CNA Specialized Care Prep Free

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1. In the context of end-of-life care, what term describes the final stage of a person's illness?

A. optimal

B. terminal

C. minimal

D. maximal

Answer: B. terminal

The correct term for the final stage of a person's illness in end-of-life care is terminal.

A terminal illness is one that cannot be cured and is expected to end in death, so "terminal" describes the final stage of the disease process. In end-of-life care, the care team shifts focus to comfort, dignity, and quality of life rather than cure. Knowing this term helps the nurse aide understand the resident's plan of care, communicate respectfully with the family, and provide supportive physical and emotional care within the CNA scope of practice.

A) optimal

"Optimal" means the best or most favorable condition, which describes an ideal state rather than the last stage of an illness. It may seem tempting because care teams aim for optimal comfort, but it does not name the final stage of disease.

C) minimal

"Minimal" means the least amount or smallest degree, such as minimal pain or minimal assistance. It may sound appealing because comfort care tries to keep discomfort minimal, but it does not describe the last stage of an illness.

D) maximal

"Maximal" means the greatest possible amount, such as maximal support or maximal effort. It may seem tempting because care teams sometimes provide maximal comfort measures, but the word refers to intensity of care, not the final stage of an illness.

Conclusion

Remember that "terminal" refers to the final stage of an illness that is not expected to be cured. Recognizing this term helps you understand the goals of end-of-life care and respond to residents and families with sensitivity and clarity.

2. When emptying an ostomy device, the nurse aide SHOULD:

A. tape the ostomy device securely to the skin

B. observe the output

C. change the pouch each time

D. ensure the client is wearing tight clothing

Answer: B. observe the output

When emptying an ostomy device, the nurse aide should observe the output.

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Emptying an ostomy pouch is a routine personal care task, and the output itself carries important information about the client's digestion, hydration, and overall status. The aide should look at the amount, color, consistency, and any unusual features of the stool or effluent, then report findings to the nurse. This observation helps the care team catch problems early, such as bleeding, dehydration, or a blockage, without the aide needing to make any clinical judgment or change the plan of care.

A) Tape the ostomy device securely to the skin

Taping the device down is not part of emptying it, and tape can irritate the skin or damage the barrier seal around the stoma. This option sounds helpful because keeping the pouch in place feels like good care, but securing the device is handled with the proper ostomy barrier and skin prep, not tape.

C) Change the pouch each time

Pouches are typically emptied when they are about one-third to one-half full and are replaced on a schedule set by the nurse or ostomy specialist, not at every emptying. Changing the pouch too often wastes supplies, irritates the skin, and breaks the seal, so this option sounds thorough but actually works against skin protection.

D) Ensure the client is wearing tight clothing

Tight clothing can press on the pouch, cause leakage, and irritate the stoma area, so loose, comfortable clothing is preferred. This option may seem like a way to keep the pouch hidden or secure, but pressure on the device increases the risk of skin problems and accidents.

Conclusion

For ostomy care questions, remember that the aide's key role during emptying is to inspect and report the output. Focus on observation and reporting to the nurse, and leave decisions about securing or changing the device to the care plan.

3. Indwelling catheter tubing should always be placed:

A. above insertion site

B. over bedrail

C. under leg

D. over leg

Answer: A. above insertion site

Indwelling catheter tubing should always be placed above the insertion site to allow gravity to drain urine and prevent backflow.

Urine flows downhill, so keeping the drainage bag and tubing positioned above the insertion site lets gravity pull urine away from the bladder. This continuous flow helps prevent urine from pooling in the tubing and flowing back into the bladder, which could introduce bacteria and cause a urinary tract infection. It also keeps the tubing from kinking or pulling on the catheter. As a CNA, check that the bag hangs below bladder level but the tubing is arranged so it drains freely, and never let the bag rest on the floor.

B) Over bedrail

Draping tubing over a bedrail can create a loop where urine collects, and when the rail is lowered the bag may rise above the bladder, allowing backflow. It may seem convenient to keep the tubing out of the way, but this position interferes with gravity drainage and raises infection risk.

C) Under leg

Routing the tubing under the leg can cause kinks, pressure, or pulling on the catheter, which blocks urine flow and can injure the urethra. It might look tidy, but it compromises drainage and patient comfort.

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D) Over leg

Placing tubing over the leg can create dependent loops and tension on the catheter that disrupt gravity drainage and may cause leakage or trauma. It may seem like a simple way to keep tubing off the floor, but it does not support proper flow.

Conclusion

Remember that gravity is the key to catheter drainage: keep the tubing above the insertion site and the bag below bladder level, free of kinks and loops, to protect the resident from infection and injury.

4. A client with diabetes has long toenails that are chipped and broken. The nurse aide SHOULD:

A. get the client a pair of scissors and tell the client to trim the client's own nails

B. soak the client's feet in warm water and cut the client's nails straight across

C. report the need for nail care to a supervisor

D. ask the client's family to take care of the client's nails

Answer: C. report the need for nail care to a supervisor

Report the need for nail care to a supervisor, since a client with diabetes needs special foot care handled by a qualified professional.

Clients with diabetes often have poor circulation and reduced sensation in their feet, so even a small cut or nick during nail trimming can become a serious wound or infection. Nurse aides are not trained or permitted to trim the nails of a client with diabetes, so the safe action is to observe the condition of the nails and report it to the supervisor. The supervisor can then arrange for a podiatrist or other qualified professional to provide the care. This keeps the client safe and stays within the aide's scope of practice.

A) Giving the client scissors to trim their own nails

This option may seem helpful because it respects the client's independence, but a client with diabetes may have reduced feeling and vision problems that make self-trimming risky. Handing over scissors does not protect the client from injury or infection, and the aide is still responsible for reporting the foot care need.

B) Soaking the feet and cutting the nails straight across

Cutting nails straight across sounds like standard nail care, but for a client with diabetes this goes beyond the aide's scope. Soaking and trimming can lead to cuts, skin breakdown, and infection in feet with poor circulation. This task belongs to a podiatrist or other qualified professional.

D) Asking the family to take care of the nails

Involving the family may feel like a caring solution, but family members are not trained to trim the nails of a client with diabetes either. The proper step is to report to the supervisor so that professional foot care can be arranged and the client's safety is protected.

Conclusion

When a client with diabetes has nail or foot care needs, the aide's role is to observe and report, not to trim. Remember that diabetic foot care is a specialized task, and reporting to the supervisor keeps the client safe and within the aide's scope of practice.

5. During dying, the last sense believed to leave is:

A. sight

B. taste

C. hearing

D. smell

Answer: C. hearing

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Hearing is generally considered the last sense to fade during the dying process.

As death approaches, the body's systems slow down and the senses shut down one by one. Hearing is widely believed to be the last sense to leave, which is why caregivers are encouraged to keep speaking gently and reassuringly to a dying resident, even if the person seems unresponsive. Because hearing may persist, CNAs should avoid discussing upsetting or inappropriate topics at the bedside and should continue to offer calm, comforting words and explanations of care.

A) Sight

Vision often changes earlier in the dying process, with decreased awareness, blurring, and reduced responsiveness to visual cues. It can seem logical that sight, being a major sense, would linger, but it typically declines before hearing does.

B) Taste

Taste depends on eating and drinking, which usually stop well before death as appetite and swallowing decline. It may seem like a basic sense that would remain, but it fades earlier than hearing.

D) Smell

Smell, like taste, is tied to oral intake and the body's sensory functions that diminish as the person becomes less responsive. It may appear to be a lasting sense, yet it is not the one believed to remain longest.

Conclusion

Remember that hearing is thought to be the last sense to leave, so always speak to dying residents with respect and reassurance, assuming they can hear you even when they cannot respond.

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