M_CNAPQ (400+ Questions) - Quiz Questions with Answers

1.

Which of the following is NOT considered personal protective equipment?

Gloves

Gowns or other outer clothing

Hand washing equipment

Masks, face shields, goggles, and glasses

Explanation:

Hand washing equipment is not personal protective equipment, but hand washing is a precaution for infection control and should be performed before donning and after removing gloves (A) and at many other times. Personal protective equipment (PPE), which should be worn whenever you may be in contact with blood and other bodily fluids, includes gloves (A); gowns or other removable outer clothing (B); and face protection (D) against splashes or airborne pathogens, including a mask and a face shield, goggles, or protective glasses.

2.

Hospital disaster/emergency response plans should all of the following EXCEPT:

Budget plan for disaster response

Chain of command

Hospital’s capacity to receive individuals

Supplies on hand and methods to obtain added supplies

Explanation:

Disaster/emergency response plans *should be in place for the facility based on the Hospital Emergency Incident Command System (HEICS), which provides a model for management, responsibilities, and communication. Disasters can include a multi-casualty influx of individuals from a community emergency, such as a train accident; an epidemic; fire or other internal hospital problem requiring evacuation; or inadequate staffing to safely treat ED individuals. Plans should include/address:*

- *Readily available information and disaster preparedness drills.*
- *Activation of the plan, including the individual(s) responsible.*
- *Chain of command.*
- *Facility damage assessment, usually conducted by plant safety officer.*
- *Hospital/ED capacity to receive individuals.*
- *Triage, including in community and in the ED.*
- *Transfer protocols for distributing individuals to other facilities.*
- *Staffing, including telephone tree to notify staff to report to facility.*
- *Intra- and Inter-facility communication and communication with pre-hospital EMS personnel.*
- *Supplies on hand and methods to obtain added supplies.*
- *Delineation of receiving and treatment areas.*

3.

What should you do if you find that a patient has fallen on the floor but does not appear to be hurt?

Help the patient up and assist him/her back to bed and resume your work

Write a note to your supervisor

Fill out an incident report that correctly records what happened and file it with the facility's risk manager

Tell an administrator about the conditions that led to the fall

Explanation:

Whenever a fall occurs, the aide or other professional should fill out an incident report and convey it to the facility's risk manager, regardless of whether or not the person appears to be hurt. Merely writing a note to your supervisor (B) or telling an administrator (D) is not enough.

You and another professional may end up helping the patient up and assisting him/her back to bed (A), but the report must be filed.

4.

Which of the following should NOT be done when caring for a patient with an indwelling catheter?

The patient should be positioned on his/her side

The urethra should be cleansed using a downward circular motion

The bag should be hung below the level of the bladder, but not touching the floor

The tubing should be fixed firmly to the person's inner thigh

Explanation:

The patient should be in a supine position with the head of the bed lowered, not on his/her side. All of the other choices given should be part of the procedure. The aide should also wash his/her hands and use gloves, place a waterproof pad under the hips, and dry the perineal area when finished.

5.

What is the best way to provide for your patient's spiritual needs?

Refer him/her to some type of religious counselor

Alert him/her to religious services in the facility

Establish rapport with the patient and find out about his/her spiritual needs and views on spirituality

Pray with the patient

Explanation:

The nursing assistant should establish rapport with the patient and listen to his/her views about spirituality and spiritual needs. Spirituality is any means of finding inner meaning from life in order to feel completeness or self-actualization. It can be associated with established religion but can also come from other sources such as nature. If you find that the patient does have a particular religious affiliation that nurtures him/her, any of the other choices might be utilized.

6.

What should be suspected if a patient being treated for pain experiences a sudden drop in blood pressure, a change in respiration, and the appearance of a rash?

Anxiety or stress

Fluid loss

An adverse drug effect from the analgesic

Hypertension

Explanation:

The most likely cause is an adverse drug effect (ADE) due to administration of an analgesic drug for the pain, which should be immediately reported to the supervising nurse to address the emergency. A rash generally would not be associated with any of the other conditions. Dehydration from fluid loss (B) can adversely affect various bodily systems but since fluid intake and output should be monitored it is less likely. Conversely, hypertension (D), or high blood pressure, is often due to fluid overload. Anxiety (A) alone would not cause this combination of symptoms.

7.

Under what circumstances should a nursing aide have access to a patient's files?

A nursing aide can access files on any patient that he/she has cared for

A nursing aide can access files on patients currently under his/her care

A nursing aide can access files in order to show information to family members

A nursing aide can access files in order to correct computer information

Explanation:

The patient has a right to confidentiality, which means that nursing aides or other professionals should only have access to files on patients currently under their care, not those they have previously cared for (A). Under the right to privacy, family members generally cannot access information unless they provide the patient's privacy code number; if they do not have this, the nursing assistant can only confirm the patient's presence (C). Legally, the nursing assistant should not be making computer changes (D).

8.

Which of the following is a good method of communicating with a patient?

Keep the conversation light and questions short

Maintain eye contact, speak slowly using laymen's terms, and try to ask open-ended questions

Be authoritative, letting the patient know your expertise

Always be positive and assuring

Explanation:

This response lists some of the features of good communication, namely maintaining eye contact, using terms the individual can understand, and asking questions that are open-ended to encourage the person to give more information. A is incorrect because it negates the seriousness of the situation and encourages yes or no responses which lead nowhere. C is wrong because your role is to be supportive, not authoritative, and D is also wrong because you should not give the person false hope.

9.

What should you do if a patient who is ambulating with your help and a gait belt begins to fall?

Try to prevent the fall by any means

Change your position to block the fall

Keep your feet wide apart, bend your knees, lower the patient to the floor, and then let him/her rest on your leg

Let the patient fall and then, using good body mechanics, pick him/her back up

Explanation:

A patient using a gait belt to ambulate with your help generally needs minimum assistance, and this sequence is suggested if he/she begins to fall. You should not move the patient. Call for help, notify your supervisor, and file an incident report. The fall should not be prevented (A), blocked (B), or allowed to occur haphazardly (D).

10.

Which of the following is incorrect regarding placing a vest (jacket) restraint on a patient?

doctor's order and family consent must be obtained beforehand

The straps should be tied to a chair or the bed frame with a quick-release knot

The distance between the chest and the vest should be about the width of two fingers

The opening and straps should be across the front

Explanation:

The vest restraint opening and the straps crossing should both be behind the back, not in the front. Doctor and family permission must be obtained prior to using this type of restraint (A), the straps should be secured to a chair or the bed frame (B), and to permit breathing a distance of about the width of two fingers should be allowed (C).

11.

What should you do if a patient makes a blatant sexual comment to you?

Counter with sexual remarks of your own

Firmly but politely inform him/her that these types of comments are unacceptable and will not be tolerated

Immediately inform your supervisor

Ignore the behavior and continue as usual

Explanation:

You need to first let him/her know firmly and politely that these comments are unacceptable and cannot continue. If the behavior persists, then your supervisor should be notified (C). Joking or sexual responses are inappropriate (A), and the behavior should not be ignored and allowed to continue (D).

12.

When a nurse prioritizes doing good for her patient through compassion, advocacy and empathy, she is displaying the ethical principle of:

Nonmaleficence

Beneficence

Veracity

Confidentiality

Explanation:

These are all ethical principles, which are standards of correct moral conduct. Beneficence (B) is the correct term for doing good for others. Nonmaleficence (A) refers to the ethical principle of providing care that does not cause harm. Veracity (C) means speaking truthfully at all times. Confidentiality (D) is the code of maintaining the privacy of the patient's information.

13.

How does the right to informed consent impact nursing home residents?

Since they may be incapacitated, it must be obtained from any family member

Informed consent must be obtained from the residents or their health care power of attorney prior to every test, treatment, or procedure

It prevents them from changing or stopping treatments once a decision has been made

Its applicability is broader than in other circumstances

Explanation:

Just as with other types of patients, the right of informed consent applies and means that prior to performance of any test, treatment, or procedure, the patient or his/her representative must be informed of the risks and benefits so that he/she may consent or decline. That negates responses A and D. However, under the right of freedom of choice, the patient can later change or stop treatments (C).

14.

You badger a patient into allowing you to give him/her a bath with the door open. Of what legally liable acts could you possibly be accused?

Assault and battery

Abuse

Invasion of privacy

Assault, battery, invasion of privacy, and abuse

Explanation:

You could possibly be accused of all of these acts: assault (the threat of touching without permission); battery (actual personal violence without permission); invasion of privacy

(exposing the client's body during care or failure to maintain confidentiality); and abuse (threatened or actual physical or mental harm to the patient).

15.

What is the most likely isolation scenario for a patient who has MRSA?

Placement of the patient in a clearly marked private room, and wearing by the nurse aide (and others) of an isolation gown and gloves at all times while in the room

Same precautions as choice A (above) plus wearing a mask

Placement of the patient in a negative pressure room and use by the nurse aide of a mask or respirator and gloves while in the room

Isolation of the patient in a separate ward with other MRSA patients

Explanation:

MRSA, methicillin-resistant Staphylococcus aureus, is primarily a bloodborne pathogen spread via direct contact, and therefore contact precautions as indicated in A should be used. Scenario B describes droplet precautions for microorganisms spread via mucous or respiratory secretions, while C expresses airborne precautions for organisms that can survive a long time in the environment. The patient probably would not be put in a separate ward (D) where he/she would be in contact with others.

16.

Which of the following are signs that your patient is dehydrated?

He/she has peripheral edema, bulging veins, and lung crackles

He/she has cloudy urine, fever and flank pain

He/she has a weak, fast pulse, low blood pressure, dark urine, and sunken eyes

He/she is constipated

Explanation:

These are all signs of dehydration, which indicate that fluids should be encouraged. Constipation (D) may be a sign of dehydration but could also be due to use of medications that reduce GI motility. Scenario A suggests fluid overload, and B suggests the presence of a urinary tract infection.

17.

A nurse aide finds her patient nonresponsive with no evidence of breathing or a pulse. Her first response should be to:

Lower the patient's head of bed and prepare for CPR

Apply oxygen to the patient via facemask

Maneuver behind the patient and initiate the Heimlich remover

Call for help using the appropriate signal, such as "Code blue!"

Explanation:

*If the patient experiences a **cardiac arrest** (no evidence of breathing or pulse, nonresponsive) the nurse aide should immediately call for the nurse (emergency light) and call for help using the appropriate signal ("Code blue!"), lower the patient's head (if in bed) and prepare the patient for CPR. A backboard can be placed if available and patient's clothing loosened. If the patient is in a chair, the patient should be eased onto the floor and placed in supine position. Depending on CPR training and protocol, the nurse aide may initiate chest compressions if the patient is positioned appropriately and no nurse is readily available. Compression only CPR is at the rate of 100 compressions per minute. If two rescuers, the rate is 30 compression to 2 respirations. CPR should be performed for one minute prior to defibrillation with AED.*

18.

For what type of patients is the use of the logrolling technique appropriate?

Patients from whom you need to obtain a urine specimen

Patients with a broken leg

Patients in respiratory distress

Patients who have sustained a neck or spinal cord injury

Explanation:

The logrolling technique, in which at least two caregivers turn the patient together toward them to a side-lying or Sims' position using a pull sheet, should be used with patients who have sustained a neck or spinal injury because it keeps those areas in a stable position, preventing further injury. These patients are not capable of assisting in the move (B), and there is no need to use the technique to obtain a urine specimen (A) or when a patient is in respiratory distress (C).

19.

An electrical fire starts in your patient's room. What should you do?

Immediately try to extinguish it with a type A fire extinguisher

Remove the patient, activate the fire alarm, close doors, and use a type A fire extinguisher on the fire

Immediately try to extinguish it with a type C or ABC fire extinguisher

Remove the patient, activate the fire alarm, close doors, and use a type C or ABC fire extinguisher on the fire

Explanation:

When any fire occurs, the RACE system illustrated in answers B and D should be utilized. In this case, a silver type A fire extinguisher (A or B) should not be used because it shoots water and is only appropriate for ordinary combustibles such as paper. Type C is red, discharges dry chemicals, and is appropriate for an electrical fire. Multipurpose type ABC is also red and can be used for fires involving combustibles, liquid chemicals, or electrical sources.

20.

Your patient has an area of skin that is somewhat worn away and red. What condition does he/she have?

A stage I pressure sore

A stage II pressure sore

A stage III pressure sore

A stage IV pressure sore

Explanation:

The patient has a stage II pressure sore. Both stage I and II pressure sores show areas of redness, but with stage II there is also wearing away of the outer layer of skin. Stage III sores are black and indicate wearing of the full thickness of skin, and with stage IV there is an exposed area of visible bone.

21.

When a patient complains of chest pain, the appropriate first response by the nurse aide is:

to ask the patient to describe the pain quality, when it started, and where it is located

to leave to notify the nurse to further assess the patient

to call for the nurse and remain with the patient, loosening their clothing and taking their vitals

to raise the head of the patient's bed and ask if the pain subsides

Explanation:

*When a patient complains of **chest pain,** the immediate response should be to call a nurse to evaluate and assist the patient. (If pain is severe or patient in distress use emergency light). The nurse aide should remain with the patient, loosen clothing (especially about the neck), and take the patient's pulse and respirations. If equipment is available in the room, the nurse should take the patient's blood pressure and oxygen saturation level as well. The nurse aide can also gather*

information if the patient is able to talk about when the pain started, what the pain feels like (dull, aching, sharp, crushing, burning), and exactly where the pain is located. This information is especially valuable in the event the patient experiences a cardiac arrest before the nurse arrives.

22.

Your patient has aphasia. Which of the following is NOT a possible cause?

A cerebrovascular accident

A brain tumor

Diabetes

Parkinson's disease

Explanation:

Diabetes is unrelated to the presence of aphasia, which is difficulty speaking due to brain lesions caused by factors such as a cerebrovascular accident (stroke, A), a brain tumor (B), progressive diseases such as Parkinson's or Alzheimer's (D), or brain injury.

23.

When bathing a patient, the nursing aide should NOT:

Wash the dirtiest area first

Use standard precautions

Use an assistive device

Apply nonprescription ointments afterwards

Explanation:

When the aide is bathing the patient, he/she should wash starting with the cleanest area and progressing to the dirtiest. Bathing as well as grooming activities should employ standard precautions (B). Assistive devices (C) are not always used, but should be utilized for patients at high risk for falls. While prescription ointments must be applied by a licensed nurse, nonprescription emollients (D) can be applied sparingly afterwards by the aide.

24.

You take your patient's temperature and find it to be 97.3°F. Which of the following could definitely NOT have caused this?

The patient is starting to get an infection

The patient has been resting

The patient drank something within 15 minutes of an oral temperature reading

The patient has recently come out of the operating room

Explanation:

At rest, a person who is otherwise healthy should have a normal core temperature of between 97.8°F and 99.1°F. While elevated temperature generally indicates infection, initially a person could have a low core temperature (A). If the method of taking temperature is oral, the reading should not be taken within 15 minutes of drinking as that can lower the value (C). Operating rooms can be cold and thus lower core temperature temporarily (D).

25.

What should you NEVER do if a patient insists on using the call light or bell whether or not he/she really needs to?

Ignore the call light or bell if you are aware of this behavior

Tape gauze over the call button

Stop in as often as possible to talk to that patient

Make sure the items the patient will need are readily available

Explanation:

You should never ignore a call light or bell, regardless of assumed patient behavior. Item B is actually a means by which the patient can find the correct button if he/she needs to call the aide or nurse. C and D are ways of hopefully cutting down on use of the call light or bell.

26.

Directives for what types of measures are generally covered on a DNR order?

Organ/tissue donation after death

Use of long-term mechanical ventilation, continuous dialysis, and/or a feeding tube

Use of new intubation, CPR, and/or defibrillation if near death or unconscious

Designation of another person to make medical decisions if the patient is unable to do so

Explanation:

Directions for use of the heroic measures listed in C are part of a Do Not Resuscitate (DNR) order. Items A and B are addressed in an advanced directive regarding end-of-life care, and item D refers to designation of a medical durable power of attorney.

27.

How should a thermometer used for taking a resident's temperature be treated in terms of potential for infection?

It should be sterilized between uses

It should be treated with a high-level disinfectant between uses

It should be cleaned with soap and rinsed between uses

It should be wiped off between uses

Explanation:

Even if it is covered with a plastic probe cover, a thermometer would be considered an intermediate-risk item that comes in contact with mucous membranes but does not penetrate the skin, and as such should be cleaned with a high-level disinfectant. Even if it does pierce the skin, a thermometer really cannot undergo sterilization procedures (A) appropriate for high-risk items like surgical instruments. C is appropriate for low-risk items, and D is insufficient for anything touching skin.

28.

Which of the following is NOT a possible treatment for a contracture?

Use of a splint

Range-of-motion exercises

Use of a dressing

Use of heat therapy

Explanation:

A contracture is an area of muscle tightening, which is a problem when it affects joint motion. Therefore, a splint for stretching the joint (A), range-of-motion exercises (B), and heat (D) are all helpful, but there is no need for a dressing.

29.

How does oral care for an unconscious patient differ from that for a conscious one?

The unconscious patient should be placed in the Fowler's position

A towel should be draped over the patient's chest

A tongue depressor should be used to keep the patient's mouth open and suctioning should be done afterwards

The aide should wear gloves during the procedure

Explanation:

The unique parts of oral care for an unconscious patient are keeping the mouth open with a tongue depressor and use of suctioning afterwards. All patients should receive oral care in the Fowler's position (head of bed elevation of 30 to 90 degrees, A) with a towel over the chest (B) and use of gloves by the aide (D).

30.

Which of the following is ALWAYS outside the scope of practice of a nursing assistant?

Insertion or removal of an indwelling catheter

Administration of medications to the patient

Helping the patient with self-administration of drugs

Following the supervising nurse's orders

Explanation:

Insertion or removal of a device such as an indwelling catheter (or performance of any sterile procedure) is outside the nursing assistant's scope of practice and could result in liability for the action. Choices B and C having to do with administration of drugs are usually outside the scope of practice but may be allowed in some states or instances if the assistant has received special training. Following a supervising nurse's orders (D) is a normal part of the nursing assistant's daily duties.

31.

Which of the following should NOT be done for a patient who has Sundowner's syndrome?

Promote daytime exercise

Allow sleeping during the day

Darken the room when it is time to sleep

Give a therapeutic massage at night

Explanation:

The patient with Sundowner's syndrome gets confused or agitated in late afternoon or early evening. The syndrome may or may not be associated with dementia. The patient should not be allowed to sleep during the day since he/she will have more difficulty sleeping at night. All of the other actions are generally helpful.

32.

If you have given a patient 4 ounces of juice, how should you report that on his/her chart?

As 4 ounces of juice

As a half cup of juice

As 60 mL or cc of juice

As 120 mL or cc of juice

Explanation:

Fluid measurements should be reported as mL (milliliters) or cc (cubic centimeters). Since the conversion factor is 30 mL per ounce, the correct answer is 120 mL or cc.

33.

What is H.S. care?

Care provided at bedtime

Washing of the patient's hair

Care provided in the morning

Bathing of the patient

Explanation:

The term H.S. care stands for hour of sleep care provided at night. It includes a condensed version of skin care with washing of the face and hands, oral care, and possibly a back rub. Care provided in the morning (C) is termed a.m. care and is more extensive, including a full bath, shaving, dressing, and hair, oral, and nail care. The other choices are part of providing for activities of daily living but are incorrect.

34.

At what point is cognitive dysfunction considered dementia?

Anytime an individual experiences problems with memory, language, or problem solving

When memory, language, and problem-solving difficulties exceed six months

When a person has depression along with some memory loss

When bodily functions as well as cognition are impaired

Explanation:

When an individual experiences cognitive dysfunction such as loss of memory, language, and problem-solving ability for over six months, that is considered dementia. These losses for less than six months (A) are classified as delirium. Depression along with memory loss (C) does occur often with dementia but the combination alone is not definitive. Impairment of bodily functions in addition to cognitive dysfunction (D) is often an end stage for the most common form of dementia, Alzheimer's disease.

35.

What is the correct way to transfer a patient from the bed to a wheelchair?

While you hold under the axilla, have the patient pivot into the chair from dangling on the side of the bed

While you hold under the axilla, help the patient push down on the mattress from the side of the bed and stand up; then pivot and lower the patient into the wheelchair

With another helper, lift the patient into the wheelchair

Use the logrolling technique

Explanation:

The patient should be assisted to stand up first, not to directly pivot to sit in the wheelchair (A). Wheels on the bed and wheelchair should be locked. The other responses are incorrect.

36.

What is the first stage of grief a person experiences after being informed that he/she is dying?

Anger

Denial

Depression

Acceptance

Explanation:

There are five stages in the grieving process, the first being denial. Subsequent stages in order are anger (A), bargaining, depression (C), and acceptance (D).

37.

Which of the following changes is probably NOT a sign of impending death?

Heart rate slows and becomes irregular

Breathing sounds rattling or raspy

Eyes flicker

Blood pressure and core temperature decrease

Explanation:

Flickering or other unique eye movements are not associated with impending death, but all the other signs listed are, as well as depression of respiratory rhythm and rate, cyanotic lips, cold skin, and other indications.

38.

How does taking an apical pulse differ from taking a peripheral pulse?

An apical pulse is taken using the index and middle fingers over the hollow of the wrist

An apical pulse reading utilizes auscultation with a stethoscope over the left chest

Pressure is applied when taking an apical pulse

An apical pulse is counted for a longer period of time

Explanation:

Auscultation is the method for taking an apical pulse, whereas A is the method for taking a peripheral pulse. D is wrong because both methods count for 30 seconds (multiplied by 2) for a regular heart rate or 60 seconds for an irregular rate. Gentle pressure (C) is used for taking a peripheral, not an apical, pulse.

39.

If you as a nursing assistant fail to perform or incorrectly perform procedures that you were taught, for what could you potentially be sued?

Defamation

Malpractice

Neglect

Negligence

Explanation:

This is the definition of negligence. If you were a doctor or other professional who must have a license in order to practice, you could also be sued for malpractice (B); nursing assistants cannot be sued for malpractice since they only need to maintain certification. Neglect (C) refers to harm subsequent to the accidental or deliberate ignoring of patient needs. Defamation (A) is the making of damaging statements about another individual.

40.

Which of the following types of patients can include pork in their diet?

Muslim

Jewish

Catholic

Hindu

Explanation:

Only Catholics and other Christians typically include pork in their diet. Muslims (A) and Jews (B) typically do not, and Hindus (D) are generally vegetarians or vegans. These cultural differences should be respected when ordering meals.

41.

Which of the following is NOT a principle of good body mechanics to prevent injuries during lifting?

Maintain good posture while lifting

Stand with a wide base of support

Bend to pick up the person or object with legs straight

Maintain body alignment and keep items close to you

Explanation:

This is a violation of the first principle of good body mechanics, which is to retain a proper center of gravity by bending and lifting using the legs, not by bending over. The other answers comprise the other three principles of good body mechanics.

42.

What type of information can a nursing assistant communicate to family members?

Lab results

The patient's prognosis

Information about procedures within his/her own scope of practice

Information about the overall care of the patient

Explanation:

The nursing assistant should only discuss procedures that are within his/her own scope of practice, not any of the other choices. If family members have questions about the patient's overall care (D), they should be referred to the supervising nurse.

43.

Which of the following scenarios do NOT require you to do proper hand washing?

You have just entered the patient's room but have not touched anyone or any surface

You are getting ready to feed the patient

You have just used the restroom

You have come into contact with the patient's bodily fluids but were wearing gloves

Explanation:

Of the choices, this is the only one where you do not need to have done proper hand washing, but once you plan to start a procedure such as feeding (B) you need to wash your hands. Anytime you could have been exposed to microorganisms, such as when using the restroom (C), eating, sneezing, or touching blood or body fluids—even if wearing gloves (D)—you should wash your hands.

44.

Which of the following are typical requirements to become a certified nursing assistant?

On-the-job training

On-the-job training, recommendation by a supervisor, and passing an administered exam

At least 75 hours of classroom and basic skills training, and passing a state certification exam including a written examination and a demonstration of skills

At least 120 hours of classroom and basic skills training, and passing a state certification exam including a written examination and a demonstration of skills

Explanation:

At least 75 hours of classroom and basic skills training along with passing a written examination and skills demonstration are required in most states to be a CNA. Unspecified on-the-job training is not enough.

45.

You observe a low respiration rate of less than 12 breaths per minute in a patient. What could be the cause?

The patient is in pain or under stress

The patient is in respiratory distress

The patient is taking narcotics

The patient has an infection

Explanation:

Use of narcotics can depress the respiratory drive and rate. A low rate (less than 12 breaths per minute) also can occur when at rest or lying on one's back. The other choices (as well as a heart attack and fluid overload) all generally result in an elevated respiratory rate.

46.

When might an NPO diet be ordered for a patient?

If the patient is diabetic

When the patient is about to undergo some type of testing or surgical procedure, or if the patient is in a situation where he/she cannot swallow

If the patient has hypertension

If the patient has difficulty chewing

Explanation:

An NPO diet means that the patient should not be given any food or drink by mouth. It is one type of therapeutic or prescribed diet based on health issues, as are the other listed alternatives: a calorie-count diet for diabetics (A), a low-sodium diet for those with hypertension or renal problems (C), and a mechanical soft diet for people who cannot chew, such as those without teeth.

47.

What is the correct sequence for removal of soiled linen from an isolation room?

Put soiled linen in a plastic linen bag, tie the bag shut upon completion of bathing the patient, slip that bag into another one being held by another aide outside the door, other aide ties and leaves the double bag outside the door, remove personal protective equipment (PPE) and wash hands, take double bag to soiled utility area

Put soiled linen in a plastic linen bag, tie the bag shut upon completion of bathing the patient, put bag outside door, remove PPE and wash hands, take bag to soiled utility area

Put soiled linen in a plastic linen bag, tie bag shut and insert into another bag, leave double bag in room until several have been collected, take bags to soiled utility area

Put linen in soiled utility bin in the room until full, double bag while using PPE, remove PPE and wash hands, take bag to soiled utility area

Explanation:

This is the correct sequence. All the other responses leave out essential components of infection control.

48.

All EXCEPT which of the following might be utilized if a patient experiences redness, swelling, and pain in his/her leg?

A sequential compression device

Use of anticoagulants or surgery

Massaging of the affected leg

Anti-embolism stockings

Explanation:

These symptoms are indications of possible deep vein thrombosis (DVT). The goal in this case is to prevent blood clots and to promote blood flow by applying pressure to the legs with a sequential compression device (A) or anti-embolism stockings (D). Anticoagulant therapy is a common treatment and surgery is performed if necessary (B). Massaging the leg (C), however, might dislodge a clot and lead to a heart attack or other serious complications.

49.

What should you do if an alert, mentally capable patient expresses a wish to leave the health-care facility?

Have the patient sign an Against Medical Advice form, and let him/her leave

Notify the charge nurse who will talk to the patient and notify the doctor if the patient leaves

Try to talk the patient out of doing so

Notify the family to deal with the matter

Explanation:

If the patient is alert and capable of making decisions, you should not try to intervene (C) but refer him/her to the charge nurse. If the nurse cannot dissuade the patient, he/she is free to leave but the doctor should be notified. The patient may be asked to sign an Against Medical Advice form (A), but that is not your responsibility. Family members might be contacted, but ultimately the patient's decision to leave is his/her responsibility alone.

50.

What may dark, tarry stools indicate?

Diarrhea

Constipation

Intestinal bleeding

Dehydration

Explanation:

Dark, tarry stools are generally an indication of intestinal bleeding, not diarrhea (A), constipation (B), or dehydration (D).

51.

The capacity to understand what a patient is feeling and respond appropriately is known as what?

Active listening

Empathy

Caring

Respect

Explanation:

This is the definition of empathy. All of the responses, however, are good tools for communicating with a patient. Active listening (A) is listening attentively while conversing, caring (C) is having genuine regard for the patient's safety and welfare, and respect (D) is showing consideration and regard for the patient's values.

52.

When you are making an occupied bed, what should be observed in terms of the orientation of the patient and the use of the side rails?

The patient should be lying supine with the side rail down on the side of the bed you are making but up on the other side

The patient should be lying on his/her side facing you with the side rail down on the side you are making but up on the other side

The patient should be lying on his/her side facing away from you with the side rail down on the side you are making but up on the other side

The patient should be lying supine and neither side rail should be lowered throughout

Explanation:

The patient should be lying on his/her side facing away from you with the side rail down on the side you are making but up on the other side. This prevents back strain for the nursing aid by preventing poor body mechanics, while preventing the patient from falling out of the bed on the side they are turned to. All other combinations threaten the patient and/or nursing aide's safety.

53.

Which of the following procedures is NOT generally done as part of postmortem care?

Closing of the patient's eyes and removal of lines and tubes

All hygienic, grooming, and other procedures normally provided to a living patient

Placing the patient in a supine position

Placing the body in a plastic bag

Explanation:

The body should be washed, the perineal area covered, and a clean gown applied, but some other aspects of hygiene and grooming are unnecessary. Rigor mortis, the stiffening of muscles that occurs after death, makes limbs difficult to move, so placing the patient in a supine

position (C) as soon as possible will make other postmortem tasks easier. All of the other responses are things that should be included in postmortem care.

54.

How should you proceed if the Heimlich maneuver is needed on a choking patient?

Stand behind the person, drape your arms around him/her, make a fist with your thumb toward the person just above the navel, grab that fist with the other hand, quickly and forcefully thrust in and up on the abdomen, repeating until the object dislodges

Same as choice A (above) but if person becomes unconscious, check for respirations and pulse and do rescue breathing and/or CPR if necessary

Same as choice A (above) but do the thrusts gently to avoid injuring the person

Call emergency services immediately

Explanation:

Answer A is technically correct as long as the individual does not lose consciousness, but you should be aware of the possible need for rescue breathing and/or CPR. Gentle thrusts (C) may not dislodge the item, and you should not wait for emergency services (D).

55.

What is the Patient's Bill of Rights?

A federal law listing rights of hospitalized patients

A federal act guaranteeing the privacy of patient health information

A document given to an admitted patient or resident listing his/her responsibilities while staying in the facility

A document given to an admitted patient or resident listing his/her rights while staying in the facility

Explanation:

A Patient's Bill of Rights is a listing of his/her rights while in the facility; it is specific to the facility but generally covers rights such as privacy, confidentiality, respectful care, etc. Patients generally get a list of responsibilities (C) when admitted but that is a different issue. There is a federal act governing privacy of health-care information (B) called HIPAA or Health Insurance Portability and Accountability Act.

56.

Your patient refuses to see certain visitors, is withdrawn, and shows signs of bruising. What should you do?

Mention this to the nurse

Try to get the patient to see the aforementioned visitors

Report suspected abuse according to facility policy

Talk to the patient about his/her fears

Explanation:

These are signs of possible physical, sexual, and/or mental abuse, and therefore the aide has a moral, ethical, and legal obligation to inform authorities of his/her suspicions. It is not enough to merely inform the nurse (A), the issue is too sensitive to talk about with the patient (D), and the patient should not be encouraged to meet with the visitors who may be abusing him/her (B).

57.

Which of the following is an example of an unintentional tort?

The nursing assistant checks out early without telling her supervisor and the patient falls out of bed and breaks a bone

The nursing assistant inadvertently forgets to put up the side rails on a patient's bed and the patient falls out and breaks a bone

The nursing assistant stabs a member of the patient's family

The nursing assistant beats a patient unconscious

Explanation:

A tort is damage committed for which restitution is generally awarded in a civil case, which excludes both C and D as they are considered criminal offenses. There are two types of torts: unintentional (B), in which the offender did not intend to cause harm; and intentional (A), in which the offender acts in a manner that he/she knows could result in harm.

58.

In what direction(s) should you wash and dry the perineal area of a female patient?

You should wash from the front to the back going from the urinary meatus to vulva to perineum, rinse using a clean cloth, and then dry in the same front to back direction

You should wash the same areas listed in choice A (above) from back to front, rinse using a clean cloth, and then dry from back to front

You should wash and then rinse and dry the urinary meatus, then wash and dry the vulva, and then wash and dry the perineum

You should wash and then rinse and dry the perineum, wash and then rinse and dry the vulva, and then wash and rinse and dry the urinary meatus

Explanation:

You should always wash the perineal area of a female patient from front to back, rinse, and dry from front to back. The perineum extends from the vaginal opening to the anus. The other responses are incorrect.

59.

The most dangerous consequence of a severe burn is:

shock

dehydration

infection

loss of sensation

Explanation:

Depending on the severity and the amount of body surface it covers; a burn can be a life-threatening injury. Shock induced by a burn and the resultant impairment of the immune system can cause serious harm to the patient. It is important to act quickly if the patient has been severely burned. A burn that extends over a small area of the body should be treated by running cool water over the affected area. A sterile dressing should be applied over the burn to protect the skin and to prevent the introduction of germs. Ice packs should also be applied to protect the skin and nerve endings.

60.

What are signs that your diabetic patient might have low blood sugar?

The skin is hot and flushed, respirations are deep, pulse is slow, breath is fruity, and/or speech is garbled

The patient is confused

The skin is cold and sweaty, respirations are shallow, and pulse is rapid and barely perceptible

The patient is very thirsty

Explanation:

These are symptoms that the patient currently has low blood sugar (hypoglycemia) as opposed to those listed in (A) indicating hyperglycemia. The patient could become confused (B) from either abnormality, and excessive thirst (D) is a general sign of diabetes.

61.

How should you refer to a patient who has severe vision and hearing problems?

Disabled

Blind and deaf

Vision-impaired and hearing-impaired

Sightless and hard-of-hearing

Explanation:

You should always strive to use terms that are the most respectful with regard to an impairment. All of the other choices could be considered demeaning.

62.

When recording intake and output, what should be recorded as output?

Urine and stool total output in milliliters (mL) or cubic centimeters (cc)

All fluids secreted by the patient in mL or cc

Urine output in mL or cc

Urine output in ounces

Explanation:

When measuring input and output (I & O), input should include liquid food or other types of liquid intake, and output should include all fluids secreted. The primary output that is measurable is urine, but loss in other forms such as fluid in stool or vomit should also be estimated. Quantities should be logged in mL or cc, not ounces.

63.

A patient is wearing several pieces of valuable jewelry upon admission. Which of the following is NOT a proper way to deal with this situation?

Ask the patient to give the jewelry to a family member to hold onto and take home

Catalogue the jewelry and put it in a marked box in the hospital safe

Give the patient a case to keep the jewelry in alongside his/her bed

Bring in a witness if you handle the jewelry

Explanation:

Valuable items such as dentures or hearing aids that patients will need on a daily basis can be kept in a box alongside the bed, but valuable jewelry should not be kept there. It should be sent home with a family member (A) or catalogued and stored in the facility safe (B), and you should only handle it in the presence of a witness (D).

64.

When measuring blood pressure, where should the individual's arm be placed?

Below the level of the heart

At the level of the heart if seated and at his/her side if lying down

Above the level of the heart

Initially at the level of the heart and then lowered upon starting the cuff deflating sequence

Explanation:

The arm should be at the level of the heart throughout the measurement. Blood pressure is recorded as the systolic pressure (during contraction of the heart) over the diastolic pressure (when heart chambers are filling and at rest).

65.

What is continuity of care?

Transfer of patient care from one facility to another

Transfer of patient care to a provider on another shift

A recognized standard of patient care

A patient's right to and the caregiver's performance of continual and consistent high-quality health care

Explanation:

Continuity of care is a patient's right, and its components are both continuous and consistent high-quality care. The other choices do not ensure one of these components.

66.

Name the institution responsible for overseeing the certification of, qualification of and complaints against nurse aides:

National Council State Board of Nursing

American Association of Nurse Aides

Nurse Aide Registry

National League for Nursing

Explanation:

*A **Nurse Aide Registry** is maintained by all 50 states and the District of Columbia, and each has individuals or departments assigned to investigate complaints about nurse aides. Long-term care facilities are required to verify that an individual applying for a position as a nurse aide is certified and has met competency requirements prior to employment. The registry provides information about the individual regarding education, work experience, and any substantiated findings of abuse, neglect, or misappropriation of property (these findings preclude an individual*

from employment). Copies of disciplinary actions may be available. While state laws may vary somewhat, generally nurse aides must report employment in order to maintain current status. Nurse aides who have been unemployed for extended periods (typically 24 months) may need to take a competency test before certification renewal and listing on the Registry.

67.

Which of the following is NOT a reason to do range-of-motion exercises with a patient?

To protect his/her muscles from atrophy, maintain joint motion, and increase circulation

To lessen the likelihood of pressure ulcers

To maintain mobility

To normalize his/her vital signs

Explanation:

ROM exercises might, but do not directly, improve vital signs. Range-of-motion (ROM) or passive range-of-motion exercises (PROM) are actively or passively assisted exercises for maintaining joint mobility (C). They encourage all positive aspects associated with mobility, including prevention of muscle atrophy, increased joint motion, and better circulation (A); they decrease the likelihood of development of pressure ulcers (B); and they help reduce the propensity to develop respiratory infections, gastrointestinal problems, and osteoporosis.

68.

What is the proper water temperature for a tub bath?

90°F

100°F

115°F

120°F

Explanation:

A tub bath should be performed near the maximum temperature for bathing, which is 115°F. The acceptable range for a bed bath is 105°F to 115°F.

69.

To whom should you report as a nursing assistant/nurse aide?

A licensed physician

The registered nurse or licensed practical nurse on your service

The administrative desk person at the facility

The professional assigning a particular task, which may be an RN, LPN, physical therapist, dietitian, etc.

Explanation:

A nursing assistant or nurse aide (CNA) is assigned duties by either a registered nurse (RN) or licensed practical nurse (LPN) under the RN, and the aide should generally report to the nurse. There may be situations when a licensed physician (A) is in charge, but usually an RN is employed to carry out the medical plan. It is inappropriate to report to administrators (C) or other professionals (D).

70.

Special care for the needs of a patient with psychological impairments includes all of the following EXCEPT:

Noting changes in behavior, attitude, or emotional state and reporting to the nurse

Allowing the patient to rest by responding only when called

Engaging the patient with encouraging interactions

Monitoring intake and output to ensure diet is adequate and nutritious

Explanation:

Patients with psychological impairments often have difficulty managing ADLs and may have poor social skills, which may interfere with their ability to interact with others or make their needs known. For that reason, checking on the patient often is critical. Special considerations for patient safety and comfort may include:

- *Utilizing locked facility or wander management system.*
- *Assisting patient with ADLs and basic hygiene.*
- *Noting changes in behavior, attitude, or emotional state and reporting to nurse.*
- *Monitoring intake and output to ensure diet is adequate and nutritious.*
- *Utilizing any prescribed safety precautions at all times.*
- *Ensuring no dangerous items (knives, scissors) are within access of patients who may be violent or self-harm.*
- *Anticipating patient needs and responding appropriately.*
- *Engaging with the patient and encouraging interactions.*
- *Reassuring the frightened or anxious patient.*

71.

A physician tells the nurse aide that a resident's Foley catheter can be removed. The nurse aide should

remind the physician that nurse aides cannot take orders and offer to get a nurse.

find a nurse and report the physician's order.

ask the physician for more details about when to remove the catheter.

tell the physician the order must be given to a nurse.

Explanation:

If a physician tells the nurse aide that a patient's Foley catheter can be removed, the nurse aide should remind the physician that nurse aides cannot take orders and offer to get a nurse. Only licensed nurses (which may include LVNs/LPNs and RNs) can legally take a physician's order.

The nurse aide may carry out orders under direction of a nurse or physician as long as the action is within the nurse aide's scope of practice.

72.

If a fire occurs on the unit, and the nurse aide is using the RACE method of response, the first action should be to

remove residents from harm.

run to the fire alarm.

reach for help.

recognize danger areas.

Explanation:

The acronym RACE is used to help staff members remember the steps to take in the event of fire:

- ***R**emove residents from danger.*
- ***A**ctivate alarm (call for help)*
- ***C**ontain fire (close doors and windows if possible).*
- ***E**xtinguish the fire (using a fire extinguisher if fire is small and able to do so without risk).*

*Additionally, the acronym PASS is used to guide use of the fire extinguisher: **P**ull pin, **A**im at base of fire, **S**queeze handle, and **S**weep back and forth.*

73.

If a resident accidentally spills hot coffee on her hand, the nurse aide should immediately

call the nurse.

apply lotion to the burn.

advise the resident to blow on the burn.

flush the burn with cold water.

Explanation:

If a resident accidentally spills hot coffee on her hand, the nurse aide should immediately flush the area with cold water to stop the burning and call the nurse. For example, if a water pitcher is nearby, the hand can be placed momentarily in the pitcher or water poured over the burned area. First degree burns cause only redness and tenderness, but second degree burns result in blistering, severe pain, and sloughing of outer layers of skin. Third degree burns go through the skin and may have a pale or charred appearance.

74.

The nurse aide has a number of routine tasks to complete, but the licensed nurse asks the nurse aide to measure a resident's urinary catheter output. Which of the following tasks should have priority?

Assisting a resident with ROM exercises.

Measuring the resident's urinary catheter output.

Assisting a resident who is calling loudly for a bedpan.

Taking routine vital signs for assigned patients.

Explanation:

While delegated tasks usually have priority, if a resident is calling loudly for a bedpan, the nurse aide should attend to this first, as this is a health and safety issue. The resident may try to climb out of bed if no one answers the call or may be incontinent. Once the resident's needs are attended to, the nurse aide should measure the urinary catheter output, then take the vital signs because a change in vital signs may require medical treatment, and then assist the resident with ROM exercises.

75.

A resident who is partially paralyzed and unable to assist with transfer must be transferred from the bed to a bedside commode. The best method of moving the patient is to

utilize a Hoyer lift.

use a stand-pivot transfer.

use a two-person lift.

use a transfer board.

Explanation:

If a resident who is partially paralyzed and unable to assist with transfer must be transferred from the bed to a bedside commode, the best method of moving the patient is to utilize a Hoyer lift. The nurse aide should avoid lifting patients even with help because of the risk of back injury. The stand-pivot transfer and transfer board both require that the resident be able to assist with the transfer by holding onto the nurse, supporting weight, or lifting hips.

76.

Which of the following is a normal age-related change in memory?

Resident cannot recall her birthdate or place of birth.

Resident sometimes forgets to keep appointments.

Resident mistakes the nurse aide for resident's daughter.

Resident does not recall her address or telephone number.

Explanation:

A normal age-related change to memory is when a resident sometimes forgets to keep appointments. Forgetfulness is quite common as people age. Short-term memory is most affected by age while long-term memories usually remain intact. If a resident mistakes the aide for the resident's daughter or cannot recall important personal information, such as address or telephone number, these may be signs of dementia. Older residents may call people by the wrong name or occasionally forget someone's name but are usually able to recall the information.

77.

If a resident in the recreation room falls to the floor and has no pulse or respirations, the nurse aide should immediately

use emergency light to call for nurse.

begin cardiopulmonary resuscitation.

attempt to take resident's blood pressure.

send other residents out of the recreation room.

Explanation:

While protocols may vary, if a resident has no pulse or respirations (indications of a cardiac arrest), the nurse aide should immediately use the emergency light to call for a nurse and call out a signal ("Code blue") if part of protocol. The nurse aide should position the patient onto the back and loosen clothing, especially about the neck. Depending on CPR training and protocol, the nurse aide may initiate chest compressions if the patient is positioned appropriately and no nurse is readily available.

78.

A resident who is sitting up in bed experiences a generalized seizure while the nurse aide is providing care. The nurse aide should call for the nurse and then

place a padded tongue blade between the resident's teeth.

restrain the resident to prevent injury.

place pillows on both sides of the patient to prevent injury.

lower the head of the bed and turn patient to one side.

Explanation:

If a resident who is sitting up in bed experiences a generalized seizure while the nurse aide is providing care, the nurse aide should call for the nurse and then lower the head of the bed and

turn the patient with head supported to one side to prevent aspiration. Clothing should be loosened, especially around the neck. The nurse aide should put nothing in the resident's mouth and should not try to restrain the patient in any way but should pad side rails to prevent injury, draw curtains to provide privacy, and stay with the patient.

79.

A resident with diabetes mellitus, type 1, received insulin before lunch but ate little and is now confused and trembling, and the resident's skin is cold and clammy. The nurse aide should

provide resident with oral glucose tablet.

advise the patient to drink some juice.

use emergency light to call nurse.

advise the patient to lie down.

Explanation:

If a patient with diabetes mellitus, type 1, (insulin-dependent) takes insulin and does not eat adequately, the patient is at risk for an insulin reaction, which can be life threatening, so the nurse aide should use the emergency light to call the nurse and remain with the patient until the nurse arrives. Signs of insulin reaction (hypoglycemia or low sugar) include confusion, trembling, cold clammy skin, numbness/tingling, and blurred or double vision. The nurse may delegate the nurse aide to provide the patient juice, candy or other food.

80.

An older resident has been sitting up in bed but has slid down the bed about 6 inches. When the nurse aide repositions the resident, the nurse aide notes that the coccygeal (tailbone) area is reddened. In addition to notifying the nurse, the nurse aide should

massage the reddened area vigorously.

position the patient on a side.

place a soft blanket under the patient's hips.

wash the reddened area with warm soapy water.

Explanation:

If an older resident has been sitting up in bed but has slid down the bed about 6 inches, the resident is at risk for both friction (skin rubbing against sheet) and shear (skin and tissue staying in one place while body moves), which can lead to a pressure sore. Any redness should be immediately reported to the nurse and the patient positioned on the side. Reddened areas should not be massaged as this may cause further tissue injury.

81.

The nurse aide goes into a room and discovers that the resident has a large bleeding skin tear on the right arm. The nurse aide calls for the nurse, applies gloves, and then should

lower the arm and apply pressure with sterile gauze or clean linen.

take no action until the nurse arrives.

raise the arm and apply pressure with sterile gauze or clean linen.

take the resident's vital signs.

Explanation:

If the nurse aide goes into a room and discovers that the resident has a large bleeding skin tear on the right arm, the nurse aide should call for the nurse, apply gloves, and then should raise the resident's arm (above the heart) and apply pressure with sterile gauze (if available) or clean linen (such as a clean dry washcloth). The pressure helps to control the bleeding. Once the nurse arrives, the nurse aide can assist by taking the resident's vital signs and getting any supplies needed.

82.

A resident who has been withdrawn and unhappy suddenly appears more cheerful and has begun to give away many belongings to other residents. The nurse aide should

remind the resident that the belongings may be needed.

alert the nurse to a change in the resident's mood.

gather the belongings and return then to the resident.

compliment the resident for the generosity.

Explanation:

If a resident who has been withdrawn and unhappy suddenly appears more cheerful and has begun to give away many belongings to other residents, the nurse aide should alert the nurse to a change in the resident's mood. Residents who are withdrawn and unhappy are often depressed, and a sudden brightening of mood may occur if they make a decision to commit suicide. Additionally, giving away belongings is another sign that the resident plans to die.

83.

When examining a resident's skin during a bath to check for pressure sores, the nurse aide should focus on

bony prominences.

large areas of skin.

back.

feet.

Explanation:

When examining a residence's skin during a bath to check for pressure sores, the nurse aide should focus on bony prominences because there is less fatty tissue and cushioning over these areas, so they are at high risk of pressure sores. Bony prominences of special concern are the tailbone, hipbones, anklebones, and elbows. Other areas that should be carefully examined include the ears, scrotum, and under the breasts and stomach folds. Any area where skin rubs against skin (such as the thighs of overweight individuals) is at risk from friction.

84.

If a resident assigned to the nurse aide is in arm restraints because the patient is pulling her hair out, the resident must be temporarily released while awake at least every

one hour.

two hours.

three hours.

four hours.

Explanation:

Residents who are placed in restraints for their own safety must be checked by the nurses at least every hour and temporarily released from restraints while awake at least every two hours. When restraints are released, the resident should be offered fluids, food (if appropriate), and toileting, and the resident's position changed. The resident's skin should be carefully checked to ensure that pulling against the restraints has not injured the skin.

85.

Following right hip transplantation, the resident has been told to avoid adduction. This means that the resident should not

bend the knee of the right leg.

turn the right foot outward.

sit with knees below hips.

cross the right leg over the left.

Explanation:

Following hip transplantation, residents are routinely advised to avoid adduction (movement toward the body or across midline) to prevent dislocation of the prosthesis. This means that the resident with a right hip transplantation should not cross the right leg over the left but should

keep the legs apart. Other common restrictions include avoiding bending over at the waist, avoiding turning the foot on surgical side inward, and avoiding sitting with the knees higher than the hips.

86.

A newly-arrived resident yells that the nurse aide is "stupid and careless" when the nurse aide is helping the resident to unpack the resident's belongings. The most appropriate response is to

express disapproval: "I don't appreciate being talked to like this!"

remain calm but assert authority: "You cannot treat staff like this."

leave the room immediately and report the resident to the nurse.

remain calm and express empathy: "It's difficult to have other people handling your things."

Explanation:

New residents may be very stressed by the change in their living situation and often react by becoming passive or aggressive. The best response to a resident who yells that the nurse aide is "stupid and careless" when the nurse aide is helping the resident to unpack the resident's belongings is to remain calm and show empathy by trying to identify in words that which is upsetting to the patient: "It's difficult to have other people handling your things." The nurse aide should involve the resident in decision making as much as possible, "Which drawer do you want your sweaters in?"

87.

Restraints can be applied to residents for

medical symptoms/needs.

discipline.

convenience.

prevention.

Explanation:

Restraints can only be applied to residents for medical symptoms/needs, and use requires a physician's order. Restraints must be carefully monitored. Restraints cannot be applied as punishment to control a resident's negative behavior unless this behavior is putting the resident or others at risk of injury. Restraints also cannot be applied for the sake of convenience so that residents require less monitoring or interventions or because staffing levels are not adequate to provide supervision of residents.

88.

Standard precautions are required for

residents with infectious diseases.

residents with draining wounds.

residents with diarrhea.

all residents.

Explanation:

Standard precautions must be used for all patients. Standard precautions include maintaining hand hygiene by using an alcohol-based hand rub or handwashing with soap and water (required for any residue on hands) before touching a patient, when completing care, after any contact with body fluids, and before applying and after removing gloves. Required personal protective equipment includes gloves for contact with body fluids and gowns, facemasks, and goggles or face shields if needed. Standard precautions also include respiratory hygiene and cough etiquette.

89.

Which of the following is a risk factor for elopement?

Being in long-term care.

Staying near exits.

Having few visitors.

Having chronic pain.

Explanation:

Risk factors for elopement include staying near exits or pacing to and from exits. Residents may also dress completely in clothes, shoes, and coat. Before elopement, residents often express desire to leave and may begin to pack belongings or try to give some belongings away to other residents or staff. In secured facilities, residents may attempt to open doors by shaking door handles. Residents who are confused, depressed, or agitated may also try to elope.

90.

A resident has influenza with a high fever and cough. What type of precaution(s) is/are indicated?

Standard only.

Droplet only.

Standard and droplet.

Standard and airborne.

Explanation:

If a resident has influenza with a high cough and fever, both standard and droplet precautions are needed. Standard (all patients) and droplet precautions are needed for pathogens that can spread through droplets in the air. This can include influenza and the common cold. The patient's door should be kept closed as much as possible, especially with a cough. The nurse aid should wear a mask and if spraying of sputum is a possibility, gloves, gown, and goggles or face shield. The resident should wear a facemask for contact with others.

91.

Which of the following abbreviations is appropriate to use in documentation?

Abd (abdomen)

BR (bedrest)

w (with)

QD (every day)

Explanation:

The abbreviation that is appropriate to use in documentation is "abd" for abdomen because it cannot be easily misunderstood. BR (bedrest) could be confused with BRP (bathroom privileges). The proper abbreviation for with is a c with a line above the letter. QD (every day) should be avoided because it can be easily mistaken for QID (4 times a day). In fact, neither abbreviation should be used. The nurse aide should always check the approved list of abbreviations for the facility because they may differ slightly from one facility to another.

92.

Which of the following contributes most to the spread of infection in the workplace?

Inadequate environmental cleaning.

Poor hand hygiene.

Poor food handling.

Inadequate treatment of infections.

Explanation:

The factor that contributes the most to the spread of infection in the workplace is poor hand hygiene. The nurse aide can easily spread bacteria from one resident to another. Some types of infection are especially easy to spread, including Clostridium difficile (C.diff), which causes

severe watery diarrhea. C. Diff is spread by spores that are extremely difficult to kill and can be on surfaces, such as tray tables and bedpans, which the nurse aide touches.

93.

A resident was diagnosed with advanced pancreatic cancer and has been experiencing much nausea and pain. Although aware of the diagnosis, the resident claims that the cause of the problems is "food poisoning" from a poor diet. The resident is likely experiencing

projection.

substitution.

withdrawal.

denial.

Explanation:

If a resident was diagnosed with advanced pancreatic cancer and has been experiencing much nausea and pain but blames the cause on "food poisoning" from a poor diet even though the resident is aware of the cancer diagnosis, the resident is likely experiencing denial. Denial, failure to recognize or accept a painful truth, often helps residents cope with difficult issues. Some denial is often a normal response to stressful situations, but prolonged denial may prevent a resident from coming to terms with a problem.

94.

If nurse aides have verified complaints filed against them on the Nurse Aide Registry, they will

receive a warning.

be placed on suspension.

be fined.

lose certification permanently.

Explanation:

If nurse aides have verified complaints filed against them on the Nurse Aide Registry, they will lose certification permanently, making it almost impossible to find employment as a nurse aide. Complaints may be about resident abuse (physical, emotional, sexual), neglect, or misappropriation (stealing) of resident's property or money. Employers at long-term care facilities are required to check the registry before hiring a nurse aide. The Nurse Aide Registry is required by federal law but maintained by each state and the District of Columbia.

95.

Which of the following is a common sign of impending death?

Irregular shallow (Cheyne-Stokes) breathing pattern

Sudden increase in level of consciousness.

Hands and feet warm to the touch.

Pulse slow and strong.

Explanation:

A common sign of impending death is an irregular shallow (Cheyne-Stokes) breathing pattern, usually with periods of apnea (no breathing). Additionally, the circulation slows and the heartbeat often becomes rapid and very weak and difficult to feel or hear. Muscle tone is lost and the resident's jaw may begin to sag open and the arms and legs go limp. The resident is often incontinent of urine and feces. Sensory perceptions slow and the resident may not respond although hearing is believed to last longer than other senses.

96.

Which of the following is appropriate in documenting patient care?

Documenting in advance.

Erasing statements made in error.

Using ditto marks to save time.

Writing in black or blue permanent ink.

Explanation:

In documenting patient care, the nurse aide should write in blue or black permanent ink only. The nurse aide should never document in advance of carrying out a procedure, erase anything on the patient record, or use ditto marks to save time. Documentation should be accurate, written clearly in permanent ink or typed, and done in a timely manner. The nurse aide should make sure that the resident's name is present on each page and should leave no blank lines.

97.

Which is an example of information about a resident that requires urgent rather than routine reporting?

BP 138/86.

Bowel movement

Blood in stool

Fluid intake of 1000 mL

Explanation:

Blood in the stool is information about a patient that requires urgent rather than routine reporting. Urgent reporting is needed for any change in a resident's condition or unusual finding, such as elevated temperature, BP that is very high or very low (compared to the patient's normal BP), bleeding, nausea or vomiting, change in mental status or physical ability (such as inability to use one side), and onset of diarrhea. Any accidents that involve the resident, even if no injury is evident, must be reported immediately.

98.

The nurse aide notes that a resident has bruises on both arms and seems increasingly fearful and withdrawn. The nurse aide should suspect

falls.

abuse.

self-injury.

depression.

Explanation:

If a resident has bruises on both arms and seems increasingly fearful and withdrawn, the nurse aide should suspect abuse and should immediately report the observations to a nurse. Bilateral bruising to the same area is unusual with falls but quite common with abuse, and bruises on the arms often suggest the resident put the arms up as protection. The fact that the patient is increasingly fearful and withdrawn is a key sign of abuse.

99.

A resident who does not eat pork for religious reasons but is increasingly confused because of Alzheimer's disease is sent a lunch tray with a ham sandwich. The nurse aide should

advise the resident that the sandwich is ham.

suggest that the resident try the ham sandwich.

remove the ham sandwich and order a replacement.

say nothing because the patient may not realize its pork.

Explanation:

If a resident who does not eat pork for religious reasons is sent a lunch tray with a ham sandwich, the nurse aide should remove the ham sandwich (before serving the tray if possible) and order a replacement. Resident's religious preferences should always be respected even if the resident becomes confused and may no longer remember. Allowing or encouraging the resident to eat pork without the resident clearly understanding would be taking advantage of the resident's confusion, an abusive act.

100.

If a nurse aide believes that the work assignments are unfair, the nurse aide should first take the concern to the

- **immediate supervisor.**
- director of nursing.
- human resources department.
- board of directors.

Explanation:

If a nurse aide believes that the work assignments are unfair, the nurse aide should first take the concern to the immediate supervisor because complaints should generally follow the chain of command. If the immediate supervisor does not respond or take action, then the nurse aide may consider discussing the issue with the director of nursing. Each facility should have a grievance procedure, which may vary somewhat from one organization to another.

101.

A resident's daughter asks a nurse aide what is wrong with another resident (who recently had a stroke) in an adjoining room. The correct response is to say,

- "The resident had a stroke."
- "I'm sorry, that's none of your business."
- "The resident has had a recent illness."
- **"I'm sorry, I can't give out information about residents."**

Explanation:

If a resident's daughter asks a nurse aide what is wrong with a resident (who recently had a stroke) in an adjoining room, the correct response is "I'm sorry, I can't give out information about residents." HIPAA regulations require that no information about a resident be shared with those

who are not authorized to receive information. The response should always be polite but clearly stated. People who are authorized to receive information are the spouse, individual with power of attorney, and those persons the resident designates.

102.

A resident who is mentally alert refuses to take a shower in the morning, preferring to take it after lunch. The nurse aide should

demand the resident take the shower in the morning.

respect the resident's wishes.

acknowledge the resident's desire, then kindly remind him of the morning routine.

threaten to stop assisting the resident with showers.

Explanation:

Residents have a right to refuse treatment (including showers) and to state a preference, such as preferring the shower at a different time. Whenever possible, these types of preferences should be allowed because they let the residents have some degree of control over their lives. If there is a good reason the nurse aide cannot accommodate a resident's preference, then the nurse aide should explain this to the resident and try to reach some compromise.

103.

If a resident begins to choke while the nurse aide is assisting the resident with eating lunch, the nurse aide should immediately call for the nurse and then

hit the resident on the back between the shoulder blades.

carry out the Heimlich maneuver (abdominal thrusts).

ask the resident if able to speak or cough.

offer the resident a sip of water to clear throat.

Explanation:

If a resident begins to choke while the nurse aide is assisting the resident with eating lunch, the nurse aide should immediately call for the nurse and then ask the resident if the person is able to speak of cough. If able to do so, air exchange is occurring, but if not able to do so, the airway is blocked and the nurse aide should then carry out the Heimlich maneuver (abdominal thrusts) if trained to do so and the nurse has not arrived to take over care.

104.

Which of the following is the primary purpose of applying a footboard to a resident's bed?

Allow air to circulate about the feet.

Allow the resident to move more easily.

Prevent the resident from developing footdrop.

Prevent pressure sores on the toes.

Explanation:

The primary purpose of applying a footboard to a resident's bed is to prevent footdrop. The footboard should be positioned so that the feet rest against the board in upright position (90 degree angle to the ankle). This helps to keep the feet in normal position. The footboard should be padded with linen (such as a bath blanket) so that the feet don't rest on the board itself. A pillow or roll should be placed alongside each of the resident's feet to keep the feet upright.

105.

A resident has developed frequent constipation. In addition to increasing fluid intake, what other dietary change may help to relieve the constipation?

Increased fiber.

Increased refined carbohydrates.

Increased fat.

Increased dairy products.

Explanation:

If a resident has developed frequent constipation, in addition to increasing fluid intake the dietary change that may help to relieve constipation is increased fiber in the diet. Fiber makes bulk, which helps to move the stool more rapidly through the bowels so that it loses less fluid and stays softer. Foods high in fiber include most fruits and vegetables (whole rather than juiced) as well as bran and other whole grains. Dairy products (even yogurt) and refined carbohydrates tend to be constipating.

106.

For which of the following residents is taking an oral temperature appropriate?

A resident who is not conscious.

A resident using oxygen.

A resident who is confused.

A resident who has slight nausea.

Explanation:

Unless a resident is actively vomiting or nausea is severe, the nurse aide can take an oral temperature on a resident with nausea. However, an oral temperature should not be taken with a resident who is not conscious or is confused as the resident may be unable to hold the thermometer securely in the mouth or may bite down on the thermometer. Oxygen use may lower the temperature in the mouth, making it inaccurate. Oral temperatures should also not be taken within 20 minutes of drinking cold liquids or smoking.

107.

When assisting a resident to ambulate with a walker after hip replacement surgery, the nurse aide should remind the patient to move the walker forward about

2 to 3 inches.

4 to 5 inches.

6 to 10 inches.

12 to 18 inches.

Explanation:

When assisting a resident to ambulate with a walker, the nurse aide should remind the patient to move the walker forward about 6 to 10 inches and then step to the walker with the weaker leg while bearing some weight with the hands on the walker handles and then (maintaining pressure on the handles) moving the other leg up to the weak leg. It's important to remind the resident to step just up to the walker but not into it as stepping too far forward may cause the resident to lose balance and fall.

108.

When transferring a resident from a bed to a wheelchair, the bed should be

the same height as the seat of the wheelchair.

1 to 2 inches higher than the seat of the wheelchair.

1 to 2 inches lower than the seat of the wheelchair.

4 to 5 inches higher than the seat of the wheelchair.

Explanation:

When transferring a resident from a bed to a wheelchair, the bed should be 1 to 2 inches higher than the seat of the wheelchair because it's easier to move a patient from higher to lower. The wheelchair should be placed next to the bed on the resident's strong side; otherwise, to the side most convenient. The brakes must be locked on the wheelchair and bed before beginning to transfer the resident.

109.

Pressure reducing heel boots are intended for residents who

- **are not ambulatory.**
- spend more than 10 hours a day in bed.
- complain of foot pain.
- complain of cold feet at night.

Explanation:

Pressure reducing heel boots are intended for residents who are not ambulatory and should not be used with ambulatory residents. Heel boots have a cushioned lining (such as foam, gel, or sheepskin) to protect the heel and the rest of the foot from pressure and have a firm outer boot that prevents foot drop and holds the foot in upright position, preventing the ankle from rolling to one side or the other. The heel boot should be removed at least every 4 hours to check the resident's skin and do ROM exercises.

110.

According to Maslow's Hierarchy of Needs, which of the following needs is the most important to meet first?

- Esteem
- Love/Belonging
- Safety
- **Physiological**

Explanation:

According to Maslow's Hierarch of needs, the needs that need to be met first are physiological (food, water, breathing, sex, sleep). The next needs are those related to safety and security (employment, health, resources). This is followed by needs for love and belonging (family,

friends, relationships) and then esteem (self-esteem, respect, confidence). The last level, self-actualization, must be achieved after the other 4 types of needs are met.

111.

An older resident who takes a 3-hour nap every afternoon is concerned because she is unable to sleep more than 4 or 5 hours at night. The nurse aide tells the resident that the average number of hours of needed sleep (including nap time) is

5 to 7.

7 to 9.

8 to 10.

10 or more.

Explanation:

While older adults often have difficulty sleeping because of sleep apnea, pain, or other health issues, the average sleep requirements stay essentially the same—7 to 9 hours. However, this includes naptime, and residents often fail to count the hours they nap or doze in their chairs. To sleep more at night, the resident may need to reduce the naptime. Sleep needs do vary, and people who have always needed fewer or more hours of sleep will likely continue with that pattern into older age.

112.

When assisting a male resident to use a urinal, the nurse aide should ideally position the head of the bed

flat.

elevated to 30 degrees.

elevated to 60 degrees.

elevated to 80 to 90 degrees.

Explanation:

When assisting a male resident to use a urinal, the nurse aide should ideally position the head of the bed elevated to 80 to 90 degrees (upright) so that the pressure of gravity on the bladder can assist the resident to urinate. If the resident is able, he should position the urinal himself; otherwise, the nurse aide should position the urinal and insert the penis into the mouth of the urinal, cover the resident with a blanket, give the resident a call light, and leave to allow the resident privacy.

113.

When feeding a bedbound resident, the resident should, if possible, have the head elevated to at least

45 degrees.

60 degrees.

75 degrees.

90 degrees (upright).

Explanation:

When feeding a bedbound resident, the resident should, if possible, have the head elevated to at least 45 degrees. If the resident's head is lower than 45 degrees, the risk of choking and aspiration increases. Food should be cut into small bite-sized pieces, and the spoon filled only half full. If the resident has a weakness on one side, such as after a stroke, the food should be directed toward the opposite side of the mouth so the resident can feel and taste it.

114.

A resident with diabetes mellitus asks the nurse aide to help to trim the resident's toenails. The nurse aide should

explain that a nurse or podiatrist must trim the nails.

soak the feet in soapy water before trimming the nails.

trim only with clippers, not with scissors.

be sure to cut the nails straight across.

Explanation:

If a resident with diabetes mellitus asks the nurse aide to him to trim the resident's toenails, the nurse aide should advise the resident that a nurse or podiatrist must trim the nails. In most facilities, nurse aides are not allowed to trim any toenails, but especially those of diabetics because circulatory impairment increases the risk of developing ulcerations or infections on the foot. The nurse aide should offer to report the need to the nurse.

115.

If a resident is on bedrest, the most important measure to prevent skin breakdown is to

turn the resident at least every 2 hours.

massage the resident's skin.

remind the resident to move frequently.

place an egg crate mattress on the bed.

Explanation:

If a resident is on bedrest, the most important measure to prevent skin breakdown is to turn the resident at least every 2 hours, making sure that the body is in proper alignment and supported with a pillow to the back and between the legs. Each time the resident is turned, the nurse aide should examine the skin for signs of redness or irritation, which should be reported immediately to the nurse.

116.

A resident is on a low-fat diet. Which of the following foods is likely to be restricted?

Steamed vegetables

Pasta with tomato sauce

Steak

Baked fish

Explanation:

If a resident is on a low-fat diet, the resident's foods are more likely to be boiled, steamed, or baked because that requires little additional fat. Naturally fatty foods, such as bacon and steak, should be avoided, along with any fried food. Residents are usually encouraged to use olive oil instead of butter; to avoid high fat dairy products; to eat chicken, turkey, fish, and lean meats; and to have diets with plentiful whole grains, fruits, and vegetables.

117.

A resident who is dying tells the nurse, "I used to have such an interesting life." The best response is,

"I'm sure you did."

"I'd like to hear about your life."

"You're lucky to have those memories."

"Does your family know about your life?"

Explanation:

Many residents who are dying find comfort in reviewing their lives, so if a dying resident tells the nurse aide, "I used to have such an interesting life," the best response is to encourage the resident to talk about it: "I'd like to hear about your life." The nurse aide should listen attentively and ask questions to encourage the resident to continue talking. If the resident becomes tired

or the nurse aide must attend to other residents, the nurse aide should suggest they talk more about the resident's life later.

118.

If a resident has a prosthetic leg, the resident's routine weight should be taken

only with the prosthetic leg off.

only with the prosthetic leg on.

either way, accounting for the weight of the prosthetic leg.

consistently with the prosthetic leg either on or off.

Explanation:

If a resident has a prosthetic leg, the resident's weight should be taken consistently with the prosthetic leg either on or off. The purpose of routine weights is to help evaluate the nutritional and health status of the individual, so the baseline weight taken the first time is used as a gauge against which later weights are measured. In this case then, whether or not the baseline weight includes the weight of the prosthesis is of little importance. However, if weight is taken to determine dosage of medication, then the weight should be taken without the prosthesis.

119.

Which of the following may best provide reality orientation for a resident with mild cognitive impairment (confusion)?

Redirecting the resident when confusion is apparent.

Telling resident to try to remember important information.

Providing calendars, clocks, pictures, and signs.

Having resident practice answering orienting questions.

Explanation:

Residents with mild cognitive impairment may have difficulty remembering date, time, place, and person, including the names of friends and family members. One method of reality orientation is providing calendars ("Today is…"), clocks, pictures (labeled photographs of staff members, family, and close friends), and signs (common directions and information that the resident may need, such as the time of therapy or when lunch is served). The nurse aide should always be patient and provide gentle reminders to help the resident stay oriented.

120.

The nurse aide enters a resident's room and finds the resident tearful and obviously upset. The most appropriate response is to

ignore the situation and proceed with care.

ask, "Why are you upset?"

observe, "You seem upset this morning."

reassure, "I'm sure everything will be all right."

Explanation:

If a nurse aide enters a resident's room and finds the resident tearful and obviously upset, the most appropriate response is to observe, "You seem upset this morning" and allow the resident to express or withhold feelings or information as desired. Directly questioning the resident, "Why are you upset?" should be avoided as this invades the resident's privacy. Additionally, making reassurances, "I'm sure everything will be all right," without knowledge of the situation serves no purpose, and may be wrong.

121.

The nurse aide is caring for a resident who is non-responsive and is doing passive range of motion (ROM) exercises. Which of the following ROM exercises are indicated for the ankle?

Flexion, extension, and rotation.

Inversion (turning in), eversion (turning out), flexion, and extension.

Inversion, eversion, and rotation.

Flexion and extension.

Explanation:

If the nurse aid is caring for a resident who is non-responsive and is doing passive range of motion (ROM) exercises, the ankle should be put through eversion (turning outward) about 20 degrees and inversion (turning inward) about 30 degrees. Additionally, the ankles should be put through dorsal flexion (guiding the foot toward the head) about 20 degrees and plantar flexion (guiding the foot downward) about 40 degrees. ROM should be done on both sides and any limitations or difference from one side to the other documented.

122.

The purpose of the kidneys is to

remove waste products and produce urine.

store urine prior to urination.

aid in digestion of fats.

protect the body against infection.

Explanation:

The purpose of the kidneys is to remove waste products from the blood and to produce urine. From the kidneys, the urine flows down the ureters to the bladder, where it is stored until urination. During urination, urine flows down the urethra and through the urinary meatus. There are two kidneys (located on either side of the spine in the lower back), which together produce one to two liters of urine daily.

123.

The nurse aide awakens a resident and notes that, for the first time, the resident's right arm seems weak and the resident's speech is slow and slurred. The nurse aide should

give the resident time to awaken completely.

tell the nurse the patient has had a stroke.

call the nurse immediately.

ask the resident how long the arm has been weak.

Explanation:

If the nurse aide awakens a resident and notes that, for the first time, the resident's right arm seems weak and the resident's speech is slurred, the nurse aide should immediately call the nurse and discuss these observations. While these symptoms are consistent with a stroke, they could also be caused by other problems (such as a brain tumor), and the nurse aide should avoid trying to diagnose a resident. Because there is a change in the resident's condition, the nurse aide should also take and report the resident's vital signs.

124.

A resident who is frequently unfriendly and complains about staff members and other residents claims that the staff and residents all dislike him. This is an example of which defense mechanism?

Denial

Projection

Resistance

Suppression

Explanation:

If a resident who is frequently unfriendly and complains about staff members and other residents claims that the staff and residents all dislike him, this is an example of the ego defense mechanism of projection. The resident is seeing in others the characteristics that are within himself. Residents may use ego defense mechanisms in order to protect themselves

from painful truths about themselves. An appropriate response is to reflect back what the resident is saying, "You feel others dislike you" to encourage the resident to discuss the issue.

125.

When entering the room of a resident who is deaf but sitting turned away, the nurse aide should

approach and touch the resident on the shoulder.

approach as with other residents.

tap a foot or clap before entering.

flash the lights on and off.

Explanation:

When entering the room of a resident who is deaf but sitting turned away, the nurse aide should tap a foot or clap before entering. People who are deaf are often very sensitive to vibrations and can sense tapping and clapping. The nurse aide should never approach a deaf person from behind because this can startle and frighten the resident. The nurse aid should circle about the resident and approach from the front or otherwise gain the resident's attention.

126.

The nurse aide must move a box of supplies weighing 15 pounds from the lowest shelf in a supply room to a nursing station. The best method is to

use a foot to scoot the box off the shelf before lifting.

bend over and grip the box with both hands to pull and lift.

squat down and grip the box with both hands to pull and lift.

use a foot to slide the box along the floor to the nursing station.

Explanation:

If the nurse aide must move a box of supplies weighing 15 pounds from the lowest shelf in a supply room to a nursing station, the best method is to squat down bending the knees and hip and to grip the box with both hands to pull it toward the nurse and to lift. Items should never be moved with a foot, placed on the floor, or scooted along the floor, as the bottom of the shoe and the floor are always considered dirty.

127.

The nurse aide is bringing colostomy supplies to a resident who is blind. When putting the supplies away, the nurse aide should say,

"I'm bringing your colostomy supplies."

"I'm putting the colostomy supplies in the drawer under the sink in your bathroom."

"I'm just putting your colostomy supplies away."

"I'm putting your colostomy supplies in the bathroom."

Explanation:

Because residents who are blind must rely on touch and memory to find things, it's important to form a habit of stating clearly where items are placed even if this is the usual place for the items: "I'm putting your colostomy supplies in the drawer under the sink in your bathroom." Having things out of place can be very frustrating to a person who is blind. The nurse aide should always announce presence when entering the room, announce position: ("I'm on your left side."), and tell the resident before touching the person, "I'm going to take your right-sided blood pressure."

128.

When changing a resident's colostomy bag, which of the following should the nurse aide report immediately to the nurse?

The stoma is dusky bluish in appearance.

The stoma is about one-third inch above the skin level.

The stool in the bag is soft and brown.

A couple drops of blood are on the gauze after cleaning the stoma.

Explanation:

When changing a resident's colostomy bag, the nurse aide should immediately report to the nurse if the stoma is dusky bluish in color because this indicates that the stoma is not getting enough oxygen. This is a serious complication and may require surgical repair. Stool quality varies depending on where the colostomy is placed. The stoma level in comparison to the skin may vary slightly from day to day, but one-third inch is common. A slight amount of blood from the stoma is normal when cleansing, but frank bleeding should be reported immediately.

129.

The nurse aide finds a plastic bag full of assorted pills in the back of a resident's bedside table. The resident states they are "vitamins." The nurse aide should

praise the resident for taking vitamins.

suggest the pills be sorted into different kinds.

tell the resident she should not have a bag of pills.

report the observation to the nurse.

Explanation:

If the nurse aide finds a plastic bag full of assorted pills in the back of a resident's bedside table and the resident states they are "vitamins," the nurse aide should report the observation to the nurse. It is never safe for residents to have multiple unlabeled medications (even vitamins) mixed together. Additionally, residents who are addicted to pills often hide them or claim they are "vitamins" or other over-the-counter or prescription drugs.

130.

An Asian resident's spouse died recently, but the resident expresses little emotion about the spouse's death. This probably means that the resident

didn't care about the spouse.

prefers not to show grief outwardly.

is in a state of denial.

is in a state of depression.

Explanation:

While cultural norms don't always apply to all members of a culture, people in Asian cultures are often less open about emotions and may not display signs of grief, such as crying, in front of other people. This does not mean that they feel less, so the nurse should remain supportive and show sympathy and understanding. If the nurse aide knew the spouse, stating a memory of the spouse may be comforting to the resident.

131.

A resident has been nauseated and vomiting frequently for the last 3 to 4 hours. Which of the following types of vomitus/emesis should the nurse aide report immediately to the nurse?

Watery vomitus with streaks of mucus.

Partially-digested food vomitus.

Coffee ground-appearing vomitus.

Clear slightly yellow-tinged vomitus.

Explanation:

Vomitus/Emesis may appear differently depending how long it's been since a resident has eaten, but commonly appears as partially digested food or watery vomitus with streaks of mucus. Vomitus may also be slightly yellow-tinged or green-tinged from bile. The nurse aide should immediately report to the nurse coffee ground-appearing vomitus because this usually indicates the presence of clotted blood, indicating bleeding somewhere in the gastrointestinal

tract. Bright red blood in the vomitus should also be reported as this can indicate acute bleeding.

132.

A resident is on a low carbohydrate, limited calorie diabetic diet, but the nurse aide finds a box of chocolates in the resident's room. The nurse aide should

tell the resident not to eat any of the chocolates.

ask the resident if the chocolates are sugar free.

ask the dietician if the resident can eat the chocolates.

alert the nurse about the chocolates.

Explanation:

If a resident is on a low carbohydrate, limited calorie diabetic diet, but the nurse aide finds a box of chocolates in the resident's room, the nurse aide should alert the nurse about the chocolates. The chocolates likely do not fit into the diet, but it is the nurse's responsibility to discuss this issue with the resident and the dietician. In some cases, residents sneak food not on their diets, but others may simply keep candy to give to visitors.

133.

The universal sign of choking is

grabbing at the throat.

coughing.

gagging.

yelling for help.

Explanation:

The universal sign of choking is grabbing at the throat, often with the mouth open. If the airway is blocked, the person will be unable to speak or cough although a slight hacking or clicking noise may be heard as the resident tries to suck in air. The resident's lips and face may begin to take on a blue tinge from the lack of oxygen. Small children may flail their arms about in panic, but this is not typical of older children or adults.

134.

If a resident with a history of a mental disorder becomes very violent and begins screaming and throwing things at the nurse aide, the nurse aide should

lock the resident in her room.

speak calmly to the resident.

try to physically restrain the resident.

get to safety and call the nurse.

Explanation:

if a resident with a history of a mental disorder becomes very violent and begins screaming and throwing things at the nurse aide, the nurse aide should get to safety and call the nurse. Getting to safety may involve backing up out of harm's way or leaving the room, but if other residents are present (for example if the incident occurs in the dining room) the nurse aide should try to ensure the safety of the other residents. The nurse aide should keep watch over the violent resident until the nurse arrives.

135.

A resident with moderate dementia has gotten out of bed during the night a number of times and gotten lost in the facility and grounds. Which of the following may provide the best solution?

Applying bed restraints to the patient during the night.

Elevating bed rails when the patient is in bed.

Checking on the resident every hour.

Utilizing a wander management system (Wanderguard®/RoamAlert®).

Explanation:

The best solution for a resident with moderate dementia who has gotten out of bed during the night a number of times and gotten lost in the facility and grounds is a wander management system. The patient wears a device (such as a bracelet) that has a locator and may also have a door controller that automatically locks doors or sounds alarms if the resident attempts to go through a door. Restraints should be avoided, and leaving side rails up increases the risk of falls. Checking on the resident hourly is not sufficient.

136.

If a resident has global aphasia and has difficulty understanding or producing language in speaking, reading, or writing, the nurse aide should try to communicate with

gestures and pictures.

slow clear speech.

nods and smiles.

letter boards.

Explanation:

If a resident has global (non-fluent) aphasia and has difficulty understanding or producing language in speaking, reading, or writing, the nurse aid should try to communicate with gestures and pictures or illustrations because the resident may be able to understand those non-language types of communication. The nurse aide can also show the resident items, such as the toothbrush or water glass, to help the person understand what the nurse aide is trying to communicate.

137.

The nurse aide is walking with a resident who calls out, “Help, I’m falling!” The best initial action is to

hold the resident up to prevent from falling.

ease the resident onto the floor.

call for help to prevent the fall.

get a chair for the resident.

Explanation:

If the nurse aide is walking with a resident who calls out, "Help, I'm falling," the best initial action is to ease the resident onto the floor. Once a patient is actively falling, there is little time to call for help or to get a chair. The nurse aide should control the fall, sliding the patient down the nurse aide's leg onto the floor, in sitting position if possible. Then, the nurse aide should call for the nurse to come to examine the resident for injuries.

138.

The purpose of a palm cone is to

improve circulation of the hand.

prevent contractures of the fingers.

prevent contractures of the wrist.

relieve pain in the hand.

Explanation:

The purpose of a palm cone is to prevent contractures of the fingers. The palm cone is a roll of soft material (such as foam) that fits into the palm of the hand and allows the fingers to curve about the cone but keeps the fingers from curling into the palm of the hand and the fingernails from digging into the skin. The palm cone may also have finger separators to ensure that the fingers stay apart.

139.

When a nurse aide observes another nurse aide mishandling and swearing at a confused resident, the initial action should be to

report the abuse to the nurse.

advise the other nurse aide that the action is abusive.

bring the issue up in end-of-shift report.

intervene to stop abuse.

Explanation:

If a nurse aide observes another nurse aide mishandling and swearing at a confused resident, the initial action should be to intervene to stop the abuse, "I'll take care of Mrs. Jones." The nurse aide should not address the abuse directly with the other nurse aide but should make sure the patient is safe. Then, the nurse aide should immediately report the observation to the nurse who is responsible for the resident's care.

140.

The nurse aide is transferring a resident from a wheelchair to the resident's bed. Once the wheelchair is in position, the next action should be to

remove the foot supports and place feet on the floor.

lock the wheelchair so that it does not move.

remove the wheelchair arm nearest the bed.

ask the resident to slide forward in the wheelchair.

Explanation:

If a nurse aide is transferring a resident from a wheelchair to the resident's bed, once the wheelchair is in position, the next action should be to lock the wheelchair so that it doesn't move. If the wheelchair moves when the patient begins to transfer, the patient may fall. The

nurse aide should also be sure that the bed is in low position with the side rail on the transfer side down before positioning the wheelchair next to the bed.

141.

Which of the following is NOT considered personal protective equipment?

Gloves

Gowns or other outer clothing

Hand washing equipment

Masks, face shields, goggles, and glasses

Explanation:

Hand washing equipment is not personal protective equipment, but hand washing is a precaution for infection control and should be performed before donning and after removing gloves (A) and at many other times. Personal protective equipment (PPE), which should be worn whenever you may be in contact with blood and other bodily fluids, includes gloves (A); gowns or other removable outer clothing (B); and face protection (D) against splashes or airborne pathogens, including a mask and a face shield, goggles, or protective glasses.

142.

Hospital disaster/emergency response plans should all of the following EXCEPT:

Budget plan for disaster response

Chain of command

Hospital's capacity to receive individuals

Supplies on hand and methods to obtain added supplies

Explanation:

Disaster/emergency response plans *should be in place for the facility based on the Hospital Emergency Incident Command System (HEICS), which provides a model for management, responsibilities, and communication. Disasters can include a multi-casualty influx of individuals from a community emergency, such as a train accident; an epidemic; fire or other internal hospital problem requiring evacuation; or inadequate staffing to safely treat ED individuals. Plans should include/address:*

- *Readily available information and disaster preparedness drills.*
- *Activation of the plan, including the individual(s) responsible.*
- *Chain of command.*
- *Facility damage assessment, usually conducted by plant safety officer.*
- *Hospital/ED capacity to receive individuals.*
- *Triage, including in community and in the ED.*
- *Transfer protocols for distributing individuals to other facilities.*
- *Staffing, including telephone tree to notify staff to report to facility.*
- *Intra- and Inter-facility communication and communication with pre-hospital EMS personnel.*
- *Supplies on hand and methods to obtain added supplies.*
- *Delineation of receiving and treatment areas.*

143.

What should you do if you find that a patient has fallen on the floor but does not appear to be hurt?

Help the patient up and assist him/her back to bed and resume your work

Write a note to your supervisor

Fill out an incident report that correctly records what happened and file it with the facility's risk manager

Tell an administrator about the conditions that led to the fall

Explanation:

Whenever a fall occurs, the aide or other professional should fill out an incident report and convey it to the facility's risk manager, regardless of whether or not the person appears to be hurt. Merely writing a note to your supervisor (B) or telling an administrator (D) is not enough. You and another professional may end up helping the patient up and assisting him/her back to bed (A), but the report must be filed.

144.

Which of the following should NOT be done when caring for a patient with an indwelling catheter?

The patient should be positioned on his/her side

The urethra should be cleansed using a downward circular motion

The bag should be hung below the level of the bladder, but not touching the floor

The tubing should be fixed firmly to the person's inner thigh

Explanation:

The patient should be in a supine position with the head of the bed lowered, not on his/her side. All of the other choices given should be part of the procedure. The aide should also wash his/her hands and use gloves, place a waterproof pad under the hips, and dry the perineal area when finished.

145.

What is the best way to provide for your patient's spiritual needs?

Refer him/her to some type of religious counselor

Alert him/her to religious services in the facility

Establish rapport with the patient and find out about his/her spiritual needs and views on spirituality

Pray with the patient

Explanation:

The nursing assistant should establish rapport with the patient and listen to his/her views about spirituality and spiritual needs. Spirituality is any means of finding inner meaning from life in order to feel completeness or self-actualization. It can be associated with established religion but can also come from other sources such as nature. If you find that the patient does have a particular religious affiliation that nurtures him/her, any of the other choices might be utilized.

146.

What should be suspected if a patient being treated for pain experiences a sudden drop in blood pressure, a change in respiration, and the appearance of a rash?

Anxiety or stress

Fluid loss

An adverse drug effect from the analgesic

Hypertension

Explanation:

The most likely cause is an adverse drug effect (ADE) due to administration of an analgesic drug for the pain, which should be immediately reported to the supervising nurse to address the emergency. A rash generally would not be associated with any of the other conditions. Dehydration from fluid loss (B) can adversely affect various bodily systems but since fluid intake and output should be monitored it is less likely. Conversely, hypertension (D), or high blood pressure, is often due to fluid overload. Anxiety (A) alone would not cause this combination of symptoms.

147.

Under what circumstances should a nursing aide have access to a patient's files?

A nursing aide can access files on any patient that he/she has cared for

A nursing aide can access files on patients currently under his/her care

A nursing aide can access files in order to show information to family members

A nursing aide can access files in order to correct computer information

Explanation:

The patient has a right to confidentiality, which means that nursing aides or other professionals should only have access to files on patients currently under their care, not those they have previously cared for (A). Under the right to privacy, family members generally cannot access information unless they provide the patient's privacy code number; if they do not have this, the nursing assistant can only confirm the patient's presence (C). Legally, the nursing assistant should not be making computer changes (D).

148.

Which of the following is a good method of communicating with a patient?

Keep the conversation light and questions short

Maintain eye contact, speak slowly using laymen's terms, and try to ask open-ended questions

Be authoritative, letting the patient know your expertise

Always be positive and assuring

Explanation:

This response lists some of the features of good communication, namely maintaining eye contact, using terms the individual can understand, and asking questions that are open-ended to encourage the person to give more information. A is incorrect because it negates the seriousness of the situation and encourages yes or no responses which lead nowhere. C is wrong because your role is to be supportive, not authoritative, and D is also wrong because you should not give the person false hope.

149.

What should you do if a patient who is ambulating with your help and a gait belt begins to fall?

Try to prevent the fall by any means

Change your position to block the fall

Keep your feet wide apart, bend your knees, lower the patient to the floor, and then let him/her rest on your leg

Let the patient fall and then, using good body mechanics, pick him/her back up

Explanation:

A patient using a gait belt to ambulate with your help generally needs minimum assistance, and this sequence is suggested if he/she begins to fall. You should not move the patient. Call for help, notify your supervisor, and file an incident report. The fall should not be prevented (A), blocked (B), or allowed to occur haphazardly (D).

150.

Which of the following is incorrect regarding placing a vest (jacket) restraint on a patient?

doctor's order and family consent must be obtained beforehand

The straps should be tied to a chair or the bed frame with a quick-release knot

The distance between the chest and the vest should be about the width of two fingers

The opening and straps should be across the front

Explanation:

The vest restraint opening and the straps crossing should both be behind the back, not in the front. Doctor and family permission must be obtained prior to using this type of restraint (A), the straps should be secured to a chair or the bed frame (B), and to permit breathing a distance of about the width of two fingers should be allowed (C).

151.

What should you do if a patient makes a blatant sexual comment to you?

Counter with sexual remarks of your own

Firmly but politely inform him/her that these types of comments are unacceptable and will not be tolerated

Immediately inform your supervisor

Ignore the behavior and continue as usual

Explanation:

You need to first let him/her know firmly and politely that these comments are unacceptable and cannot continue. If the behavior persists, then your supervisor should be notified (C). Joking or sexual responses are inappropriate (A), and the behavior should not be ignored and allowed to continue (D).

152.

When a nurse prioritizes doing good for her patient through compassion, advocacy and empathy, she is displaying the ethical principle of:

Nonmaleficence

Beneficence

Veracity

Confidentiality

Explanation:

These are all ethical principles, which are standards of correct moral conduct. Beneficence (B) is the correct term for doing good for others. Nonmaleficence (A) refers to the ethical principle of providing care that does not cause harm. Veracity (C) means speaking truthfully at all times. Confidentiality (D) is the code of maintaining the privacy of the patient's information.

153.

How does the right to informed consent impact nursing home residents?

Since they may be incapacitated, it must be obtained from any family member

Informed consent must be obtained from the residents or their health care power of attorney prior to every test, treatment, or procedure

It prevents them from changing or stopping treatments once a decision has been made

Its applicability is broader than in other circumstances

Explanation:

Just as with other types of patients, the right of informed consent applies and means that prior to performance of any test, treatment, or procedure, the patient or his/her representative must be informed of the risks and benefits so that he/she may consent or decline. That negates responses A and D. However, under the right of freedom of choice, the patient can later change or stop treatments (C).

154.

You badger a patient into allowing you to give him/her a bath with the door open. Of what legally liable acts could you possibly be accused?

Assault and battery

Abuse

Invasion of privacy

Assault, battery, invasion of privacy, and abuse

Explanation:

You could possibly be accused of all of these acts: assault (the threat of touching without permission); battery (actual personal violence without permission); invasion of privacy (exposing the client's body during care or failure to maintain confidentiality); and abuse (threatened or actual physical or mental harm to the patient).

155.

What is the most likely isolation scenario for a patient who has MRSA?

Placement of the patient in a clearly marked private room, and wearing by the nurse aide (and others) of an isolation gown and gloves at all times while in the room

Same precautions as choice A (above) plus wearing a mask

Placement of the patient in a negative pressure room and use by the nurse aide of a mask or respirator and gloves while in the room

Isolation of the patient in a separate ward with other MRSA patients

Explanation:

MRSA, methicillin-resistant Staphylococcus aureus, is primarily a bloodborne pathogen spread via direct contact, and therefore contact precautions as indicated in A should be used. Scenario B describes droplet precautions for microorganisms spread via mucous or respiratory secretions, while C expresses airborne precautions for organisms that can survive a long time in the environment. The patient probably would not be put in a separate ward (D) where he/she would be in contact with others.

156.

Which of the following are signs that your patient is dehydrated?

He/she has peripheral edema, bulging veins, and lung crackles

He/she has cloudy urine, fever and flank pain

He/she has a weak, fast pulse, low blood pressure, dark urine, and sunken eyes

He/she is constipated

Explanation:

These are all signs of dehydration, which indicate that fluids should be encouraged. Constipation (D) may be a sign of dehydration but could also be due to use of medications that reduce GI motility. Scenario A suggests fluid overload, and B suggests the presence of a urinary tract infection.

157.

A nurse aide finds her patient nonresponsive with no evidence of breathing or a pulse. Her first response should be to:

Lower the patient's head of bed and prepare for CPR

Apply oxygen to the patient via facemask

Maneuver behind the patient and initiate the Heimlich remover

Call for help using the appropriate signal, such as "Code blue!"

Explanation:

*If the patient experiences a **cardiac arrest** (no evidence of breathing or pulse, nonresponsive) the nurse aide should immediately call for the nurse (emergency light) and call for help using the appropriate signal ("Code blue!"), lower the patient's head (if in bed) and prepare the patient for CPR. A backboard can be placed if available and patient's clothing loosened. If the patient is in a chair, the patient should be eased onto the floor and placed in supine position. Depending on CPR training and protocol, the nurse aide may initiate chest compressions if the patient is positioned appropriately and no nurse is readily available. Compression only CPR is at the rate of 100 compressions per minute. If two rescuers, the rate is 30 compression to 2 respirations. CPR should be performed for one minute prior to defibrillation with AED.*

158.

For what type of patients is the use of the logrolling technique appropriate?

Patients from whom you need to obtain a urine specimen

Patients with a broken leg

Patients in respiratory distress

Patients who have sustained a neck or spinal cord injury

Explanation:

The logrolling technique, in which at least two caregivers turn the patient together toward them to a side-lying or Sims' position using a pull sheet, should be used with patients who have sustained a neck or spinal injury because it keeps those areas in a stable position, preventing further injury. These patients are not capable of assisting in the move (B), and there is no need to use the technique to obtain a urine specimen (A) or when a patient is in respiratory distress (C).

159.

An electrical fire starts in your patient's room. What should you do?

Immediately try to extinguish it with a type A fire extinguisher

Remove the patient, activate the fire alarm, close doors, and use a type A fire extinguisher on the fire

Immediately try to extinguish it with a type C or ABC fire extinguisher

Remove the patient, activate the fire alarm, close doors, and use a type C or ABC fire extinguisher on the fire

Explanation:

When any fire occurs, the RACE system illustrated in answers B and D should be utilized. In this case, a silver type A fire extinguisher (A or B) should not be used because it shoots water and is only appropriate for ordinary combustibles such as paper. Type C is red, discharges dry chemicals, and is appropriate for an electrical fire. Multipurpose type ABC is also red and can be used for fires involving combustibles, liquid chemicals, or electrical sources.

160.

Your patient has an area of skin that is somewhat worn away and red. What condition does he/she have?

A stage I pressure sore

A stage II pressure sore

A stage III pressure sore

A stage IV pressure sore

Explanation:

The patient has a stage II pressure sore. Both stage I and II pressure sores show areas of redness, but with stage II there is also wearing away of the outer layer of skin. Stage III sores are black and indicate wearing of the full thickness of skin, and with stage IV there is an exposed area of visible bone.

161.

When a patient complains of chest pain, the appropriate first response by the nurse aide is:

to ask the patient to describe the pain quality, when it started, and where it is located

to leave to notify the nurse to further assess the patient

to call for the nurse and remain with the patient, loosening their clothing and taking their vitals

to raise the head of the patient's bed and ask if the pain subsides

Explanation:

*When a patient complains of **chest pain,** the immediate response should be to call a nurse to evaluate and assist the patient. (If pain is severe or patient in distress use emergency light). The nurse aide should remain with the patient, loosen clothing (especially about the neck), and take the patient's pulse and respirations. If equipment is available in the room, the nurse should take the patient's blood pressure and oxygen saturation level as well. The nurse aide can also gather information if the patient is able to talk about when the pain started, what the pain feels like (dull, aching, sharp, crushing, burning), and exactly where the pain is located. This information is especially valuable in the event the patient experiences a cardiac arrest before the nurse arrives.*

162.

Your patient has aphasia. Which of the following is NOT a possible cause?

A cerebrovascular accident

A brain tumor

Diabetes

Parkinson's disease

Explanation:

Diabetes is unrelated to the presence of aphasia, which is difficulty speaking due to brain lesions caused by factors such as a cerebrovascular accident (stroke, A), a brain tumor (B), progressive diseases such as Parkinson's or Alzheimer's (D), or brain injury.

163.

When bathing a patient, the nursing aide should NOT:

Wash the dirtiest area first

Use standard precautions

Use an assistive device

Apply nonprescription ointments afterwards

Explanation:

When the aide is bathing the patient, he/she should wash starting with the cleanest area and progressing to the dirtiest. Bathing as well as grooming activities should employ standard precautions (B). Assistive devices (C) are not always used, but should be utilized for patients at high risk for falls. While prescription ointments must be applied by a licensed nurse, nonprescription emollients (D) can be applied sparingly afterwards by the aide.

164.

You take your patient's temperature and find it to be 97.3°F. Which of the following could definitely NOT have caused this?

The patient is starting to get an infection

The patient has been resting

The patient drank something within 15 minutes of an oral temperature reading

The patient has recently come out of the operating room

Explanation:

At rest, a person who is otherwise healthy should have a normal core temperature of between 97.8°F and 99.1°F. While elevated temperature generally indicates infection, initially a person could have a low core temperature (A). If the method of taking temperature is oral, the reading should not be taken within 15 minutes of drinking as that can lower the value (C). Operating rooms can be cold and thus lower core temperature temporarily (D).

165.

What should you NEVER do if a patient insists on using the call light or bell whether or not he/she really needs to?

Ignore the call light or bell if you are aware of this behavior

Tape gauze over the call button

Stop in as often as possible to talk to that patient

Make sure the items the patient will need are readily available

Explanation:

You should never ignore a call light or bell, regardless of assumed patient behavior. Item B is actually a means by which the patient can find the correct button if he/she needs to call the aide or nurse. C and D are ways of hopefully cutting down on use of the call light or bell.

166.

Directives for what types of measures are generally covered on a DNR order?

Organ/tissue donation after death

Use of long-term mechanical ventilation, continuous dialysis, and/or a feeding tube

Use of new intubation, CPR, and/or defibrillation if near death or unconscious

Designation of another person to make medical decisions if the patient is unable to do so

Explanation:

Directions for use of the heroic measures listed in C are part of a Do Not Resuscitate (DNR) order. Items A and B are addressed in an advanced directive regarding end-of-life care, and item D refers to designation of a medical durable power of attorney.

167.

How should a thermometer used for taking a resident's temperature be treated in terms of potential for infection?

It should be sterilized between uses

It should be treated with a high-level disinfectant between uses

It should be cleaned with soap and rinsed between uses

It should be wiped off between uses

Explanation:

Even if it is covered with a plastic probe cover, a thermometer would be considered an intermediate-risk item that comes in contact with mucous membranes but does not penetrate the skin, and as such should be cleaned with a high-level disinfectant. Even if it does pierce the skin, a thermometer really cannot undergo sterilization procedures (A) appropriate for high-risk items like surgical instruments. C is appropriate for low-risk items, and D is insufficient for anything touching skin.

168.

Which of the following is NOT a possible treatment for a contracture?

Use of a splint

Range-of-motion exercises

Use of a dressing

Use of heat therapy

Explanation:

A contracture is an area of muscle tightening, which is a problem when it affects joint motion. Therefore, a splint for stretching the joint (A), range-of-motion exercises (B), and heat (D) are all helpful, but there is no need for a dressing.

169.

How does oral care for an unconscious patient differ from that for a conscious one?

The unconscious patient should be placed in the Fowler's position

A towel should be draped over the patient's chest

A tongue depressor should be used to keep the patient's mouth open and suctioning should be done afterwards

The aide should wear gloves during the procedure

Explanation:

The unique parts of oral care for an unconscious patient are keeping the mouth open with a tongue depressor and use of suctioning afterwards. All patients should receive oral care in the Fowler's position (head of bed elevation of 30 to 90 degrees, A) with a towel over the chest (B) and use of gloves by the aide (D).

170.

Which of the following is ALWAYS outside the scope of practice of a nursing assistant?

Insertion or removal of an indwelling catheter

Administration of medications to the patient

Helping the patient with self-administration of drugs

Following the supervising nurse's orders

Explanation:

Insertion or removal of a device such as an indwelling catheter (or performance of any sterile procedure) is outside the nursing assistant's scope of practice and could result in liability for the action. Choices B and C having to do with administration of drugs are usually outside the

scope of practice but may be allowed in some states or instances if the assistant has received special training. Following a supervising nurse's orders (D) is a normal part of the nursing assistant's daily duties.

171.

Which of the following should NOT be done for a patient who has Sundowner's syndrome?

Promote daytime exercise

Allow sleeping during the day

Darken the room when it is time to sleep

Give a therapeutic massage at night

Explanation:

The patient with Sundowner's syndrome gets confused or agitated in late afternoon or early evening. The syndrome may or may not be associated with dementia. The patient should not be allowed to sleep during the day since he/she will have more difficulty sleeping at night. All of the other actions are generally helpful.

172.

If you have given a patient 4 ounces of juice, how should you report that on his/her chart?

As 4 ounces of juice

As a half cup of juice

As 60 mL or cc of juice

As 120 mL or cc of juice

Explanation:

Fluid measurements should be reported as mL (milliliters) or cc (cubic centimeters). Since the conversion factor is 30 mL per ounce, the correct answer is 120 mL or cc.

173.

What is H.S. care?

Care provided at bedtime

Washing of the patient's hair

Care provided in the morning

Bathing of the patient

Explanation:

The term H.S. care stands for hour of sleep care provided at night. It includes a condensed version of skin care with washing of the face and hands, oral care, and possibly a back rub. Care provided in the morning (C) is termed a.m. care and is more extensive, including a full bath, shaving, dressing, and hair, oral, and nail care. The other choices are part of providing for activities of daily living but are incorrect.

174.