

Practice Exam Questions



NNAAP

National Nurse Aide Assessment Program



EXAMAIDES

PASS YOUR EXAM AT FIRST TRY

Total Question: 250 QAs

Question No: 1

What should be the first action to help a client who is bleeding from the left forearm?

- A. Lower the body part.
- B. Apply pressure to the brachial artery.
- C. Apply direct pressure to the wound.
- D. Cover the person.

Answer: C

Explanation: To control external bleeding, apply pressure with your hand over the bleeding site. Do not release the pressure until the bleeding stops. The affected part should be elevated. Applying pressure over the artery above the bleeding site, e.g. to the brachial artery, is only applicable if the direct pressure does not control the bleeding. Remember the question is asking for the first action. Covering the person is not a correct action.

Question No: 2

You are a client who just had an abdominal surgery with coughing and deep breathing. Which of the following is not a correct procedure?

- A. The client inhales through pursed lips.
- B. The client sits in a comfortable sitting position.
- C. The client inhales deeply through the nose.
- D. The person holds a pillow over the incision.

Answer: A

Explanation: The client should exhale slowly through pursed lips, not inhale. The client should exhale until the ribs move as far down as possible. The other responses are correct procedures to assist in coughing and deep breathing exercises.

Question No: 3

Melrose (CNA) is taking care of Mr. Wilkins, a COPD client who is on oxygen therapy. Her knowledge about oxygen flow rates is important in order to provide efficient and safe nursing care to her client. Which of the following signifies her true understanding of oxygen flow rates?

- A. She can check the flow rate.
- B. She knows that the flow rate is measured in milliliters (ml).
- C. She knows that the flow rate is the amount of oxygen given in 1 minute.
- D. She knows that the flow rate is the same for all persons.

Answer: A

Explanation: The nurse assistant should monitor the flow rate that is ordered by the physician. Tell the nurse at once if it is too high or too low. Some states and agencies let nursing assistants adjust flow rates. Know your agency's policy. Flow rate is the amount of oxygen given. It is measured in liters per minute (L/min). The nurse or respiratory therapist sets the flow rate.

Question No: 4

Rehabilitation and restorative care focus on:

- A. What the person cannot do.

- B. What the person can do.
- C. The whole person.
- D. The person's rights.

Answer: C

Explanation: The person with a disability needs to adjust physically, psychologically, socially, and economically. Rehabilitation is the process of restoring the person to his or her highest possible level of physical, psychological, social, and economical functions. Abilities - what the person can do - are stressed.

Question No: 5

Using the principles of standard precautions, the nurse assistant would apply gloves when performing which of the following procedures?

- A. Providing back massage
- B. Feeding a client
- C. Providing hair care
- D. Providing oral hygiene

Answer: D

Explanation: Providing oral hygiene is a procedure that exposes the nurse assistant to a client's body fluids. The other responses do not require the use of gloves because contact with body fluids is not a concern.

Question No: 6

Kristine (CNA) is working in a geriatric screening clinic. Kristine would expect that the skin of normal elderly clients will demonstrate which of the following characteristics?

- A. Dehydration, causing the skin to swell
- B. Moist skin turgor
- C. Skin turgor showing loss of elasticity
- D. Over hydration, causing the skin to wrinkle

Answer: C

Explanation: A loss of elastic skin turgor is a normal process of aging. The other options are not normal findings for elderly clients.

Question No: 7

The nurse assistant is helping a hemiplegic client get dressed. Which of the following is a correct way to help this client get dressed?

- A. Undress the client's weak or involved extremity first.
- B. Undress the upper extremity first, then the lower extremity.
- C. Undress the client's non-involved extremity last.
- D. Dress the weak or most involved extremity first.

Answer: D

Explanation: The nurse assistant is assisting a hemiplegic client get dressed correctly by dressing the client's weak or involved extremity first and undressing the client's weak or involved extremity last.

Question No: 8

You are assisting the nurse in collecting a urine specimen from a client who has been catheterized. When the urine begins to flow through the catheter, you will help:

- A. Inflate the catheter balloon with sterile water.
- B. Place the catheter tip into the specimen container.
- C. Connect the catheter into the drainage tubing.
- D. Place the catheter tip into the urine collection receptacle.

Answer: B

Explanation: When the urine begins to flow through the catheter, you will help place the catheter tip into the specimen container. Catheterization is performed by a licensed nurse upon the order of the physician. In this particular scenario, the client is catheterized for the purpose of urine specimen collection. If the nurse assistant is asked to assist the nurse in this procedure, make sure that a sterile specimen container is available for urine collection. The other options are incorrect because these are steps in inserting an indwelling a catheter.

Question No: 9

The nurse assistant would expect a client diagnosed with hypertension to report which common symptom?

- A. Fatigue
- B. Headache
- C. Nosebleeds
- D. Flushed face

Answer: B

Explanation: Headache is the most common symptom of hypertension. Hypertension has been called "the silent killer" because it gives no warning. In the early stages of this disease, there are often no symptoms. As the disease develops, people may complain of headaches, vision changes, or problems with their urinary output.

Question No: 10

Mr. Gonzales was advised by his doctor to limit salt intake because of his hypertension. Which of the following dietary practices will help him reduce his sodium intake?

- A. Increasing the use of dairy products
- B. Using an artificial sweetener in coffee
- C. Avoiding boxed and instant foods
- D. Using catsup for cooking and flavoring foods

Answer: C

Explanation: A sodium-controlled diet is ordered by the physician for clients with heart diseases, fluid retention, liver diseases, and some kidney diseases. Foods that have high salt contents include frozen, instant, smoked, pickled, and boxed foods. Lunch meats, soy sauce, salad dressings, fast foods, soups and snacks such as potato chips and pretzels also contain large amounts of salt.

Question No: 11

Mrs. Lippett, age 66, is experiencing sensory and perceptual problems that affect her right visual field (right homonymous hemianopia) because of stroke. When placing a meal tray in front of Mrs. Lippett, the nurse assistant should:

- A. Place all the food on the right side of the tray.
- B. Before leaving the room, remind the client to look all over the tray.
- C. Place food and utensils within the client's left visual field.
- D. Stay with the client & periodically draw her attention to the food on the right side of the tray to prevent

unilateral neglect.

Answer: D

Explanation: The client has blindness in the same visual field of both eyes. The safety of the client is the priority of care. Appropriate measures to manage this problem are:

§Approach the client from the unaffected side.

§Place the client's personal objects within the unaffected visual field.

§Encourage the client to turn the head to scan the complete range of vision; otherwise, he or she does not see half of the visual field.

§Encourage independence in activities of daily living to promote self-esteem.

Question No: 12

Mrs. Ricketts has chronic gouty arthritis. The diet appropriate for Mrs. Ricketts would include:

A. Aged cheese, broiled chicken, and pasta

B. Low fat milk, green salad, citrus fruits

C. Mackerel, meat extracts, anchovies

D. Sweetbreads, steak with gravy, scallops

Answer: B

Explanation: Mrs. Ricketts should eat low fat milk, green salad, and citrus fruits. Gout is a systemic disease in which urate crystals deposit in joints and other body tissues. The diet appropriate for clients with gouty arthritis is a low-purine diet. Avoid foods such as organ meats, wines, aged cheese, mackerel, sardines, scallops, sweetbreads, gravies, meat extracts, and anchovies. Encourage a high fluid intake to prevent stone formation.

Question No: 13

One evening, Lizbeth suddenly begins running up and down the hall. She strips off her clothing and strikes out widely at anyone she sees. All of the following interventions would be appropriate except:

A. Restrain the patient.

B. Call for the assistance of at least three staff members.

C. Clear the area of other patients.

D. Call the nurse for the administration of a prn drug.

Answer: A

Explanation: Applying restraints is only appropriate after other measures fail to protect the client. The care plan must include measure to protect the client and prevent harm to others.

Question No: 14

The most appropriate time for the nurse assistant to obtain a sputum specimen is:

A. Early in the morning.

B. After the client eats a light breakfast

C. After aerosol therapy

D. After back tapping and back massage

Answer: A

Explanation: The best time to collect a sputum specimen is in the morning, right after the client awakens. Make sure that a sterile container is available to collect the specimen. The client may be instructed not to eat or rinse his mouth upon rising until the specimen is obtained. If the client has eaten recently, have him rinse out his mouth. Ask the client to take three consecutive deep breaths. On the third breath, ask him to exhale

deeply and cough. The client should be able to bring up sputum from within the lungs. Explain to him that saliva is not adequate for this test.

Question No: 15

Which of the following interventions promotes client safety?

- A. Asses the client's ability to ambulate and transfer from a bed to a chair.
- B. Demonstrate the signal system to the client.
- C. Check to see that the client is wearing his identification band.
- D. All of the above.

Answer: D

Explanation: Safety is a basic need. You must protect clients from harm. Safety measures include:

Always identify the client right before you begin a task or procedure. The ID bracelet is checked against the assignment sheet to accurately identify the client.

The client is checked often. Frequent checks are made on clients with poor judgment or memory.

The client is taught how to use the signal light. The signal light is always within the person's reach.

Question No: 16

Studies have shown that about 40% of patients fall out of bed despite the use of side rails; this has led to which of the following conclusions?

- A. Side rails are ineffective.
- B. Side rails should not be used.
- C. Side rails are a deterrent that prevent a patient from falling out of bed.
- D. Side rails are a reminder to a patient not to get out of bed.

Answer: D

Explanation: Side rails are a reminder to a patient not to get out of bed. The nurse and care plan tell you when to raise side rails. They are needed by clients who are unconscious or sedated with drugs. Some confused or disoriented clients need them. If a client needs side rails, keep them up at all times except when giving bedside care.

Question No: 17

The most common injury among elderly persons is:

- A. Heart attack
- B. Hip fracture
- C. Increased incidence of gallbladder disease
- D. Urinary tract infection

Answer: B

Explanation: Normal changes to the musculoskeletal system that come with aging include a decrease in calcium absorption, a decrease in bone replacement, and loss of muscle mass and tone. These predispose the elderly person to hip fractures, a common injury, because many elderly people attempt tasks they cannot execute cause themselves harm.

Question No: 18

Which of the following factors contributes to constipation?

- A. Excessive exercise

- B. High fiber diet
- C. No regular time for defecation daily
- D. Microbes in food and water

Answer: C

Explanation: Constipation is the passage of a hard, dry stool. The person usually strains to have a bowel movement. Common causes include a low-fiber diet, ignoring the urge to defecate and not having a regular time for defecation daily, decreased fluid intake, inactivity, drugs, aging, and certain diseases. Microbes in food and water are attributed to diarrhea.

Question No: 19

Which of the following is the most important risk factor for development of chronic obstructive pulmonary disease?

- A. Cigarette smoking
- B. Occupational exposure
- C. Air pollution
- D. Genetic abnormalities

Answer: A

Explanation: Chronic obstructive pulmonary disease (COPD) is a respiratory ailment that is comprised of three disorders: chronic bronchitis, emphysema, and asthma. Smoking is the most common cause.

Question No: 20

An incontinent elderly client frequently wets his bed and eventually develops redness and skin excoriation at the perianal area. The best care goal for this client is to:

- A. Make sure that the bed linen is always dry.
- B. Frequently check the bed for wetness and always keep it dry.
- C. Place a rubber sheet under the client's buttocks.
- D. Keep the client clean and dry.

Answer: D

Explanation: Urinary incontinence is the loss of bladder control. The client is at risk for skin irritation, infection, and pressure ulcers. The best care goal is to keep the client clean and dry at all times. The other options are also nursing measures for persons with urinary incontinence, but the focus of care should be on the client and not on the linens and bed.

Question No: 21

Angie is a disoriented client who frequently falls from the bed. Which of the following is the best intervention to prevent future falls?

- A. Tell Angie not to get up from bed unassisted.
- B. Put the call bell within her reach.
- C. Put bedside commode at the bedside to prevent Angie from getting up.
- D. Put the bed in the lowest position.

Answer: D

Explanation: Put the bed in the lowest position possible. The risk of falling increases with age. Most falls occur in the evening, between 6:00 PM and 9:00 PM. The care plan for preventing falls from bed includes:

Placing the bed in the lowest horizontal position, except when giving bedside care. The distance from the bed

to the floor is reduced if the client falls or gets out of bed.

A special mattress or mat is on the floor next to the bed if ordered. This reduces the chance of injury if the person falls.

If the person uses bed rails, check the person often.

Furniture is placed for easy movement.

A telephone and lamp are placed within the person's reach.

Question No: 22

Which of the following measure(s) is /are included in the care plan of clients with fecal incontinence?

I. Help with elimination after meals and every 2 to 3 hours

II. Provide good skin care after every elimination

III. Assist the nurse in the insertion of a suppository as ordered by the physician

IV. Apply of incontinence products

V. Eliminate foods that are gas-forming (cabbage, cauliflower, radish, beans, onions, and cucumbers)

A. II and IV

B. I, II, IV, and V

C. All of the above.

D. II only

Answer: B

Explanation: Fecal incontinence is the inability to control the passage of feces and gas through the anus. The client may need bowel training, help with elimination after meals and every 2 to 3 hours, incontinence products to keep garments and linens clean, good skin care, and avoidance of gas-forming foods.

Question No: 23

Ms. Walsh scratches and picks at a wound in her right foot. Because she is diabetic, the nurse obtained a doctor's order to apply mitt restraints. You were delegated by the nurse to monitor Ms. Walsh after the restraints were applied. Which of the following are important to report to the nurse?

A. Her heart rate

B. Her respiratory rate

C. The appearance of the wound

D. If you feel a pulse in the restrained extremities

Answer: D

Explanation: Make sure the restraint is snug, not tight. Slide one or two fingers between the restraint and the wrist. Adjust the straps if the restraint is too loose or too tight. Check the client and the restraint every fifteen minutes; check for pulse, color, and temperature of the restrained part.

Question No: 24

The nurse aide identifies a reddened area that does not blanch over the client's sacrum. The nurse aide should

A. Massage the area four times each day.

B. Perform range-of-motion exercises with the client.

C. Keep the area covered with a sterile dressing.

D. Reposition the client regularly throughout the day.

Answer: D

Explanation: The nurse aide should reposition an immobile client every two hours while in bed and every hour

in a chair in order to prevent pressure ulcers. Massaging the area will help increase blood flow, but the priority treatment to prevent further breakdown is repositioning. Performing range-of-motion exercises with the client will help to prevent complications of immobility, but frequent repositioning, pressure relief devices, and skin care can help prevent pressure ulcers. If a pressure ulcer forms, a dressing can be used to expedite healing by removing unwanted debris from the ulcer surface, protecting exposed viable tissues, and or providing a barrier between an open ulcer and the environment. Applying sterile dressings is more of a responsibility of the licensed nurse.

Question No: 25

The physician has ordered to bladder training for a client with an indwelling catheter. The goal of bladder training is to

- A. Remove the catheter.
- B. Allow the person to walk to the bathroom.
- C. Gain control of urination.
- D. Void every 3 to 4 hours.

Answer: C

Explanation: Bladder training programs help some persons with urinary incontinence. Control of urination is the goal. Bladder control promotes comfort and quality of life. You assist with bladder training as directed by the nurse and the care plan.

Question No: 26

Jeremy (CNA) is assisting Mr. Shank walk in the hallway. After several steps, the client complained of light-headedness and suddenly fainted. What should be Jeremy's initial action?

- A. Call the nurse to check on the client.
- B. Bring the client as close to his body as fast as possible.
- C. Lower the client to the floor.
- D. Prevent the client from falling.

Answer: B

Explanation: If a client starts to fall, bring him/her close to your body as fast as possible or wrap your arms around the client's waist. If necessary, you can also hold the client under the arms. Then lower him/her to the floor. The client slides down your leg to the floor. Bend at your hips and knees as you lower the client. Call a nurse to check the client. Stay with the client. Help the nurse return the client to bed. Get other staff to help if needed.

Question No: 27

When removing gowns and gloves, which of the following is inappropriate?

- A. Wash gloved hands first.
- B. Peel off gloves inside out.
- C. Use the glove-to-glove, skin-to-skin technique.
- D. Remove mask and gown before removing gloves.

Answer: D

Explanation: When removing gloves, it is inappropriate to remove your mask and gown before removing your gloves. The correct order in removing protective wear is: gloves, mask, gown, eyewear or goggles, cap, shoe cover. Washing your gloved hands reduces the number of microorganisms that could contaminate the hands.

When you remove your gloves, first use your gloved, dominant hand to remove other glove by grasping it just below wrist. Pull this glove down over your non-dominant hand so that it is inside out. Hold the removed glove in your gloved hand. With the first two fingers of your ungloved hand, reach inside the glove without touching the outside of the glove. Pull the glove down (inside out) over your hand and remaining glove. Discard the gloves in a waste receptacle. Remember the technique of glove-to-glove and skin-to-skin contact in removing gloves.

Question No: 28

Which of the following is the most effective practice by caregivers and family when caring for a client with low resistance to infection due to cancer?

- A. Allow two visitors only, at a time.
- B. Wash hands thoroughly.
- C. Wear masks in the client's room at all times.
- D. Meticulous cleaning of the client's room.

Answer: B

Explanation: Hand washing is the most effective practice to prevent transfer of microorganisms. The other choices do not apply to the situation.

Question No: 29

Macy, the new nurse aide, is about to take a client's rectal temperature as ordered by the nurse. Which of the following actions show that Macy is doing the procedure inappropriately?

- A. Explaining the procedure to the client and assisting in the right-side lying position.
- B. Dipping probe into liberal amount of lubricant applied to a tissue, covering the probe at least 1 to 2 inches.
- C. With non-dominant hand, separating buttocks to expose anus; asking the resident to breathe slowly and relax.
- D. With dominant hand, inserting thermometer probe gently into anus, aiming the probe in the direction of the umbilicus, which is 1-2 inches.

Answer: A

Explanation: Explaining the procedure to the client before doing it decreases or eliminates anxiety; however, the client should be placed in the left-side lying position, not the right-side lying position. This position facilitates easy insertion of the probe into the anus as it follows the normal anatomical position of the colon. The other choices are correct actions for the nursing assistant in obtaining rectal temperature.

Question No: 30

Mrs. Moore, a 69-year-old client, is emaciated. The nurse aide takes precautionary measures in order to prevent which of the following problems in skin integrity?

- A. Blisters
- B. Pressure sores
- C. Reddening of the skin
- D. Pustules

Answer: B

Explanation: Pressure sores are a concern with emaciated clients. Factors that contribute to the formation of pressure ulcers include the following: immobility, prolonged inadequate nutrition that causes weight loss, muscle atrophy, and loss of subcutaneous tissue; fecal and urinary incontinence; decreased mental status;

diminished sensation; excessive body heat; and advanced age.

Question No: 31

All of the following are correct methods in obtaining blood pressure except:

- A. Take the blood pressure reading on both arms for comparison.
- B. Listen to and identify the phases of Korotkoff's sound.
- C. Pump the cuff to around 50 mmHg above the point where the pulse is obliterated.
- D. Observe procedures for infection control.

Answer: C

Explanation: Do not pump the cuff to 50 mmHg above the point where the pulse is obliterated. The cuff should be inflated within 30 mmHg above estimated systolic pressure (around 8 seconds). If measuring the blood pressure for the first time, measure the blood pressure in both arms and record the second set of measurements as the baseline. For subsequent measurements, use the arm with the highest initial reading. The audible sounds heard over the stethoscope while deflating the cuff are called Korotkoff's sounds. The nursing assistant needs to be familiar with the different phase of Korotkoff's sounds. In taking the blood pressure, the nursing assistant needs to observe infection control as well.

Question No: 32

A client is admitted to the unit with an order for hourly monitoring of blood pressure. The nurse aide finds that the cuff is too small. This will cause the blood pressure reading to be:

- A. Inconsistent.
- B. Low systolic and high diastolic.
- C. Higher than what the reading should be.
- D. Lower than what the reading should be.

Answer: C

Explanation: Using a cuff that is too small will cause the blood pressure reading to be higher than what it should be. In obtaining the blood pressure it is important to select the proper size blood pressure cuff (sphygmomanometer). The cuff should fit 40% of the upper arm (if cuff is too small, the reading will be falsely high; if too large, the reading will be a false low reading).

Question No: 33

In order to get an accurate reading, how long should you wait after a client smokes or drinks coffee before taking his or her blood pressure?

- A. 15 minutes
- B. 30 minutes
- C. 1 hour
- D. 5 minutes

Answer: B

Explanation: You should wait 30 minutes to take the client's blood pressure. Cigarette smoking and coffee cause vasoconstriction. Vasoconstriction leads to increased BP. Allowing the client to rest for 30 minutes will facilitate the return of normal blood circulation and can provide accurate BP reading.

Question No: 34

When performing oral care on an unconscious client, which of the following prevents aspiration of fluids into

the lungs?

- A. Put the client on a side-lying position with the head of bed lowered.
- B. Keep the client dry by placing a towel under the chin.
- C. Wash hands and observe appropriate infection control.
- D. Clean the client's mouth with oral swabs in a careful and an orderly progression.

Answer: A

Explanation: Put the client on a side-lying position with the head of the bed lowered. When giving oral care to a comatose client (one who is unconscious), turn the client's head to the side and gently swab his or her mouth and mucous membranes with the recommended equipment and supplies while being careful not to cause the client to aspirate, which means accidentally drawing food or fluid into the air passage.

Question No: 35

The doctor orders for a "daily urine specimen to be sent to the laboratory" for Eileen, who was operated on for renal stones. Eileen has a Foley catheter attached to a urinary drainage system. How will you collect the urine specimen?

- A. Remove urine from the drainage tube with a sterile needle and syringe and empty urine from the syringe into the specimen container.
- B. Empty a sample of urine from the collecting bag into the specimen container.
- C. Disconnect the drainage tube from the indwelling catheter and allow urine to flow from the catheter into the specimen container.
- D. Disconnect the drainage from the collecting bag and allow the urine to flow from the catheter into the specimen container.

Answer: A

Explanation: Remove urine from the drainage tube with a sterile needle and syringe and empty urine from the syringe into the specimen container.

Question No: 36

Just as the nurse aide was entering the room, the client who was sitting on his chair begins to have a seizure. Which of the following must the nurse aide do first?

- A. Ease the client to the floor.
- B. Lift the client and put him on the bed.
- C. Insert a padded tongue depressor between his jaws.
- D. Restrain client's body movement.

Answer: A

Explanation: The nurse aide should first ease the client to the floor. Seizures or convulsions are violent and sudden contractions or tremors of muscle groups. You cannot stop a seizure. However, you can protect the client from injury. Guidelines to follow during a seizure activity are:

§Do not leave the person alone.

§Lower the person on the floor. This protects the person from falling.

§Place a folded blanket, towel, cushion, pillow, or other soft item under the person's head or cradle the person's head in your lap.

§Turn the person onto his or her side. Make sure the head is turned to the side.

§Loosen tight jewelry and clothing (ties, scarves, collars, necklaces) around the neck.

§Move furniture, equipment, and sharp objects away from the person.

§Do not give the person food and fluids.

§Do not try to restrain body movements during the seizure.

§Do not put any object or your fingers between the person's teeth.

Question No: 37

Mr. Santos is placed on seizure precaution. Which of the following would be contraindicated?

- A. Obtaining his oral temperature
- B. Encouraging him to perform his own personal hygiene.
- C. Allowing him to wear his own clothing.
- D. Encouraging him to be out of bed

Answer: A

Explanation: Obtaining his oral temperature would be contraindicated. Seizures occur suddenly; sometimes the person is not aware that a seizure just happened. Obtaining the temperature orally can pose an injury as the person bites into the thermometer while the seizure is going on.

Question No: 38

The nurse aide is demonstrating proper foot care to a diabetic client. Which of the following is an appropriate action?

- A. Soaking the client's feet in hot water
- B. Avoiding using mild soap on the feet
- C. Applying a moisturizing lotion to dry feet, but not between the toes
- D. Cutting nails and removing cuticles weekly

Answer: C

Explanation: The nurse assistant should apply a moisturizing lotion to dry feet, but not between the toes. The moisture between the toes can encourage fungus growth. Other guidelines for foot care are the following:

§Wash feet every day. Dry them carefully, especially between the toes.

§If the person can see and reach the toenails, trim them when needed. Trim toenails straight across, and file the edges with an emery board or nail file.

§Wear shoes and socks at all times. Never walk barefoot. Wear comfortable shoes that fit well and protect the feet. Check the insides of the shoes before wearing them. Make sure the lining is smooth and there are no objects inside.

§Protect feet from hot and cold. Wear shoes at the beach or on hot pavement. Don't put feet into hot water. Test water before putting the feet in it. Never use hot water bottles, heating pads, or electric blankets. The person can burn his feet without feeling it.

§Keep the blood flowing to the feet. Put feet up when sitting. Wiggle toes and move ankles up and down for 5 minutes, two (2) or three (3) times a day. Don't cross legs for long periods of time. Don't smoke.

Question No: 39

When you say sterile, it means:

- A. The material is clean.
- B. The material and the equipment are sterilized and have undergone a rigorous sterilization process.
- C. There is a black stripe on the paper indicator.
- D. The material has no microorganism nor spores present that might cause an infection.

Answer: D

Explanation: Sterilization is the process of killing all microorganisms, including spores and viruses. Cleaning a material, rather than sterilizing it, only limits the number of pathogens present and reduces the ability of the pathogen to cause infection. The presence of a black stripe on the paper indicator is not a reliable indicator that the material is sterile, even though the autoclave tape turns black after fifteen minutes of sterilization.

Question No: 40

Apnea seen in clients with Cheyne-Stokes respiration is defined as:

- A. Inability to breath in a supine position, so the patient sits up in bed to breathe.
- B. The client is dead; the breathing stops.
- C. There is an absence of breathing for a period of time, usually 15 seconds or more.
- D. Slow, shallow, and sometimes irregular respirations

Answer: C

Explanation: Apnea in clients with Cheyne-Stokes respiration is defined as an absence of breathing for a period of time, usually 15 seconds or more. Choice A refers to orthopnea. Technically, apnea is lack or absence of breathing, but choice B is not the correct answer. The question is asking for the description of apnea in a Cheyne-Stokes respiration, not referring to a dead person. Choice D refers to hypoventilation.

Question No: 41

Lulu Simpson, 52 years old, is scheduled for a colonoscopy. Prior to the diagnostic procedure, a cleansing enema was ordered by the physician. As the nurse informs Ms. Simpson of the order, you are aware that the common position for this procedure is:

- A. Sims left lateral.
- B. Dorsal Recumbent.
- C. Supine.
- D. Prone.

Answer: A

Explanation: Sim's left lateral position allows easy insertion of the probe into the colon as it accesses the correct anatomical location of the colon as it terminates into the rectum, i.e., in the left position. This position places the upper leg sharply flexed so it is not on the lower leg. The lower arm is behind the person. Sim's position is also called the semi-prone side position.

Question No: 42

Which of the following actions should the nurse aide take to use a wide base support when assisting a client to get up in a chair?

- A. Bend at the waist and place arms under the client's arms and lift.
- B. Face the client, bend knees and place hands on client's forearm and lift.
- C. Spread feet apart.
- D. Tighten pelvic muscles.

Answer: B

Explanation: When assisting a client to stand up, use a wide base support by facing the client, bending your knees, placing your hands on client's forearm, and lifting. Using the rules for body mechanics, the person has to face the working area to prevent unnecessary twisting. The base of support is the area on which an object rests. A good base of support is needed for balance, especially when lifting clients or helping them getting up in a chair. Bend your knees and squat to lift heavy object. Do not bend from your waist. That places strain

on small back muscles.

Question No: 43

What should be done in order to prevent contamination of the environment in bed making?

- A. Avoid fanning soiled linens.
- B. Strip all linens at the same time.
- C. Finish both sides at the time.
- D. Embrace soiled linen.

Answer: A

Explanation: In order to prevent contamination of the environment, avoid fanning soiled linens. One consideration in bed making is to never shake or fan linens as it spreads the microorganisms. Choices B and C refer to principles in bed making that save time and energy. Embracing soiled linen (Choice D) is an inappropriate action which would introduce microorganisms to the nursing assistant's body.

Question No: 44

Hillary Stank (CNA) is about to bring the meal tray to the room of Mrs. Agnes Wilbur, a 69 year-old resident, who survived a stroke with some neurological deficits and moderate dysphagia. Which of the following statement is incorrect about a client with dysphagia?

- A. The client will find pureed or soft foods, such as custards, easier to swallow than water.
- B. Fowler's or semi Fowler's position reduces the risk of aspiration during swallowing.
- C. The client should always feed herself.
- D. The nurse aid should perform oral hygiene before assisting with feeding.

Answer: C

Explanation: A client with dysphagia should not always feed herself. Dysphagia means difficulty swallowing. The client is never left alone to eat because this can result to aspiration, wherein food enters the airway and obstructs the lungs. In clients with dysphagia, consistency in food thickness (dysphagia diet) and positioning the client in Fowler's or semi-Fowler's position are necessary to prevent aspiration. Prior to giving the meal, clients need to eliminate (to prevent interruptions) and be given oral care (to promote satiety of the food intake).

Question No: 45

Rina (CNA) is assisting the nurse with transferring a client from the operating room table to a stretcher. To provide safety to the client, Rina is aware that she should:

- A. Move the client rapidly from the table to the stretcher.
- B. Uncover the client completely before transferring to the stretcher.
- C. Secure the client's safety belts after transferring to the stretcher.
- D. Instruct the client to move self from the table to the stretcher.

Answer: C

Explanation: Rina should secure the client's safety belts after transferring her to the stretcher. During the transfer of the client after surgery, the nurse aide should avoid exposure of the client because of the risk for potential heat loss. Hurried movements and rapid changes in position should be avoided because these predispose the client to hypotension. At the time of the transfer from the surgery table to the stretcher, the client is still affected by the anesthesia; therefore, the client should not move herself. Safety belts can prevent the client from falling off the stretcher.