To apply for work as a LPN, you will need all of the following:

1. Current driver's license
2. Social Security Card
3. Current TB Skin test
4. CPR Card

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

LPN

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:

RN's & LPN's

- 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.
- Nursing License
- TB Skin test - We do administer TB shots at the Greensboro office by appointment. The cost for the shot is $20.00 which 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.

CNA's & PCA's

- 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 $20.00 which 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 process your application without the required documentation. We will only hold an incomplete file for 30 days from the date of the application. At that point, we will discard the file, and you would be required to reapply should you wish to.

All CNA's will be required to take client Vital Signs 1-5 times weekly 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. If you do decide to purchase them through us, the following payment arrangements below are available. **RETURN POLICY:** Unfortunately because of the nature of these items, we once you have agreed to purchase them and leave our premises with them, we cannot accept them for return or refund. If one of the items breaks due to manufacturer defect within the first 30 days, we will replace the item and return it for credit. If the item is broken due to abuse or misuse on the part of the user, no

Nurse Aid, LLC/Angel Hands Home Care

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

LPN

CURRENT PAY SCHEDULE FOR LPN'S

STAFF RELIEF:

Regular Time:

MONDAY – FRIDAY

7A-3P = BASE RATE =	$20.00
3P-11P = BASE RATE + 2.00 =	$22.00
11P-7A = BASE RATE + 2.00 =	$22.00

SATURDAY – SUNDAY

7A-3P = BASE RATE + 3.00 =	$23.00
3P-11P = BASE RATE + 3.00 =	$23.00
11P-7A = BASE RATE +3.00 =	$23.00

Overtime:

MONDAY – FRIDAY

7A-3P = BASE RATE =	$30.00
3P-11P = BASE RATE +1.00 =	$32.00
11P-7A = BASE RATE +1.00 =	$32.00

SATURDAY - SUNDAY

7A-3P = BASE RATE + 2.00 =	$33.00
3P-11P = BASE RATE + 2.00 =	$33.00
11P-7A = BASE RATE +2.00 =	$33.00

*Because we have a special contract with **Westchester Manor,** any employee who works at that facility will be working at the following pay rate:

Monday – Friday
All shifts = $20.00

Saturday - Sunday
All Shifts = $22.00

OUR WORK WEEK RUNS MONDAY - SUNDAY. OVERTIME BEGINS AFTER 40 HOURS DURING ONE PAY PERIOD. ALL OVERTIME HOURS AS WELL AS HOLIDAYS ARE PAID AT TIME AND A HALF OF THE BASE RATE WHICH AT THE PRESENT TIME IS $20.00.

PRIVATE DUTY:

REGULAR

MONDAY – FRIDAY BASE RATE = $15.00

SATURDAY – SUNDAY BASE RATE = $16.50

HOLIDAY

MONDAY – FRIDAY BASE RATE = $19.00

SATURDAY – SUNDAY BASE RATE = $21.50

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: ____ COMPANION: ____ 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:____________________________________

LIST ANY FRIENDS OR RELATIVES WORKING WITH US NOW:____

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

Nurses Skills Assessment

Name: ______________________________ Title: ____RN ____LPN

Date: ______/_______/______

Please indicate skill level according to the following scale:
(A) Competent to Perform (B) Require In-Service (C) No experience – training required

SKILL	LEVEL	IN-SERVICE	INITIALS
A. GENERAL INFORMATION			
❖ Patient Physical Assessment	A B C		
❖ Fire Safety	A B C		
❖ Knowledge: Bill of Rights	A B C		
❖ Knowledge: Patient Self Determination Act	A B C		
❖ Witnessing & Informed Consent	A B C		
❖ Post-Mortem Care	A B C		
❖ Knowledge: Advanced Directives	A B C		
❖ Incident and/or Abuse Reporting	A B C		
B. UNIVERSAL PRECAUTIONS			
❖ Hand Washing	A B C		
❖ Universal Precautions/Infection Control	A B C		
❖ Personal Protective Equipment	A B C		
C. CATHETERIZATION			
❖ Urinary – Female	A B C		
❖ Urinary – Male	A B C		
❖ Urinary – Pediatric	A B C		
❖ Catheter Care and Maintenance	A B C		
❖ Collection of Urine Specimen	A B C		
❖ Care of Suprapubic Catheter	A B C		
D. ENTERAL FEEDING			
❖ Gravity	A B C		
❖ Pump	A B C		
❖ Insertion: Nasogastric Tube	A B C		
❖ Insertion: Gastrostomy Tube	A B C		
❖ Maintenance of Feeding Tube: NGT, GT	A B C		
E. ORTHOPEDIC			
❖ Cast Care	A B C		
❖ Abduction Pillow	A B C		
❖ Application Brace/Splint	A B C		
❖ Application Prosthesis	A B C		
❖ ACE Wraps	A B C		
❖ Immobilizer	A B C		
F. OXYGEN			
❖ Equipment Management	A B C		
❖ Administration: (NC, Mask, Bi-Pap)	A B C		
❖ Safety and Storage	A B C		

Nurse Aid, LLC/Angel Hands Home Care

Nurses Skills Assessment

Name: ______________________________ Title: ____RN ____LPN

Date: ______/_______/______

Please indicate skill level according to the following scale:

(A) Competent to Perform (B) Require In-Service (C) No experience – training required

SKILL	LEVEL	IN-SERVICE	INITIALS
G. RESPIRATORY			
❖ Percussion	A B C		
❖ Postural Drainage	A B C		
❖ Suctioning: Oropharyngeal	A B C		
❖ Suctioning: Endotracheal	A B C		
❖ Suctioning: Tracheal	A B C		
❖ Tracheostomy Care	A B C		
❖ Chest Tubes, Pleurevac, Straight Drainage, Heimlich Valve	A B C		
❖ Nebulizer Treatments	A B C		
❖ Inhalers	A B C		
❖ Ventilator Management	A B C		
H. MEDICATION ADMINISTRATION			
❖ Administration via Feeding Tube	A B C		
❖ Subcutaneous	A B C		
❖ Subcutaneous: Heparin ABD	A B C		
❖ Intramuscular	A B C		
❖ Intravenous: IVP, IVPB	A B C		
❖ Oral and Sublingual	A B C		
❖ Topical: Lotion or Patch	A B C		
❖ Rectal or Vaginal	A B C		
❖ Reconstitution	A B C		
❖ Blood Glucose Testing	A B C		
❖ Documentation	A B C		
I. WOUND CARE			
❖ Wound Assessment and Documentation	A B C		
❖ Wound Irrigation and Medication	A B C		
❖ Sterile Dressing	A B C		
❖ Removal of Staples and/or Sutures	A B C		
❖ Obtaining Culture	A B C		
❖ Decubitis Care	A B C		
❖ Wound Packing and Dressing	A B C		
❖ Drains	A B C		
J. VENIPUNCTURE			
❖ Peripheral Blood Draw with Vacutainer	A B C		
❖ Peripheral Blood Draw with Butterfly	A B C		
❖ Peripheral Blood Draw (Pediatric)	A B C		
❖ IV Start: Angiocath	A B C		

Nurse Aid, LLC/Angel Hands Home Care

Nurses Skills Assessment

Name: ____Title: ____RN ____LPN

Date: _______/________/_______

Please indicate skill level according to the following scale:
(A) Competent to Perform (B) Require In-Service (C) No experience – training required

SKILL	LEVEL	IN-SERVICE	INITIALS
❖ Peripheral Stick for IV (Pediatric)	A B C		
❖ Establish a Heparin Lock	A B C		
❖ IV Set-up/IVPB	A B C		
❖ Calculation of IV Drip Rate	A B C		
❖ IV Start Success: G = Good, F = Fair, P = Poor, N = No experience	G F P N		
K. INFUSION ACCESS DEVICES			
❖ Hickman/Broviac Catheter	A B C		
❖ Groshong Catheter	A B C		
❖ Portacath Single and/or Double Port	A B C		
❖ Peripherally Inserted Central Catheter (PICC)	A B C		
❖ Mid Line or Landmark Catheter	A B C		
❖ Epidural Catheter	A B C		
❖ Irrigation of Groshong Catheter	A B C		
❖ Irrigation of Port-A-Cath	A B C		
❖ Application of Injection Cap	A B C		
❖ Insertion of Huber Needle	A B C		
❖ Use of Needleless System	A B C		
❖ Application of Central Line Dressing	A B C		
❖ Measurement of PICC Line for Migration	A B C		
❖ Administration of Medication via Central Line	A B C		
❖ Sash Technique	A B C		
❖ Administration of Medication via Epidural Catheter	A B C		
L. HOME THERAPY			
❖ Home Antibiotic Therapy	A B C		
❖ Home Chemotherapy	A B C		
❖ Home Pain Management	A B C		
❖ Home Blood Transfusions	A B C		
❖ Administration of TPN and/or Lipids	A B C		
❖ Preparation of IV/TPN Solution	A B C		
❖ Knowledge of Required Lab Work and Frequency	A B C		
❖ Blood Draw via Central Line	A B C		
❖ Proper Storage and Transport of Blood	A B C		
❖ Administration of Urokinase	A B C		
M. PUMPS			
❖ CADD	A B C		
❖ QUEST	A B C		
❖ MVP	A B C		

Nurse Aid, LLC/Angel Hands Home Care

Nurses Skills Assessment

Name: ____________________________Title: ____RN ____LPN

Date: _______/________/_______

Please indicate skill level according to the following scale:
(A) Competent to Perform (B) Require In-Service (C) No experience – training required

SKILL	LEVEL	IN-SERVICE	INITIALS
❖ Lumbar Puncture	A B C		
❖ Removal of Tubes, Drains, Invasive Devices	A B C		
❖ Examinations	A B C		
❖ Insertion of Central Line	A B C		
❖ Endoscopy Procedures	A B C		
❖ Radiology Procedures	A B C		
❖ Transportation of Patient	A B C		
❖ Dressing Changes, Wound Management	A B C		
❖ Insertion of Tubes	A B C		
O. ADVANCES SKILLS			
❖ Arterial Line Management	A B C		
❖ Remoral Line Management	A B C		
❖ Swan-Ganz Catheter Management	A B C		
❖ Cardiac Output	A B C		
❖ IABP	A B C		
❖ Ventric Drain	A B C		
❖ Measurement CSP	A B C		
❖ Titration of Drips	A B C		
❖ Ventilator Management, Weaning	A B C		
❖ Care of Critical Patient	A B C		

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

______________________________ ________/________/________

Employee's Signature Date

______________________________ ________/________/________

Reviewer's Signature Date

❖ Title: ______________________________

NURSE AID, LLC/ANGEL HANDS HOME CARE

2722 North Church Street
Suite E
GREENSBORO, NC 27405

Phone (336)375-8288 or (336)375-8289 ~ Fax (336)375-8926

LPN JOB DESCRIPTION

1. LPN'S must have a current North Carolina license and be free of sanctions and/or other disciplinary actions.

2. LPN'S are encouraged to maintain current CPR certification.

3. Prior to being assigned to a shift, LPN'S must obtain a passing score on a written test.

4. Dress Code: white uniform, white shoes, white hose, and a Nurse Aid, LLC name tag.

5. Job description includes the following responsibilities:

    - Provide general nursing care (i.e. treatments, dressing changes, tube feedings, IV site care and tubing changes, colostomy and NG irrigations, postmortem care).
    - Administer oral IM subcutaneous and IV piggyback medications. You may also be required to administer controlled drugs, which must be signed out for.
    - Monitor IV infusion rates and patient's response.
    - If certified, may start and/or restart peripheral IV's.
    - Obtain an initial report before rendering care to the patient.
    - Report immediately to the team leader any changes in patient's condition from the LPN'S initial assessment. In addition, the patient's condition must be reported to the team leader at least twice within an eight (8) hour shift and again at the end of the shift.
    - Remain in attendance and participate as directed in a patient crisis.
    - Document care/treatment on specified patient care record(s) consistent with patient's diagnosis and plan of care.
    - SHOULD NOT receive and document verbal or telephone orders from physicians.
    - SHOULD NOT administer IV push medications or blood products.
    - Appraise the team leader prior to initiating calls to family and/or physician regarding patient problems and/or complaints.

I have read and understand all of the above job descriptions for LPN'S

X______________________________ ______________________

EMPLOYEE'S SIGNATURE DATE

NURSE AID, LLC.
ANGEL HANDS HOME CARE

RN/LPN TEST

The following areas are covered in this test:
Cardiovascular; neurological; musculoskeletal; GI; GU;
Metabolic; endocrine; infection control; geriatrics; medication administration;
Moral, ethical, and legal aspects.

Circle the one correct answer to each question.

1. Medications administered through the wrong access line can be prevented by:
   a. knowing your patient's acuity level
   b. complete a thorough assessment
   c. identifying devices, access ports
   d. all of the above

2. Clonidine is a:
   a. anti-infective
   b. anti-hypertensive
   c. anti-psychotic
   d. anti-spasmodic

3. Digoxin:
   a. should not be administered if the pulse is less than 60/min
   b. should not be crushed
   c. a only
   d. a and b

4. Plavix:
   a. reduces the risk of stroke
   b. inhibits the formation of platelets
   c. should not be taken with aspirin
   d. all of the above

5. Theo-dur:
   a. contracts smooth muscle of the respiratory system
   b. relaxes the smooth muscles of the respiratory system
   c. is contraindicated with COPD
   d. interacts with anti-coagulants

6. The following nursing considerations are appropriate for which medications: Daily weights; check skin tugor; monitor electrolytes; daily BP; possible fatigue; leg cramps:
   a. Dioxin
   b. Cardizem
   c. Lasix
   d. Lopressor

7. Your patient's feeding tube is plugged. What could have caused this?
   a. inadequate pill-crushing
   b. positioning, kinking
   c. inadequate water flushes
   d. all of the above

8. Your feeding tube is still plugged. Now what can you do?
   a. flush with carbonated soda (I.E. Coke)
   b. force in more water
   c. D/C the feeding tube
   d. Wait 2 hrs, and try to flush again

9. Passive abuse to the patient may include: withholding medication, food, treatment, and personal care. This is:
   a. abuse
   b. neglect
   c. assault
   d. abandonment

10. Your 91 year old patient refuses her medications. What do you do FIRST?
    a. call the family
    b. come back an hour later
    c. respect her rights, ask her why
    d. crush and give in applesauce

11. Hearing loss in the elderly:
    a. affects 27 million older adults
    b. increase with aging
    c. is gradual
    d. all of the above

12. Vision loss in the elderly:
    a. involves increasing curvature of the cornea
    b. includes glaucoma, the leading cause of blindness in the elderly
    c. includes diabetic retinopathy, the leading cause of blindness in the elderly
    d. usually caused by medication toxicity

13. Which statement is TRUE about Alzheimer's Disease?
    a. the disease is reversible with treatment
    b. early stages include the inability to perform ADL's
    c. routine and consistency have been proven to have no effect
    d. the goal is comfort, safety, satisfaction to the maximum level of function

14. Risk factors for CHF include:
    a. CAD, HTN, DM, peripheral disease
    b. CAD, HTN, cardiomyopathy, valve disease
    c. CAD, HTN, age, renal insufficiency
    d. CAD, HTN, sex, alcoholism

15. The cause of HTN can be:
    a. Obesity, atherosclerosis, CVA
    b. Obesity, diabetes, peripheral disease
    c. Obesity, high salt and fat intake
    d. Obesity, heredity, atherosclerosis

16. The following is a definition of PVD (peripheral vascular disease): condition affecting the lower extremities, in which there is an abnormal narrowing or dilation of the:
    a. Veins and/or arteries
    b. Aorta and vena cava
    c. veins
    d. arteries

17. Prior to beginning CPR on the adult patient, the pulse rate is best located where?
    a. The radial artery
    b. The apex of the heart
    c. The carotid artery
    d. The brachial artery

18. The brain suffers anoxia (lack of oxygen) with possible irreversible damage after:
    a. 2 min.
    b. 3 min.
    c. 4 min.
    d. 5 min.

19. Vasotec:
    a. is an ACE inhibitor, lowers BP
    b. is a beta-blocker, lowers BP
    c. acts as a diuretic
    d. slows the heart rate

20. Care of the patient with pneumonia includes:
    a. HOB 45 degrees; turn q2h; CDB; encourage fluid intake; TPR q4h; oxygen
    b. HOB 15 degrees; turn PRN; CDB; water as requested; TPR daily; oxygen
    c. Complete bed rest; I&O; liquid diet; collect sputum; prohibit smoking
    d. BRP; I&O; soft diet; discard sputum; limit smoking

21. Potassium is excreted in:
    a. urine
    b. feces
    c. a only
    d. a and b

22. A variety of cardiopulmonary complications related to sodium and water retention, anemia and metabolic abnormalities are associated with end-stage renal failure. They include:
    a. HTN, DM, PVD, malnutrition
    b. HTN, CHF, pulmonary edema, pericarditis
    c. HTN, dehydration, mitral valve disease
    d. HTN, CHF, aortic valve disease

23. Care of the diabetic patient includes:
    a. prevent, monitor, manage episodes of hyper and hypoglycemia
    b. keep nails cut short
    c. hot foot soaks
    d. a only

24. Which of the following describes the clinical picture of diabetes?
    a. fatigue, diarrhea, peripheral numbness, thirst, headache
    b. restlessness, constipation, peripheral numbness, thirst, headache
    c. fatigue, decrease in urinary output, chest pain, dry mouth
    d. restlessness, diarrhea, cloudy urine, thirst

25. The blood supply of the brain is:
    a. external carotid and vertebral veins
    b. subclavian and carotid arteries
    c. internal carotid and vertebral arteries
    d. basilar and cerebellar veins

26. Which is NOT true about CVA:
    a. results from a decrease in cerebral blood flow, or embolism
    b. risk factors are HTN, DM, CAD, smoking and heredity
    c. symptoms may be tachycardia, seizures, N&V
    d. cerebrovascular events are not reversible

27. The following are symptoms of GERD (gastroesophagel reflux disease):
    a. heartburn, dysphasia, diarrhea
    b. heartburn, regurgitation, jaw pain
    c. heartburn, chest pain, SOB
    d. heartburn, chest pain relieved by lying down

28. Treatment for diverticulosis includes:
    a. high-fiber diet, limit spicy foods, increase water intake, stool softener
    b. regular diet, daily laxative, suppositories
    c. a only
    d. b only

29. Which symptoms do cancer patients rank as the most distressing?
    a. hair loss
    b. vomiting
    c. nausea
    d. fatigue

30. TB is treated with the medication:
    a. RIF
    b. PZA
    c. EMB
    d. INH

31. Infection outbreaks that could be fatal usually can be traced to :
    a. hand washing technique
    b. artificial fingernails and nail length
    c. cross-contamination
    d. all of the above

32. STRICT isolation (gown, gloves, and masks) must be practiced with:
    a. MRSA
    b. TB
    c. A only
    d. B only

33. You find the wrong IV hanging when you are making your initial shift rounds. The order is for D5NS and D5 1/2NS is running. You:
    a. D/C the IV
    b. Treat this as medication error, call the supervisor, prepare an incident report, all the physician
    c. Change the IV, there's not much difference between D5NS and D5 1/2NS
    d. Call the previous nurse at home

34. Upon making rounds, you discover a patient has purulent drainage from both eyes. You found some eye drops in your med cart drawer, and instilled them into the eyes. Describe this:
    a. providing comfort, care and healing
    b. using initiative and being conscientious
    c. being 'on top of things' on your hall
    d. acting beyond the scope of practice

35. The following constitutes a breach of patient confidentiality
    a. discussing a wound with another nurse in the hall during visiting hours
    b. discussing your patient's HIV status with your neighbor
    c. gossiping about your patient's marital problems in the cafeteria
    d. all of the above

36. A patient has been referred to a surgeon by his medical physician. The patient and family have expressed the desire for another referral name. His medical physician stated that he could only refer to this particular surgeon. Describe this event:
    a. This is probably in the best interest of the patient if his physician knows the surgeon personally.
    b. This is a violation of the patient's Bill of Rights
    c. This will ease the accessibility of medical records and also expedite the transfer of test results
    d. It has been directed by the insurance company, HMO, or Medicare

37. The patient has Advanced Directives, with specific instructions for "No Life Support, or Extraordinary measures to be utilized in case of death." This patient then 'codes'. You:
    a. call a Code Blue
    b. call 911
    c. call the supervisor for what to do
    d. know in advance your patient's Code status, and what the facility's policy is for acting accordingly to follow the Advance Directives of the patient

38. The patient's family can overrule the patient's request to be an Organ Donor. What can be done to assure the patient's own wishes are honored?
    a. Enlist the help of clergy or social services in advance to prepare the family when this decision has to be made.
    b. Do whatever you can to abide by his/her wishes, but also consider the family's feelings.
    c. Don't try to handle this delicate and perhaps legal situation yourself.
    d. All of the above.

39. Your patient has suffered a fall. You have notified the Supervisor, the family, and the physician. You also performed a physical assessment on the patient, and followed any medical instructions for treatment of injuries that may have occurred. You then complete the Incident Report. What do you do next?
    a. Document in the chart that the Incident Report was complete.
    b. Make a copy for the family and their attorney.
    c. Make a copy for the physician.
    d. Deliver the form to the facility's designated location.

Name____ Date__________________

TEST: "PREVENTING MED. ERRORS"

Circle the correct answer

Name:______________________________________ RN / LPN Date:_______________

You may miss NO MORE than 2 (two) questions on this test, so read each question carefully.

1. T F Digoxin normal dosage is: 0.5mg.
2. T F Albuterol puffs when given by inhaler should be 1 min. apart
3. T F Bumex could act as an antihypertensive
4. T F Lopressor could cause hypotension.
5. T F Phenobarbital doses are based upon serum blood levels
6. T F Dilantin can cause blurred vision.
7. T F Cardizem is the same as Cardene.
8. T F Plavix is administered as an HS medication
9. T F Coumadin can cause hematuria.
10. T F Xanax is a Schedule II drug.
11. T F Aricept is for diarrhea.
12. T F Celexa is for depression.
13. T F Tranxene should not be crushed.
14. T F Ambien is safe to be given as a long-term sedative.
15. T F Diabetic Shock is treated with Insulin
    Diabetic Coma is treated with orange juice and glucose
16. T F ECASA cannot be crushed.
17. T F Lactulose may cause hypokalemia
18. T F Prednisone is administered as part of the treatment for HIV/AIDS.
19. T F Ampicillin can be toxic to the kidneys.
20. T F Robaxin may turn the urine green
21. T F Heparin subcutaneous sites should be rotated.
22. T F Morphine is also called "Hydromorphone".
23. T F Zantac is the same as Ranitidine.

24. T F Haldol is not a recommended safe antipsychotic to be administered to the elderly.

25. T F Mylanta may be substituted for Maalox.

25. T F Vioxx cannot be crushed.

26. T F Prilosec capsules may be opened to be given in applesauce.

27. T F Klor-Con is often administered to patients receiving Digoxin and Lasix.

28. T F Vicodin should not be administered if an allergy to Codeine is documented.

29. T F You are in a patient's room administering medications. Your Med. Cart is in full view at the doorway of the patient's room. North Carolina DFS regulations state: 'medication carts need not be kept locked if in full view at all times of the responsible Nurse."

30. T F You have just returned home from work. You are changing clothes and discover the Med. Cart keys in your pocket. You call the facility, prepare to immediately drive back to return the keys, and also call your supervisor to report the occurrence.

31. T F You have made a med. Error. The FIRST thing you do is fill out an Incident Report.

32. T F Your patient has accused you of a med. Error. The FIRST thing you do is try and convince the patient you haven't made an error.

33. T F Multiple, repeated medication errors could cause you to lose your license.

34. T F The 5 R's to Medication Administration are: RIGHT patient, RIGHT medication, RIGHT dose, RIGHT time, RIGHT route.

35. T F Your patient has suffered irreversible damage from a medication error that was your fault (permanent sciatic nerve injury causing leg paralysis). You not only used poor technique, but also administered the medication via the wrong route. This is negligent nursing practice, and you probably will be sued. Your employer will support you under their Malpractice Insurance Policy.