525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

TEMPORARY NURSING ASSISTANT (TNA)

SKILLS TRAINING GUIDE

Administration of Competency Evaluation

The Performance Skills are trained and evaluated in the classroom or laboratory setting. The competency checklist is performed on patients/residents where possible once the instructor has determined skills competency in the lab or classroom setting.

Resident rights and preferences are to be observed at all times. It is not acceptable to ask patients/residents to leave their room in order to administer the skills portion of the competency examination. Visitors may be asked to leave the room but are not required to do so unless the patient/resident requests them to leave.

Each program will determine how many opportunities will be given to students to pass each performance skill evaluation, typically three attempts. If a student fails any of the Performance Skills after the required number of attempts, the student cannot work as a Temporary Nursing Assistant (TNA).

Skills competency must be recorded on the checklists enclosed with this guide and made available to Illinois Department of Public Health surveyors.

Temporary nursing assistants are required to be entered onto the Health Care Worker Registry and facilities must continue to comply with the Health Care Worker Background Check Act. Instructions for correctly entering a TNA on the registry are in a separate document entitled "New Position Type--TNA."

All of the skills listed on the next page are demonstrated at https://nurseaidetesting.com/program-coordinators-instructors/performance-skills-videos/ and may be used as introductory material or review for skills testing.

Please note that the 8-hours of training at the American Health Care Association website at https://educate.ahcancal.org/products/temporary-nurse-aide includes more skills than are allowable by this manual. ***Only the skills listed on the next page are allowed in Illinois for Temporary Nursing Assistants (TNA).***

The skills are listed below with the performance steps that must included to show competency.

Selected Manual Performance Skills

A separate performance skill checklist is provided for each of the following skills:

- Performance Skill #1 Wash hands
- Performance Skill #2 Perform Oral Hygiene
- Performance Skill #3 Shave a Resident with an electric razor
- Performance Skill #4 Give Partial Bath
- Performance Skill #5 Give a Shower or Tub Bath
- Performance Skill #6 Make Occupied Bed
- Performance Skill #7 Dress a Resident
- Performance Skill #8 Transfer Resident to Wheelchair Using a Transfer/Gait Belt
- **Performance Skill #9 Assist with Transfer Using Mechanical Lift**
- Performance Skill #10 Ambulate with Transfer Belt
- Performance Skill #11 Feed A Resident
- Performance Skill #12 Calculate Intake and Output
- Performance Skill #13 Place Resident in a Side-Lying Position
- **Performance Skill #14 Measure and Record Temperature, Pulse and Respirations**
- **Performance Skill #15 Measure and Record Blood Pressure**
- **Performance Skill #16 Measure and Record Weight**
- **Performance Skill #17 Measure and Record Height**
- Performance Skill #18 Donning and Doffing non-sterile gloves
- Performance Skill #19 Choking: Heimlich Maneuver

STUDENTS MUST SHOW COMPENTENCY IN ALL OF THE MANDATORY PERFORMANCE SKILLS IN ORDER TO SUCCESSFULLY COMPLETE A TEMPORARY NURSING ASSISTANT TRAINING PROGRAM.

Note that use of a mechanical lift, measurement of temperature, pulse, respirations, blood pressure, height, and weight are not mandatory. These skills are indicated in bold font above.

Beginning and Completion Tasks

Some skills have beginning and completion tasks. All skills have beginning tasks.

BEGINNING TASKS

1. Wash Hands.
2. Assemble Equipment.
3. Knock and pause before entering.
4. Introduce self and verify resident identity as appropriate.
5. Ask visitors to leave.
6. Provide privacy for the resident.
7. Explain the procedure and answer questions.

Note: Let the resident assist as much as possible and honor preferences.

COMPLETION TASKS

1. Position the resident comfortably.
2. Remove or discard gloves/protective equipment.
3. Wash hands.
4. Return the bed to an appropriate position.
5. Place signal cords, phone and water within reach of the resident.
6. Conduct general safety check/resident and environment.
7. Open the curtains.
8. Care for the equipment as necessary.
9. Wash hands.
10. Allow visitors to reenter, as appropriate.
11. Report completion of task, as appropriate.
12. Document actions and observations.

WASH HANDS

STANDARD: HANDS ARE WASHED WITHOUT RECONTAMINATION.

While equipment may vary, the principles noted on the competency exam must be followed at all times.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Stood so that clothes did not touch sink.	
2	Turned on water and adjusted temperature; left water running.	
3	Wet wrists and hands; kept hands lower than level of elbow throughout procedure.	
4	Applied soap or cleaning agent to hands using available products.	
5	Washed hands and wrists using friction for 20 seconds.	
6	Rinsed hands and wrists well under running water with fingertips pointed down.	
7	Dried hands thoroughly with paper towel(s) from fingertips to wrists.	
8	Used paper towel between hand and faucet to turn off water.	
9	Disposed of used paper towels.	

PERFORM ORAL HYGIENE

STANDARD: MOUTH, TEETH AND/OR DENTURES WILL BE FREE OF DEBRIS.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks	
2	Positioned resident.	
3	Cleaned oral cavity using appropriate oral hygiene products.	
4	Rinsed oral cavity.	
5	Repeated steps 3 and 4 until oral cavity was clean.	
6	Cleaned and rinsed teeth, dentures if applicable.	
7	Assisted resident to clean and dry mouth area.	
8	Performed completion tasks	

SHAVE A RESIDENT WITH AN ELECTRIC RAZOR

STANDARD: RESIDENT IS FREE OF FACIAL HAIR WITH NO ABRASIONS OR LACERATIONS.

The student is assigned the task of shaving a resident's (preferably male) face. The evaluator must obtain a list
of residents who need to be shaved and for whom shaving is not contraindicated.
Example: Residents taking anticoagulants should not be assigned.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks	
2	Positioned resident.	
3	Shaved resident: **Electric Shave:**	
	a. Checked to be sure that the razor was clean.	
	b. Verified that the resident was prepared with a clean, dry face.	
	c. Turned on razor, observing precautions for using electrical equipment.	
	d. Shaved resident by holding skin taut and moving the razor over a small area of the face in the direction of the hair growth until the hair was removed.	
	e. Cleaned the razor after use.	
	f. Applied after shave product as appropriate.	
4	Performed completion tasks	

GIVE PARTIAL BATH

STANDARD: DESIGNATED BODY AREAS, INCLUDING THE PERINEAL AREA, ARE WASHED, RINSED AND DRIED.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks	
2	Prepared resident for partial bath.	
3	Filled basin with water at correct temperature to resident preference.	
4	Washed, rinsed and dried face, hands, axilla, perineal area and other areas as appropriate.	
5	Removed linen used for bathing and placed in appropriate container.	
6	Prepared resident for dressing.	
7	Performed completion tasks	

GIVE A SHOWER OR TUB BATH

STANDARD: BODY IS CLEAN USING A SHOWER OR TUB BATH.

Directions: Place a “p” for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks	
2	Prepared resident for shower or tub bath.	
3	Adjusted water temperature to resident preference throughout bath.	
4	Washed, rinsed and dried in appropriate head to toe sequence allowing for resident independence.	
5	Shampooed hair as appropriate.	
6	Prepared resident to leave shower or tub bath area.	
7	Performed completion tasks	

MAKING AN OCCUPIED BED

STANDARD: OCCUPIED BED MUST BE NEAT, WRINKLE FREE WITH PERSON AND BED PLACED IN THE APPROPRIATE POSITIONS.

The person must be in bed with the side rails up (if applicable) while the bed is being made. If side rails are not available, an alternative safety measure shall be used. When side rails are used as a safety measure during this procedure, care must be taken to prevent personal injury.

Gloves shall be worn when handling soiled linen.

At the completion of this task the bed must be left in the appropriate position with side rails up or down as indicated by the needs of the individual and/or as indicated on the care plan.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks	
2	Removed top linen, keeping person covered.	
3	Positioned individual on one side of bed with side rail up (if applicable) using appropriate safety measures on unprotected side and using appropriate body mechanics.	
4	Tucked dirty linen under individual. Used gloves if linen is contaminated with blood or body fluids.	
5	Replaced bottom linen on first side. Tucked corners and sides neatly under mattress.	
6	Repositioned individual to other side using appropriate safety measures on unprotected side.	
7	Removed dirty linen by rolling together, held away from clothing, and placed dirty linen in appropriate container. Disposed of gloves, if used, and washed hands.	
8	Completed tucking clean linen under mattress with corners and sides tucked neatly under mattress on the second side.	

9	Repositioned the individual to a comfortable position.	
10	Placed top sheet over individual. Removed dirty covering. Tucked bottom corners and bottom edge of sheet under mattress, as indicated.	
11	Placed blanket/spread over person. Tucked bottom corners and bottom edge or blanket/spread under mattress, as indicated. Pulled top edge of sheet over top edge of blanket/spread.	
12	Removed and replaced pillowcase appropriately. Replaced pillow under individual's head.	
13	Placed bed in appropriate position.	
14	Performed completion tasks	

DRESSING A PATIENT/RESIDENT

STANDARD: RESIDENT IS DRESSED IN OWN CLOTHING, INCLUDING FOOTWEAR, WHICH IS NEAT AND CLEAN. RESIDENT IS COMFORTABLE DURING DRESSING PROCEDURE AND CHOOSES OWN CLOTHING WHEN ABLE.

Clothing should consist of undergarments, dress, or shirt or blouse and pants, socks and footwear.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks	
2	Asked resident preference and gathered resident’s own clean clothing.	
3	Dressed the resident in undergarments, top, pants (or dress) and footwear, as appropriate.	
4	Performed completion tasks	

TRANSFER PATIENT/RESIDENT TO WHEELCHAIR WITH TRANSFER/GAIT BELT

STANDARD: APPLIED TRANSFER/GAIT BELT; ASSISTED RESIDENT TO STAND, PIVOT AND SIT IN WHEELCHAIR WITH BODY ALIGNED.

This skill requires that a resident be transferred from the bed to a wheelchair with the use of a transfer/gait belt.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks	
2	Lowered bed to appropriate position.	
3	Positioned wheelchair at bedside.	
4	Locked brakes.	
5	Assisted resident to sitting position.	
6	Applied transfer belt firmly around the resident's waist (should be adjusted to allow evaluator to place one or two fingers between the belt and the resident).	
7	Adjusted transfer belt over clothing so that buckle is off center.	
8	Applied non-skid footwear to resident.	
9	Grasped transfer belt on both sides with underhand grasp.	
10	Assisted resident to stand; pivot and sit in wheelchair.	
11	Placed resident's feet on footrests, if applicable.	
12	Aligned resident's body in wheelchair.	
13	Performed completion tasks	

ASSIST **WITH TRANSFER USING A MECHANICAL LIFT**

STANDARD: TRANSFERRED PERSON SAFELY UTILIZING A MECHANICAL LIFT ***(This skill is not mandatory).***

Note: Temporary nursing assistants cannot be the primary operator of a mechanical Lift. A temporary nursing assistant can only assist with a transfer.

Followed facility policy for use of lift according to manufacturer's instructions.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks	
2	Identified appropriate lift for resident.	
3	Applied correct sling/belt.	
4	Attached sling/belt to mechanical lift.	
5	Verified resident's readiness for transfer.	
6	Operated the mechanical lift controls according to manufacturer's instructions.	
7	Maneuvered the lift safely.	
8	Lowered resident safely.	
9	Disconnected sling/belt from lift.	
10	Removed sling/belt if applicable.	
11	Performed completion tasks	

AMBULATE WITH TRANSFER/GAIT BELT

STANDARD: AMBULATED PERSON SAFELY UTILIZING TRANSFER BELT.

May be tested in the classroom or in the clinical setting.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Locked bed or chair wheels, if appropriate.	
3	Ensured the person was appropriately attired including non-skid footwear.	
4	Applied transfer belt firmly around person's waist (should be adjusted to allow evaluator to place two fingers between the belt and the person.)	
5	Assisted the person to standing position.	
6	Stood at the person's affected side (if applicable) while balance is gained.	
7	Ensured the person stood erect with head up and back straight, as tolerated.	
8	Assisted the person to walk. Walked to the side and slightly behind the person. Held transfer belt using under hand grasp.	
9	Encouraged the person to ambulate normally with the heel striking the floor first. Discouraged shuffling or sliding, if noted.	
10	Ambulated the required distance, if tolerated.	
11	Assisted the person to return to bed or chair.	
12	Removed transfer belt appropriately.	
13	Performed completion tasks.	

FEED A RESIDENT

STANDARD: RESIDENT IS FED PRESCRIBED DIET IN A COURTEOUS AND SAFE MANNER.

The student should be assigned to feed someone without any special feeding techniques required.

Temporary nursing assistants cannot feed patients/residents with swallowing deficits.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Prepared the resident for the meal (i.e. allowed resident to use toilet and wash hands).	
3	Positioned resident in sitting position as appropriate.	
4	Matched food tray/diet items with resident's diet order.	
5	Matched food tray/dietary items with appropriate resident.	
6	Protected resident's clothing, as appropriate or as resident prefers.	
7	Noted temperature of food and liquids to avoid food that is too hot or too cold.	
8	Fed moderate-sized bites with appropriate utensil.	
9	Interacted with resident as appropriate (i.e., conversation, coaxing, cueing, being positioned at eye level with the resident).	
10	Alternated liquids with solids, asking resident preference.	
11	Ensured the resident has swallowed food before proceeding.	
12	Cleaned resident as appropriate when completed.	
13	Removed tray, cleaned area.	
14	Performed completion tasks.	

CALCULATE INTAKE AND OUTPUT

STANDARD: TOTAL INTAKE AND OUTPUT QUANTITIES CALCULATED WITHOUT ERROR.

The student is to measure intake and output in cubic centimeters (cc) or milliliters (ml). The student may be told the fluid capacity of the containers (glasses, cups, bowls).

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Wrote down the intake and output amounts in the units used to measure the intake and output quantities (i.e., cc=cubic centimeters, ml=milliliters, oz=ounces).	
3	Converted the measured unit into the units to be recorded on resident intake and output chart.	
4	Calculated all the measured quantities listed as resident intake to obtain a total amount of intake for the time period.	
5	Added all the measured quantities listed as resident output to obtain a total amount of output for the time period.	
6	Recorded the total intake and output to be compared to the recorded intake and output calculation of the evaluator.	
7	Performed completion tasks.	

PLACE RESIDENT IN SIDE-LYING POSITION

STANDARD: BODY ALIGNED WITH DEPENDENT EXTREMITIES SUPPORTED AND BONY PROMINENCES PROTECTED.

Either of two positions is acceptable: side-lying position or a variation in which knees are flexed with appropriate padding between the knees and ankles.

Directions: Place a “p” for PASSED in the column to the right or each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Raised side rail on unprotected side of bed (if applicable).	
3	Positioned resident on side in the center of the bed in side-lying position.	
4	Placed appropriate padding.	
	a. Behind back.	
	b. Under head.	
	c. Between legs.	
	d. Supporting dependent arm.	
5	Ensured resident is in good body alignment.	
6	Raised side rails, if appropriate.	
7	Performed completion tasks.	

MEASURE & RECORD TEMPERATURE, PULSE, AND RESPIRATIONS

STANDARD: ORAL TEMPERATURE IS MEASURED TO WITHIN + OR – 0.2 DEGREES OF EVALUATOR'S READING UNLESS A DIGITAL THERMOMETER IS USED. RADIAL PULSE IS MEASURED TO WITHIN + OR – TWO BEATS OF EVALUATOR'S RECORDING OF RATE. RESPIRATON IS MEASURED TO WITHIN + OR – TWO RESPIRATIONS OF EVALUATOR'S RECORDING OF RATE. ***(This skill is not mandatory)***

The evaluator must simultaneously count the rate for the length of time specified by the student and determine the correct rate.

Pulse and Respiration cannot be a combined procedure; they must be measured separately.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

	MEASURE ORAL TEMPERATURE:	
1	Performed beginning tasks.	
2	Positioned resident, sitting or lying down.	
3	Activated the thermometer.	
4	Covered thermometer as appropriate.	
5	Placed the thermometer probe appropriately.	
6	Instructed the resident to close mouth around the thermometer.	
7	Stayed with the resident during the entire procedure.	
8	Removed the thermometer when appropriate.	
9	Read the thermometer.	
10	Recorded and reported the results within + or – 0.2 degrees of the evaluator's recorded temperature reading.	
11	Performed completion tasks.	

	MEASURE RADIAL PULSE:	
1	Performed beginning tasks.	
2	Positioned resident, sitting or lying down.	
3	Located radial pulse at wrist.	
4	Placed fingers over radial artery. Student does this first, then evaluator locates pulse on opposite wrist.	
5	Determined whether to count for 30 seconds or 60 seconds.	
6	Counted pulsations for 30 seconds and multiplied the count by 2; or for one minute if irregular beat. Student must tell when to start and end count.	
7	Recorded the pulse rate within + or – two beats per minute of pulse rate recorded by evaluator.	
	MEASURE RESPIRATION:	
8	Positioned hand on wrist as if taking the pulse as appropriate.	
9	Determined whether to count for 30 seconds or 60 seconds.	
10	Counted respirations for 30 seconds and multiplied the count by 2; or for one minute if irregular. Student must tell when to start and end count.	
11	Recorded the respiratory rate within + or – two respirations per minute of respiratory rate recorded by evaluator.	
12	Performed completion tasks.	

<u>MEASURE BLOOD PRESSURE</u>

STANDARD: MEASURE AND RECORD BLOOD PRESSURE TO WITHIN + OR – 4MM OF THE EVALUATOR'S READING USING STETHOSCOPE
(***This skill is not mandatory)***

A teaching/training (dual head design) stethoscope may be used simultaneously by the student and the evaluator. In the event that a student is hearing impaired, that student will be allowed to use an amplified stethoscope. If facility policy allows automatic blood pressure measuring, the student should be trained per the facility policy.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Cleaned earpieces of stethoscope.	
3	Positioned resident sitting or lying.	
4	Made sure the room was quiet; turned down loud TV or radio.	
5	Selected the appropriate size cuff and applied it directly over the skin, above the elbow.	
6	Positioned the stethoscope over the brachial artery.	
7	Inflated the cuff per the instructor's direction.	
8	Identified the systolic and diastolic measurements while deflating the cuff.	
9	Deflated the cuff in a timely manner.	
10	Re-measured, if necessary, to determine the accuracy (waited one minute if using the same arm or use the other arm, if appropriate).	
11	Recorded blood pressure measurement to be compared with the blood pressure recorded by the evaluator.	
12	Performed completion tasks.	

MEASURE AND RECORD WEIGHT

STANDARD: MEASURE AND RECORD WEIGHT TO WITHIN + OR – ½ POUND.
(***This skill is not mandatory)***

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Balanced scale at zero.	
3	Weighed individual.	
	A. Individual who is able to stand to be weighed:	
	a. Placed paper towel on scale platform.	
	b. Assisted individual to stand on scale platform without footwear.	
	c. Read weight measurement.	
	d. Recorded weight measurement to be compared to the weight measurement recorded by the evaluator.	
	e. Assisted individual off of scale with appropriate assistance as necessary.	
	OR	
	B. Individual who is weighed by wheelchair or bed scale:	
	a. Sanitized wheelchair/bed scale according to facility policy.	
	b. Assisted individual on wheelchair scale or bed scale as appropriate.	
	c. Read weight measurement.	
	d. Recorded weight measurement to be compared to the weight measurement recorded by the evaluator.	
	e. Assisted resident off wheelchair/bed scale as appropriate.	
4	Returned scale balanced to zero.	
5	Performed completion tasks.	

MEASURE AND RECORD HEIGHT

STANDARD: HEIGHT IS MEASURED TO WITHIN ½ INCH IN EITHER STANDING OR NON-STANDING INDIVIDUAL ***(This skill is not mandatory)***

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Measured height.	
	A. Individuals who are ABLE TO STAND:	
	a. Used appropriate measuring device.	
	b. Placed paper towel on platform as appropriate.	
	c. Instructed individual to stand erect without shoes.	
	d. Read height measurement.	
	e. Recorded height measurement and converted appropriately to be compared to the height measurement recorded by the evaluator.	
	OR	
	B. Individuals who are UNABLE TO STAND:	
	a. Position individual on side or back without shoes.	
	b. Used appropriate measuring device.	
	c. Read height measurement.	
	d. Recorded height measurement and converted appropriately to be compared with the height measurement recorded by the evaluator.	
	e. Repositioned individual, as necessary.	
3	Performed completion tasks	

DONNING AND DOFFING NON-STERILE EXAMINATION GLOVES

STANDARD: GLOVES ARE APPLIED AND REMOVED WITHOUT CONTAMINATION.

1	Perform hand washing/sanitizing.	
2	Selected correct type and size of glove. Remove glove from box/container.	
3	Touch only the cuff edge of the glove when possible.	
4	Don the first glove.	
5	Remove the second glove from the box/container.	
6	Don the second glove without touching the arm.	
7	Does not touch any surface/person not defined by the indications for use.	
8	Remove gloves by pinching one glove at the wrist level to remove it without touching the skin of the forearm.	
9	Peel glove away from the hand allowing the glove to turn inside out. Continue to hold the removed glove in the gloved hand.	
10	Slide the fingers of the ungloved hand between the glove and the wrist.	
11	Remove second glove by rolling it down the hand and folding over the first glove.	
12	Discard the removed gloves.	
13	Perform handwashing/sanitizing.	

HEIMLICH MANEUVER

STANDARD: STUDENT WILL PERFORM STEPS OF THE HEIMLICH MANEUVER CORRECTLY.

1	Patient/resident exhibits signs of choking. Student identifies need for abdominal thrusts.	
2	Get person to stand up if able.	
3	Student positions self behind choking person.	
4	Student places arms around choking person's waist	
5	Student makes fist and places it thumb side in just above the umbilicus (navel)	
6	Student grabs fist with the other hand and pushes it inward and upward at the same time. Student performs five abdominal thrusts.	
7	If choking person cannot stand, student straddles the waist facing the person and pushes fist inward and upward in the same manner as if standing.	
8	Student repeats thrusts until object is expelled or person becomes unconscious.	
9	If person becomes unconscious, begin CPR if qualified.	