CNA Health Promotion Questions Quizlet

CNA TestBank · Prepared Nov 29, 2026 · Ref CGDFWSBW

This PDF contains all **10** questions in this exam.

For personal study only. Do not share or redistribute. Educational use only; not a substitute for accredited CNA training.

1. The nurse aide is caring for a group of clients with dementia. The nurse aide understands that these clients are at high risk for accidents because:

A. they are well aware of dangerous situations

B. their cognitive abilities still allow them to sense danger

C. their judgment is completely intact

D. they may access closets, cupboards, or other unsafe areas

Answer: D. they may access closets, cupboards, or other unsafe areas

Clients with dementia are at high risk for accidents because they may access closets, cupboards, or other unsafe areas.

Dementia impairs memory, judgment, and the ability to recognize danger, so clients may wander into places they should not go and may not understand hazards such as cleaning supplies, medications, sharp objects, or stairways. Because they cannot reliably judge safety, the nurse aide must protect them by keeping unsafe areas locked or secured, supervising them closely, and removing hazards from reach. This is a core part of fall and injury prevention in dementia care.

A) they are well aware of dangerous situations

Dementia reduces awareness of danger rather than preserving it, so this does not explain the increased accident risk. It may seem reassuring to think clients understand hazards, but assuming this can lead to inadequate supervision and preventable injuries.

B) their cognitive abilities still allow them to sense danger

Cognitive decline affects the ability to recognize and respond to danger, so this statement does not fit the diagnosis of dementia. It can be tempting to believe basic safety sense remains intact, but overestimating a client's ability to sense danger puts them at risk.

C) their judgment is completely intact

Impaired judgment is a hallmark of dementia, and intact judgment would actually lower accident risk rather than raise it. This option may appeal because the client can still seem capable in familiar routines, but judgment is not reliable in unfamiliar or hazardous situations.

Conclusion

Remember that dementia affects judgment and safety awareness, so clients may enter unsafe areas without recognizing the danger. The nurse aide's job is to secure hazards, supervise closely, and keep the environment safe.

2. If you make a mistake on the job, the first thing you must do is:

A. keep it confidential

B. report it to charge nurse

C. tell co-workers

D. deny it

Answer: B. report it to charge nurse

cnatestbank.com
Guest download · Ref CGDFWSBW

Report the mistake to the charge nurse right away.

Making a mistake is human, but in a care setting the safety of the resident comes first. The charge nurse is the person who can assess the situation, check on the resident, and decide what steps are needed to correct or prevent harm. Reporting promptly is part of being a responsible, honest member of the care team and stays within the CNA's scope of practice. Hiding a mistake or waiting can allow a small problem to become a serious one.

A) Keep it confidential

Keeping a mistake to yourself may feel like protecting the resident's privacy or avoiding embarrassment, but it actually delays the care team from responding. Privacy rules protect resident information, not errors that could affect a resident's safety. Silence can let harm continue unchecked.

C) Tell co-workers

Sharing with co-workers may seem like a quick way to get advice, but they cannot direct the response or document the event. The person with the authority and responsibility to act is the charge nurse. Talking to peers first can also spread information inappropriately.

D) Deny it

Denying a mistake may feel like a way to avoid trouble, but dishonesty breaks trust and puts the resident at risk. Care teams depend on accurate reporting so they can fix problems and keep residents safe. Denial can turn a simple error into a serious safety and accountability issue.

Conclusion

When a mistake happens, honesty and prompt reporting to the charge nurse protect the resident and keep you within your role. Remember that the first priority is always resident safety, and the charge nurse is the right person to notify.

3. When using a gait belt it should be:

A. under clothing

B. over clothing

C. overhand grasp

D. buckled in back

Answer: B. over clothing

A gait belt should be placed over clothing so it can be seen, checked, and gripped safely.

A gait belt is a wide strap that gives the caregiver a secure hold to support a resident during standing, walking, and transfers. Placing it over clothing keeps it visible and accessible, allows you to check the fit and any wear or damage, and lets you get a firm grip without fabric bunching underneath. It should be snug but not tight, with enough room to slide a flat hand underneath, and it should be fastened securely before any movement begins. Keeping it on the outside of clothing also makes it easier to remove quickly and reduces skin irritation from friction against bare skin.

A) Under clothing

Tucking the belt beneath clothing hides it from view, makes it hard to check the fit and condition, and lets fabric bunch under the strap, which can pinch the skin and weaken your grip. It may seem more comfortable or modest, but it interferes with safe use.

C) Overhand grasp

This describes how a caregiver grips the belt, not where the belt is placed. An overhand grasp is actually the recommended way to hold the belt, so it can feel like the right answer, but the question asks about the belt itself rather than the hand position.

cnatestbank.com
Guest download · Ref CGDFWSBW

D) Buckled in back

Fastening the buckle at the back puts it out of sight and out of easy reach, so it cannot be checked or released quickly in an emergency. It may seem logical to keep the buckle away from the front of the body, but it reduces safety and access.

Conclusion

Remember that a gait belt belongs over clothing, snug but with room for a flat hand, and positioned so you can see it, check it, and grip it securely. Focus on what the question is really asking, since grasp technique and buckle placement are separate details from belt placement.

4. The role of the nurse aide in restorative care is to:

A. combine short steps into a long list to keep a client motivated

B. recognize that setbacks occur and encourage a client to keep trying

C. let a client know when progress is not happening as quickly as planned

D. complete a task for a client if the client is taking too long to complete it

Answer: B. recognize that setbacks occur and encourage a client to keep trying

Recognizing that setbacks happen and encouraging the client to keep trying is the nurse aide's role in restorative care.

Restorative care focuses on helping clients regain and maintain function through practice and repetition of daily activities. Progress is rarely a straight line, and clients often become discouraged when gains are slow or when they lose ground temporarily. The nurse aide supports the client by staying positive, acknowledging that setbacks are a normal part of recovery, and encouraging continued effort. This builds confidence and motivation, which are essential to the restorative process, and it stays within the CNA's scope of practice by reinforcing the care plan rather than changing it.

A) Combining short steps into a long list

Breaking tasks into small, manageable steps is the usual approach in restorative care, so the idea of keeping a client motivated may sound appealing. However, turning those steps into one long list can overwhelm the client and undermine confidence, making it harder to complete the activity.

C) Pointing out when progress is slower than planned

It is natural to think that honest feedback about pace would motivate a client. In practice, drawing attention to slow progress can increase frustration and discouragement, which works against the encouragement that restorative care depends on.

D) Completing a task for a client who is taking too long

Finishing the task may seem efficient and kind when a client struggles. Yet doing the activity for the client takes away the practice that builds strength and independence, and it can reduce the client's confidence and willingness to keep trying.

Conclusion

In restorative care, the nurse aide's job is to encourage effort and normalize setbacks, not to rush, criticize, or take over. Remember that practice and positive support preserve independence, which is the heart of restorative care.

5. Normal aging change in circulation is:

A. vessels widen

B. total vision loss

C. total hearing loss

D. less effective heartbeat

Answer: D. less effective heartbeat

cnatestbank.com
Guest download · Ref CGDFWSBW

Normal aging change in circulation is a less effective heartbeat.

As people age, the heart muscle and its electrical conduction system undergo natural changes that can make each beat pump a bit less forcefully and respond more slowly to the body's demands. Blood vessels also tend to stiffen over time, so circulation becomes somewhat less efficient. This is a normal age-related change, not a disease, and it is why older adults are monitored more closely for blood pressure, pulse, and signs of fatigue or poor circulation.

A) vessels widen

With aging, arteries typically lose elasticity and become stiffer rather than wider, which can raise blood pressure. It is easy to picture "widening" as a way to improve flow, but the normal change is reduced flexibility, not widening.

B) total vision loss

Vision changes such as needing more light or having trouble with close-up tasks are common with age, but total vision loss is not a normal aging change and points to disease or injury. This option mixes up a sensory change with circulation and overstates what is normal.

C) total hearing loss

Hearing loss, especially for high-pitched sounds, can occur with aging, but complete hearing loss is not a normal expectation and is unrelated to circulation. This choice confuses a sensory issue with the cardiovascular system.

Conclusion

Focus on the word "normal" and on the circulatory system. Aging brings a slower, less forceful heartbeat and stiffer vessels, while total loss of vision or hearing is not a normal change. When answering vital signs questions, link each option to the body system named in the stem.

6. A low-fat diet is ordered for a client. Which of the following foods is restricted?

A. Fish

B. Butter

C. Bread

D. Sugar

Answer: B. Butter

Butter is restricted on a low-fat diet because it is a concentrated source of fat.

A low-fat diet limits foods that are high in fat, especially saturated fat and added fats. Butter is almost entirely fat, so it is one of the first foods reduced or removed when a low-fat diet is ordered. The CNA's role is to serve the foods allowed on the diet, respect the restriction, and report to the nurse if the client asks for or receives a restricted food.

A) Fish

Fish is not restricted as a category on a low-fat diet. Many fish are lean and are encouraged as a protein source. Some fish are higher in fat, but the dietitian selects specific types, and the CNA does not decide this independently.

C) Bread

Plain bread is generally low in fat and is usually allowed on a low-fat diet. The tempting mistake is to think all carbohydrates are limited, but fat content, not carbohydrate content, is the focus of this diet.

D) Sugar

Sugar contains no fat, so it is not restricted by a low-fat diet. It may be limited on other diets, such as a diabetic or calorie-controlled diet, which can make this option seem plausible.

cnatestbank.com
Guest download · Ref CGDFWSBW

Conclusion

On a low-fat diet, the CNA should focus on foods high in fat, such as butter, and follow the care plan and diet order exactly. When in doubt about whether a food is allowed, ask the nurse or dietitian rather than making an independent decision.

7. A client may be dehydrated due to:

A. a lack of activity

B. inadequate fluid intake

C. excessive food ingestion

D. a salt-free diet

Answer: B. inadequate fluid intake

Dehydration most often results from inadequate fluid intake, so the correct answer is B.

Dehydration happens when the body loses more water than it takes in, and the simplest and most common cause is simply not drinking enough fluids. Older adults, people who are ill, and clients who depend on others for drinks are especially at risk. As a CNA, watching how much a client drinks, offering fluids regularly, and reporting signs like dark urine, dry mouth, or confusion help catch dehydration early.

A) a lack of activity

Being inactive can slow digestion and affect overall wellness, which makes this choice sound health-related. However, activity level does not directly control the body's water balance, so it is not a primary cause of dehydration.

C) excessive food ingestion

Eating a large amount of food may cause discomfort or affect blood sugar, so it can seem connected to nutrition problems. Still, food intake by itself does not drain body water, and many foods actually add fluid to the diet.

D) a salt-free diet

A low-salt diet is often ordered for heart or blood pressure problems, so it may seem linked to fluid issues. In reality, limiting salt does not cause dehydration; if anything, high salt intake increases the body's water needs.

Conclusion

For the exam, link dehydration to not getting enough fluids. Remember that monitoring intake and offering fluids are key CNA actions for preventing dehydration.

8. White blood cells are responsible for:

A. delivering oxygen

B. blood clotting

C. fighting infection

D. making synovial fluid

Answer: C. fighting infection

White blood cells fight infection, serving as the body's main defense against invading germs.

White blood cells (leukocytes) are part of the immune system. They travel in the blood to find and destroy bacteria, viruses, and other organisms that cause infection. When a person has an infection, the body often makes more white blood cells, which is why a high white blood cell count can be a clue that the body is fighting something. For a CNA, understanding this helps explain why hand hygiene and proper use of personal protective equipment matter so much: these practices reduce the spread of germs that white blood cells must fight.

cnatestbank.com
Guest download · Ref CGDFWSBW

A) Delivering oxygen

Red blood cells, not white blood cells, carry oxygen. Hemoglobin inside red blood cells binds oxygen in the lungs and releases it to tissues. It is easy to mix up blood cell types, but oxygen transport is a job for red blood cells.

B) Blood clotting

Clotting is mainly the work of platelets and clotting factors in the plasma. Platelets gather at a break in a vessel and help form a plug. White blood cells are not the primary cells for stopping bleeding.

D) Making synovial fluid

Synovial fluid, which lubricates joints, is produced by the synovial membrane lining the joint capsule. It is not made by white blood cells, so this choice does not match the role of these cells.

Conclusion

Remember that white blood cells defend the body by fighting infection, while red blood cells carry oxygen and platelets help with clotting. Knowing each blood cell's job supports good infection control practice and safe care.

9. A nurse aide is caring for a client enrolled in a bowel retraining program. Which intervention best supports the client in achieving regular bowel movements?

A. Limiting the client's fluid intake

B. Encouraging the client to eat a high-fiber diet

C. Remaining with the client during elimination

D. Advising the client to decrease physical activity

Answer: B. Encouraging the client to eat a high-fiber diet

Encouraging the client to eat a high-fiber diet helps promote regular bowel movements by adding bulk and softening stool.

Bowel retraining works best when the body is given the tools it needs to form and pass stool regularly. Fiber adds bulk to the stool, which helps the bowel move contents along and makes elimination easier and more predictable. This supports the goals of a retraining program along with adequate fluids, activity, and a consistent toileting schedule. The nurse aide should encourage fiber-rich foods such as fruits, vegetables, and whole grains within the client's prescribed diet and report tolerance issues to the nurse.

A) Limiting fluid intake

Restricting fluids tends to make stool harder and more difficult to pass, which works against the goals of bowel retraining. It may seem helpful for someone worried about accidents, but adequate fluids are part of healthy elimination.

C) Remaining with the client during elimination

Staying nearby can offer comfort and safety, but it does not directly change bowel function or help establish regularity. It may feel supportive, yet it does not address the physical factors that drive regular bowel movements.

D) Advising the client to decrease physical activity

Activity helps stimulate the bowel and supports normal elimination, so reducing it can slow things down. This option may seem appealing for a client who tires easily, but it does not promote regularity.

Conclusion

For bowel retraining, focus on interventions that support healthy stool formation and movement, such as a high-fiber diet, adequate fluids, and activity. Remember that the nurse aide encourages healthy habits within the care plan and reports concerns to the nurse.

cnatestbank.com
Guest download · Ref CGDFWSBW

10. A client asks the nurse aide about the use of assistive devices. What SHOULD the nurse aide tell the client?

A. Assistive devices are difficult to use

B. All clients use at least 1 assistive device

C. Assistive devices are used only once daily

D. Assistive devices will help maintain the client's independence

Answer: D. Assistive devices will help maintain the client's independence

Assistive devices help clients maintain their independence by supporting safe function in daily activities.

When a client asks about assistive devices, the nurse aide should give a positive, accurate message that these tools are meant to help the person do things for themselves as safely as possible. Promoting independence is a core part of the CNA role, and encouraging the use of prescribed devices supports dignity, safety, and function. The aide should answer simply and, if the client has detailed questions about a specific device, refer them to the nurse or therapist.

A) Difficult to use

This paints assistive devices in a negative light and may discourage the client from using something that could keep them safe and independent. Devices can take some practice, but they are designed to make tasks easier, not harder.

B) All clients use at least 1 assistive device

This is an overgeneralization. Many clients do not need any assistive device, and telling a client that everyone uses one is inaccurate and could cause confusion or unnecessary worry.

C) Used only once daily

There is no rule that assistive devices are used only once a day. How often a device is used depends on the client's needs and care plan, so this statement is misleading.

Conclusion

Focus on the purpose of assistive devices: they promote safety and independence. Choose the answer that gives the client an accurate, encouraging message and stays within the nurse aide's scope by referring detailed device questions to the appropriate team member.

cnatestbank.com
Guest download · Ref CGDFWSBW