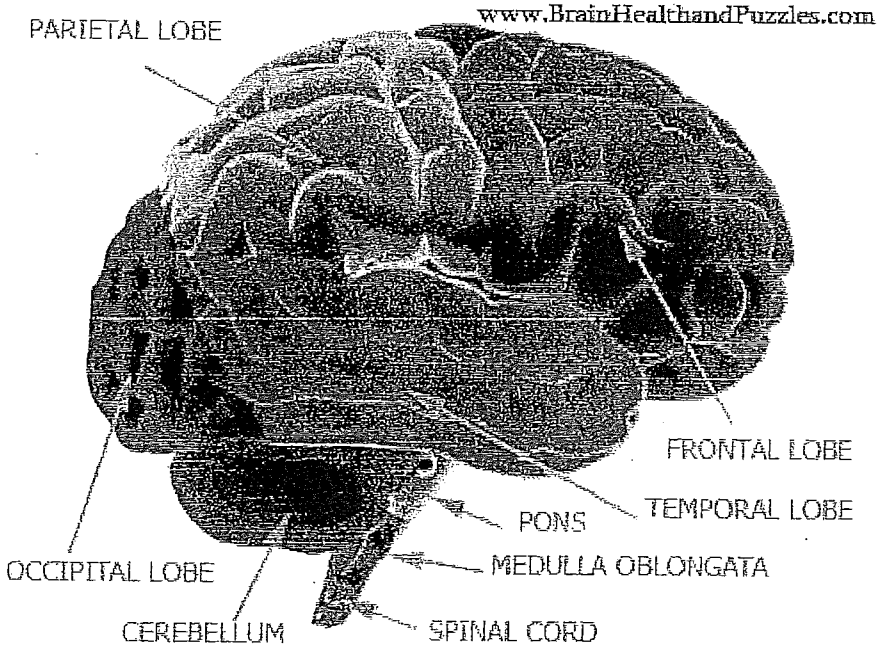
Review Guide for

Nursing Assisting Test



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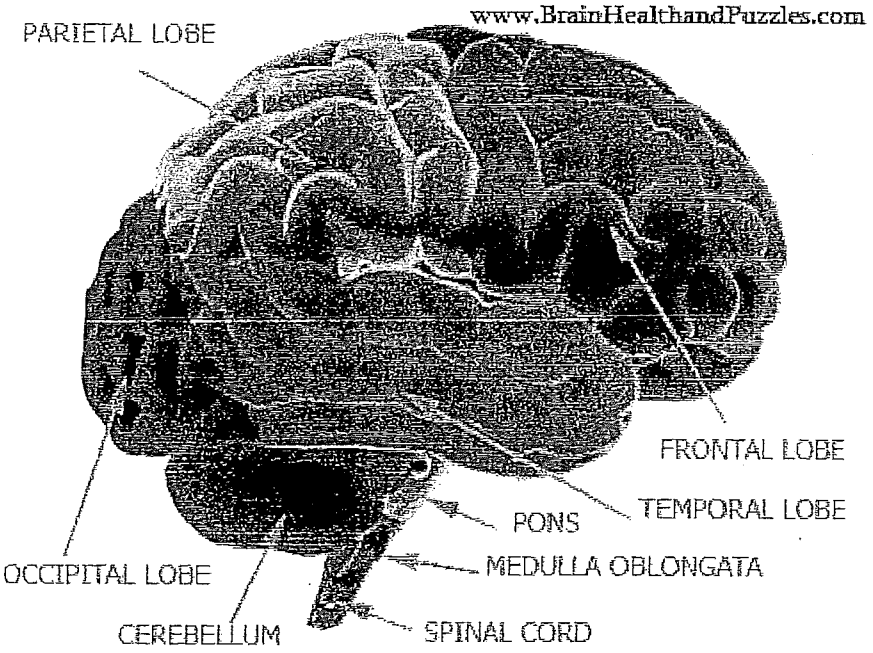

Nursing Assisting Review Sheet No. 1

Take

- The correct term for the device that is used to replace a body part that is missing is a:

  Prosthesis

  Rationale: A prosthesis is molded and shaped to fit a person's body to replace a limb that was lost due to disease, injury or a congenital defect.

- When a patient has lost a loved one, the CNA can help them cope the best if they:

  Encourage the patient to talk

  Rationale: When a patient has lost a loved one, talking about it can often help the patient express their feelings and cope with the reality of the loss. A patient should never be forced to discuss it, but should know that the nursing assistant is available if the patient wants to talk.

- The purpose of padding a patient's bed side rails is to:

  Protect the patient from injury

  Rationale: Patient's siderails are padded to protect a patient from injury in case of seizure, confusion, or violent outbursts. They are not used as restraints.

- If a patient's left side is their weakest side then the part of their sweater that is put on first is their:

  Left sleeve

  Rationale: When a patient is weak on one side, that side should be dressed first because the other side will be more difficult to put through an armhole, and the patient will be able to assist more with their strong arm.

- When a CNA is caring for an aggravated patient, they should:

  Speak in a slow and calm manner

  Rationale: When a patient is agitated, a calm environment should be provided if possible. Yelling, hitting or threatening the patient doesn't provide this type of environment and is illegal. Speaking in a calm and slow manner allows the patient to comprehend what is being said and provides a tranquil environment.

- A CNA is not allowed to show a patient's record to:

  The roommate

  Rationale: Due to privacy laws, only employees taking care of that patient are allowed to see their records. The patient's physician is also allowed to view them. Under most circumstances, family is also allowed to know what is going on with their family member.

- After a patient has had a stroke, the CNA should assist:

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On the patient's weak side

Rationale: Because a patient won't be able to use their weak side as effectively as the strong side, the CNA should assist on their weak side.

- Exercises that move each muscle and joint are called:

Range of motion

Rationale: Range of motion should be performed everyday as ordered by a physician. This includes exercising all joints in the arms and legs. A physicians order must be written in order for this to be performed.

- A CNA wear gloves:

While doing peri-care

Rationale: When doing peri-care, a nursing assistant can come into contact with many types of body fluids including urine and stool. Gloves should always be worn to prevent skin contact with these and to prevent the spread of disease.

- The Heimlich is used:

When someone has a blocked airway

Rationale: The Heimlich maneuver, which includes abdominal thrusts to expel an object blocking a patients airway, should on be performed by someone certified to perform this maneuver.

- A CNA can assist with a patient's spiritual needs by:

Allowing patient's to talk about their own beliefs

Rationale: The spiritual needs of a patient are an important aspect of their care. A nursing assistant should listen to the patient and never voice their opinion or own beliefs.

- If a patient is completely deaf, the best way for a CNA to communicate with the patient is to:

Write out the information

Rationale: When a patient is deaf, trying to speak to them can make them feel as though you don't care. Not communicating to them is negligence. Letting the patient write out their needs or wants is the most effective way to speak with them.

- If asked "what day is it?" by a confused patient, the CNA should:

Point to the date on the calendar and say the date

Rationale: By saying the date and pointing it out on a calendar, you are providing two ways of orienting the patient to what day it is. Double reinforcement is a good way of helping a confused patient reorient themselves.

- In order to avoid pulling out a catheter tube accidentally from a male patient, the catheter should be attached to:

Upper thigh

Rationale: By attaching the catheter tube to the patient's upper thigh, it moves with them when they walk, roll or are re-positoned that way it is not accidently pulled out. Get a nurse immediately if it does come out, or the tape comes loose.

- When a CNA is getting ready to dress a patient, they should:

Let the patient choose

Rationale: By letting the patient make choices about their care, this helps foster independence. This also might help the patient be cooperative by knowing they took control of the situation by making their own choices.

- The FIRST thing that a CNA should do upon discovering a fire in a patient's room is to:

Remove the patient

Rationale: Patient safety is always first! If a patient is near the fire, immediately move them to safety before any other action is taken.

- The role of the ombudsman is:

To work with the nursing home to protect the patients' rights

Rationale: An omsbudman is a trusted mediator between two parties that acts as an unbiased judge. In healthcare, they work between the facility and it's patients to ensure the patient's rights are not violated.

- Usually, the final stage of dying is:

Acceptance

Rationale: The stages of grief related to dying include denial ("This isn't happening to me"), anger ("I hate you God for doing this to me"), bargaining ("If I can just live to see my daughter graduate, I'll be ready to die"), depression and acceptance.

- In order to communicate clearly with a patient who has hearing loss, a CNA should:

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- If a patient says "why me?" or "God is punishing me!":

Listen quietly

Rationale: A nursing assistant should never judge or ignore a patient that is depressed and angry. Listening to the patient express their feelings is the best thing a nursing assistant can do. The nursing assistant should also report these feelings to the nurse for further investigation.

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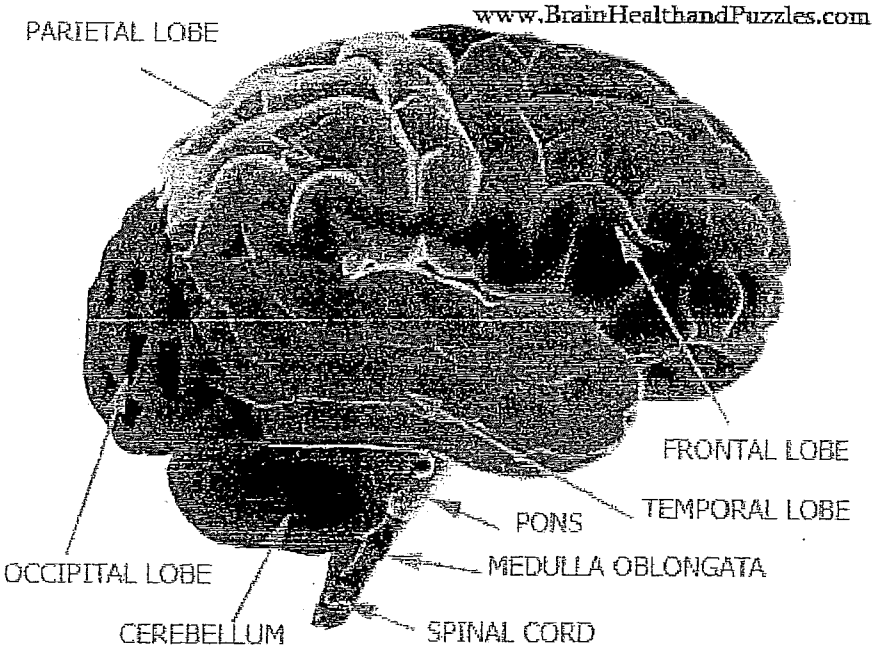

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- When taking vital signs on a 78 year old female for the nurse on duty, you would want to alert the nurse of the following vital sign immediately:

  A blood pressure of 80/45 mmHg

  Rationale: A blood pressure of 80/45 mmHg is low. A normal blood pressure should be between 110/70 mmHg and 120/80 mmHg, although a result that: little higher or lower is generally okay. The lower the blood pressure, the less the heart is perfusing blood to the rest of the blood. A temperature of 99.5 is within normal limits. A pulse of 60 beats per minute is also normal, as the range for a normal heart rate is 60-100 beats per minute. Respirations should be between 12 and 20 per minute.

- You are not allowed to perform the following as a nursing assistant

  Monitoring the patient while he/she takes their medications

  Rationale: Only a licensed nurse or physician is allowed to monitor a patient while they take their medications. Nursing assistants can give bed baths including applying lotion, take oral temperatures and report them to the nurse, and take urine samples.

- You find a patient that has fallen on the ground. They are conscious and tell you that they are not hurt. You should do the following immediately

  Stay with the patient and yell for someone to assist you

  Rationale: You should always stay with a patient if they have fallen until a nurse arrives to check for injuries. Patients may not always be initially aware o injuries and moving them without a nurse saying you may can make the injury worse. You never want to leave a patient that has fallen, whether they are injured or not. As a nursing assistant, you are not allowed to assist a resident back up after falling unless the nurse asks for your assistance. Assessing a resident is out of the scope of practice for a nursing assistant and should only be done by the nurse.

- You enter your female patients' room to find that she was incontinent of her bowels. Here is how you provide peri-care to help clean her up.

  Wiping her perineal area from front to back

  Rationale: Wiping the perineal area from front to back is the best way to reduce getting a urinary tract infection (UTI) from feces. Wiping her perineal are other directions of not wiping at all both promote the possibility of getting a UTI.

- The best way to prevent the spread of infection is by:

  Washing your hands before and after any patient care is given

  Rationale: Frequent handwashing is the best way to prevent the spread of infection according to the Center for Disease Control. Wearing gloves while fee a patient makes them feel uncomfortable. Coughing into your sleeve instead of your hand is the best practice, but not the best way to prevent the spread of infection. Patient interaction should never be limited to prevent infection unless it's specified by a physician.

- Dentures should be removed from your patient:

  In the evening, before the patient goes to bed

  Rationale: Dentures should always be removed before a resident goes to bed. They are not needed during sleep, and if left in, can irritate the gums. This al allows time to clean the dentures. They should always be in for meals, as it helps chew the food so the patient can safely swallow. Keeping the dentures in through the day helps the patient feel comfortable when interacting with other residents and participating in activities.

- When your patient has a doctor's order to be weighed daily, the best time to weigh your patient is:

  At the same time everyday

  Rationale: For the most accurate results and to see if there are variations in a patients weight, he/she should be weighed at the same time everyday. The be time is first thing in the morning before the patient has consumed any food.

- The following should be reported to the nurse immediately:

  A patient with a history of heart attacks complaining of chest pain

  Rationale: Any complaints of chest pain should be reported to the nurse immediately.

- When you notice several new bruises on a patient, and the patient tells you one of the aides hit them several times, your first action should be to:

  Notify the nurse immediately

  Rationale: Although paperwork is an important part of this process, notifying the nurse of the situation is the first action you should take. Confronting the is the job of the nurse, or another authority figure. Telling the patient they are confused is an inappropriate response, and all accusations of abuse should b investigated immediately.

- If your patient's plan of care says they need to be showered QD, this abbreviation means:

  Every day

  Rationale: The abbreviation Q means "every". D means "day". The appropriate abbreviation for "before bed" is HS.

- If you are asked as a nursing assistants to give a patient their insulin injection, the appropriate response is:

  "I'm sorry, as a nursing assistant, I am not allowed to give injections."

  Rationale: Nursing assistants are legally not allowed to give any kind of injection to patients. There should be no exceptions to this.

- When a nurse says she would like you to collect a patient's I & O's for your shift, this means:

  Intake & output

  Rationale: Nurses will give a great many communications and orders to the CNAs during a shift. Sometimes they will be actions that need to be carried ou other times it will be to record certain aspects of a patient's care and report back with specific pieces of information so that the nursing staff may report th totality of a patient's status to the physician. One important measurement that needs to be taken is called the I&O (Intake and Output). Intake is any measurable fluid that is given to the patient. This can include water, juices, soup, even ice cream. Output is a measurable fluid that comes out of the body. This can include sweat, vomit, urine, and drainage such as feces or blood.

- When taking a patient's oral temperature, if the patient informs you that they just took a drink of cold water, do not proceed and take the temperature but instead:

  Instruct them not to drink for 15 minutes and then return to take their temperature

  Rationale: There should always be a 15 minutes waiting period after a patient has had a drink before an oral temperature is taken. This allows for the most accurate result.

- When a patient becomes extremely agitated while they are receiving care, do not yell at them, restrain them, or continue with the care that you are giving t is agitating them. The appropriate action for the nursing assistant to take is to:

  Reassure and comfort the patient

  Rationale: You want to try to make the patient as comfortable as possible while you are providing care. Do not take action that will agitate the patient furtl

- The Heimlich Maneuver is performed on patients that:

  Are choking

  Rationale: The Heimlich Maneuver involves abdominal thrusts that help dislodge whatever a patient may be choking on. Urination problems, other breath

problems or having no pulse are not treated by the Heimlich Maneuver.

- The best way to get a patient to participate in their daily care is to:

  Allow them to make decisions

  Rationale: Patients often lose their independence when they are in a hospital or nursing facility. Allowing them to make decisions about their care gives th the highest level of independence possible. Doing everything for them, demanding they do it all themselves, or rushing their care can make them feel uncomfortable and not trust the staff.

- When a patient is confused and is asking you where they are, the nursing assistant should:

  Remind them of where they are

  Rationale: Never ignore them or tell them that they should know where they are. This can be considered emotional abuse. Never ask the patient why they so confused. This isn't an appropriate question for a nursing assistant to ask a patient.

- Nail care, especially trimming, should never be performed on:

  Diabetic patients

  Rationale: Diabetic patients have decreased bloodflow to their extremities, especially their feet. Nursing assistants should not perform nail care, especially trimming the nails, on diabetics due to the possibility of injury and their inability to heal like a healthy patient would.

- Gloves should always be worn for:

  Changing a soiled brief

  Rationale: Gloves should always be worn when changing a soiled brief due to the chance of coming in contact with the patient's urine and/or feces. Glove are not needed to be worn by nursing assistants when transferring patients from their beds to chairs, when feeding a patient, or when refilling a patient's w glass.

- If a patient is complaining of a headache and asks for pain medication, the nursing assistant:

  Notifies the nurse

  Rationale: The nursing assistant is only allowed to notify the nurse. The nursing assistant can not assess the headache and pain, put a washcloth on the patient's forehead, or provide Tylenol.

- Certified Patient Care Worker (CPCW) CNA means Certified Nursing Assistant or sometimes

  Rationale: A CNA is a healthcare professional known as a Certified Nursing Assistant. CNA's are known by a few other alternate titles. Patient Care Assistants (PCA), State Tested Nurse's Aide (STNA), and a Nursing Assistant – Registered (NA/R) are positions held in different capacities of healthcare that are equal to that of the certified nursing assistant profession. Certifications for these positions are generally compatible. So, for example, an individual that possesses an STNA certification would be competent and capable of fulfilling a PCA position as well.

  Certified Nursing Aide. Other titles of healthcare workers that are like CNAs are Home Health Assistants/aides (HHA), Patient Care Assistants (PCA), State Tested Nurse's Aide (STNA), and Nursing Assistant – Registered (NA/R) among others. CNAs are not known as a:

- The median salary for a CNA is:

  $11.14 hourly

  Rationale: The salary expectation for a certified nursing aide can fluctuate by not only state and city of the employment, but by the type of care required from the CNA. Long term care facilities tend to pay more per hour for the care of a certified nursing assistant in comparison to a home health care position or short term care facility. The average salary expectation for a CNA in any capacity is about $11.14 per hour, or about $23,617 a year with full-time employment. Because of the fluctuation in wage, it is best to research your market value in the area you are seeking employment to be best prepared for your position's worth.

- The lengths of the state training course that a CNA takes is, on average about

  75 hours long

  Rationale: Every state requires a different time commitment to be trained as a certified nursing aide. For example, California requires a minimum of 150 hours for their CNA courses, New York requires 100 hours, and Utah requires 80 hours. It is critical that you research the minimum required hourly expectation for a CNA course in your state of residence. The state average for time commitment in CNA training courses is a minimum of 75 hours. Federal guidelines currently require that 16 of these hours must include discussions on infection control, communication and interpersonal skills, emergency and safety procedures, promotion of patient independence, and a respect for patient rights.

- The length of a CNA state training course in supervised clinical training is

  16 hours

  Rationale: Clinical training is an aspect of a CNA's education where they experience hands-on application of learned skills during their didactic coursework. This expectation can change from state to state. For example, in New York there is a 30 hour expectation for clinical interactions. The average for supervised clinical training per state is currently 16 hours. This clinical time will include direct patient interaction and allow the trainee to become more comfortable working in the environment of their profession while under the direct supervision of a trained and certified professional.

- The length in hours of continuing education classes that a CNA must take annually is

  12 hours

  Rationale: Once a CNA passes certification and begins practicing their skills in the professional environment, there is an expectation that you will continue to improve and educate yourself throughout your career. These are known as continuing

education units (CEU's) or continuing education credits. As with all aspects of the CNA profession, there is a variance to the number of hours or units required per state. The average amount of CE hours required per state is 12 hours per year. In New York, you must take 48 hours of in-service training in the first two years, but 12 of those must be during the first year of employment. So make sure that you are researching the requirements of your state regulations before beginning the collection of your CEU's.

- The definition of a CNA is

  Someone who assists patients with healthcare needs under the supervision of an RN or LPN.

  Rationale: a medical professional that assists patients with healthcare needs while under the supervision of an RN or LPN. CNAs usually work in a nursing home or hospital setting and perform everyday tasks for the old age, those chronically ill or rehab patients.

- CNAs can be found in hospitals, nursing homes and personal homes but not in

  Schools

  Rationale: There are many different facilities that certified nursing assistants can work in. The most common areas that a CNA will hold a profession are in hospitals, nursing homes, and visiting a patient's house when involved in home health care. CNAs generally hold the title of a PCA in hospitals. They can be involved everywhere from the emergency room to the intensive care units. Registered nurses exercise a lot of delegation to the CNAs because of the constant monitoring and interaction with the patients. In nursing homes, CNAs generally hold a majority of the contact with the patients. They assist with everything from meals and bathing to helping the patient walk around.

- CNA courses can be taken in a local Red Cross building, at certain local nursing homes, and at community colleges but not at

  girl scout meetings

  Rationale: When looking for courses to take for your certified nursing assistant certifications, it is best to do some research in your area. The best places to look when investigating locations for classes are at local Red Cross facilities, certain local nursing home and local community colleges. Make sure you look into who is teaching the classes, what their current degree and experience is, and what level of certification you will be receiving.

- Most CNA state certification tests are made up of

  2 parts

  Rationale: All state CNA testing involves two parts. The first a written test, the second is a hands-on test performed in front of an instructor. The written portion of the examination will be comprised of around 70 questions. The percentage of correct answers to pass will vary from state to state. The hands-on testing is a skill performance examination. Every candidate will be graded on the ability to perform 5 different nurse aide skills live in front of the evaluator. There is a long list of possible skills, but they can include taking vital signs, washing hands, measuring urine output, bedpan procedures and patient transfers.

- The very first thing that you will need to demonstrate when taking the clinical part of a CNA Certifiation test is your

  hand washing technique

  Rationale: During the hands-on portion of the examination, you need to demonstrate certain skills in a precise and appropriate order to successfully pass. No matter what skills are selected for the hands-on exam, there is one constant for

each examination. Demonstrating a hand washing technique will always be the most important step, and the easiest to over look. For the rest of your career in the healthcare field you will be expected to maintain a constant pattern of washing your hands before and after every patient you encounter. This begins with your final exam.

- To become a CNA, you must be

  Any legal working age in your state

  Rationale: One of the great aspects about holding a career in the medical field is job security. In the modern age of employment, that is something that is difficult to find. You are able to become a certified nursing assistant at the age of 18, once you have graduated from high school or have received your GED. It is a great opportunity to help people and to build experience while moving onto other areas of healthcare.

- The number of years of experience that a CNA needs is

  0 years

  Rationale: A certified nursing assistant is considered to be an entry level job in the healthcare industry. They are Unlicensed Assistive Personnel, technically. This means that during your training you are given the skills and experience necessary for you to enter the profession and be capable of succeeding. Your level of comfort and ability will increase once you have applied the skills you learned during your education. This means that you do not have to have any experience in healthcare to be successful as a certified nursing assistant.

- A CNA must be empathetic, sympathetic, patient, compassionate, adaptable, excellent with time management, proactive, and a team player but must not be

  inflexible and selfish

  Rationale: A certified nursing assistant needs to be empathetic, sympathetic, patient, and compassionate. You should be able to adapt quickly in situations of rising stress. A CNA must be excellent with time management, proactive, and good with teamwork. CNAs should not act selfish or be inflexible. These are not qualities that are helpful to patients, and can actually inhibit their care.

- One of the most important services for a CNA to perform is

  listening to the residents

  Rationale: A certified nursing assistant should never be selfish, inflexible, rude or impatient. You shouldn't be taking personal calls on the clock, you should always be on time, and almost never call off of work. These qualities are unbecoming of a healthcare worker who needs to place the patient's needs and care requirements before all else. You should always be empathetic, patient, and compassionate. You should always listen to the residents to know what aspects of a patient's healthcare take priority on any given shift.

- The number of CNAs who live and work in the U.S.A is

  2.5 million

  Rationale: Certified nursing assistants are holding positions in all levels of healthcare from hospitals to nursing homes. Currently in the USA, there are 2.5 million positions being held as certified nursing assistants, and the profession is growing all the time.

Nursing Assisting Review Sheet No. 2

- The number of CNA positions that will need to be filled over the next 25 years is

  700,000 CNA positions

  Rationale: The healthcare field is a constantly evolving and growing job market. There is an expectation that most medical job markets will increase exponentially in the coming years. The certified nursing assistant job field is expected to grow by 700,000 positions in the next 25 years. This communicates great opportunities for employment in the medical field. And with the ability to get a certificate with little demands on the time during the education process, becoming a CNA is a great way to get a job with wonderful experience and benefits.

- The percentage (%) of patient care that a CNA provides is

  80-90%

  Rationale: Depending on what facility you work for, you may be expected to give a majority of the care to the patients. A certified nursing assistant may be expected to give anywhere from 80-90% of the care to the patients. In nursing homes the percentage is much higher than it would be in a hospital, but the expectation to deliver a lot of care is still there. Registered nurses are involved with not only extensive charting, but also communications with physicians, and assisting with the development of a patient's care for implementation. They cannot be expected to juggle these administrative tasks and deliver the appropriate level of care to the patient. That is where the CNA comes into play.

- A CNA would never be

  giving a diagnosis

  Rationale: When dealing with patients, it is important to always listen to the complaints and information given to you from the patients. All of this should be included into a report and given to the RN or physician in charge of the patient's care. However, even though you have some minimal access to the patient's chart, this does not authorize you in any way to give a diagnosis to the patient. You may encounter a situation where a patient has just had a lab taken or a procedure performed and they will ask you what the result was. You cannot reveal this because you could be taking a portion of their care out of context and undermine what the physician is trying to accomplish. It is best to tell them to touch base with their physician or nurse for that information because you are not permitted to share it.

- CNA's will typically work with

  the elderly

  Rationale: Certified nursing assistants hold a great deal of jobs in nursing homes. It is expected that a majority of the patients that a CNA will interact with will be elderly or geriatric patients. It pays to have an empathetic and patient personality when dealing with older patients. Their levels of care requirements are generally higher, and you will need to be able to move at a slower speed, but with the same level of attention to the patient.

- A CNA reports to

  RN's/LPN's

  Rationale: A certified nursing assistant can be an autonomous healthcare professional up to a point. They have skill sets that they may demonstrate on any patient that they have been assigned. However, their workload may be assigned and adjusted by an RN (registered nurse) or an LPN (licensed practical nurse). RN's and LPN's are the main people that a certified nursing assistant will report to in their work place.

Review sheet #5
Fall Prevention

- You enter a patient's room and find that they have fallen on the floor. You immediately:

Have someone get the nurse

Rationale: If you find a patient that has fallen, do not leave them. Yell for someone to get the nurse immediately. Do not move them, because they may have injured themselves and moving them can worsen the injury. The nurse must assess the patient before they can be moved.

- The following percentage of adults over the age of 65 have a chance of falling:

33%

Rationale: 1 in 3 adults over 65 will fall. Falls increase the chance of injury, which can lead to an early death, especially in patients who fracture a hip.

- The following will NOT help in preventing falls:

Placing throw rugs around the patient's room so they can get traction while walking

Rationale: Loose rugs can dramatically increase a patient's chance of tripping and falling. They should be removed from any areas that the patient walks. Making sure the room is well-lit and clutter-free are important, and people over 65 should have their hearing and vision checked yearly.

- The doctor writes a prescription for your patient to have a pressure alarm. The purpose of this type of alarm is:

To prevent falls

Rationale: Pressure alarms work by alarming only when pressure if taken off of the pad because a patient is trying to stand or walk. Nursing assistants should respond immediately to these alarms to prevent injury from a fall.

- This would be a safety issue for a patient with a history of falls:

No hand rails in the shower

Rationale: Patient's with fall risks should have as many adaptations as possible to prevent a fall. Having a handrail in the shower will help stabilize the patient while they shower. Other adaptations include using a walker while ambulating, using a raised toilet seat, and getting a bed that can be lowered to the floor each night.

- As a CNA, you will <u>fill out</u> this type of paperwork after you find a patient that has fallen:

Witness statement

Rationale: After a fall, there are several papers that must be filled out. The nurse will take care of most of the papers, but if you are the nursing assistant that found the patient, you must fill out a witness statement accurately describing how and where you found the patient.

- You are taking care of a patient suspected of having tuberculosis. The following type of protective equipment should be worn whenever you enter this patient's room:

Mask

Rationale: Tuberculosis is transmitted through droplets that come out of the infected patient's mouth and enter through the nose or mouth of a healthy person. By wearing a special filter mask, the healthy person is protected from the infected droplets entering their body. Your employer will have a special type of filter mask for this situation, because a regular mask may not fully protect you.

- You are assigned to a patient that has a diagnosis of clostridium difficile (C-Diff). They have diarrhea, and after changing their adult brief, the nursing assistant must:

Wash their hands to prevent the spread of infection

Rationale: C-Diff is spread because the spores from the infection are transferred and ingested. Fecal-oral transmission is how it is passed around, which means spores are on the hands and then ingested through the mouth. Spores cannot be killed by simply using an alcohol based sanitizer, therefore the hands must be washed with soap and warm water for 30 seconds.

- If you are accidently stuck with a dirty needle, you should immediately:

Wash the area

Rationale: If you are stuck, you will first clean the wound with soap and warm water. Do not squeeze or pinch blood out of the wound, or clean it with bleach. You will want to wash the area for several minutes. Once the wound is clean, you will then report the incident to the charge nurse, fill out the proper paperwork, and then have bloodwork done to test for hepatitis, HIV and other blood borne diseases. Your doctor may prescribe antibiotics as a precaution. Typically, you will have bloodwork drawn again several months after the initial incident to retest for any diseases.

- The quickest, cheapest and easiest way to prevent the spread of infection is:

Handwashing

Rationale: Handwashing before and after contact with each patient has proven to be the best way to prevent the spread of infection between patients and employees. Using soap and warm water and washing the hands for 30 seconds is the most effective way to kill germs. Using hand sanitizer is acceptable in most circumstances as a replacement for hand washing, except when the patient has C-Diff, MRSA or other infections that your facility deems hand sanitizer inappropriate for.

- It's necessary to take special precautions when you are taking care of a patient diagnosed with MRSA because:

MRSA can be a serious infection and is hard to treat

Rationale: MRSA, or methicillin resistant staph aureus, is an infection that can't be treated by many antibiotics normally used. It is resistant to their effects, therefore a limited amount of medicine will treat it and may not treat it in time to save a life. Infection continues to spread, and eventually into the blood if it isn't treated quickly and with the right antibiotics.

- You would use standard precautions with the following types of patients:

All patients

Rationale: Standard precautions should be used with all patients. Standard precautions prevent the spread of diseases and infections. These include protective equipment like gloves and hand washing after each patient.

- PPE stands for:

Personal protective equipment

Rationale: PPE, or personal protective equipment, is the primary barrier between you and a sick patient. It includes gloves, gowns, masks, shoe covers, respirators, face shields, safety glasses and more. This equipment is specially designed to protect you from hazards like contaminated blood or sputum.

- The following is NOT a bloodborne pathogen:

RSV

Rationale: RSV is a respiratory virus that children are infected with and is not transmitted via the blood. Bloodborne pathogens include HIV, hepatitis B and hepatitis C are the most commonly known and can be spread through a single droplet of infected blood entering the body through an orifice, cut or any open area.

- Approximately this many healthcare workers are at risk for exposure to blood borne disease:

5.6 million

Rationale: OSHA (Occupational Safety and Health Administration) estimates that there are approximately 5.6 million healthcare workers in the US that are at risk for exposure to blood borne diseases like HIV and hepatitis.

- The following vaccine is offered to healthcare workers through their place of employment:

Hepatitis B

Rationale: Healthcare workers are offered Hepatitis B vaccines by their employers to prevent contracting this disease. It is not required, but is recommended. It is a series of 3 shots. The first shot can be given anytime, the second shot is given 1 month after the first injection and the third is given six months after the first dose. It is very safe and has very few potential side effects.

- The following is NOT a requirement for a sharps container:

Red in color

Rationale: The color of the container doesn't effect it's safety, but it must have a biohazard label on it. It should also be puncture resistant, closable and leak proof. There are proper ways to dispose of these containers, and your employer will have more information about their policies. Biohazard containers

generally do not go in a normal wastebasket or garbage can.

- An inappropriate place to wear personal protective equipment would be:

The cafeteria

Rationale: Personal protective equipment should only be worn in patient environments where you have a chance of being exposed to body fluids and blood borne pathogens. A cafeteria is a clean area and should not be contaminated with personal protective equipment because it is not necessary for this environment.

- You are accidentally stuck with a dirty needle. You should report the incident:

Immediately

Rationale: Regardless of it you think the needle was contaminated, you should report it immediately. Do not wait to see if you become ill. Wash the wound first after the stick, and then report the accident to the charge nurse or designated person to fill out the proper paperwork.

- A healthcare worker should get a PPD test for tuberculosis:

Every year

Rationale: Healthcare workers are usually required by their facility to get a PPD test annually. It consists of a very small injection into one of the forearms. It is accessed 2-3 days later to see if there is a reaction or not. A positive PPD test does not necessarily mean you have tuberculosis. A chest x-ray and sputum culture must be taken to officially diagnosis the disease.

- You accidentally spill body fluids on the outside of a biohazard bag. You should:

Place that bag inside of another biohazard bag

Rationale: All body fluids must be contained in a biohazard container to prevent the chance of contracting a bloodborne pathogen. If the outside of the container is contaminated, simply place it inside of another one. Do not throw it away in a regular wastebasket, or leave it for someone else to clean up.

Review sheet #5
Fall Prevention

- If a patient has an order to have an alarm on, it should be on:

At all times

Rationale: Alarms prevent falls, and since falls can occur at any time, alarms should always be on and attached to the patient. This includes during sleep, meals and when in their wheelchairs if applicable. Not attaching the alarm to the patient is negligence and a nursing assistant could lose their job over this, especially if injury occurs.

- After a fall, patient's usually fracture a bone because of:

Osteoporosis

Rationale: Osteoporosis is the thinning of bone tissue and a loss of bone density that occurs with age. Bones aren't able to tolerate as much trauma with this disease, so a fall can fracture one or multiple bones at the same time. This costs thousands of dollars to fix, and a long stay at the hospital and in rehab.

- You are walking with a patient and they start to fall. The best thing to do next is:

Slide them down your leg onto the ground

Rationale: If a patient is falling, don't force trying to prevent the fall. This can injure joints or cause skin tears. Simply slide the patient down your leg to cause minimum impact on the ground. Then stay with the patient and have someone go get the nurse to assess the patient.

- You are taking care of a confused patient who is a fall risk and keeps trying to stand up. The following is an appropriate way to try to prevent falling:

Distract them by turning on their favorite TV show

Rationale: A confused patient can often be distracted by giving them something to do, turning on their favorite show, etc. Restraining them is not allowed without a doctor's order, and is something only a nurse can do. They should never be left alone, because they are more likely to try and stand up on their own and fall.

Review SHEET #6
EMERGENCIES

- You find your patient unresponsive and not breathing. You should immediately:

Yell for help

Rationale: An unresponsive patient should never be left alone. Yell for help immediately and the nurse will respond to the patient and begin CPR if the patient's living will allows him/her to do so.

- You notice your patient is having trouble speaking and they aren't able to use their left arm very well. You notify the nurse immediately because your patient may be having:

A stroke

Rationale: Signs of a stroke including trouble speaking, weakness on one side of the body, facial drooping, confusion and trouble seeing. Any of these signs should be reported to the nurse immediately for evaluation. The longer a stroke goes untreated, the more damage there is. If a stroke can be treated within 90 minutes, the patient has a very good chance of not having any permanent deficits.

- You would immediately notify the nurse of:

A pulse of 41

Rationale: A pulse of 41 is low. Normal pulse rate should be between 60 and 100 beats per minute. The lower the pulse, the less the heart is perfusing blood to the rest of the body. Because oxygen is in your blood, your body is also not getting enough oxygen. Although this low heart rate may be normal for some patients, it is for the nurse to decide if it normal so he/she should be notified immediately.

- CNA's should renew their CPR card every:

2 years

Rationale: Because a CNA may play a part in performing CPR on a patient that is in cardiac arrest, he/she must renew their CPR card every 2 years. The quicker CPR is performed on a dying patient, the better chance that patient has of living without any permanent damage. Many facilities require that you have your CPR card and will pay for you to take the class and keep your card up to date.

- The following is considered a medical emergency:

Blood in stool

Rationale: Blood in the stool signifies that the patient is bleeding somewhere. Although the bleeding could just be from a hemorrhoid, the patient should be checked by a physician to make sure they are not bleeding somewhere internally, like the intestines or stomach. If you find a patient with blood in their stool, notify the nurse immediately. Make sure not to flush or dispose of the stool because the nurse will need to assess it.

- Your patient rings his call light and tells you that his chest hurts. Your first action is to:

Notify the nurse immediately

Rationale: Chest pain is a sign of a something serious, like a heart attack. The CNA should notify the nurse of the patient's complaint so he/she can access him and take further action. The CNA is not

allowed to assess the patient or begin treatment themselves. Even if the CNA thinks it is nothing, they must notify the nurse to investigate.

- You notice that your patient's urine has been darker and has a foul odor. You notify the nurse of this change because it is a sign of:

Urinary tract infection

Rationale: Sign of a UTI are burning during urination, dark urine, frequent urges to urinate and foul smelling urine. If left untreated, a UTI can turn into a kidney infection, or even kidney failure. In older patients, UTI's often make them confused and disoriented. If you have an older patient that is confused or disoriented, check their urine for any changes and report them to the nurse.

- You enter a patient's room to find them not breathing. They are a DNR. This means that you should now do which of the following:

Yell for the nurse, but do not start CPR

Rationale: When a patient signs a DNR, this means they do not want extraordinary measures taken to save them in case of severe illness or death. It is the nurse's ultimate decision and knowledge to decide whether or not CPR is to be performed, but if there is a signed and legal DNR, CPR is not performed. Yell for the nurse immediately and let him or her decide the next course of action.

- If you discover a fire, you should R.A.C.E. R.A.C.E. stands for:

Rescue, alarm, contain, evacuate

Rationale: According to OSHA fire safety, R.A.C.E. is the acronym that should be following in case of a fire. Rescue any patients in the vicinity of the fire that it could immediately danger (without injuring yourself), alarm the building, contain the fire by closing doors and windows and evacuate the building of all patients, employees and visitors.

- You are assigned to a patient that is prone to having seizures. As a nursing assistant, you are most concerned about the patient's:

Safety

Rationale: The nursing assistant should be constantly aware of the safety of any patient, but especially for one with a history of seizures. Look around the room for anything that could be dangerous if a patient begins to seize, and make sure the siderails of the bed are padded if this is allowed at your facility. It is the responsibility of all employees to make sure every patient is safe, but as a nursing assistant, this will be your priority with this type of patient.

- You are assigned to a patient who has lost a lot of blood due to a tear in his intestine. He is receiving blood for the first time. When changing him, you notice he has a new rash. You notify the nurse immediately because he:

Could be having a reaction to the blood he is receiving

Rationale: Although most patients don't have reactions to receiving blood, it does occur. The nurse will stay with the patient and monitor him/her for several minutes initially to make sure nothing negative

occurs. A rash is one of the first signs that the body is having a reaction to something, and if the patient is reacting to the blood, this could have deadly results.

- Your patient is a diabetic and tells you that they think their sugar is getting low. You should:

Notify the nurse

Rationale: Diabetic patients often can sense when their blood sugar isn't right. The nursing assistant should immediately notify the nurse and she can delegate a further course of action. Some nursing assistants are allowed to check a patient's blood sugar. This will be the first step. The nurse may then ask you to get the patient some orange juice to raise their blood sugar if it is low. No steps should be taken by the nursing assistant without the approval by the nurse.

- While bathing a patient, she tells you she is going to take all of her medication today because she just wants to die. You react by:

Having someone else notify the nurse while you stay with the patient

Rationale: Whenever a patient threatens to harm themselves, they should never be left alone. The nurse should be notified immediately so he/she can further assess the patient. No matter how small the threat may be, it should always be taken seriously. The nursing assistant isn't allowed to remove the patient's medications or dispose of them, so just stay with the patient until you are given further instructions by the nurse.

- While you are taking vital signs on a patient, you notice the patient's pulse is jumping from 90 to 120 beats per minute on the machine you're using. Your next action should be:

To manually check the patient's pulse

Rationale: Because machines can always dysfunction, the nursing assistant should manually check the pulse before reporting it to the nurse. There are certain heart conditions where the pulse can jump like what was mentioned, but these can only be determined by a physician. If the manual re-check is similar to what the machine said, notify the nurse immediately.

- You are taking care of a patient that hasn't voided at all during your 12 hour shift. You notify the nurse knowing that the next step is:

Insert a catheter

Rationale: Urinating is the body ways of removing toxins. If these toxins aren't removed, they are harmful to the patient. An average of 30ml per hour is normal urine output, and no output for 12 hours is something that should be dealt with immediately. CNA's generally aren't allowed to insert catheter, but often must assist the nurse with the procedure. Inserting a catheter will show whether the patient just can't begin the urination process, or if they are not making any urine. Both should be treated urgently.

- You notice that your resident is less social than normal and tends to want to stay in bed all day. You notify thenurse because these are signs of:

Depression

Rationale: Although depression is believed by many to just be part of the aging process, it is something that needs to be treated and dealt just like any other disease. Signs of depression include changes in sleep habits, feeling worthless or sad, changes in eating habits, changes in mood and trouble concentrating.

- You are taking care of a very angry patient that was just admitted to your facility. You should help the patient deal with his anger by:

Letting the patient discuss their feelings with you

Rationale: Talking out a patient's feelings and listening to a patient discuss things is the best way you can help an angry patient feel better. Don't antagonize them or threaten them as this can make the situation worse. If you are concerned that the patient may become violent, let the nurse know the safety of the other patient's and staff isn't compromised.

- You are taking care of an alzheimer's patient who is very confused. The following is an inappropriate way to deal with this type of patient:

Explaining everything with great detail until it is understood

Rationale: When dealing with someone that is confused, use short, simple sentences to get your point across. The more detailed and lengthy your sentences are, the more confused the patient may become. Keep it simple!

- The following is NOT a factor that can cause depression in a patient:

The birth of a grandchild

Rationale: Depression can be caused by many things, including the loss of friends or family, a change in sleep habits or nutrition, a new lifestyle or being diagnosed with a new disease. If you suspect your patient might be depressed, notify the nurse so they can speak with the patient about it and alert the doctor.

- Your patient told you that when his roommate is angry, he tries to hit him. The first thing you should do is:

Remove the non-violent patient

Rationale: Although it is rare, roommate conflict does occur. Safety of the patients should be everyone's biggest concern. First, remove the patient that is being hit is possible. Then, notify the nurse of the situation. She can take the next steps in providing a safe environment for both patients.

- The following statement is NOT true regarding mental health in the elderly:

Psychosis is not considered a mental health disorder

Rationale: Mental health concerns specific to the elderly include dementia, delirium, psychosis, and depression. 1/3 of patients diagnosed with a mental health disorders are left untreated. If you are concerned your patient may have a change in their mental status, notify the nurse so she can assess the patient and investigate further.

- The following is something nursing assistants allowed to do when they are taking care of a violent patient:

Move the patient to a private area and speak with them

Rationale: Unless there is a physician's order in place, restraints can never be placed regardless of it they are physical or medicinal. Threatening a patient may only agitate them more and cause the situation to escalate. Allowing the patient to vent their feelings may make them feel more in control and relaxed.

- The following is not a sign of depression:

Too much energy

Rationale: Changes in a persons sleeping and eating habits, as well as feelings of worthlessness and loss of interest in acitivies are all signs of depression. Patients tend to have less energy, not more, when suffering from depression. If you notice any of these changes in your patient, notify the nurse.

- A patient tells you they have been thinking about hurting themselves because they are depressed. You should:

Stay with the patient and have someone get the nurse

Rationale: Never leave a patient alone if they are thinking of hurting themselves. Get another employees attention and have them inform the nurse of the situation. Do not judge or yell at the patient. Only listen to them and be sympathetic to their situation.

- You are taking care of a confused patient that is a fall-risk and keeps trying to get out of their wheelchair. You should:

Place the patient in a well-monitored area

Rationale: Never leave a confused patient at risk for falling by themselves. Make sure they are somewhere in the facility or on the unit where they can be monitored by staff. The only exception to this is if they are in bed napping or sleeping. Don't force the patient to go to bed if they are clearly awake, it may agitate them and make things worse.

Review Sheet #8
Medical Terminology

- You have been assigned to care for a 75 year old female. The physician has ordered blood glucose testing to be done ac and hs. You understand that "ac and hs" means

before meals and at bedtime.

Rationale: Both terms are from Latin terms. "ac" means before meals and "hs" means hour of sleep, or bedtime.

- Your patient sees a sign over their bed that says "NPO" and asks you what it means. The correct response would be:

nothing by mouth.

Rationale: NPO comes from the latin phrase "nil per os" which means nothing by mouth.

- The abbreviation that means "stroke" is:

CVA.

Rationale: The abbreviation "CVA" stands for cerebral vascular accident. It is another name for a stroke. A CVA refers to damage to the brain caused by a disruption of the blood supply to a part of the brain. Without blood and oxygen, brain cells can die, causing permanent damage. The two major types of stroke are ischemic(caused by a blood clot) and hemorrhagic (caused by a ruptured artery).

- A term used in healthcare that refers to daily self-care activities is

ADL.

Rationale: Activities of Daily Living, or ADL's, are defined as "the things we normally do...such as hygiene (bathing, grooming, shaving and oral care), continence, dressing, eating (the ability to feed oneself), toileting (the ability to use a restroom), and transferring (actions such as going from a seated to standing position and getting in and out of bed).

- "I & O" means:

Intake and Output.

Rationale: Input and output is calculated for a variety of patients in different settings. The process involves recording all the fluid that goes into the patient and the fluid that leaves the body. Intake includes drinks (water, milk, juice), IV fluids, or NG/PEG tube feedings. Output includes urine, diarrhea, blood or drainage from wounds.

- In healthcare, ABC stands for:

Airway, Breathing, Circulation.

Rationale: When someone is found unconscious and unresponsive, remembering the mnemonic ABC, can help to save a life. Airway, breathing, and circulation are vital for life, and each is required, in that order, for the next to be effective.

Review Sheet #8
Medical Terminology

- Thanks to their small size and ease of use, AEDs have been installed in many public locations, such as schools, malls and airports. AED's serve a role in expanding the number of opportunities for life-saving defibrillation. AED stands for:

Automated External Defibrillator.

Rationale: AED stands for Automated External Defibrillator. It is a device that automatically analyzes the heart rhythm and, if it detects a problem that may respond to an electrical shock, that permits a shock to be delivered to restore a normal heart rhythm.

- The doctor has written orders for vital signs to be assessed every 4 hours. Which of the following terms refers to this order?

TPR

Rationale: TPR stands for Temperature, Pulse and Respiration. It is typically thought to include Blood Pressure, assessment of pain and oxygen saturation.

- The doctor has ordered for your patient to undergo a CT scan. CT stands for:

Computerized Tomography.

Rationale: CT scans (sometimes referred to as CAT scans) are diagnostic tests to obtain cross-sectional images of the area being studied that can then be examined on a computer monitor, printed or transferred to a CD. These CT scans of internal organs, bones, soft tissue and blood vessels provide greater clarity and reveal more details than regular x-ray exams.

- The following is true:

One cc (cubic centimeter) = One ml (milliliter).

Rationale: CC's and ml's are equivalent measurements related to volume. The metric system has been coordinated so that length measurements are easily compared to volume measurements. The amount of volume of fluid that would fit in one cubic centimeter will be the same amount of volume of fluid that would fit in one milliliter.

Review Sheet #9

Assistant CNA Activities of Daily Living - Bathing, Dressing & Grooming

- You are assigned to dress a rehab patient that doesn't like to assist you in dressing them. To try and get their assistance, you should:

Explain to them that showing they can help will play a part in them being able to go home

Rationale: Rehab patients aren't discharged home until the doctor feels the patient can perform all of the activities of daily living by themselves, or with very minimal help. Getting dressed is a basic activity that the patient must be independent in doing before being discharged.

- You should not do which of the following when bathing a patient:

Leave the patient to answer a call light

Rationale: Patients who need help bathing often feel embarrassed or ashamed and privacy should be respected. Communicate with the patient and tell them what you will be washing next. Never leave the patient alone in the middle of bathing. Instead, have someone else answer your call lights while you are bathing your patient.

- Mouth care should be performed on a patient:

Several times a day

Rationale: Mouth care should be done on patients every morning, afternoon and evening. This is often overlooked, but is one of the most important parts of patient care. Mouth care includes brushing the teeth, wiping the mouth, using mouthwash and possibly even flossing.

- You are dressing a patient with right arm weakness. Which side do you start dressing first?

The right side

Rationale: Because the patient's right arm is weak and they won't be able to assist as much with that side, start with that side first because it will be easier to maneuver. They will be able to assist you in putting their left arm through a sleeve hole much easier. This will be the most comfortable for the patient, too.

- Patients should be bathed:

Everyday

Rationale: Patients should be bathed everyday. This includes either a shower or bed bath. Clean skin prevents infection and skin breakdown and promotes confidence in patients. Patients usually have an assigned shower schedule which may only allow for 2-3 showers a week. Nursing assistants can be found negligent and lose their license if they do not bath patients daily.

- A patient's hair should be brushed:

After getting them ready for the day

Rationale: A patient's hair should be brushed every morning after they are dressed for the day, or after a shower. Keeping a patient well-groomed can help them be confident and socialize with other patients. If it

is not a shower day, wet the hair and comb it to prevent pulling it.

- Peri-care should be provided:

During bathing and after each episode of incontinence

Rationale: Peri-care prevents patients from getting urinary tract infections and yeast infections. It should be performed each time a patient is bathed and after each episode of bowel and/or bladder incontinence. Nursing assistants can use a washing cloth with gentle soap and warm water, or with a special wipe made specifically for peri-care.

- The following should be done after a patient is bathed:

Put lotion on the patient to prevent any dryness or skin breakdown

Rationale: Unless there is a restriction, lotion should always be put on a patient after bathing to prevent skin breakdown. Never send the patient to an activity in a robe or gown unless it is their wish to go that way, and never leave them alone in the bathroom unless they are an independent patient.

- The best way to get a patient to participate in getting dressed is:

Let them make decisions about what to wear

Rationale: Patient's will cooperate best and be more helpful in getting dressed if they can make decisions about what to wear and how to put on the clothes. Threatening them or doing the work for them does not foster independence.

- The following is NOT appropriate when bathing a patient:

Using the same washcloth throughout the bath

Rationale: Several washcloths should be used during bathing to prevent the spreading of bacteria to openings in the body such as the mouth, or genital area. Using a bath blanket to provide privacy is a must, covering all areas of the body that aren't currently being washed. When bathing, start with the face first, working your way down, leaving the peri-area for last.

Review Sheet #10

CNA Activities of Daily Living - Eating, Nutrition & Hydration

- You are assigned to feed a patient that gets their food pureed. Their meal tray arrives and it has not been pureed. You should:

Send it back and ask them to puree it

Rationale: Patients are on pureed diets to prevent them from choking. Because patient's are weak and/or unable to chew, pureed diets will essentially do the chewing for them to prevent large pieces of food getting stuck in the esophagus and choking the patient.

- You are setting up a meal tray for a patient who had a stroke and has left-sided weakness. You should set the eating utensils:

On the right side

Rationale: Utensils should be used by the strong hand, and when a nursing assistant sets up the meal, they should place them on the strong side. Physical therapy may eventually want the patient to use the affected side, but unless otherwise instructed, set up the utensils on the unaffected side.

- The nurse informs you that your patient is on aspiration precautions. You know this effects how the patient eats because:

They are at risk for choking

Rationale: Patient's on aspiration precautions are at risk for choking on their food and drink and inhaling it into the lungs which leads to pneumonia and even death. The patients should be fed slowly, while they are sitting up, and be on thickened liquids. If the nursing assistant has any concerns or questions, they should ask the nurse for advice.

- You are taking care of a patient that isn't able to set themselves up to take a drink. You should check on them and offer them a drink:

Every 1-2 hours

Rationale: Because you should be checking on your patients every 1-2 hours, ask this patient during rounds if he/she would like a drink of water during this time. Make sure the water is cold and fresh.

- You are collecting meal trays and notice that your patient didn't eat much of their dinner. You should:

Ask the patient if they would like a different meal

Rationale: Good nutrition is an important part in a patient's healing process. Proteins play a vital role in the healing process, and without eating, many of these proteins are not available for the body to use. The patient may simply not like the food offered and would like a different meal. Never take the meal away if it wasn't eaten and simply disregard the fact that the patient didn't eat.

- You should pass fresh water and ice to your patients:

Every 8 hours

CNA Activities of Daily Living - Eating, Nutrition & Hydration

Rationale: Fresh water and ice should be passed every 8 hours or sooner if the patient is out or requests it. Ideally, fresh water and ice should be passed every 4-6 hours, but it must be passed every 8 hours to prevent the growth of bacteria and particles in the water.

- Your patient ate all of their main course, and one side dish. He still has one side dish leftover and doesn't want it. You record that the patient ate this much:

75%

Rationale: Facilities generally count 0, 25, 50, 75 and 100% In this case, the main course would count for 50% and each side dish 25%. Since only one side dish was consumed, 75% of the meal was eaten. Check your facilities policies for specifics on intake documentation.

- You see that your patient is on a NAS diet. You know that this means:

There should be no added salt

Rationale: NAS, or no added sodium, is for patients with cardiac problems, kidney disease and/or high blood pressure. Sodium attracts fluids and can cause fluids overload, high blood pressure, and more. The amount of sodium should be restricted to 2 grams per day.

- Your patient is diagnosed with dehydration. You should make the following change in the amount of fluid consumed daily:

Offer your patient a drink more frequently than normal

Rationale: Dehydration is caused by a number of things, but as part of treatment, a patient should consume a lot of fluids. Because they will need to drink more than patients that aren't dehydrated, they should be offered water more often. Do not force the patient to drink, or threaten that they won't get better. If the patient continually refuses the water, tell the nurse so they can be educated on it being part of their treatment.

- You are assigned to help a patient eat dinner and notice that their beverages must be thickened. This is because:

Thin liquids can cause the patient to choke

Rationale: Patients who are at risk for choking or aspirating their drink are put on thickened liquids to prevent that from happening. Thickener comes in powder and liquid form and can be mixed with any beverage.

- Your diabetic patient asks for an evening snack. Because they are a diabetic, you know the best snack for them is:

Almonds

Rationale: Many kinds of nuts are a great snack for diabetics. They are filling and low in sugar. Chips, cooking, pudding, ice creams and more are full of sugar and should be avoided as a snack for a diabetic. If you are unsure of a good snack idea, ask your nurse for further advice.

Review Sheet #10

CNA Activities of Daily Living - Eating, Nutrition & Hydration

- You are assigned to take care of a patient with cancer that is being treated with chemotherapy. You know that their eating habits and appetite will:

Decrease

Rationale: Chemotherapy patients lose their appetite because the treatment makes them nauseous and tired. They generally eat little at meal, or not at all. Do not force them to eat if they are ill. If they are nauseous, let the nurse know and he/she may be able to give them medicine to help with that so they are able to eat.

- Which of the following is NOT appropriate when feeding a patient:

Feeding them in 10 minutes so you have a chance to feed all of your patients

Rationale: When feeding a patient, you should never rush because this can cause the patient to choke or just give up on trying to eat. Feeding patients can take a while, especially if they are weak or tired and chew slowly. Do not to try speed up the process because this can make them choke. Ask for assistance in feeding your other patients if you are running behind.

- You are getting a new patient on the unit that has a PEG tube. You know that you won't need to feed this patient because:

They will be fed by a nurse through the tube

Rationale: Patients with PEG tubes are fed a special concoction of food through their tube. Only a nurse can set up their tube feedings, and a machine regulates how much they get and how often. These are usually given to patients that aren't able to eat through their mouths and can be temporary or permanent.

- The nurse tells you that one of the patients on your assignment is NPO. This means:

They aren't allowed to have anything to eat or drink

Rationale: Patients that are NPO should consume nothing by mouth until the physician says they may. Patients are generally NPO before surgery, if they are intubated or if they have a feeding tube. Their mouths may be swabbed with a moist swab, and ice chips may be allowed. NPO patients are not allowed to consume food or drink beverages.

Review Sheet #11

CNA Vital Signs

- The least accurate method of assessing body temperature is:

axillary.

Rationale: The axillary method is the least reliable as movement of the arm may affect the reading of the thermometer.

- Difficulty in breathing is called:

dyspnea.

Rationale: Dyspnea, shortness of breath (SOB), or air hunger, is the subjective symptom of breathlessness. It is a normal symptom of heavy exertion.

- Korotkoff sounds are heard when auscultating

Blood pressure.

Rationale: Korotkoff sounds are heard as the arterial wall distends when the blood pressure cuff compresses.

- One full count of a respiration includes:

An inspiration and expiration

Rationale: One respiratory cycle includes one full inspiration and one complete expiration. The volume of air that enters or leaves during a single respiratory cycle is called the tidal volume. Tidal volume is typically 500 milliliters, meaning that 500 milliliters of air enters during inspiration and the same amount leaves during expiration.

- The normal average temperature of an adult patient is:

98.6 F

Rationale: Normal human body temperature at the body core is 98.6°F or 37°C. There are variations of the temperature based on the time of the measurement and where the body temperature is measured. The temperature can also vary for babies, children and adults.

- The most common site for taking a pulse is the:

radial artery.

Rationale: There are several sites on the body where a pulse is normally taken. All arteries have a pulse, but it is easier to palpate (feel) the pulse at certain locations. It is easier to feel the pulse when the artery is near the surface of the skin and when there is firm tissue (such as a bone) beneath the artery. The two most common sites are the radial (wrist) and carotid (throat).

- The average heart rate for an adult is:

Review Sheet #11

CNA Vital Signs

60-80 bpm.

Rationale: For healthy adults, a lower heart rate at rest generally implies more efficient heart function and better cardiovascular fitness. Heart rate can be affected by activity level, fitness level, air temperature, body position (standing up or lying down, for example), emotions, body size, and medication use.

- The term that means that a doctor has written orders for vital signs to be assessed every 4 hours is:

TPR

Rationale: TPR stands for Temperature, Pulse and Respiration. It is typically thought to include Blood Pressure, assessment of pain and oxygen saturation.

- The doctor has ordered for your patient to undergo a CT scan. CT stands for:

Computerized Tomography.

Rationale: CT scans (sometimes referred to as CAT scans) are diagnostic tests to obtain cross-sectional images of the area being studied that can then be examined on a computer monitor, printed or transferred to a CD. These CT scans of internal organs, bones, soft tissue and blood vessels provide greater clarity and reveal more details than regular x-ray exams.

- The following is true:

One cc (cubic centimeter) = One ml (milliliter).

Rationale: CC's and ml's are equivalent measurements related to volume. The metric system has been coordinated so that length measurements are easily compared to volume measurements. The amount of volume of fluid that would fit in one cubic centimeter will be the same amount of volume of fluid that would fit in one milliliter.

Review Sheet #12

Communication & Interpersonal Skills

- It is appropriate for the nursing assistant to tell the patient which of the following things:

Their father ate 75% of their dinner

Rationale: You may only tell the family things that you have witnessed yourself that do not diagnose a patient. Such as, you cannot say the patient has diarrhea because this is an assessment. You must say the patient has loose stools. Only a nursecan tell the family a patient has diarrhea. You can tell the family the the amount of food the patient has or hasn't eaten, their bowel and bladder habits, their mood lately, etc. Only a nurse can discuss a patient's condition with the family, and only the family can learn things about the patient if it is okay with the patient.

- You should communicate patient's statuses with the nurse:

As often as needed

Rationale: When there is a change in patient status, for better or worse, the nurse should be notified immediately. You should get information from the nurse at the beginning of your shift on the baseline of your patient and monitor for changes from this baseline.

- The doctor calls and tells the nursing assistant to write a new order for a dressing change on Mrs. Jones' knee. You should:

Get the nurse to take the order

Rationale: Only a nurse can take a verbal order from a physician. This is a legal issue. If the physician tries to give you an order, place him or her on hold and get the nurse to take it.

- Your patient sits in his room all day and appears to be depressed. You should:

Inform him about the activities going on and offer to walk him to the activity if he is interested

Rationale: Letting a patient know of activities that are going on and that his participation is wanted can make him feel more at home. Don't force him to partake in the activities, but make sure he is aware of the social activities available.

- You are taking care of a patient who strikes you out of anger. You should communicate that this is inappropriate by saying:

"Please don't hit sir, it hurts and isn't appropriate"

Rationale: Never threaten a patient or tell them you are going to medicate them if they hit again. This is illegal and can be punished in a court of law. Explain to the patient why they should not hit and that it is painful. If it continues, remove yourself from the room and tell the charge nurse about what happened.

- You hear a female visitor tell her husband, who is a patient, that she would like to be intimate with him. As a nursing assistant, you must:

Provide them with privacy and inform other employees that privacy is needed

Communication & Interpersonal Skills

Rationale: Patients have the right to be sexually active as long as it is with a consenting adult and not done in a public place and is not revealing to others. Employees must provide privacy for them because this is a right they have.

- You should inform the nurse immediately of which of the following:

Abnormal vital signs

Rationale: Abnormal vital signs should always be reported to the nurse right away. To understand what is abnormal, the nursing assistant is responsible to know what is normal, and/or what is normal for that specific patient. If the nursing assistant is unsure, let the nurse know anyways so she can decide if there is something to be concerned of.

- As a nursing assistant, you will communicate with what type of healthcare workers:

All healthcare providers

Rationale: Nursing assistants will communicate with all healthcare workers. They are usually with patients the most, especially during their activities of daily living like bathing, eating and toileting. They must communicate the patients habits and moods to the rest of the staff.

- When entering a patient's room, you should communicate:

Your name, title and task you will be doing

Rationale: When entering a patient's room, always knock first and them communicate your name and title and what you are entering the room for. This is a common courtesy and provides them with privacy.

- When giving report to the next shift, you should give report and communicate changes in patients by:

Walking around from room to room

Rationale: Walking from room to room and physically seeing the patients is the best way to give report to the next shift in case there is a specific change you need to show the nursing assistant.

- The following people are not allowed to communicate a change in condition to a patient's family:

A nursing assistant

Rationale: Only licensed healthcare workers, such as doctors and nurses, are allowed to communicate condition changes to a patients family. This is not only a legal issue, but a nurse or doctor will have more knowledge of the situation than a nursing assistant may have. However, not all licensed healthcare workers are allowed to report all changes.

- You see two nurses in a heated discussion in front of a patient. You should:

Ask them to take the discussion to a private area

Rationale: Whenever there is conflict between employees, this should be dealt with in a private manner

outside of business hours. If it needs to be discussed immediately, it should be away from patients and their families. If you witness this occurring in front of patients and their families, ask them to go to a private place if they must continue.

- When communicating with a patient that is hard of hearing, you should:

Look directly at the patient

Rationale: Always communicate to a deaf patient by facing them and making eye contact. You may need to raise your voice more than normal but do not yell at them or talk directly into their ear. Always communicate what you will be doing even if it takes longer to explain to them than it would versus a patient with normal hearing.

- The nursing assistant should communicate which of the following to the nurse:

The patient complaining of their roommate being verbally abusive

Rationale: Any allegations of abuse should be reported to the nurse immediately whether it is verbal, physical, sexual or emotional. The nurse must further investigate these claims and make any changes accordingly.

- When communicating with a patient, you should not show:

Hostility

Rationale: When communicating with a patient, only project positive emotions even if you are frustrated, angry or sad. Whether you are sad or angry with work or something outside of work, positive attitudes around your patient will help them feel safe and happy. If you are unable to project positive emotions, talk to your charge nurse about taking a quick break or ask to be assigned to a different patient.

- When communicating with a patient, you should be:

Clear

Rationale: When speaking with a patient, always be clear and concise and try not to mumble. Make eye contact and don't cross your arms or put your hands on your hips: this makes you appear interested. Use words that are appropriate for the age you are talking to. Don't use big words around children, and don't use childish words around adults.

- When telling a nurse about a new wound found on one of your patients, you should include:

The patients room number, what the wound is or looks like and where it is located

Rationale: Due to HIPAA privacy acts, you should protect the patient's name from being revealed in case visitors or other patients can hear it. Only tell the nurse the room number, location of the wound and what it is or what it looks like.

- You are assigned to a patient who was just diagnosed with having a stroke. You know this may impair your ability to communicate with the patient because:

Review Sheet #12

Communication & Interpersonal Skills

The stroke may have taken away their ability to talk

Rationale: When a patient has a stroke, their ability to speak may be taken away depending on the side and area of the brain that was damaged. This ability may or may not return depending on how long it was damaged and how quickly it was treated. Your employer should provide you with special cards for the patient to use to communicate with the staff, or with a dry erase board.

- You have noticed that a couple of your long-term patients get in arguments often. After reporting this to the nurse, you should:

Separate the patients

Rationale: When patients don't get along, try to keep them apart when possible. Arrange their dinner times so they are at different times, take them to different activities if possible, etc. You can't force them to remain apart unless there is abuse or violence, but try to keep further arguments from happening by separating them when possible.

- When talking to your patient's you are NOT allowed to tell them:

Their roommate's condition

Rationale: Due to HIPAA, you are never allowed to communicate a patient's condition, treatment, diagnosis, etc. with any other patient. This is illegal and can be fined up to $50,000 and can cause the nursing assistant to lose their license.

What we didn't know 2011

1) Chain of Command
2) HIPAA
3) OBRA
4) Medicare
5) Medicaid
6) Physician are Doctors
7) Kinds of nursing homes
    a. Functional
    b. Primary
    c. Team
    d. Resident Centered
8) MDS
9) MSDS
10) Sun downing
11) Sentinel event
12) TIA
13) LTC
14) Delegation
15) Policy
16) Procedure
17) OMBUDSMAN
18) 24 hour clock
19) Mental Health problems

a. Denial

b. Regression

c. Projection

d. Rationalization

20) Order of PPE

a. Putting on

b. Taking off

21) Standard Precautions

22) Transmission based

23) TPR

24) Endentulous

25) Food Pyramid

26) Systiolic

27) Diastolic

28) Ac and pc

29) CRF

30) Diets

a. Regular

b. Pureed

c. Soft

d. Renal

e. Diabetic

f. High fiber

g. Low fiber

31) A+P

32) GERD

33) Ulcerative Colitis

34) Crohnes Disease

35) Sims position

36) Prone position

37) Supine position

38) Ova and parasites

39) Daily urine output

40) C/V system

41) Which side to lift

42) Finding a person on the floor what to do

43) Ligaments vs Tendons

44) TKR

45) Dementia

46) Alzheimer's Disease

47) Subjective vs Objective

48) Scabies

49) 1 oz equal 30 cc

50) Where do you tie a restraint

51) What is a patient's Bill of Rights

52) Know the Chain of Infection

53) Know Maslow's Hierarchy

54) What is Apnea