Nursing

Nurse-Aides-CNA
Certified Nurse Assistant

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Question: 1

Which of the following is a measurement of the pressure in a patient's heart during contraction?

A. Systolic blood pressure
B. Diastolic blood pressure
C. Apical pulse
D. Pulse oximetry

Answer: A

Explanation:
Systolic blood pressure, or the top number of the patient's blood pressure, looks at the pressure in the patient's heart during contraction. Diastolic blood pressure, or the lower number, looks at the pressure in the heart during rest. The pulse measures the number of cardiac contractions per minute. Pulse oximetry measures the amount of oxygen in the blood.

Question: 2

Which of the following abnormal vital signs should be immediately reported to the nurse?

A. Oral temperature of 99.2 degrees
B. Respiratory rate of 5
C. Blood pressure of 126/72
D. Pulse rate of 59

Answer: B

Explanation:
Choices A and D are slightly abnormal and should be reported to the nurse, although it is not necessary to do this immediately. A blood pressure of 126/72 is technically considered abnormal, but can probably be largely attributed to the stress of being in the hospital. It is nothing to be overly concerned about. A respiratory rate of five breaths per minute is very slow, and can indicate impending respiratory failure. The CNA should notify the nurse immediately.

Question: 3

Which fluids should be included in the measurement of a patient's intake?

A. 8 oz. of milk
B. 250 mL of intravenous fluid

C. 6 oz. of Jell-O
D. All of the above

Answer: D

Explanation:
All of the choices are liquids or melt at room temperature (Jell-O), and should be included in the measurement of a patient's intake. The CNA should also measure the amount of tube feeding (including what is used to flush the tube) and other IV medications or fluids. Total intake should be in mLs and recorded every 24 hours.

Question: 4

What is the first thing a CNA should do when measuring a patient's height and weight?

A. Wash her hands
B. Verify the patients identity by inspecting her armband
C. Allow the patients legs to dangle for a few moments before allowing her to stand up
D. Assist the patient with ambulation to the scale

Answer: A

Explanation:
Whenever a CNA enters a patients room to initiate care or perform a task, she should wash her hands, introduce herself to the patient, and explain what she is going to do. Next, she should identify the patient using the patient's armband and two identifiers. Finally, she can perform the task she came in to do, which in this case is measuring the patient's height and weight.

Question: 5

Which of the following is an example of subjective data?

A. The patient has a pulse rate of 88 bpm.
B. The patient states that she has a pain level of 8.
C. The CNA notes that the patient has flushed cheeks.
D. The CNA notes that the patient has cloudy urine.

Answer: B

Explanation:
Subjective data is anything the patient notes or feels, such as her pain level. Objective data is information that can be measured (such as vital signs) or observed by another person (such as the patient having cloudy urine or flushed cheeks).

Question: 6

While completing her documentation, a CNA notices that she made a mistake while writing in a patient's blood pressure. How should she correct the notation?

A. Use correction fluid to cover the mistake
B. Scribble out the incorrect number and write the correct number next to it
C. Draw a single line through the incorrect notation, and write "error," along with her initials. The correct number should be written next to it
D. Erase the incorrect notation; documentation is always completed using a pencil

Answer: C

Explanation:
Making documentation errors is common. However, the CNA must understand how to deal with these errors. She should never use correction fluid or scribble out the error so it is illegible. A pencil should never be used for documentation. When an error is made, simply draw a single line through the mistake and place the correction, the word "error," and your initials next to it.

Question: 7

A patient with which of the following conditions is MOST at risk for dehydration?

A. Diarrhea
B. Liver disease
C. Heart disease
D. Pneumonia

Answer: A

Explanation:
A patient with diarrhea is at a high risk for dehydration, so all complaints from the patient and direct observations of diarrhea should be reported to the nurse. Signs of dehydration include dry mucus membranes, weakness, and thirst. The CNA may also observe dark urine or sunken eyes. As long as it's not contraindicated, the CNA should encourage the patient to drink extra water to help replace the lost fluids.

Question: 8

When caring for a patient with diarrhea, which of the following should be recorded in the patient's chart?

A. Odor of the stool
B. Types and amounts of fluids the patient is drinking
C. Number of stools
D. All of the above

Answer: D

Explanation:
When caring for a patient with diarrhea, it is important to note all of the information in the answer choices in the patients chart, as it can be vitally important to the care and treatment plan for the patient. Additionally, the doctor will need the information to gauge the severity of the diarrhea and dehydration. The CNA should also note how much fluid is passed with each stool and how often the patient is having episodes of diarrhea.

Question: 9

How often should a patient who is lying on an egg crate or an inflatable mattress be turned?

A. Never — patients shouldn't be turned when they are lying on inflatable mattresses.
B. Every 12 hours
C. Every 6 hours
D. Every 2 hours

Answer: D

Explanation:
Unless the patient is on a special bed that is designed to be used without turning, the patient should always be turned every hours. Simply adding an egg crate or inflatable mattress to the existing bed is not enough to eliminate or reduce the need to turn the patient. An egg crate can help reduce the pressure on the patient's skin and bony prominences, but the patient should still be turned every hours.

Question: 10

Which of the following is NOT an intervention a CNA can use to manage edema?

A. Elevate the affected extremity
B. Use ice or a cold pack to reduce swelling
C. Massage the affected extremity using lotion
D. Encourage activity or use range of motion exercises

Answer: B

Explanation:
True edema is usually a result of poor circulation, so using an ice or cold pack would be of little use in managing it. Useful interventions help stimulate blood flow and blood return. Elevating the extremity will help promote lymphatic drainage and venous return to minimize edema. Movement through ambulation, massage, or range of motion exercises are also great ways to treat and minimize edema.

Question: 11

A patient with a shuffling gait, difficulty swallowing and speaking, and short-term memory loss MOST likely has which of the following?

A. Alzheimers disease
B. Dementia
C. Parkinson's disease
D. Sundowner's syndrome

Answer: C

Explanation:
All of these symptoms are signs of Parkinson's disease. Alzheimer's disease, dementia, and Sundowner's syndrome all produce similar symptoms, which include confusion, agitation, and wandering. A shuffling gait, though, is the hallmark symptom of Parkinson's disease. A patient with Parkinson's needs special help with ambulation because their gait is so unsteady, and with eating because they frequently have difficulty swallowing their food.

Question: 12

A CNA is caring for a patient with Sundowner's syndrome. Which of the following symptoms should he be especially aware oP

A. Worsening confusion at night
B. Risk for falls
C. Aggression
D. Difficulty swallowing

Answer: A

Explanation:
Patients with Sundowner's syndrome typically have worsening confusion at night. They may become agitated and wander off the unit. During the day, patients with Sundowner's typically aren't as confused. Possible interventions include checking on and reorienting the patient frequently, and preventing day time sleep so that it is easier for the patient to sleep at night. A patient with Sundowner’s may also be at risk for falls or aggression or have difficulty swallowing, but these symptoms are secondary to the confusion they experience at night.

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