Please download file and use Adobe Reader to complete.

Angel Hands Home Care

To apply for work as a CNA, you will need all of the following in order for your application to be processed:

1. Must be current on the **North Carolina** CNA registry
2. Current Driver's License
3. Social Security Card
4. Current TB Skin test
5. Proof of Current Vehicle Insurance
6. Criminal Record Check from your County Clerk of Court*
7. I.N.S. Card (If you are not a U.S. Citizen)
8. Fingerprint Card (If you have not lived in North Carolina for 5 consecutive Years) (cost is $10.00)
9. CPR Certification
10. Starting pay rate for CNAs is $10.00 per hour if you have at least 1 year of CNA experience, if you have less than 1 year the starting rate is $9.75 per hour.

*-check with Human Resources for alternative background check options

Nurse Aid, LLC/Angel Hands Home Care

2722 NORTH CHURCH STREET ▪ SUITE E ▪ GREENSBORO, NC 27405 ▪ PHONE (336) 375-8288 FAX (336) 375-8926
E-mail: nurseaid98 @bellsouth.net

WELCOME

CNA

Dear Applicant,

I would like to take this opportunity to welcome you to Nurse Aid, LLC/Angel Hands Home Care. We hope your new job will live up to your expectations and your stay with us will be a rewarding one.

We are a small company that strives to work together as a team to achieve maximum results. This is necessary if we wish to sustain our growth and achievement in a highly competitive and changing industry. By working together, I am confident that the future will be both productive and prosperous for all of us.

In order to be considered for employment at Nurse Aid, LLC/Angel Hands Home Care, the state of North Carolina requires you to supply certain documentation at the time you apply. That documentation is listed below:

****All CNA's will be required to take client Vital Signs****

As a CNA providing in home care you are required to take vital signs on all patients assigned to you at Angel Hands Home Care unless directed otherwise; therefore, you will need the following pieces of equipment:
BP Cuff, Stethoscope, Thermometer (preferably digital) and probe covers.
We do make all of those items available to you either separately or as a kit, but you are not obligated to purchase them through us. You may purchase one or all of the items from anywhere you chose; however, **you MUST have the proper equipment before you will be hired and given a case.**

Additional Requirements:

CNAs

- Positive Photo Identification – We will make a copy. A copy brought in WILL NOT be accepted.
- Original Social Security Card - We will make a copy. A copy brought in WILL NOT be accepted.
- TB Skin Test - We do administer TB shots at the Greensboro office by appointment. The cost for the shot is subject to change, please contact the office for current charge, cost must be paid for in cash prior to the shot being given. If you cannot take the TB shot and/or have tested positive in the past, you must provide a Chest X-Ray and you will be asked to complete a screening.
- INS Card – if you are not a legal permanent resident of the United States.
- CERTIFICATION - We will verify your certification status with DFS by your SSN. If you have any charges currently and/or pending against your certification, please let us know up front. It will show-up when we check your certification, and your honesty will play an important role in our decision whether to hire you or not, depending on the nature of the charges.
- Criminal Record Check – This report MUST come from the Clerk of Court from the county you reside in. If you have recently moved to a new county, it must come from the county in which you just moved from.

Other documentation may be required for certain facilities and/or special assignments. If you have any of the following items, please submit them, and we will place them in your personnel file.

- CPR Card
- Hepatitis B Vaccine Dates
- Med Tech Certification
- Health Immunization Record
- Medical Records Training

We will not accept your application without the required documentation.

Sincerely,
Leslie Westmoreland
Administrator

EMPLOYEE INFORMATION

THE INFORMATION ON THIS FORM WILL BE USED TO ENTER YOU, AS AN EMPLOYEE, INTO THE PAYROLL PROGRAM FOR THIS COMPANY. ALL INFORMATION ASKED IS NEEDED, AND IF THIS FORM IS INCOMPLETE, YOU WILL NOT BE PAID UNTIL YOU RETURN TO THE OFFICE TO COMPLETE IT.

NAME: ____

MAILING ADDRESS:: ____

CITY: ____________________ STATE: __________ ZIP: ______________

PHYSICAL STREET ADDRESS:(if different from above) **(NO P.O. BOXES ALLOWED):** ______________________________

HOME PHONE:(________)______________________ E-MAIL ADDRESS: ________________________

WORK PHONE: (________)______________________PAGER/CELL: (_______)________________

SOCIAL SECURITY NUMBER: __________-_________-__________ MARITAL STATUS: SINGLE: _______ MARRIED: _______

SEX: ___________ ORIGIN/RACE: ________________ DATE OF BIRTH: ________/_______/________

CLASSIFICATION: PLEASE CHECK APPROPRIATE LEVEL(S) RN: _____ LPN: _____ CNA II: _____ CNA I: _____ OTHER: _____

IN CASE OF EMERGENCY; PLEASE CONTACT:

NAME: ______________________RELATIONSHIP: ________________ PHONE: (_______)____________

THIS INFORMATION WILL BE USED TO DETERMINE YOUR TAX WITHHOLDINGS EACH WEEK, SO IF YOU LEAVE IT BLANK, YOUR TAX DEDUCTIONS WILL BE BASED ON SINGLE WITH ZERO (0) DEPENDENTS.

TAX INFORMATION: PLEASE CHECK APPROPRIATE STATUS

________ SINGLE (49)
________ MARRIED FILING SEPARATELY (79)
________ MARRIED FILING JOINTLY (79)
________ HEAD OF HOUSEHOLD (78)

HOW MANY DEPENDANTS ARE YOU CLAIMING?

W4: ____________
NC4: ___________

ARE YOU FILING EXEMPT?

YES________
NO________

DO YOU WISH TO HAVE ANY ADDITIONAL WITHHOLDINGS? IF SO, PLEASE INDICATE: STATE:________________FEDERAL:________________

EMPLOYEE SURVEY

I would prefer to be available for: Private Duty Cases Only ______ Staff Relief Only _______ Both Private Duty & Staff Relief _______

I would prefer to work the following shift(s): If more than one shift please list 1st, 2nd, 3rd choice.

❑ 7a-3p ___________
❑ 3p-11p __________
❑ 11p-7a __________
❑ 7a-7p __________ (if available)
❑ 7p-7a __________ (if available

I would prefer to work in the following area(s):

— Greensboro
— High Point
— Winston-Salem
— Archdale/Trinity
— Kernersville
— Lexington
— Asheboro
— Burlington
— Thomasville
— Stokesdale
— Eden
— Madison/Mayodan
— Reidsville
— Clemmons
— King
— Other ______________
____
____

Please be aware that limiting your availability may limit your hours.

NURSE AID, LLC/ANGEL HANDS HOME CARE

AN EQUAL OPPORTUNITY EMPLOYER

APPLICATION FOR EMPLOYMENT

PERSONAL **DATE:____/____/____**

NAME: ____ D.O.B: ________/________/________

STREET ADDRESS: ____ SS #: ___________________________________

CITY: ____ STATE: ___________ ZIP: ___________________________

HOME PHONE: ___________________________________ PAGER/CELL: ____

ANY ADDITIONAL NUMBERS THAT MIGHT BE HELPFUL: ____

TRAINING LEVEL - CLASSIFICATION: (PLEASE CHECK APPROPRIATE LEVEL)

REGISTERED NURSE __________ LICENSED PRACTICAL NURSE __________ CERTIFIED NURSING ASSISTANT II ___________

CERTIFIED NURSING ASSISTANT I ___________ OTHER: __________ SPECIFY ____

SPECIAL TRAINING: (CPR, ACLS, PALS, ETC) ____

EDUCATION

HIGHEST GRADE ATTENDED _______________ **SCHOOL** ____________________________________ **YEAR FINISHED** _______________

COLLEGE ADDRESS ____ **DEGREE/YEAR** ________________

COLLEGE ADDRESS ____ **DEGREE/YEAR** ________________

EMPLOYMENT **(START WITH MOST RECENT) BE SURE TO INCLUDE A PHONE NUMBER AND ACCURATE DATES.**

FROM:_______________ TO:_______________ EMPLOYER:____

JOB TITLE:________________________________ PHONE:_________________________________

SUPERVISOR'S NAME:_____________________ DUTIES:____

STARTING SALARY:______________________ ____

ENDING SALARY:_________________________ REASON FOR LEAVING:____________________________________

MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? YES__________ NO__________

==

FROM:_______________ TO:_______________ EMPLOYER:____

JOB TITLE:________________________________ PHONE:_________________________________

SUPERVISOR'S NAME:_____________________ DUTIES:____

STARTING SALARY:______________________ ____

ENDING SALARY:_________________________ REASON FOR LEAVING:____________________________________

MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? YES__________ NO__________

==

FROM:_______________ TO:_______________ EMPLOYER:____

JOB TITLE:________________________________ PHONE:_________________________________

SUPERVISOR'S NAME:_____________________ DUTIES:____

STARTING SALARY:______________________ ____

ENDING SALARY:_________________________ REASON FOR LEAVING:____________________________________

MAY WE CONTACT EMPLOYER AT ABOVE PHONE NUMBER? YES__________ NO__________

OTHER INFORMATION

SCHEDULE DESIRED: FULL TIME_______PART TIME_______ TEMPORARY_______ PRN_________

RATE OF PAY DESIRED:_________________HOW DID YOU HEAR ABOUT OUR COMPANY?____________________________________

HAVE YOU LIVED IN THE STATE OF NORTH CAROLINA FOR AT LEAST **5 CONSECUTIVE** YEARS? YES_______NO_______

HAVE YOU EVER HAD ANY TYPE OF INJURY THAT WOULD PREVENT OR LIMIT YOUR ABILITY TO PERFORM THE DUTIES

REQUIRED OF A MEDICAL PROFESSIONAL OF YOUR CLASSIFICATION? YES _______ NO _______

IF YES, WHEN? ________________________ WHAT WAS/IS THE INJURY? _________________________________

DOES IT CURRENTLY AFFECT YOU? YES _______ NO _______ HOW? _____________________________________

HAVE YOU **EVER** FILED A WORKERS COMPENSATION CLAIM? YES _______ NO _______

HAVE YOU **EVER** BEEN CHARGED WITH / CONVICTED OF A FELONY? YES ______ NO ______ IF SO, WHEN? _____________________

HAVE YOU **EVER** BEEN ON PROBATION? YES ______ NO ______ IF SO, WHAT FOR? ____

ARE YOU **CURRENTLY** ON PROBATION? YES ______ NO ______ IF SO, WHAT FOR? ____

HAVE YOU WORKED **ANY AGENCY** BEFORE? YES_______ NO_______ REASON FOR LEAVING:______________________________

HAVE YOU **EVER** WORKED AT OR APPLIED TO ***ANGEL HANDS HOME CARE OR NURSE AID, LLC***? YES_______ NO_______

IF SO, UNDER WHAT NAME? _________________________________ REASON FOR LEAVING:_____________________________________

HOW DID YOU HEAR ABOUT OUR COMPANY/THE OPENING?____

LIST ANY FRIENDS OR RELATIVES WORKING WITH US NOW:____

PLEASE LIST ANY PETS/ANIMALS THAT YOU ARE AFRAID TO WORK AROUND.____

PERSONAL REFERENCES (BE SURE TO INCLUDE PHONE NUMBER)

NOTE: Personal references should not include family members.

	NAME	ADDRESS	RELATIONSHIP	PHONE
1.				
2.				
3.				

PROVIDE THE DATE YOU ARE AVAILABLE TO START: _______/_______/_______

WHAT DAYS AND SHIFTS ARE YOU AVAILABLE FOR WORK?

____

A patient's care plan often calls for the caregiver to run errands with or for the patient one day per week. This would require the caregiver to have a valid driver's license, valid insurance, as well as their own means of transportation.

Do YOU have a vehicle? _____ Do YOU have a VALID driver's license? _____DL#: ____________________

Do YOU have valid insurance on your vehicle? _______Insurance Co. Name: __________________________

APPLICANT: READ AND SIGN BELOW

THE INFORMATION PROVIDED BY ME IN THIS APPLICATION FOR EMPLOYMENT IS **TRUE AND COMPLETE** TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I AM EMPLOYED, **ANY FALSE STATEMENT WILL BE CONSIDERED AS CAUSE FOR POSSIBLE DISMISSAL**. FURTHERMORE, I HEREBY AUTHORIZE NURSE AID, LLC/ANGEL HANDS HOME CARE TO SEEK ANY INFORMATION NEEDED FROM ALL MY PREVIOUS EMPLOYERS, PERSONAL REFERENCES, AND/OR ACADEMIC INSTITUTIONS. I RELEASE ALL PARTIES FROM ANY LIABILITY THAT MAY ARISE FROM THEIR GIVING OR RECEIVING INFORMATION ABOUT ME AND MY SUITABILITY FOR EMPLOYMENT.

____(SEAL) ______________________________

SIGNATURE OF APPLICANT DATE

Nurse Aid, LLC/Angel Hands Home Care

2722 N Church Street Suite E Greensboro, NC 27405
Phone (336) 375-8288 Fax (336) 375-8926

TERMS AND CONDITIONS OF EMPLOYMENT

I, the undersigned applicant, understand that Nurse Aid, LLC, dba Angel Hands Home Care, is a Part-Time PRN Staffing agency. As such, I understand that I am being employed as a "Part Time PRN" nursing assistant and I am not guaranteed 40 hours per week or any certain number of hours per week. I also understand that I am accepting the terms and conditions of this employment by my Signature/Seal below.

I further understand that my assigned client's condition may deteriorate and that the client may be placed in a hospital or nursing facility for an extended period of time, or expire or have their service suspended for a period of time, so my continued employment is not guaranteed.

I understand that I am being employed to work part time and that the hours I accept for work may be controlled by the State of North Carolina through Administrative Policy and Procedure and North Carolina Medicaid Regulations.
I agree to those terms and conditions.

I understand that it is my responsibility to check with the staffing coordinator on a daily basis for available fill-in cases or new permanent cases should any initial case be interrupted or end.

I also understand that I must have a working telephone number available to me and that I must return all calls made to that number asking me to call within a 6-hour time frame.

I also understand that it is a law and regulation in the State of North Carolina that I must maintain my medical records and that those medical records be updated as required and provided to the company. These Medical records include but are not limited to an annual TB Skin Test or a Chest X-Ray Screening conducted by a licensed health professional as outlined in General Statute 15A NCAC 19A. I further understand that my failure to provide proof of an annual test for tuberculosis will result in my not being eligible to work for Angel Hands Home Care or in a health care setting in the state.

Applicant Seal____Date_____________

Witness Seal____Date______________

Nurse Aid, LLC/Angel Hands Home Care

2722 N Church Street Suite E Greensboro, NC 27405 ∆ Phone (336) 375-8288 Fax (336) 375-8926

CNA JOB DESCRIPTION

Requirements:

CNA's must:

- Must be listed with the Division of Facility Services or NC Board of Nursing and be free of sanctions and/or other disciplinary actions.
- Obtain a passing score on any tests required for the proper care of the clients.

Dress code:

- CNA's must wear white uniforms with white shoes and socks, or any color scrubs with white shoes and socks.
- Please do not wear cut-offs, jeans, or mini-skirts. We want to present a professional appearance.

Responsibilities:

- Arrive on time and depart as scheduled or when relieved by another staff member or caregiver.
- Deliver personal hygiene including bath, AM and PM care, shave, hair grooming, and mouth care, give bed baths, tub baths, showers, skin care and clothing changes.
- Maintain clean environment.
- Feed and encourage or resist fluids.
- Position the patient, turn, transfer chair, stretcher, and lifts using proper body mechanics, perform ROM exercises.
- Walk ambulatory patients and assist to the bathroom.
- Inform the charge nurse of changes in the patient's condition, before notifying the family or physician.
- Maintain patient safety, side rails, call lights, mitts, and restraints, CPR and Heimlich maneuver, and use of infection control measures- hand washing, isolation technique, standard/universal precautions.
- Make beds.
- Bowel and bladder care including bedpans, urinals, bowel/bladder restraining, collect/test specimens, perineal/catheter care, applying condom catheters, douches, enemas, inserting rectal tubes, flatus bags, emptying drainage devices from body cavities and wounds, maintaining gastric suction.
- Measure fluid intake and output.
- Take TPR's (oral, rectal, auxiliary), BP's, height and weight using stand up scales, bed scales and baby scales, application of heat/cold, prevention and care of decubitis ulcers, surgical skin preps and scrubs, clean dressing changes, ace bandages, TED's and binders, EKG leads, pulmonary toilet, diabetic urine, assist with Sitz baths and enemas, obtain specimens, administer Foley care and postmortem care
- Document care provided on specified patient care records
- Obtain initial report before rendering care to the patient.
- Document actual time worked on Visit Report. This report will be used as your time slip, therefore everything must be accurate and time indicated should be represented correctly.
- Turn in previous week's time slip(s)/Visit Report by no later than 9 a.m. each Monday.

*The licensed nurse maintains accountability and responsibility for the delivery of safe and competent care. Decisions regarding delegation of ANY of the above activities are made by the licensed nurse on a client-by-client basis. The following criteria must be met before delegation of any task may occur:

- task is performed frequently in the daily care of a client or group of clients.
- task is performed according to an established sequence of steps.
- task may be performed with a predictable outcome.
- task does not involve on-going assessment, interpretation or decision-making that cannot be logically separated from the task.

As a part of accountability, the licensed nurse must validate the competencies of the CNA prior to delegating tasks, as well as monitor the clients' status and response to care provided on an on-going basis.

I have read and understand all of the above job descriptions for CNA's.

______________________________ ______________

(Signature) (Date)

CNA SKILLS COMPETENCY CHECKLIST

Name: ____

Applicant: Please **circle** the appropriate skills level at which you are comfortable to perform these tasks.

(1) Need Instruction **(2) Competent to perform**

CNA SKILLS	LEVEL		CNA SKILLS	LEVEL	
TEMPERATURE	1	2	DRESSING	1	2
PULSE	1	2	GROOMING	1	2
RESPIRATION	1	2	HYGIENE	1	2
BLOOD PRESSURE	1	2	BEDPAN/URINAL/BED SIDE COMMODE	1	2
BED BATH	1	2	TOILETING / ASSIST	1	2
SPONGE BATH	1	2	TOILETING / COMPLETE	1	2
TUB OR SHOWER BATH	1	2	TOILETING / BRIEFS	1	2
SHAMPOO –BED	1	2	TRANSFER TECHNIQUES	1	2
SHAMPOO-SINK OR TUB	1	2	AMBULATION WITH DEVICE	1	2
NAIL CARE	1	2	AMBULATION WITH OUT DEVICE	1	2
SKIN CARE	1	2	RANGE OF MOTION EX.	1	2
BACKRUB	1	2	POSITIONING	1	2
ORAL HYGIENE	1	2	MAKE OCCUPIED BED	1	2
DOCUMENT ACCORDING TO POLICIES	1	2	COMPLY WITH PATIENTS BILL OF RIGHTS	1	2
HOME CARE TASKS	**LEVEL**		**HOME CARE TASKS**	**LEVEL**	
HOUSEKEEPING: ▪ Clean client's bedroom, kitchen, bathroom, and common living areas. ▪ Dust, Mop, Sweep, Vacuum	1	2	MEALS: ▪ Preparation/Clean-up ▪ Set-up ▪ Feeding	1	2
LAUNDRY: ▪ Make bed (unoccupied) ▪ Change bed linens ▪ Wash, dry, and fold linens, towels, etc.	1	2	INFECTION CONTROL: ▪ Universal Precautions	1	2
SAFETY: ▪ Fire Safety ▪ Falls Prevention ▪ Hazard Awareness ▪ Prevention of injury (skin tears, bruises, lacerations, bumps, etc.)	1	2	COORDINATION OF CARE: ▪ Follow Plan of Care ▪ Communicate well ▪ Comply to Patients Bill of Rights ▪ Plan and coordinate patient transportation needs ▪ Document appropriately, completely, and accurately ▪ Report concerns immediately to supervisor	1	2

Demonstrated ability to use one handed "scoop" technique. ____(HR)

I HEREBY VERIFY MY COMPETENCY TO PERFORM THE TASKS AND SKILLS AS INDICATED ABOVE.

____ ________/________/________

Employee's Signature Date

____ _____ ________/________/________

Reviewer's Signature HR Date

Title: ________________________________

CNA I & II TEST

NAME: ____ CNA I: _______ CNA II: _______

(DARKEN IN THE BOX FOR THE ONE (1) BEST ANSWER)

1. The ultimate goal of nursing care is:
- ❒ a. complete recovery for every patient
- ❒ b. proper diagnosing and successful treatment of illness
- ❒ c. restoration of the patient to as near his/her former state of health as possible.
- ❒ d. all of the above

2. Illness or injury may affect an individual: (a) emotionally (b) physically (c) financially (d) spiritually
- ❒ a. all of these
- ❒ b. b and d
- ❒ c. c and d
- ❒ d. a and c

3. It is especially important that the sick room be kept clean and orderly because:
- ❒ a. disorder creates mental confusion and indirectly affects the patient's mind
- ❒ b. cleanliness is more important than making the patient feel at home
- ❒ c. dirt and dust are carriers of disease
- ❒ d. most nurses need experience in house keeping methods

4. One of the best ways to judge whether or not a bed has been made by:
- ❒ a. the appearance as soon as it has been made
- ❒ b. determining the comfort of the patient who lies in it
- ❒ c. asking an experienced nurse
- ❒ d. determining the amount of linen used

5. The bath will be more relaxing and soothing if:
- ❒ a. long smooth strokes are used to clean the skin
- ❒ b. circulation is increased by vigorous rubbing of the skin with the wash cloth
- ❒ c. hot water is used for the bath
- ❒ d. the linen is changed before the bath is given

6. Dentures should not be worn: (a) when the patient is sleeping (b) if the patient is unconscious or subject to convulsions (c) if the patient is on a soft diet (d) when the patient is receiving nasal oxygen
- ❒ a. a and d
- ❒ b. b and d
- ❒ c. b and c
- ❒ d. a and b

7. The best time to clean a patient's fingernails is:
- ❒ a. during the bath after the hands have been soaked in warm water
- ❒ b. before the bed bath
- ❒ c. after breakfast
- ❒ d. before a.m. care is started

8. If a male patient asks for a urinal you should:
- ❒ a. tell him to wait until a male assistant is available
- ❒ b. place the urinal under the top covers so that the patient can grasp the handle, and then leave the room
- ❒ c. inform him that the urinal is in his bedside table for his convenience
- ❒ d. ask him to use the bedpan because female assistants cannot give urinals to male patients

9. The term urinary incontinence refers to:
- ❒ a. failure of the kidneys to excrete urine
- ❒ b. retention of the urine in the bladder
- ❒ c. incomplete emptying of the bladder
- ❒ d. having little or no control in retaining urine

10. When one is in a good sitting position the feet should be:
- ❒ a. resting on the chair round
- ❒ b. kept at least 12 inches apart
- ❒ c. resting on the floor
- ❒ d. dangling so that only the toes touch the floor

11. To avoid serious accident when getting a patient up in a wheelchair, you must be sure that:
- ❒ a. the back of the chair is cushioned with a pillow
- ❒ b. a foot stool is used
- ❒ c. the wheels are locked and the foot rests are folded up and out of the way
- ❒ d. you should have at least two other assistants to help you

12. If the position of a patient in bed is not changed frequently, they are most likely to develop:
- ❒ a. a skin infection
- ❒ b. fixation of the joints and decubitus ulcers
- ❒ c. toughening of the skin and paralysis
- ❒ d. an infection of the bones

13. Intelligent observation is one of the most important duties of the CNA. OBSERVATION can best be defined as:
- ❒ a. looking for symptoms of the disease that will help you learn more about nursing
- ❒ b. taking notice of the patient and their environment
- ❒ c. watching the patient only when they are unaware that they are being observed
- ❒ d. obtaining information from the patient and his family by asking intelligent questions

14. If a patient has just finished drinking a cup of hot coffee before his temperature is to be taken, you should know that:
- ❒ a. a rectal temperature is contraindicated
- ❒ b. an oral temperature should not be taken for 10 mins
- ❒ c. this will have no effect on an oral temperature
- ❒ d. have the patient rinse their mouth with cold water

15. Before taking an axillary temperature it is most important to:
- ❒ a. rub the arm to increase circulation
- ❒ b. dry the armpit by patting the area with a clean towel
- ❒ c. help the patient to a sitting position
- ❒ d. turn the patient on to their back

16. The most common sites for taking a pulse are:
- ❒ a. the ankle and wrist
- ❒ b. over the juglar vein and at the wrist
- ❒ c. the wrist and temple
- ❒ d. the wrist and knee

17. Patients with ill fitting dentures or other difficulties in chewing are more likely to enjoy their meals if the meal is:
- ❒ a. composed of nothing but liquids
- ❒ b. served cold
- ❒ c. a soft diet
- ❒ d. mostly made up of baby foods

18. The best method for removing mucous from an emesis basin is:
- ❒ a. submerging the emesis basin in hot water for 30 mins
- ❒ b. rinsing in hot water and soaking in a large amount of alcohol
- ❒ c. soaking for several hours in a large amount of Lysol solution
- ❒ d. rinsing in cold water before washing in warm soapy water

19. The bottom linen on the bed should be:
- ❒ a. pulled tight and tucked in well under the mattress
- ❒ b. smoothed out with the palm of the hand so that there will be no wrinkles after the patient gets into bed
- ❒ c. applied loosely to prevent strain and tearing of the linen
- ❒ d. smoothed out and tucked under the outer edges of the mattress

20. When applying any type of heat to a patient, you should remember that:
- ❒ a. prolonged application of heat will decrease circulation
- ❒ b. heat cannot be tolerated by the body for more than one hour at a time
- ❒ c. infants and elderly persons are usually more easily burned than other people
- ❒ d. heat stimulates the growth of bacteria

GRADE: ____________

GRADED BY:____________________________

Must use Adobe Reader for the button below to be functional.