Documentation Questions and Answers

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1. A nurse aide is preparing to measure a client's pulse. Where is the radial pulse located?

A. In the leg

B. In the wrist

C. In the neck

D. At the temple

Answer: B. In the wrist

The radial pulse is located in the wrist, on the thumb side of the inner forearm.

The radial artery runs along the thumb side of the wrist, where it lies close to the skin over the bone, making it easy to feel with light pressure from two fingertips. This spot is a standard choice for measuring pulse because it is safe, accessible, and does not require pressing on sensitive areas like the neck. A nurse aide should count the beats for a full minute, noting the rate and rhythm, and record the findings according to facility policy.

A) In the leg

The leg does contain pulse points, such as the femoral artery in the groin and the popliteal artery behind the knee, but these are not the radial pulse and are not routinely used by nurse aides for standard pulse checks. It may seem tempting to think any large vessel works, but the question asks specifically about the radial site.

C) In the neck

The neck is where the carotid pulse is felt, along the side of the trachea. Pressing there can stimulate nerves that affect heart rate and blood pressure, so it is not the radial pulse and is not a routine site for nurse aides to use. The word "pulse" may bring the neck to mind because it is a well-known site, but it is a different artery.

D) At the temple

The temple is where the temporal pulse can be felt, but this is a different artery from the radial one and is not the usual site for routine pulse measurement by a nurse aide. It may seem plausible because it is on the head and easy to reach, but the question specifically asks for the radial location.

Conclusion

Remember that the radial pulse is felt in the wrist on the thumb side, and keep the other pulse sites straight by matching each artery to its body location. Knowing these landmarks helps you measure vital signs accurately and report findings that support good client care.

2. What should the nurse aide use to measure the urinary output of a client who has an indwelling urethral catheter?

A. A graduated container

B. An emesis basin

C. A syringe

D. The catheter bag

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Answer: A. A graduated container

A graduated container is the correct tool for measuring a client's urinary output from an indwelling urethral catheter.

Accurate intake and output records depend on measuring urine in a container marked with volume lines, so the aide can read the exact amount. With an indwelling catheter, the aide empties the drainage bag into a graduated container, reads the level at eye level, and records the amount on the intake and output sheet. This supports monitoring for dehydration, fluid overload, and changes in kidney function, and it keeps the measurement objective rather than estimated.

B) An emesis basin

An emesis basin is designed for catching vomit or holding small supplies, and it has no volume markings, so any urine collected in it could only be guessed at. It may seem handy because it is already at the bedside, but guessing defeats the purpose of an output record.

C) A syringe

A syringe measures small volumes and is used for tasks like drawing up medications or irrigating a catheter, not for collecting a full bladder or bag emptying. It might seem precise, but it is impractical and not marked for the larger volumes a catheter bag holds.

D) The catheter bag

The drainage bag itself often has only rough markings, and urine in the tubing and bag does not give a reliable reading. Estimating from the bag may feel quick, but it produces inaccurate output totals, which can hide important changes in the client's condition.

Conclusion

For catheter output, empty the bag into a graduated container and read the volume at eye level before recording it. Choosing the marked container protects accuracy, which is the whole point of intake and output documentation.

3. A sputum specimen is collected from which body system?

A. Bowel

B. Bladder

C. Lungs

D. Skin

Answer: C. Lungs

A sputum specimen is collected from the lungs, because sputum is mucus coughed up from the respiratory tract.

Sputum is the thick mucus produced in the airways and lungs, and it is brought up by coughing. When a nurse aide collects a sputum specimen, the resident coughs deeply and expectorates into a sterile container, so the sample comes from the respiratory system. This is why the lungs are the source of a sputum specimen. Knowing which body system produces a specimen helps the aide collect it correctly and document it accurately.

A) Bowel

The bowel is part of the digestive system, and specimens from it are stool samples, not sputum. The word specimen may bring to mind stool collection, which can make this option seem plausible, but sputum is coughed up from the airways, not passed through the intestines.

B) Bladder

The bladder belongs to the urinary system, and specimens taken from it are urine samples. Because urine specimens are also common in CNA work, this choice can be tempting, but sputum is not produced or stored in the bladder.

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D) Skin

The skin is the body's outer covering, and specimens from it are usually swabs of wounds or lesions. Skin may seem related because specimens are often collected from the body surface, but sputum comes from inside the respiratory tract, not from the skin.

Conclusion

Remember that sputum is coughed-up mucus from the lungs and airways, so a sputum specimen reflects the respiratory system. Linking each specimen type to its body system helps you answer documentation and collection questions with confidence.

4. A client's blood pressure drops suddenly after standing up. What is this condition called?

A. bradycardia

B. hypertension

C. postural hypotension

D. cerebral vascular accident

Answer: C. postural hypotension

Postural hypotension is the sudden drop in blood pressure that occurs when a client stands up.

When a person stands, blood pools in the legs, and the body normally compensates by increasing heart rate and constricting blood vessels to maintain blood pressure. In postural hypotension, this compensation is inadequate, leading to a sudden drop in blood pressure. This can cause dizziness, lightheadedness, and even fainting. As a CNA, you should recognize this sign and assist the client to sit or lie down to prevent injury, then report it to the nurse.

A) bradycardia

Bradycardia refers to a slow heart rate (typically under 60 beats per minute). While a slow heart rate can sometimes contribute to low blood pressure, the question specifically describes a drop in blood pressure upon standing, not a slow heart rate. It may seem tempting because both can cause dizziness, but the key is the positional change and the blood pressure drop.

B) hypertension

Hypertension is high blood pressure, not low. A sudden drop in blood pressure is the opposite of hypertension. It might be confusing because both involve blood pressure, but hypertension is persistently elevated pressure, whereas the scenario describes a sudden decrease upon standing.

D) cerebral vascular accident

A cerebral vascular accident (CVA or stroke) is a serious condition where blood flow to part of the brain is interrupted. While a stroke can cause dizziness or fainting, it is not defined by a drop in blood pressure upon standing. It might be tempting because both can cause neurological symptoms, but the question specifically asks about the condition of blood pressure dropping after standing, which is postural hypotension.

Conclusion

Remember that postural hypotension is the correct term for a sudden drop in blood pressure when a client stands up. Recognizing this condition promptly helps prevent falls and injuries. Always report such findings to the nurse.

5. Which of the following tasks is carried out by the nurse aide?

A. Assigning care of clients to other nurse aides

B. Preparing care plans

C. Drawing blood for laboratory tests

D. Taking temperature, pulse, and respiration

Answer: D. Taking temperature, pulse, and respiration

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Taking temperature, pulse, and respiration is a routine task within the nurse aide's scope of practice.

Vital signs are basic measurements that nurse aides are trained and permitted to perform as part of daily client monitoring. The aide records these findings and reports them to the nurse, who interprets them and decides on any changes in care. This task fits the aide's role because it involves direct, hands-on observation and reporting rather than clinical judgment or decision-making.

A) Assigning care of clients to other nurse aides

Deciding who will care for which client requires evaluating staffing, skills, and client needs, which is a responsibility of the nurse or supervisor. It can seem like a natural task for an experienced aide, but delegation and assignment are outside the aide's role.

B) Preparing care plans

Care plans are developed by licensed nurses and other qualified team members based on assessment and clinical judgment. An aide may contribute observations that inform the plan, which can make this option tempting, but writing the plan itself is not an aide task.

C) Drawing blood for laboratory tests

Collecting blood is an invasive procedure that requires specific training, certification, and authorization. It may look like a routine part of client care, but it falls outside the standard scope of the nurse aide.

Conclusion

Focus on tasks that involve basic, direct client care and reporting, such as measuring vital signs. Assigning staff, writing care plans, and drawing blood all require a license or special authorization beyond the aide's role.

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