	
	The candidate's recorded consumed food intake is within 25 percentage points of the RN Test Observer's recorded solid food consumed.	
	The candidate's recorded total consumed fluid intake is within 45ml of the RN Test Observer's recorded fluid intake.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Making an Occupied Bed

(MAKING A BED -REMOVING SOILED LINENS AND REPLACING WITH CLEAN LINENS- WITH RESIDENT IN THE BED)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Gathers linen.	
	Transport linen correctly without touching your uniform.	
	Place linen on a clean barrier, such as a cloth towel or chux pad. *You may also place linen on the over-bed table, seat of the chair, bedside stand, or over the end of the bed.*	
	Explain the procedure to the resident.	
	Provide privacy for the resident; pull the privacy curtain.	
	Direct the RN Test Observer to stand on the opposite side of the bed to provide for safety. (*)	
	Raise the bed to a comfortable working height.	
	The resident is to remain covered at all times.	
	Assist the resident in rolling onto the side toward the RN Test Observer. *The candidate instructs the RN Test Observer to remain standing on the opposite side of the bed.*	
	Roll or fan fold soiled linen, soiled side inside, to the center of the bed.	
	Place a clean bottom sheet along the center of the bed, roll or fan-fold linen against the resident's back, and unfold the remaining half.	
	Secure two fitted corners.	
	The candidate directs the RN Test Observer to stand on the opposite side of the bed. (*)	
	Assist the resident in rolling over the bottom linen, preventing trauma and avoidable pain to the resident.	
	Remove soiled linen without shaking.	
	Avoid placing dirty linen on the over-bed table, chair, or floor.	
	Avoid touching linen to uniform.	
	Place soiled linen in a designated laundry hamper.	
	Pull through and smooth out the clean bottom linen.	
	Secure the other two fitted corners.	
	The resident’s body never touches the bare mattress. (*)	
	Place clean top linen and blanket or bedspread over the covered resident.	
	Remove soiled linen, keeping resident unexposed at all times.	
	Tuck in top linen and blanket or bedspread at the foot of the bed.	
	Make mitered corners at the foot of the bed.	

	Apply a clean pillowcase with zippers and/or tags to the inside.	
	Gently lift the resident's head while replacing the pillow.	
	Lower bed.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Mouth Care—Brushing Resident's Teeth

(BRUSHING ALL SURFACES OF RESIDENT'S TEETH AND TONGUE)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provide privacy for the resident; pull the privacy curtain.	
	Drape the chest with a towel to prevent soiling.	
	Put on gloves.	
	Apply toothpaste to the toothbrush.	
	Brush the resident's teeth, including the inner, outer, and chewing surfaces of all upper and lower teeth.	
	Clean tongue.	
	Assist resident in rinsing their mouth.	
	Wipe the resident's mouth.	
	Remove soiled linen.	
	Place soiled linen in a designated laundry hamper.	
	Empty container. *a. The container can be the emesis basin or a disposable cup.*	
	Rinse and dry the emesis basin if used with a clean, dry paper towel, or discard disposable items in the designated container (trash can).	
	Rinse toothbrush.	
	Return equipment to storage.	
	Remove gloves, turning inside out, and dispose of gloves in a designated container (trash can).	
	Leave the resident in a position of comfort.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Mouth Care for a Comatose Resident

(Providing mouth care to a comatose resident, cleaning all surfaces of resident's teeth, gums, and tongue)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Provide privacy for residents; pull the privacy curtain.	
	Turn the resident to a side-lying position to avoid choking or aspiration. *(If the resident is too large for the candidate to turn on their own, the candidate may ask the RN Test Observer for assistance with turning the resident.)*	
	Drape chest/bed as needed to protect from soiling.	
	Put on gloves.	
	Use swabs and cleaning solution. *(Do not use a toothbrush or toothpaste.)*	
	Gently and thoroughly clean the inner, outer, and chewing surfaces of all upper and lower teeth.	
	Gently and thoroughly clean the gums and tongue.	
	Wipe the resident's mouth.	
	Leave the resident in a position of comfort.	
	Discard disposable items, swab(s), in a designated container (trash can).	
	Place towel and/or washcloth in a designated laundry hamper.	
	Remove gloves, turning inside out, and dispose of gloves in a designated container (trash can).	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Perineal Care for a Female Resident with Hand Washing

(One of the possible mandatory first tasks) [DEMONSTRATED ON A MANIKIN]

(PROVIDING PERINEAL CARE FOR A FEMALE RESIDENT/MANIKIN)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident (manikin).	
	Provide privacy for the resident; pull the privacy curtain.	
	Remove covers from the resident.	
	Fill a basin with comfortably warm water.	
	Raise the bed to a comfortable working height.	
	Direct the RN Test Observer to stand on the opposite side of the bed to provide for safety. (*)	
	Turn the resident toward the RN Test Observer or raise the resident's hips and place a waterproof pad under the buttocks.	
	Put on gloves.	
	Lift the resident's gown to expose the perineum only.	
	Separate labia. *(Candidate must also verbalize separating.)*	
	Use water and a soapy washcloth.	
	Clean one side of the labia from top to bottom. (*)	
	Using a clean portion of the washcloth, clean the other side of the labia from top to bottom.	
	Using a clean portion of the washcloth, clean the vaginal area from top to bottom.	
	Using a clean washcloth, rinse one side of the labia from top to bottom.	
	Using a clean portion of the washcloth, rinse the other side of the labia from top to bottom.	
	Using a clean portion of the washcloth, rinse the vaginal area from top to bottom.	
	Dry the area.	
	Cover the exposed area with the resident's gown.	
	Assist the resident in turning onto their side away from the candidate.	
	With a clean washcloth, water, and soap, clean the rectal area.	
	Clean the area from the vagina to the rectal area. (*)	
	Use a clean portion of the washcloth with any stroke.	
	Using a clean portion of the washcloth, rinse the rectal area from the vagina to the rectal area.	
	Use a clean portion of the washcloth with any stroke.	

	Dry area.	
	Turn the resident toward the RN Test Observer or raise the hips and remove the waterproof pad from under the buttocks.	
	Position resident (manikin) on their back.	
	Place soiled linen in a designated laundry hamper.	
	Lower bed.	
	Empty, rinse and dry (with a clean, dry paper towel) equipment.	
	Return equipment to storage.	
	Remove gloves, turning inside out, and dispose of gloves in the designated container (trash can).	
	Wash Hands: Begin by wetting your hands.	
	Apply soap to hands.	
	Rub hands together using friction for at least 20 seconds with soap.	
	Interlace fingers pointing downward with soap.	
	Lather all surfaces of hands and wrists with soap.	
	Rinse hands thoroughly under running water with fingers pointed downward.	
	Dry hands with a clean paper towel(s).	
	Turn off the faucet with a clean, dry paper towel(s).	
	Discard paper towels into a trash container.	
	Do not re-contaminate hands at any point by touching the faucet or sink during/after the procedure.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Perineal Care for a Male Resident and Changing a Soiled Brief with Hand Washing

(One of the possible mandatory first tasks) [DEMONSTRATED ON A MANIKIN]

(REMOVING A SOILED BRIEF, PROVIDING PERINEAL CARE FOR A MALE RESIDENT/MANIKIN AND APPLYING A CLEAN BRIEF)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident (manikin).	
	Provide privacy for the resident; pull the privacy curtain.	
	Remove covers from the resident.	
	Obtain a new brief.	
	Mark the date and time on the brief.	
	Initial the brief.	
	Fill a basin with comfortably warm water.	
	Raise the bed to a comfortable working height.	
	Direct the RN Test Observer to stand on the opposite side of the bed to provide for safety.	
	Put on gloves.	
	Turn the resident toward the RN Test Observer or raise the resident's hips and place a waterproof pad under the buttocks.	
	Lift the resident's gown to expose the perineum only.	
	Remove the soiled brief from front to back.	
	Dispose of the soiled brief by placing it in a plastic bag, tying or sealing the bag, and placing it in the designated container (trash can).	
	Gently grasp the penis.	
	Use water and a soapy washcloth.	
	Using a clean portion of the washcloth, clean the tip of the penis, starting at the urethral opening, working away with a circular motion.	
	Using a clean portion of the washcloth for each stroke, clean the shaft of the penis from the urethra to the base of the shaft.	
	Using a clean portion of the washcloth, clean the scrotum.	
	Using a clean washcloth, rinse.	
	Using a clean portion of the washcloth for each stroke, rinse the penis.	
	Using a clean portion of the washcloth for each stroke, rinse the scrotum.	
	Dry area.	
	Cover the exposed area with the resident's gown.	
	Assist the resident in turning onto the side away from the candidate.	

	Using a clean washcloth with water and soap, clean the rectal area.	
	Using a clean portion of the washcloth for each stroke, clean the area from the scrotum to the rectal area.	
	Using a clean portion of the washcloth for each stroke, rinse the area from the scrotum to the rectal area.	
	Dry area.	
	Turn the resident toward the RN Test Observer or raise the resident's hips and remove the waterproof pad from under the buttocks.	
	Position resident (manikin) on their back.	
	Correctly apply brief.	
	Place soiled linen in a designated laundry hamper.	
	Lower bed.	
	Empty, rinse and dry (with a clean, dry paper towel) equipment.	
	Return equipment to storage.	
	Remove gloves, turning inside out, and dispose of gloves in the designated container (trash can).	
	Wash Hands: Begin by wetting your hands.	
	Apply soap to hands.	
	Rub hands together using friction for at least 20 seconds with soap.	
	Interlace fingers pointing downward with soap.	
	Lather all surfaces of hands and wrists with soap.	
	Rinse hands thoroughly under running water with fingers pointed downward.	
	Dry hands with a clean paper towel(s).	
	Turn off the faucet with a clean, dry paper towel(s).	
	Discard paper towels into a trash container.	
	Do not re-contaminate hands at any point by touching the faucet or sink during/after the procedure.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Position Resident on their Side in Bed

(Positioning and turning a resident in bed onto the correct side stated, and placing support devices -such as pillows, wedges or blankets- to maintain correct body alignment and protect bony prominences)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provides privacy for the resident; pull the privacy curtain.	
	Position the bed flat.	
	Raise the bed to a comfortable working height.	
	Ensure that the resident's face never becomes obstructed by the pillow. (*)	
	Direct the RN Test Observer to stand on the opposite side of the bed to provide for safety, or always turn the resident towards yourself. (*)	
	From the working side of the bed, move the resident's head toward yourself to provide room to turn the resident on their side safely.	
	From the working side of the bed, move the resident's hips toward yourself to provide room to turn the resident on their side safely.	
	From the working side of the bed, move the resident's legs toward yourself to provide room to turn the resident on their side safely.	
	The candidate may remain on the working side of the bed and turn the resident toward the previously positioned RN Test Observer. If the RN Test Observer wasn't directed to the side opposite the working side of the bed, the candidate moves to the opposite side of the bed and turns the resident toward self.	
	Assist/turn the resident on their side.	
	The resident is placed on the correct RN Test Observer stated side.	
	Ensure the resident is not lying on their downside arm.	
	Maintain correct body alignment**.**	
	Place support devices under the head, such as pillows, wedges, blankets, etc., to maintain correct body alignment and protect bony prominences. (*)	
	Place support devices under the upside arm, such as pillows, wedges, blankets, etc., to maintain correct body alignment and protect bony prominences. (*)	
	Place support devices behind the back, such as pillows, wedges, blankets, etc., to maintain correct body alignment and protect bony prominences. (*)	
	Place support devices between the knees, such as pillows, wedges, blankets, etc., to maintain correct body alignment and protect bony prominences. (*)	

	Lower bed.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Range of Motion for Resident's Hip and Knee

(PERFORMING PASSIVE RANGE OF MOTION EXERCISES TO THE RESIDENT'S HIP AND KNEE ON ONE SIDE)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provide privacy for the resident; pull the privacy curtain.	
	Position the bed flat.	
	Position the resident supine.	
	Correctly support joints at all times by placing one hand under the knee and the other hand under the ankle.	
	Move the entire leg away from the body. *(abduction)*	
	Move the entire leg back toward the body. *(adduction)*	
	Complete abduction and adduction of the hip three times.	
	Continue correctly supporting joints by placing one hand under the resident's knee and the other hand under the resident's ankle.	
	Bend the resident's knee and hip toward the resident's trunk. *(flexion of the hip and knee at the same time)*	
	Straighten the knee and hip. *(extension of the knee and hip at the same time)*	
	Complete flexion and extension of knee and hip three times.	
	Do not cause discomfort or pain, and do not force any joint beyond the point of free movement.	
	Must ask **the resident if they are causing pain or discomfort.**	
	Leave the resident in a comfortable position.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Range of Motion for Resident's Shoulder

(PERFORMING PASSIVE RANGE OF MOTION EXERCISES TO THE RESIDENT'S SHOULDER ON ONE SIDE)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provides privacy for the resident; pull the privacy curtain.	
	Positions the resident supine.	
	Correctly support the resident's joint by placing one hand under their elbow and the other hand under the resident's wrist.	
	Raise the resident's arm up and over the resident's head. *(flexion)*	
	Bring the resident's arm back down to the resident's side. *(extension)*	
	Complete full range of motion for shoulder through flexion and extension three times.	
	Continue correctly supporting joints by placing one hand under the resident's elbow and the other hand under the resident's wrist.	
	Move the resident's entire arm out away from the body. *(abduction)*	
	Return the resident's arm to the middle of the resident's body. *(adduction)*	
	Complete full range of motion for shoulder through abduction and adduction three times.	
	Do not cause discomfort or pain, and do not force any joint beyond the point of free movement.	
	Must ask **the resident if they are causing pain or discomfort.**	
	Leave the resident in a comfortable position.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Vital Signs – Count and Record Resident's Radial Pulse and Respirations, then Pivot-Transfer your Weight Bearing, Non-Ambulatory Resident from their Bed to their Wheelchair using a Gait Belt

(Counting the resident's radial pulse and recording the number of resident's pulse beats and then counting the resident's respirations and recording the number of resident's respiration breaths)

- The RN Test Observer will count at the same time as the candidate for the pulse and respirations – you must tell the RN Test Observer when you start and stop counting the radial pulse and the respirations, which are taken separately during testing

(Pivot-transferring a weight bearing (stable when standing), non-ambulatory (*cannot ambulate [take steps or walk] at all*) resident from their bed to their wheelchair using a gait belt)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Locate the resident's radial pulse by placing the tips of fingers on the thumb side of the resident's wrist.	
	Count the pulse for 60 seconds or 30x2. a. *Tell the RN Test Observer when you start counting and tell them when you stop counting.*	
	Record the pulse rate on the previously signed recording form.	
	The candidate's recorded pulse rate is within four (4) beats of the RN Test Observer's recorded pulse rate.	
	Count the respirations for 60 seconds or 30x2. a. *Tell the RN Test Observer when you start counting and tell them when you stop counting.*	
	Record respirations on the previously signed recording form.	
	The candidate's recorded respiratory rate is within two (2) breaths of the RN Test Observer's recorded respiratory rate.	
	Obtain a gait belt.	
	Position the wheelchair at the foot or head of the bed.	
	Lock wheelchair brakes to ensure resident's safety.	
	Lock bed brakes to ensure resident's safety.	
	Assist resident to a sitting position (on the edge of the bed) using proper body mechanics.	
	Place a gait belt around the resident, below the rib cage, and above the waist, to stabilize the trunk.	
	Tighten the gait belt so that the fingers of the candidate's hand can be comfortably slipped between the gait belt and the resident.	
	Assist the resident in putting on non-skid slippers/shoes. *(No non-skid socks.)*	

	Adjust the bed so that the resident's feet are comfortably flat on the floor. *(If needed, you may assist the resident in scooting to the edge of the bed.)*	
	Grasp the gait belt with both hands to stabilize the resident.	
	Bring the resident to a standing position using proper body mechanics.	
	Do not attempt to ambulate the resident.	
	Assist the resident in pivoting and sitting in a controlled manner.	
	Remove the gait belt.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place the resident within easy reach of the call light or signaling device and water.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Vital Signs – Count and Record your Resident's Radial Pulse and Respirations, then Pivot-Transfer your Weight Bearing, Non-Ambulatory Resident from their Wheelchair to their Bed using a Gait Belt

(Counting the resident's radial pulse and recording the number of resident's pulse beats and then counting the resident's respirations and recording the number of resident's respiration breaths)

- The RN Test Observer will count at the same time as the candidate for the pulse and respirations – you must tell the RN Test Observer when you START and STOP counting the radial pulse and the respirations, which are taken separately during testing

(Pivot-transferring a weight bearing (stable when standing), non-ambulatory (*cannot ambulate [take steps or walk] at all*) resident from their wheelchair to their bed using a gait belt)

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Locates the radial pulse by placing the tips of fingers on the thumb side of the resident's wrist.	
	Count the pulse for 60 seconds or 30x2. *b. Tell the RN Test Observer when you start counting and tell them when you stop counting.*	
	Record the pulse rate on the previously signed recording form.	
	The candidate's recorded pulse rate is within four (4) beats of the RN Test Observer's recorded pulse rate.	
	Count the respirations for 60 seconds or 30x2. *b. Tell the RN Test Observer when you start counting and tell them when you stop counting.*	
	Record the respirations on the previously signed recording form.	
	The candidate's recorded respiratory rate is within two (2) breaths of the RN Test Observer's recorded respiratory rate.	
	Position the wheelchair at the foot or head of the bed.	
	Adjust the bed so that the resident's feet will be comfortably flat on the floor when sitting on the bed.	
	Lock wheelchair brakes to ensure resident's safety.	
	Lock bed brakes to ensure resident's safety.	
	Place a gait belt around the resident, below the rib cage and above the waist, to stabilize the trunk.	
	Tighten the gait belt so that the fingers of the candidate's hand can be comfortably slipped between the gait belt and the resident.	
	Grasp the gait belt with both hands to stabilize the resident.	
	Bring the resident to a standing position using proper body mechanics.	
	Do not attempt to ambulate the resident.	

	Assist the resident in pivoting and sitting on the bed in a controlled manner.	
	Remove the gait belt.	
	Assist the resident in removing non-skid slippers.	
	Assist the resident to move to the center of the bed, supporting extremities as necessary.	
	Make sure the resident is comfortable and in good body alignment.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	

Vital Signs: Taking and Recording Resident's Manual Blood Pressure

(MANUALLY TAKING THE RESIDENT'S BLOOD PRESSURE AND RECORDING THE RESIDENT'S BLOOD PRESSURE READING)

- USING A DUAL STETHOSCOPE WITH THE RN TEST OBSERVER LISTENING AND WATCHING TO GET THE RESIDENT'S BLOOD PRESSURE READING AT THE SAME TIME AS THE CANDIDATE
- Candidate will only be allowed **one attempt per arm**.
  - No re-pumping on the same arm will be allowed – only one pump on each arm (this includes any re-attempts/corrections made).
  - The RN Test Observer will inform the candidate when they have reached their max number of attempts (1 per arm) and state, 'You have reached your maximum number of attempts; please move forward with your task.'

	Greet the resident by name.	
	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Introduce yourself by name.	
	Explain the procedure to the resident.	
	Provide privacy for the resident; pull the privacy curtain.	
	Assist the resident into a comfortable sitting or recumbent position with the forearm relaxed and supported in a palm-up position.	
	Roll the resident's sleeve up about 5 inches above the elbow, if wearing a shirt with sleeves.	
	Apply the cuff around the upper arm just above the elbow and line the cuff arrows up with brachial artery.	
	Clean the earpieces of the stethoscope appropriately and place them in ears.	
	Clean the diaphragm of the stethoscope.	
	Place the stethoscope over the brachial artery.	
	Hold the stethoscope snugly in place.	
	Inflate the cuff to *30mmHG above* RN Test Observer provided loss of pulse number.	
	Slowly release air from the cuff to disappearance of pulsations.	
	Remove cuff.	
	Candidate will only be allowed **1 attempt per arm**. a. No re-pumping on the same arm will be allowed – only 1 pump on each arm (this includes any re-attempts/corrections made). b. The RN Test Observer will inform the candidate when they have reached their max number of attempts (1 per arm) and state *'you have reached your maximum number of attempts, please move forward with your task'*.	
	Record the reading on the previously signed recording form.	
	The candidate's recorded systolic blood pressure is within 6mmHg of the RN Test Observer's recorded systolic reading.	
	The candidate's recorded diastolic blood pressure is within 8mmHg of the RN Test Observer's recorded diastolic reading.	

	Perform hand hygiene. a. Cover all surfaces of hands with hand sanitizer. b. Rub your hands together until they are completely dry.	
	Place call light or signaling device and water within easy reach of the resident.	
	Maintain respectful, courteous interpersonal interactions at all times.	