

Total Question: 550 QAs

1. When performing a bed bath, what temperature should the water be?

- ☐ a. 70-80 degrees Fahrenheit
- ☒ b. 105-115 degrees Fahrenheit **Correct**
- ☐ c. 130-140 degrees Fahrenheit
- ☐ d. 155-165 degrees Fahrenheit

Water for a bed bath should be heated up to approximately 105-115 degrees Fahrenheit. Any cooler and the water will cool off too much before the end of the bath, chilling the patient. Any warmer and the water will be too hot, and could potentially burn the patient. Filling the basin should be the last thing you do; gather all other supplies first to minimize the cooling of the water. If you don't have a thermometer to measure the water temperature, make sure it is comfortably warm against your elbow or inner arm.

2. Which of the following tasks is NOT completed during a routine bed bath for a diabetic?

- ☐ a. Changing the linens
- ☐ b. Inspection and cleansing of skin
- ☐ c. Perineal care
- ☒ d. Nail care **Correct**

You should check with your institution's policies on nail care, but generally speaking, a nurse aide should not provide nail care to a diabetic patient. Diabetics have impaired circulation to their extremities, which can delay healing and even cause severe damage if the skin is injured. For that reason, only a physician, podiatrist, or other specially trained clinician should perform nail care on a diabetic. Performing perineal care, changing the linens, and inspecting the skin should be done during every full bed bath, usually as part of morning care.

3. How would you classify a pressure sore that has a pink wound bed, but does not extend through the full thickness of the skin?

- ☐ a. Stage I
- ☒ b. Stage II **Correct**
- ☐ c. Stage III
- ☐ d. Stage IV

A stage I pressure sore would appear as a reddened area that does not blanch (turn white) when pressed. A stage II pressure sore involves a partial breakdown of the upper layer of skin, but does not extend all the way through the skin. A stage II pressure ulcer may look like a blister. Stage III and stage IV ulcers extend all the way through the skin. You may see the underlying subcutaneous fat in a stage III ulcer, whereas a stage IV may proceed all the way down to the muscles, tendons, or bones. Make sure to report any skin redness to the nurse so that the skin can be thoroughly assessed.

4. A patient is scheduled for surgery later in the day. What type of food would you expect on his breakfast tray?

- ☒ a. No tray – the patient is NPO **Correct**
- ☐ b. Jell-O and chicken broth
- ☐ c. Scrambled eggs
- ☐ d. French toast and fruit

A patient who is about to undergo surgery or another procedure requiring an anesthetic should be NPO for a minimum of eight hours before the procedure. If the patient receives a tray, you should double check with the nurse before serving the patient his breakfast. If a procedure is scheduled for later in the day, the anesthesiologist may be okay with the patient eating breakfast.

5. How can a nurse aide help prevent the development of pressure sores?

- ☐ a. Turning the patient every four hours
- ☐ b. Providing a full bed bath three times a day
- ☒ c. Doing partial baths every time a patient soils herself **Correct**
- ☐ d. Reducing the amount of fluids the patient drinks to minimize incontinence

A patient who is bedbound or spends a majority of the day lying or sitting down is at risk for developing pressure sores. Preventing pressure sores requires multiple interventions, including: turning the patient every two hours, doing a full bed bath once a day and partial bed baths throughout the day as necessary if the patient is incontinent (partial baths should be done whenever a patient soils himself), increasing the protein content of food, and making sure the patient is hydrated. It is not appropriate to do a full bed bath twice a day. Withholding fluids to prevent incontinence is also inappropriate.

6. When is it acceptable for a nurse aide to wash her hands using an alcohol-based hand sanitizer instead of soap and water?

- ☐ a. Before eating
- ☐ b. After performing peri care on a patient
- ☐ c. After using the bathroom
- ☒ d. Between checking on patients **Correct**

Alcohol-based sanitizers are a great tool to avoid the comparatively time-consuming process of hand washing, and are appropriate in certain situations. The nurse aide should wash her hands with soap and water before eating, after using the bathroom, after performing a procedure that involves contact with bodily fluids (such as peri care), and when her hands are visibly soiled. She should also wash her hands periodically throughout the day to remove the buildup of alcohol on the hands. It is perfectly acceptable to use an alcohol-based sanitizer between checking on patients, especially if the nurse aide is not performing care.

7. A nurse aide is providing care for a patient on contact precautions. What type of personal protective equipment should she be using?

- ☐ a. Respirator
- ☐ b. Mask
- ☒ c. Gown **Correct**
- ☐ d. All of the above

If a patient is on contact precautions the caretaker must wear a gown and gloves. Using a mask or respirator is not necessary unless the patient is on droplet or airborne precautions.

8. Before entering a patient's room, personal protective equipment (PPE) should be put on in which order?

- ☒ a. Gown, mask, gloves **Correct**
- ☐ b. Gown, gloves, mask
- ☐ c. Mask, gown, gloves
- ☐ d. Mask, gloves, gown

When entering the room of a patient on isolation precautions, the nurse aide should put on the gown first, with the opening in the back. After tying the gown closed at the neck and around the waist, the mask should be put on next. Lastly, the nurse aide should put on her gloves, ensuring that the cuff of the gloves is covering the cuff of the gown. When leaving the room, the PPE should be removed in the reverse order: gloves, mask, and gown.

9. When changing linens in an isolation room, which of the following is an appropriate measure to prevent contamination of clean materials?

- ☒ a. Placing dirty linens in a plastic bag inside of the patient's room, and then putting the plastic bag into a bag outside of the room that is held open by a second nurse aide
- ☐ b. Shaking out soiled linens to remove solid material before washing
- ☐ c. Piling soiled linens outside of the dirty utility room to avoid mixing them with non-contaminated linens
- ☐ d. Moving the soiled linens to the dirty utility room before hand washing

Correct

Anything in the patient's room is considered "contaminated," so when you place the soiled linens into the plastic linen bag, that bag is considered contaminated. The nurse aide should ask a colleague to hold a second bag open at the doorway and place the contaminated linen bag in it. The second nurse aide can then put the bag on the floor outside of the room until the first nurse aide is ready to wash her hands and bring it to the dirty utility room. The soiled linens should never be shaken out because of the risk of contaminating other nearby items.

10. Which of the following items requires cleaning with a disinfectant prior to use?

- ☐ a. Stethoscope
- ☐ b. Scalpel
- ☒ c. Thermometer
- ☐ d. Blood pressure cuff

Correct

Items that require cleaning with a disinfectant are ones that come into contact with a patient's mucus membranes but don't puncture the skin. Thermometers and respiratory equipment are good examples of items that should be disinfected but don't require sterilization. Items such as scalpels that penetrate the skin should be sterilized between patients because of the high risk of contamination. Items such as stethoscopes and blood pressure cuffs that just touch the skin can be cleaned with a mild detergent between uses.

11. What is the proper term for an infection that is transmitted during a medical procedure?

- ☐ a. Droplet
- ☒ b. Iatrogenic **Correct**
- ☐ c. Direct oral contact
- ☐ d. Fecal-oral transmission

An infection that is transmitted during a medical procedure is called iatrogenic. Droplet transmission is when bacteria or viruses are released in droplets when a person sneezes or coughs. Direct oral contact is transmission between people when there is direct oral contact, such as kissing or sharing a drinking cup. Fecal-oral contamination is exactly what it sounds like: fecal material contaminates food, usually through poor hand washing or poor food preparation techniques.

12. For a patient on fall precautions, what is the minimum number of side rails that should be raised while the patient is in bed?

- ☐ a. 1
- ☒ b. 2 **Correct**
- ☐ c. 3
- ☐ d. 4

A minimum of two bed rails should be raised when the patient is in bed. Raising four side rails is considered a restraint, and should not be done unless directly ordered by the physician. One raised bed rail leaves an entire side of the bed without any boundaries.

13. Before transferring a patient from the bed to a wheelchair, what is the very first thing the nurse aide should do?

- ☐ a. Place her arms under the patient's axilla and assist her to a standing position.
- ☐ b. Assist the patient to a sitting position.
- ☐ c. Allow the patient to dangle her legs for a few minutes before standing.
- ☐ d. Ensure the wheels on both the wheelchair and the bed are locked. **Correct**

The very first thing that should be done before transferring a patient is to make sure that the wheels on both the wheelchair and the bed are locked. This prevents falls by preventing movement of the bed or wheelchair as the patient is being transferred. Once the nurse aide has verified that the wheels are locked, she can help the patient to sit up and allow her to dangle her legs for a few moments. Then, she can help the patient stand up and slide into the wheelchair.

14. What type of assistance would be required for an elderly woman who fell recently, but is still able to ambulate?

- ☐ a. Stand by assistance
- ☐ b. Minimum assistance
- ☐ c. Contact guard assistance **Correct**
- ☐ d. Maximum assistance

An elderly woman who has fallen previously is at risk for falling again. However, she is still ambulatory, so the nurse aide should be within an arm's reach in case the patient becomes unsteady or falls again. This is known as contact guard assistance. Stand by assistance and maximum assistance are inappropriate because they provide too little and too much support, respectively.

15. Which technique is MOST appropriate for a patient with both poor upper body and lower body strength?

- ☒ a. Four-point technique **Correct**
- ☐ b. Three-point technique
- ☐ c. Swing-to method
- ☐ d. Swing-through method

Four-point technique is a great method of crutch walking for patients who have poor upper and lower body strength because it balances out the patient's weight on both arms and the alternating legs. Three-point, swing-to, and swing-through methods are all great for a patient who has good upper body strength because these gaits depend primarily on the arms to keep the patient upright.

16. A nurse aide encounters a small fire in a patient's room. The room is empty. What is her first priority?

- ☐ a. Rescue patients in the neighboring rooms
- ☒ b. Activate the fire alarm **Correct**
- ☐ c. Close all fire doors
- ☐ d. Grab a fire extinguisher and attempt to extinguish the fire

This question can be answered using the acronym R.A.C.E. (rescue, activate alarm, confine the fire, evacuate/extinguish). The nurse aide should first rescue patients in imminent danger. Because the room is empty, her first priority should be to pull the fire alarm. If the fire is small and contained, she could try to extinguish the fire herself with a fire extinguisher using the P.A.S.S. method (pull the pin, aim at the base of the fire, and sweep side to side). If not, she should start closing fire doors and rescuing patients in neighboring rooms if necessary.

17. Which of the following procedures is NOT appropriate for a patient who has been ordered to be placed in restraints?

- ☐ a. Offer toileting and water every one to two hours
- ☐ b. Check the patient at least every 30 minutes to ensure there is proper circulation where the restraints are applied
- ☐ c. Tie the restraints directly to the bed frame
- ☐ d. Tie the restraints directly to the side rails **Correct**

Whenever a patient is placed in restraints, the nurse aide should make sure there is an up-to-date order from the physician (within the last 24 hours). The patient should be offered the opportunity to use the bathroom or have a glass of water or food at least every one to two hours. The restraints should be checked at least every thirty minutes to make sure they are not too tight or cutting off circulation to the patient's limbs. The ties should be quick-release knots and the restraints should be tied directly to the bed frame. Restraints should never be tied to the side rails in case they inadvertently fall, which could cause injury to the patient.

18. How should a nurse aide clean an indwelling catheter?

- ☐ a. By using a gentle back and forth motion
- ☐ b. By using a circular motion towards the body
- ☐ c. By using a circular motion away from the body **Correct**
- ☐ d. By using an up and down motion

A patient with an indwelling catheter has a higher risk of contracting a urinary tract infection, and so catheter and perineal care is very important. The catheter should be assessed and cleaned frequently. After putting on gloves and explaining what you are going to do, you should use warm water to gently clean the urethra and, using a circular motion away from the body, the catheter. The nurse aide should never clean upwards or use a back and forth motion because of the potential to introduce bacteria into the urethra. Make sure to dry the catheter and patient, check to make sure there are no kinks in the tubing, and then hang the bag from the bed frame.

19. Before taking a meal tray into a patient's room, what should a nurse aide do?

- ☐ a. Record the amount of food/liquids on the intake/output form
- ☐ b. Assess a patient's ability to swallow properly
- ☐ c. Put on gloves
- ☐ d. Ensure that the correct food is on the tray **Correct**

Before taking a meal tray into a patient's room, the nurse aide should ensure that the tray is labeled with the correct name, room number, and diet. Once she has delivered all of the trays, the nurse aide can go back and assist patients who need help eating. Ability to swallow should be assessed each time a patient is eating. The nurse aide should always be alert for signs that the patient isn't swallowing properly. As she is collecting the used food trays, the nurse aide should document the intake for each patient. This is the best time to see what each patient actually ate.

20. If a nurse aide notices that a patient appears to be having difficulty swallowing, what should she do?

- ☐ a. Notify the nurse immediately **Correct**
- ☐ b. Mash up the food and continue feeding the patient
- ☐ c. Give the patient smaller amounts of food with each bite
- ☐ d. Nothing; the doctor checked the patient's swallowing already

Because of the serious risk of aspiration and its complications, the nurse aide should never continue feeding food to a patient with a suspected swallowing issue. She should immediately stop feeding the patient and notify the nurse. The nurse can inform the doctor and arrange for a swallowing study if necessary, or even change the patient's diet to include soft foods or purées only.

21. How often should anti-embolism stockings be removed?

- ☐ a. Every 4 hours
- ☒ b. Every 8 hours **Correct**
- ☐ c. Every 12 hours
- ☐ d. Every 24 hours

Anti-embolism stockings should be removed once every eight hours to ensure proper circulation and let the skin breathe. When removing the stockings, the nurse aide should assess the skin to make sure there are no rashes, skin breakdown, or other concerns. She should also check on the patient's toes to assess blood flow while the stockings are on. If the patient complains of numbness, tingling, or discomfort when wearing the stockings, it should be brought to the nurse's attention immediately.

22. There is a note on a patient's chart that she should be placed in the Sim's position. How should the patient be positioned?

- ☐ a. Lying on the stomach with the head turned to the side
- ☐ b. On her back with the head of the bed raised to a 90-degree angle
- ☐ c. On her back with the head of the bed raised to a 45-degree angle
- ☒ d. On her left side with the top leg flexed and supported by a pillow **Correct**

Sim's position is when a patient is lying on her side with the top leg flexed towards the chest. Choice A, on her stomach, is called the prone position. Choice B, with the head of the bed raised to a 90-degree angle, is called the High Fowler's position. Choice C, on her back with the head of the bed raised to 45 degrees, is called the Semi-Fowler's position.

23. What is the first step for a nurse aide who is about to put on sterile gloves?

- ☐ a. Use the dominant hand to grasp the glove at the cuff and slide it on to the non-dominant hand.
- ☐ b. Use the non-dominant hand to grasp the glove under the cuff and slide it on to the dominant hand.
- ☒ c. Wash and dry hands thoroughly. **Correct**
- ☐ d. Put on gloves to open the packaging.

When putting on sterile gloves, the nurse aide should first wash and dry her hands thoroughly. Then, she should open the packaging, taking care not to touch anything inside. Next, she should pick up the glove for the dominant hand at the cuff using her non-dominant hand and slide it onto the dominant hand. Finally, using the gloved hand, she should pick up the second glove beneath the cuff and slide it onto the non-dominant hand. Once both gloves are on, she can then make adjustments to the fit, taking care to avoid touching anything unsterile.

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

- ☒ a. Systolic blood pressure **Correct**
- ☐ b. Diastolic blood pressure
- ☐ c. Apical pulse
- ☐ d. Pulse oximetry

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.

25. 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 **Correct**
- ☐ c. Blood pressure of 126/72
- ☐ d. Pulse rate of 59

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 nurse aide should notify the nurse immediately.

26. 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 **Correct**

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 nurse aide 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.

27. What is the first thing a nurse aide should do when measuring a patient's height and weight?

- ☒ a. Wash her hands **Correct**
- ☐ b. Verify the patient's identity by inspecting her armband
- ☐ c. Allow the patient's legs to dangle for a few moments before allowing her to stand up
- ☐ d. Assist the patient with ambulation to the scale

Whenever a nurse aide enters a patient's 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.

28. 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. **Correct**
- ☐ c. The nurse aide notes that the patient has flushed cheeks.
- ☐ d. The nurse aide notes that the patient has cloudy urine.

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).

29. While completing her documentation, a nurse aide 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

Correct

Making documentation errors is common. However, the nurse aide 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.

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

- ☒ a. Diarrhea
- ☐ b. Liver disease
- ☐ c. Heart disease
- ☐ d. Pneumonia

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 nurse aide may also observe dark urine or sunken eyes. As long as it's not contraindicated, the nurse aide should encourage the patient to drink extra water to help replace the lost fluids.

31. 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 **Correct**

When caring for a patient with diarrhea, it is important to note all of the information in the answer choices in the patient's 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 nurse aide should also note how much fluid is passed with each stool and how often the patient is having episodes of diarrhea.

32. 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 **Correct**

Unless the patient is on a special bed that is designed to be used without turning, the patient should always be turned every two 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 two hours.

33. Which of the following is NOT an intervention a nurse aide can use to manage edema?

- ☐ a. Elevate the affected extremity
- ☒ b. Use ice or a cold pack to reduce swelling **Correct**
- ☐ c. Massage the affected extremity using lotion
- ☐ d. Encourage activity or use range of motion exercises

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.

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

- ☐ a. Alzheimer's disease
- ☐ b. Dementia
- ☒ c. Parkinson's disease **Correct**
- ☐ d. Sundowner's syndrome

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.

35. A nurse aide is caring for a patient with Sundowner's syndrome. Which of the following symptoms should he be especially aware of?

- ☒ a. Worsening confusion at night **Correct**
- ☐ b. Risk for falls
- ☐ c. Aggression
- ☐ d. Difficulty swallowing

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.

36. What is one technique a nurse aide can use to help a patient with aphasia?

- ☐ a. Providing a time limit for the patient to respond
- ☐ b. Speaking for the patient
- ☒ c. Using a picture or letter board **Correct**
- ☐ d. Giving the patient a pen

Aphasia is an acquired inability to understand language and express oneself through speech. Patients with aphasia have different levels of ability, and should be approached with patience. Setting a time limit and speaking for the patient are not productive or helpful in terms of helping the patient relearn these skills. A pen and paper may be helpful in some situations, but many patients aren't able to read or write as a result of their aphasia. A picture or letter board is a universal method of communication, and offers an easy way to communicate because it is so simple to use.

37. A nurse aide is caring for a patient who is becoming agitated. How should she speak to the patient?

- ☐ a. In an assertive and confident manner
- ☐ b. Not at all; the patient's family members or other staff should interact with the patient
- ☐ c. She should not acknowledge the inappropriate behavior and carry on as normal
- ☒ d. Calmly and clearly, while attempting to determine why the patient is agitated **Correct**

Patients may become agitated for any number of reasons. They might be in pain or be uncomfortable. They could be hungry, thirsty, have to go to the bathroom, or even be bored or scared. Understanding what is causing someone's agitation is the best way to relieve it. The nurse aide should continue to interact with the patient in a calm, clear, and professional manner. She may need to set boundaries as necessary, especially if the behavior persists.

38. Hospice care is appropriate for which of the following?

- ☐ a. Patients who are expected to live less than three months
- ☒ b. Patients who are expected to live less than six months **Correct**
- ☐ c. Patients who are actively dying
- ☐ d. Patients who have been diagnosed with a terminal disease, regardless of their clinical condition

Hospice care is appropriate for patients who are expected to live less than six months. Patients who are transferred into hospice care typically sign a DNR order and are treated using pain relief measures.

39. Which of the following answer choices correctly lists the five stages of grief in order of their expected occurrence?

- ☒ a. Denial, anger, bargaining, depression, acceptance **Correct**
- ☐ b. Anger, denial, depression, bargaining, acceptance
- ☐ c. Depression, denial, anger, bargaining, acceptance
- ☐ d. Bargaining, denial, anger, depression, acceptance

The first stage of grief is denial that the event happened or is going to happen. Following that is anger at the situation or people involved. Next is bargaining, in which the sufferer bargains with God (I'll do..... if you make this go away). Depression follows as the person starts to deal with their grief. Finally, the patient begins to accept what has happened and can start to move forward. It's important to keep in mind that not everyone goes through the same steps in a linear and straightforward manner. It's not uncommon for someone to progress through one stage quickly and then get held up at a subsequent stage or even regress back to a prior stage.

40. Unless otherwise ordered, how often should a nurse aide record the vital signs of a patient who is actively dying? The patient has a signed DNR order in place.

- ☐ a. Every 5 minutes
- ☐ b. Every 15 minutes
- ☐ c. Every hour
- ☒ d. Never **Correct**

Generally speaking, the nurse aide should never record the vital signs of a patient with a DNR order in place who is actively dying. The clinical staff, including the nurse aide, should do everything in their power to make the patient and their family comfortable. The family may want the extra time with their loved one without being interrupted. Additionally, the act of having their vital signs taken may cause pain or discomfort for the patient, both of which should be avoided if possible. If, however, the physician has ordered otherwise, the nurse aide should defer to the wishes of the physician and nurse.