Free CNA Practice Test with Answers

CNA TestBank · Prepared Nov 28, 2026 · Ref D71EPT6X

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1. A certified nursing assistant (CNA) is preparing to assist a patient with a meal. The patient is on Contact Precautions for Clostridioides difficile (C. diff). Which action by the CNA demonstrates correct infection control?

A. Using an alcohol-based hand sanitizer before entering the room

B. Donning a gown and gloves before entering the patient's room

C. Wearing a surgical mask and N95 respirator during meal assistance

D. Placing the patient's food tray on the overbed table without gloves

Answer: B. Donning a gown and gloves before entering the patient's room

Donning a gown and gloves before entering the patient's room is the correct infection control action for a patient on Contact Precautions for C. difficile.

C. difficile spores spread easily through direct contact with the patient or contaminated surfaces, so Contact Precautions require a gown and gloves for every room entry, including meal assistance. The CNA should put on personal protective equipment (PPE) before entering the room, remove it carefully before leaving, and perform hand hygiene with soap and water afterward, since alcohol does not reliably kill C. difficile spores. This approach protects the CNA, other patients, and the environment from contamination.

A) Using an alcohol-based hand sanitizer before entering the room

Alcohol-based sanitizer does not reliably kill C. difficile spores, and hand hygiene alone does not replace the gown and gloves required for Contact Precautions. This option can seem appealing because sanitizer is quick and convenient, but it does not provide the barrier protection needed for this organism.

C) Wearing a surgical mask and N95 respirator during meal assistance

Contact Precautions focus on preventing transmission through direct contact and contaminated surfaces, so gown and gloves are the key PPE. Masks and respirators are used for Droplet or Airborne Precautions, and wearing both a surgical mask and an N95 is not a standard practice. This option may seem thorough, but it does not match the precautions ordered for C. difficile.

D) Placing the patient's food tray on the overbed table without gloves

Touching items in the room without gloves allows spores to contaminate the CNA's hands and spread to other patients and surfaces. This option may seem harmless because the tray is not touching the patient directly, but Contact Precautions require gloves for any contact within the room.

Conclusion

For a patient on Contact Precautions for C. difficile, remember to don gown and gloves before entering the room and to wash hands with soap and water after removing PPE. Matching the PPE to the type of precaution ordered is the key to answering infection control questions correctly.

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2. Upon entering a patient's room, the CNA notices smoke coming from the wastebasket. What is the CNA's immediate first action according to the RACE protocol?

A. Activate the fire alarm

B. Confine the fire by closing the room door

C. Rescue the patient from immediate danger

D. Extinguish the fire using the nearest fire extinguisher

Answer: C. Rescue the patient from immediate danger

The CNA's immediate first action under RACE is to rescue the patient from immediate danger.

RACE stands for Rescue, Alarm, Confine, Extinguish, and the letters are listed in the order they should be performed. When smoke or fire is present, the top priority is getting the patient out of harm's way, since smoke and flames can harm or kill within seconds. The CNA should help the patient leave the room and move to a safe area, using a gait belt or wheelchair as needed, and call for help from coworkers if the patient cannot move easily. Only after the patient is safe should the CNA pull the fire alarm, close doors to contain the fire, and use an extinguisher if it is safe and the fire is small.

A) Activate the fire alarm

Pulling the alarm is an important step, but it comes after rescue in the RACE sequence. It can seem like the fastest way to get help, yet leaving the patient in a smoke-filled room while going to the alarm puts the patient at serious risk. The CNA should call out for help or use a nearby alarm only after the patient is out of danger.

B) Confine the fire by closing the room door

Closing the door helps limit the spread of smoke and flames, but it is the third step in RACE, not the first. Doing this before moving the patient leaves the patient trapped near the fire. It may feel like a quick way to control the situation, but patient safety must come first.

D) Extinguish the fire using the nearest fire extinguisher

Using an extinguisher is the last step in RACE and should only be attempted for a small, contained fire after the patient is safe and the alarm has been activated. Fighting the fire first delays rescue and can expose the CNA and patient to smoke and burns. CNAs should never put themselves or the patient in danger to try to put out a fire.

Conclusion

Remember that RACE puts Rescue first: get the patient away from the fire before doing anything else. Knowing the order of the steps helps CNAs act quickly and keep patients safe during a fire emergency.

3. A patient with right-sided weakness due to a recent stroke is being assisted with dressing. Which action by the CNA promotes independence and safety?

A. Dress the right (affected) arm first, then the left (unaffected) arm

B. Dress the left (unaffected) arm first, then the right (affected) arm

C. Have the patient dress themselves entirely to promote independence

D. Dress the affected arm last to prevent fatigue

Answer: A. Dress the right (affected) arm first, then the left (unaffected) arm

When dressing a patient with one-sided weakness, the CNA should guide the affected (right) arm into the garment first, then the unaffected (left) arm.

Dressing the weak side first lets the patient use the strong arm to help push the weak arm through the sleeve, which supports independence and reduces strain on the caregiver. When undressing, the order reverses: the unaffected arm comes out first, then the affected arm, so the strong side does the work. This approach protects the weaker limb from being pulled or twisted and keeps the patient actively involved in their

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own care within CNA scope of practice.

B) Unaffected arm first

Putting the strong arm in first may seem helpful since the patient can move it easily, but it leaves the weak arm to be pushed through the sleeve afterward, which is harder and often requires the CNA to pull the affected limb. That pulling increases the risk of injury and shoulder pain and takes away the patient's chance to help.

C) Patient dresses entirely alone

Encouraging independence is a good goal, but a patient with recent stroke-related weakness needs supervision and set-up assistance for safety. Leaving the patient to dress completely alone can lead to falls, frustration, or injury, and it does not match the level of help the situation requires.

D) Affected arm last to prevent fatigue

Delaying the weak arm until the end may sound like it saves energy, but it actually makes dressing harder because the strong arm is already covered and cannot assist. Fatigue is better managed by pacing, rest breaks, and adaptive techniques rather than by changing the order of dressing.

Conclusion

Remember the rule: dress the weak side first and undress the weak side last, so the strong arm can do the work. This keeps the patient safe, supports independence, and protects the affected limb.

4. A CNA is measuring a patient's blood pressure. The patient has an IV line in the left antecubital fossa. Which action is most appropriate?

A. Measure the blood pressure on the left arm, avoiding the IV site

B. Measure the blood pressure on the right arm

C. Measure the blood pressure on the left leg

D. Deflate the IV line temporarily to take the measurement

Answer: B. Measure the blood pressure on the right arm

Measure the blood pressure on the right arm to avoid interfering with the IV line.

When a patient has an IV line in the left antecubital fossa, using that arm for blood pressure measurement can compress the IV tubing, restrict fluid flow, cause discomfort, or damage the vein. The right arm is the appropriate site because it is free of the IV and provides a reliable reading. This follows standard CNA practice of avoiding any arm with an IV, fistula, or other device when measuring blood pressure.

A) Measure the blood pressure on the left arm, avoiding the IV site

Even if you try to avoid the IV site, the cuff still wraps around the arm and can press on the tubing or the vein above the insertion point. This may interrupt the infusion or cause the IV to leak or dislodge. It might seem like a careful choice, but it still puts the IV line at risk.

C) Measure the blood pressure on the left leg

Blood pressure is normally measured on the upper arm, and leg readings are not standard for routine monitoring. Using the leg can give different values and is not recommended when a simple alternative like the other arm is available. It may appear to be a way to avoid the IV, but it is not the best practice.

D) Deflate the IV line temporarily to take the measurement

CNAs are not permitted to manipulate IV lines, including deflating or stopping them. Doing so could disrupt the patient's therapy and introduce infection risk. This option might sound like a quick fix, but it is outside the CNA's scope of practice and unsafe.

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Conclusion

Always choose the arm without an IV or other device for blood pressure measurement. If one arm has an IV, use the other arm. Never adjust or interfere with IV equipment, and follow your facility's policy for special situations.

5. A patient refuses to take a scheduled afternoon bath. What is the CNA's best response?

A. Insist on the bath because it is facility policy

B. Document the refusal and report it to the charge nurse

C. Tell the patient they will lose privileges if they refuse

D. Wait until the patient is asleep and give a bed bath

Answer: B. Document the refusal and report it to the charge nurse

Document the refusal and report it to the charge nurse.

Respecting a patient's right to refuse care is a core part of resident rights. When a patient declines a scheduled bath, the CNA should honor that choice, record the refusal accurately in the chart, and notify the charge nurse so the care team can follow up, look for reasons behind the refusal, and adjust the plan if needed. Documenting and reporting protects the patient's autonomy while keeping the team informed and ensuring the refusal is part of the care record.

A) Insist on the bath because it is facility policy

Facility routines matter, but they never override a patient's right to refuse care. Forcing or pressuring a patient to bathe can harm trust and dignity and may cross into a rights violation. Policy is a guide for how care is delivered, not a reason to ignore a refusal.

C) Tell the patient they will lose privileges if they refuse

Threatening consequences to get compliance is a form of coercion and undermines the patient's right to make choices about their own care. This approach may seem like a quick way to get the task done, but it damages the therapeutic relationship and is not acceptable practice.

D) Wait until the patient is asleep and give a bed bath

Providing care to a sleeping patient without consent disregards their autonomy and privacy and can be frightening or harmful. Wanting to keep the patient clean is understandable, but the right path is to respect the refusal and let the nurse and care team address hygiene needs with the patient's agreement.

Conclusion

When a patient refuses care, honor the choice, document it clearly, and report it to the charge nurse. Respecting autonomy and communicating with the team is always the safest and most appropriate response.

6. A patient is prescribed a gait belt for ambulation. Where should the CNA correctly place the gait belt?

A. Around the patient's neck and shoulders for maximum support

B. Around the patient's waist, over their clothing, with room for two fingers

C. Around the patient's hips, under their clothing, secured tightly

D. Around the patient's chest, just below the axillae

Answer: B. Around the patient's waist, over their clothing, with room for two fingers

A gait belt belongs snugly around the patient's waist, over the clothing, with just enough room to slip two fingers underneath.

The waist is the body's natural center of gravity, so gripping the belt there lets the CNA steady and guide the patient without pulling on the arms, shoulders, or clothing. Wearing it over clothing protects the skin from pinching and lets the belt be removed quickly. The two-finger

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check confirms the belt is snug enough to control a stumble but not so tight that it restricts breathing or circulation. Before ambulation, the CNA should also check the belt's buckle and make sure it is fastened securely.

A) Around the neck and shoulders

Placing a belt around the neck creates a serious risk of choking and pressure on the airway and blood vessels in the neck. It may seem appealing because the shoulders are a large, easy-to-reach area, but a belt there offers no safe control point and could cause harm during a fall.

C) Around the hips, under clothing, secured tightly

Tucking the belt under clothing against bare skin can pinch and irritate the skin, and a tightly secured belt can restrict circulation and breathing. The hips sit lower than the body's center of gravity, giving the CNA less control if the patient begins to fall.

D) Around the chest, just below the axillae

A belt high on the chest can press on the ribs and make breathing uncomfortable, and it sits above the center of gravity, so it does not give stable support during ambulation. The chest area may look like a secure grip, but it does not provide the safe, balanced control a waist-level belt does.

Conclusion

Remember that a gait belt goes around the waist, over clothing, with room for two fingers. This placement gives safe, effective support while protecting the patient's skin, breathing, and circulation.

7. A patient with advanced Alzheimer's disease becomes agitated and attempts to pull out their IV line. What is the CNA's most appropriate initial intervention?

A. Apply bilateral soft wrist restraints immediately

B. Redirect the patient with a calming activity or conversation

C. Tell the patient firmly to stop pulling the IV line

D. Administer the prescribed PRN anti-anxiety medication

Answer: B. Redirect the patient with a calming activity or conversation

Redirecting the patient with a calming activity or conversation is the appropriate first step when a patient with advanced Alzheimer's disease becomes agitated and pulls at an IV line.

Agitation in advanced dementia often reflects confusion, fear, discomfort, or an unmet need rather than deliberate misbehavior. Before turning to physical or chemical measures, the CNA should try the least restrictive approach: speaking calmly, orienting the patient gently, offering reassurance, and redirecting attention to a soothing activity or topic. This respects the patient's dignity, lowers stimulation, and often defuses the behavior without risk. The CNA should also check for causes such as pain, a full bladder, or a kinked or uncomfortable IV site, and report findings to the nurse. Restraints and medications require a provider order and are not the CNA's initial action.

A) Apply bilateral soft wrist restraints immediately

Restraints limit movement and can increase fear, injury risk, and distress in a confused patient, and they require a provider order and strict monitoring. This option may seem tempting because it appears to protect the IV quickly, but it is not the least restrictive first step and falls outside the CNA's independent scope.

C) Tell the patient firmly to stop pulling the IV line

A firm command assumes the patient can understand and comply, which is unrealistic in advanced Alzheimer's disease and may escalate agitation. It may seem like a simple, direct fix, but it does not address the confusion driving the behavior.

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D) Administer the prescribed PRN anti-anxiety medication

Giving medication is outside the CNA's scope of practice and should follow non-drug approaches and a nurse's assessment. This option may seem appealing because an order exists, but the CNA cannot administer medications and should try calming measures first.

Conclusion

For agitated dementia patients, start with the least restrictive, person-centered approach such as calm redirection, check for unmet needs, and report to the nurse. Restraints, firm commands, and medication administration are not the CNA's initial or independent actions.

8. When performing perineal care for a female patient, which technique must the CNA use to prevent infection?

A. Wipe from the anus toward the pubic area

B. Wipe from the pubic area toward the anus

C. Use a circular motion starting from the center outward

D. Scrub vigorously to ensure all secretions are removed

Answer: B. Wipe from the pubic area toward the anus

Wiping from the pubic area toward the anus keeps bacteria away from the urinary and genital openings and is the technique the CNA must use during perineal care.

Perineal care is about cleaning gently while moving germs in the safest direction. The anus naturally carries bacteria, so wiping from the front (pubic area) toward the back (anus) carries those germs away from the urethra and vagina, which are more prone to infection. Using a clean portion of the washcloth for each stroke, front to back, and rinsing thoroughly protects the patient from urinary tract and genital infections. The CNA should also wear gloves, keep the patient covered as much as possible, and report any redness, discharge, or odor to the nurse.

A) Wiping from the anus toward the pubic area

This direction drags bacteria from the anus toward the urethra and vagina, raising the risk of infection. It can seem efficient because it starts where stool is present, but the direction of travel is what makes it unsafe.

C) Circular motion from the center outward

A circular stroke can spread germs from the anal area back over the genital area and does not control the direction of contamination. It may look thorough, but front-to-back straight strokes are what keep bacteria away from the openings that are most vulnerable.

D) Scrubbing vigorously

Vigorous scrubbing irritates delicate perineal skin and can create small breaks that let germs enter, and it does not fix the direction of wiping. It may seem like a way to get completely clean, but gentle, thorough cleansing with proper direction is safer and more effective.

Conclusion

Remember the front-to-back rule: always wipe from the pubic area toward the anus, use a clean part of the cloth each time, and be gentle. This simple habit is the key to preventing infection during perineal care.

9. A CNA is caring for a patient diagnosed with active pulmonary tuberculosis (TB). Which personal protective equipment (PPE) is required before entering the room?

A. Gown and gloves only

B. Surgical mask and face shield

C. N95 respirator

D. Standard precautions only, no special PPE needed

Answer: C. N95 respirator

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An N95 respirator must be worn before entering the room of a patient with active pulmonary TB.

Active pulmonary tuberculosis spreads through tiny airborne particles called droplet nuclei that stay suspended in the air and can be inhaled deep into the lungs. Because these particles are so small, an ordinary surgical mask does not filter them well enough to protect the wearer. An N95 respirator is specially fitted to seal against the face and filter out at least 95% of small airborne particles, which is why it is the required protection when entering a TB room. This fits within standard CNA scope of practice: the aide follows the care plan and facility policy, performs proper hand hygiene, and uses the correct PPE before crossing the doorway.

A) Gown and gloves only

Gowns and gloves protect against contact with body fluids and contaminated surfaces, which matters for many infections, but they do nothing to stop airborne droplet nuclei from being breathed in. This option can seem reasonable because gloves and gowns are common PPE, yet they leave the airway completely unprotected in a TB room.

B) Surgical mask and face shield

A surgical mask is designed mainly to keep the wearer's own droplets from spreading and does not seal tightly enough to filter tiny airborne particles, and a face shield guards against splashes rather than inhalation. This choice is tempting because it looks like full facial protection, but it does not provide the airborne-level filtration that TB requires.

D) Standard precautions only, no special PPE needed

Standard precautions apply to every patient and focus on hand hygiene and barriers against blood and body fluids, but active pulmonary TB requires additional airborne precautions beyond that baseline. This option can feel reassuring because standard precautions are always expected, yet relying on them alone would leave the CNA exposed to infectious droplet nuclei.

Conclusion

Remember that airborne diseases such as active pulmonary TB call for an N95 respirator, not a surgical mask or contact-only barriers. Knowing which precautions match which transmission route helps you protect both yourself and the patients you care for.

10. A patient is found lying on the floor next to their bed. What is the CNA's first action?

A. Immediately help the patient back into bed

B. Call for help and assess the patient for injuries while keeping them still

C. Run to the nurses' station to report the fall

D. Check the patient's blood pressure and pulse before doing anything else

Answer: B. Call for help and assess the patient for injuries while keeping them still

Call for help and assess the patient for injuries while keeping them still is the first action when a patient is found on the floor.

After any fall, the priority is to protect the patient from further harm. The CNA should stay with the patient, call for assistance using the call light or voice, and check for obvious injuries, pain, bleeding, or changes in alertness while keeping the patient still. Moving a patient who may have a fracture, head injury, or spinal injury can make things worse. The nurse will then complete a fuller assessment and decide how to safely move the patient.

A) Immediately help the patient back into bed

Moving the patient right away can worsen a hidden injury, such as a broken hip, head trauma, or spinal injury. This choice feels helpful and efficient, but safety comes first. The patient should stay still until the nurse assesses them.

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C) Run to the nurses' station to report the fall

Leaving the patient alone after a fall means no one is watching for breathing problems, bleeding, or a change in consciousness. Reporting is important, but it can be done by calling out or using the call light while staying with the patient.

D) Check the patient's blood pressure and pulse before doing anything else

Vital signs are useful, but they come after making sure the patient is safe and not seriously injured. Getting equipment and taking vitals delays calling for help and keeping the patient still, which are the most urgent steps.

Conclusion

For any fall, remember: stay with the patient, call for help, check for injuries, and keep the patient still. Do not move the patient or leave them alone until the nurse arrives.

11. A patient wears dentures. What is the most appropriate action for the CNA when cleaning the dentures?

A. Clean them over a sink filled with water or a towel to prevent breakage

B. Use hot boiling water to sterilize the dentures

C. Use a stiff-bristled brush and abrasive household cleanser

D. Wrap them in a dry tissue and place them on the overbed table

Answer: A. Clean them over a sink filled with water or a towel to prevent breakage

Cleaning dentures over a sink filled with water or a towel helps prevent breakage if they slip.

Dentures are fragile and expensive to replace, and they can easily slip out of the hands when wet. Lining the sink with water or placing a towel underneath cushions the fall if the dentures are dropped, protecting them from cracking. This is a simple safety habit that belongs in every denture care routine, along with using a soft brush and a denture cleanser as directed by the care plan.

B) Hot boiling water

Boiling water can warp or damage the plastic material of dentures, changing how they fit and making them uncomfortable or unusable. Hot water may seem like a good way to kill germs, but denture material cannot withstand that heat, and the care plan usually calls for cool or lukewarm water with a proper cleanser.

C) Stiff brush and abrasive cleanser

A stiff-bristled brush and harsh household cleanser can scratch the denture surface, and scratches create tiny grooves where bacteria and odor can build up. Abrasive products may also damage the finish. A soft denture brush with a cleanser made for dentures is gentler and safer.

D) Dry tissue on the overbed table

Wrapping dentures in a dry tissue and leaving them on a table invites accidents, since they can be knocked off, thrown away with trash, or dried out and warped. Dentures need to stay moist when not in the mouth and should be stored in a labeled denture cup as directed, not left loose on a table.

Conclusion

Remember that denture care combines cleanliness with protection: use cool or lukewarm water and a soft brush, and always work over water or a towel so a dropped denture lands softly instead of breaking.

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12. A CNA obtains a patient's oral temperature of 95.8°F (35.4°C). What is the appropriate next step?

A. Document the temperature as normal

B. Retake the temperature rectally to confirm

C. Assess if the patient recently consumed cold fluids and retake orally, or use an alternative route

D. Immediately apply a warming blanket without reporting

Answer: C. Assess if the patient recently consumed cold fluids and retake orally, or use an alternative route

When an oral temperature reads 95.8°F (35.4°C), the CNA should consider recent cold fluid intake and either retake the oral temperature or use an alternative route.

A temperature of 95.8°F (35.4°C) is below the normal oral range, so it deserves a second look before it is recorded or acted on. Drinking cold fluids, eating ice, or breathing cold air can temporarily lower an oral reading, so the first step is to ask the patient about recent intake and then retake the temperature, either orally after a short wait or by another approved route such as axillary or tympanic. This simple check helps confirm whether the low reading is real or an artifact, and any confirmed abnormal value should be reported to the nurse promptly. The CNA gathers accurate data and reports findings but does not diagnose or start treatments independently.

A) Document the temperature as normal

Recording 95.8°F as normal would miss a value that falls below the usual range and could hide a real problem. It may seem tempting to avoid extra work when the patient looks fine, but accurate documentation depends on verifying an unexpected reading first.

B) Retake the temperature rectally to confirm

Rectal temperatures are invasive and are not a routine first step for a CNA, especially without an order or facility policy allowing it. This option may appeal as a way to get a "more accurate" number, but the less invasive and more appropriate move is to check for cold fluid intake and repeat the oral reading or use another approved route.

D) Immediately apply a warming blanket without reporting

Applying a warming blanket on the CNA's own initiative goes beyond the aide's scope and skips both verification and reporting. It may seem like a caring, quick fix for a low reading, but treatment decisions belong to the nurse, and an unconfirmed temperature should not trigger independent interventions.

Conclusion

For an unexpected low oral temperature, think verification first: ask about cold fluids, retake the reading or use an approved alternative route, then report the confirmed value to the nurse. Staying within scope and confirming abnormal readings protects both the patient and the accuracy of the record.

13. A patient's family member asks the CNA for details about the patient's laboratory results. What is the CNA's best response?

A. Provide the results since the family member is visiting

B. Politely state that you cannot share medical information and direct them to the nurse

C. Tell them the results are normal to avoid worrying them

D. Ask the family member to wait in the hall while you print the results

Answer: B. Politely state that you cannot share medical information and direct them to the nurse

Politely decline to share the results and refer the family member to the nurse.

Patient medical information, including laboratory results, is protected under resident rights and privacy rules. The CNA's role is to protect confidentiality and stay within scope of practice. Sharing results, guessing at them, or handling printed reports falls outside the CNA's duties. The safe and respectful approach is to explain kindly that you cannot share medical information and guide the family member to the nurse,

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who can address questions appropriately.

A) Provide the results since the family member is visiting

Being a visiting family member does not automatically give someone the right to receive private medical information. This choice seems caring and convenient, but it risks a serious privacy breach and goes beyond what a CNA is allowed to do.

C) Tell them the results are normal to avoid worrying them

This may feel reassuring in the moment, but it means giving medical information the CNA is not authorized to interpret or share. Even a well-meant comment can be inaccurate and can damage trust and privacy.

D) Ask the family member to wait in the hall while you print the results

Printing or handing over laboratory results is not a CNA task and still exposes protected information. This option looks helpful and discreet, yet it crosses the same privacy and scope-of-practice boundaries.

Conclusion

Protecting patient privacy and staying within your role are the priorities. Politely decline to share medical information and direct the family member to the nurse for any questions about results.

14. A patient is on bed rest and is at high risk for pressure injuries. Which intervention is most effective for prevention?

A. Massage the reddened areas over bony prominences

B. Reposition the patient at least every two hours

C. Keep the head of the bed elevated at 45 degrees at all times

D. Use a donut-shaped cushion under the patient's sacrum

Answer: B. Reposition the patient at least every two hours

Repositioning the patient at least every two hours is the most effective intervention for preventing pressure injuries in a patient on bed rest.

Pressure injuries form when constant pressure on one area cuts off blood flow to the skin and underlying tissue. Turning and repositioning the patient at least every two hours relieves that pressure and lets circulation return to the skin, which is the single most important step in prevention. This schedule also gives you a chance to check the skin for early signs of breakdown, especially over bony prominences like the heels, hips, and sacrum.

A) Massaging reddened areas over bony prominences

Redness over a bony prominence can signal that tissue is already being damaged, and rubbing that area can cause further injury to fragile skin and deeper tissue. It may seem helpful because massage is often associated with comfort and circulation, but the priority is to relieve the pressure, not to massage the site.

C) Keeping the head of the bed elevated at 45 degrees at all times

A high head-of-bed position causes the body to slide down, which creates friction and shear forces that damage skin, and it concentrates pressure on the sacrum and buttocks. It may seem protective because it keeps the patient upright, but prolonged high elevation actually raises pressure injury risk.

D) Using a donut-shaped cushion under the sacrum

Ring or donut cushions concentrate pressure around the edges of the ring and can reduce blood flow to the tissue in the center, so they are not recommended for pressure injury prevention. It may seem like a good way to cushion the area, but the design works against the goal of evenly distributing pressure.

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Conclusion

For a patient at high risk for pressure injuries, regular repositioning at least every two hours is the cornerstone of prevention. Remember that skin assessment, keeping the skin clean and dry, and avoiding friction and shear support this main intervention, while massage, high head-of-bed elevation, and donut cushions do not protect the skin.

15. A patient with dementia is wandering the halls and appears lost. What is the CNA's best approach?

A. Tell the patient to go back to their room immediately

B. Calmly approach, introduce yourself, and offer to walk them back to their room

C. Ignore the behavior as it is a normal part of the disease

D. Lock the unit doors to prevent further wandering

Answer: B. Calmly approach, introduce yourself, and offer to walk them back to their room

Calmly approach, introduce yourself, and offer to walk them back to their room is the best approach for a patient with dementia who is wandering and appears lost.

Dementia affects memory, orientation, and the ability to reason, so a patient who is wandering may feel frightened or confused rather than simply disobedient. Approaching calmly and quietly, introducing yourself, and offering to walk together reduces fear and preserves dignity. Offering to walk with the patient rather than directing them gives a sense of companionship and gently redirects them without confrontation. This keeps the patient safe while respecting their autonomy and supports the CNA's role in providing person-centered care and preventing falls or injury.

A) Tell the patient to go back to their room immediately

Giving a direct order can feel threatening to a confused patient and may trigger agitation, resistance, or a defensive reaction. It assumes the patient can understand and follow directions, which dementia may make difficult. The intent to keep the patient safe is reasonable, but the abrupt tone works against cooperation.

C) Ignore the behavior as it is a normal part of the disease

Wandering can lead to falls, exhaustion, or leaving a safe area, so it needs a calm, active response. While wandering is common in dementia, treating it as something to simply overlook leaves the patient unsupervised and at risk. The idea that it is part of the disease is true, but that does not make ignoring it safe.

D) Lock the unit doors to prevent further wandering

Locking doors is a restrictive measure that usually requires facility policy, authorization, and often regulatory oversight, and it does not address the patient's confusion or distress. It may also increase agitation if the patient feels trapped. The goal of preventing wandering is understandable, but this action exceeds the CNA's independent scope and is not the first response.

Conclusion

For a lost, wandering patient with dementia, a calm introduction and an offer to walk together is the safest, most respectful response. Remember that redirection works best when it is gentle, personal, and paired with supervision.

16. When making an occupied bed, what is the most important safety measure for the CNA to take?

A. Raise the bed to the highest position to save the CNA's back

B. Keep the bed in the lowest position with wheels locked when stepping away

C. Remove all pillows from the patient's head during the entire process

D. Stand on the bed to reach the other side easily

Answer: B. Keep the bed in the lowest position with wheels locked when stepping away

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Keeping the bed in the lowest position with the wheels locked whenever stepping away is the key safety measure when making an occupied bed.

An occupied bed means a patient is in it, so fall risk is the top concern. A low bed shortens the distance a person could fall, and locked wheels keep the bed from rolling or shifting while the CNA reaches across or steps away for supplies. This protects the patient and also protects the CNA from straining or losing balance. Good body mechanics, such as raising the bed to a comfortable working height while you are actively working at the bedside, can be combined with lowering the bed and locking the wheels before stepping away.

A) Raise the bed to the highest position to save the CNA's back

A high bed may ease strain on the CNA's back during care, which makes this option tempting, but leaving an occupied bed at its highest position creates a serious fall hazard. If the patient tries to get up or rolls, the fall is from a greater height and injuries are more likely. Working height should be adjusted thoughtfully, but patient safety comes first.

C) Remove all pillows from the patient's head during the entire process

Pillows support comfort, breathing, and alignment, and removing them for the whole procedure is unnecessary and can cause discomfort or breathing difficulty. This choice sounds like it is about keeping the work area clear, but it does not address the real fall and movement risks of an occupied bed.

D) Stand on the bed to reach the other side easily

Standing on a bed is unsafe for the CNA and for the patient. The mattress is soft and unstable, the bed may roll or tip, and the CNA could fall onto the patient. Reaching across the bed is tempting when space is tight, but the safe approach is to walk around the bed or use proper positioning instead.

Conclusion

For an occupied bed, remember that fall prevention comes first: keep the bed low and the wheels locked whenever you step away. Combine that with good body mechanics and safe positioning rather than shortcuts that put the patient or yourself at risk.

17. Which of the following actions by a CNA requires immediate correction by the charge nurse?

A. Washing hands for 20 seconds with soap and water

B. Wearing the same gloves to clean a patient's bedpan and then adjust their oxygen tubing

C. Disposing of soiled linens in the designated hamper

D. Using a new alcohol wipe to clean a blood pressure cuff between patients

Answer: B. Wearing the same gloves to clean a patient's bedpan and then adjust their oxygen tubing

Wearing the same gloves to clean a bedpan and then adjust oxygen tubing requires immediate correction because it spreads contamination from a soiled item to clean patient equipment.

Gloves are task-specific personal protective equipment. Once gloves contact a bedpan and its contents, they are contaminated and must be removed and replaced before touching anything else, especially oxygen tubing that sits near the patient's face and airway. Reusing the same gloves across tasks transfers germs from a dirty surface to a clean one, which is a direct infection-control breach and a risk to the patient. This is why the charge nurse must step in right away rather than waiting.

A) Handwashing for 20 seconds

This is a proper hand hygiene practice that meets standard infection-control guidance, so it needs no correction. It can look like a routine action worth questioning, but thorough handwashing is exactly what CNAs are taught to do.

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C) Disposing of soiled linens in the designated hamper

Placing soiled linens in the proper hamper follows standard precautions and keeps contaminated items contained. It may seem like a small detail, but it is the correct handling method and does not call for correction.

D) Using a new alcohol wipe on a blood pressure cuff between patients

Cleaning shared equipment between patients with a fresh wipe is appropriate infection control. It might appear unnecessary to some, but disinfecting reusable equipment is a sound practice and not an error.

Conclusion

Remember that gloves protect only for the task at hand: remove and replace them when moving from a soiled task to a clean one. Recognizing when contaminated gloves would touch clean patient equipment is key to answering scope-of-practice and infection-control questions.

18. A patient is experiencing a seizure in bed. What is the CNA's priority action?

A. Insert a padded tongue depressor into the patient's mouth

B. Restrain the patient's limbs to prevent injury

C. Turn the patient onto their side and protect their head

D. Leave the room to get the charge nurse immediately

Answer: C. Turn the patient onto their side and protect their head

Turning the patient onto their side and protecting their head keeps the airway open and prevents injury during a seizure.

During a seizure, the person cannot control their movements or protect their own airway. Positioning the patient on their side lets saliva and vomit drain out of the mouth instead of being breathed into the lungs, and cushioning the head with something soft or your hands prevents it from striking the bed frame or side rails. The CNA should stay with the patient, note the time the seizure starts, keep the area clear of hard objects, loosen anything tight around the neck, and call for help once the patient is safe. After the seizure ends, continue to monitor breathing and stay with the patient until the nurse arrives.

A) Inserting a padded tongue depressor

Putting anything into the mouth of someone who is seizing can break teeth, injure the jaw, or be bitten off and block the airway. This idea seems appealing because people worry the tongue will be swallowed, but that cannot happen, and the mouth should never be forced open during a seizure.

B) Restraining the limbs

Holding down a seizing patient's arms or legs can cause fractures, dislocated joints, and muscle damage, and it does not stop the seizure. It feels protective to try to hold the person still, yet the safer approach is to clear the space around them and let the movements run their course.

D) Leaving to get the charge nurse

Walking away leaves the patient alone and unprotected during the most dangerous moments, when injury or airway problems can happen quickly. Getting help matters, but the CNA should call out for assistance or use the call light while staying at the bedside and keeping the patient safe.

Conclusion

For a patient seizing in bed, the priority is airway protection and injury prevention: turn the patient to the side, guard the head, stay with them, and summon help without leaving them alone.

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19. A patient has a visual impairment. Which action by the CNA best assists the patient during mealtime?

A. Feed the patient entirely to ensure they get enough nutrition

B. Use the clock face method to describe the location of food on the plate

C. Place all food items mixed together on the plate for easier scooping

D. Leave the food on the overbed table and let the patient figure it out

Answer: B. Use the clock face method to describe the location of food on the plate

Using the clock face method to describe where food is located on the plate best assists a patient with a visual impairment during mealtime.

People with limited vision can often eat independently when food positions are described clearly. The clock face method gives consistent, easy-to-understand verbal cues, such as telling the patient that meat is at 6 o'clock and vegetables are at 3 o'clock. This supports safety, dignity, and independence while lowering the risk of spills or eating the wrong item. It also fits within the CNA's role of promoting self-care and effective communication.

A) Feeding the patient entirely

This takes away independence the patient may still have and can feel demeaning. It may seem caring and efficient, but feeding should be reserved for patients who cannot safely feed themselves, not simply because of a visual impairment.

C) Mixing all food together

Combining foods makes it harder to identify textures and flavors and removes the ability to choose what to eat. It might look like it simplifies scooping, but it actually reduces control and enjoyment of the meal.

D) Leaving food and letting the patient figure it out

This ignores the patient's need for orientation and support and raises the risk of spills, burns, or missed nutrition. It may seem like a way to encourage independence, but independence works best when the CNA provides clear, respectful guidance.

Conclusion

Remember that the clock face method is a simple, respectful way to support independence and safety for patients with visual impairment. Choose communication strategies that guide the patient rather than doing everything for them.

20. A CNA is counting a patient's respirations. The patient becomes aware and starts breathing artificially. What should the CNA do?

A. Record the artificial breathing rate as the true respiratory rate

B. Keep the fingers on the patient's wrist as if still taking the pulse, and count respirations

C. Tell the patient to breathe normally and count again

D. Estimate the respiratory rate based on the previous shift's documentation

Answer: B. Keep the fingers on the patient's wrist as if still taking the pulse, and count respirations

Keep your fingers on the patient's wrist as if still taking the pulse while you count respirations, so the patient stays unaware and breathes naturally.

When people know their breathing is being watched, they often change it without meaning to, breathing faster, slower, or deeper. That altered pattern does not reflect the true respiratory rate. By leaving your fingers in place on the wrist as though you were still counting the pulse, you keep the patient relaxed and unaware, and the respirations you count are more likely to be accurate. This is a standard, respectful technique within CNA scope of practice.

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A) Record the artificial breathing rate as the true respiratory rate

Writing down a rate you know was changed by the patient's awareness gives the care team false information and could hide a real breathing problem or create a false alarm. It may seem like the simplest choice since you did count something, but that number does not represent the patient's normal breathing.

C) Tell the patient to breathe normally and count again

Pointing out the breathing draws even more attention to it, and the patient may try to control it or feel self-conscious, so the next count can still be artificial. It feels honest and direct, but it defeats the purpose of getting a natural, resting rate.

D) Estimate the respiratory rate based on the previous shift's documentation

Respiratory rate can change quickly, and an earlier reading does not describe the patient right now. Copying or guessing from old notes skips the actual assessment and could miss a developing problem. It may seem convenient, but it is not a substitute for observing the patient yourself.

Conclusion

The key takeaway is to count respirations without letting the patient know, often by keeping your fingers on the wrist after the pulse count. This protects the accuracy of a vital sign that is easily altered by awareness and keeps your documentation trustworthy.

21. A patient complains that their roommate is constantly watching them use the toilet and makes them uncomfortable. What is the CNA's appropriate action?

A. Tell the patient to ignore the roommate

B. Provide privacy by closing the curtain or door during toileting and report the concern to the nurse

C. Ask the roommate to leave the room permanently

D. Document that the patient is being overly sensitive

Answer: B. Provide privacy by closing the curtain or door during toileting and report the concern to the nurse

Providing privacy during toileting and reporting the concern to the nurse protects the patient's dignity and right to privacy.

Every patient has a right to privacy and personal dignity, especially during intimate care like toileting. When a patient says a roommate is watching and making them uncomfortable, the CNA should take the concern seriously. The first step is to protect the patient right away by closing the curtain or door and helping them use the toilet privately. Then the CNA reports what happened to the nurse, who can address the roommate situation and decide on further steps. CNAs do not resolve roommate conflicts on their own, but they do act to protect privacy and pass important information up the chain of care.

A) Tell the patient to ignore the roommate

This response dismisses a real concern and leaves the patient exposed during an intimate moment. It may seem like a quick way to avoid conflict, but it fails to protect the patient's right to privacy and dignity. CNAs should act to fix the problem, not push it back on the patient.

C) Ask the roommate to leave the room permanently

Moving a roommate out of the room is a major decision that belongs to nursing and facility staff, not the CNA. This option may feel like a strong way to solve the problem, but it goes beyond the CNA's role and could disrupt care for both patients.

D) Document that the patient is being overly sensitive

Labeling the patient as overly sensitive ignores a legitimate privacy concern and does not help the patient. Charting should record facts and actions taken, not judgments about the patient's feelings. This choice may seem like a way to note the event, but it does not protect the patient or inform the nurse.

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Conclusion

When a patient's privacy is at risk, act right away to protect them and report the concern to the nurse. Respecting dignity and knowing when to escalate are key parts of the CNA role.

22. A patient is learning to use a cane for the first time. The patient has right-sided weakness. How should the CNA instruct the patient to use the cane?

A. Hold the cane in the right hand, move the cane forward, then step with the right leg

B. Hold the cane in the left hand, move the cane forward, then step with the right leg

C. Hold the cane in the left hand, step with the left leg, then move the cane forward

D. Hold the cane in whichever hand feels most comfortable

Answer: B. Hold the cane in the left hand, move the cane forward, then step with the right leg

The cane goes in the hand opposite the weak side, so the patient holds it in the left hand, moves the cane forward, then steps with the right leg.

When one side of the body is weak, the cane is placed in the stronger hand on the opposite side. This creates a wider base of support and shifts weight away from the weak leg. The cane and the weak leg move together, so the patient moves the cane forward first, then steps with the weak right leg while the cane and the stronger left leg bear the weight. This pattern keeps the patient steadier and protects the weaker side from taking the full load.

A) Cane in the right hand with the right leg

Holding the cane on the same side as the weakness puts the support on the side that needs help the most and moves the cane together with the weak leg. This feels natural to many people because they think the cane should be next to the problem side, but it gives less stability and less protection for the weak limb.

C) Cane in the left hand, left leg first

The hand choice here is right, but the stepping order is off. Stepping with the strong left leg before moving the cane breaks the pattern of moving the cane and the weak leg together, which can make the patient feel unsteady. It may seem logical to lead with the strong leg, but the cane should move first to create support before the weak leg steps.

D) Whichever hand feels comfortable

Comfort is not a safe guide for cane placement. The side of the weakness determines which hand should hold the cane, and letting the patient choose can lead to poor support and a higher risk of falls. This option sounds patient-centered, but safety and proper body mechanics must guide the instruction.

Conclusion

Remember the rule that the cane goes in the hand opposite the weak side, and the cane moves forward before the weak leg steps. This pattern gives the best balance and protection for a patient with one-sided weakness.

23. A patient with depression refuses to get out of bed for breakfast. What is the CNA's most therapeutic response?

A. Threaten to take away their television privileges

B. Acknowledge their feelings and offer to help them sit up for a short time

C. Pull the covers off the patient to force them to wake up

D. Tell the patient that others have it much worse

Answer: B. Acknowledge their feelings and offer to help them sit up for a short time

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Acknowledging the patient's feelings and offering gentle help to sit up for a short time is the most therapeutic response.

Depression often drains a person's energy and motivation, so refusing to get out of bed is a symptom of the illness rather than simple stubbornness. A CNA builds trust by first validating what the patient is experiencing, then offering a small, realistic step such as sitting up briefly. This approach respects the patient's dignity, avoids a power struggle, and encourages gradual participation without pressure. Small successes like sitting up can support mood and engagement over time, and the CNA should report ongoing refusal or changes to the nurse.

A) Threatening to take away television privileges

Using a threat turns care into a punishment and can increase withdrawal, resentment, and distrust in a patient who is already struggling. It may seem like a quick way to gain cooperation, but it ignores the emotional cause of the behavior and damages the therapeutic relationship.

C) Pulling the covers off to force the patient to wake up

Forcing the patient physically disregards their dignity and autonomy and can escalate distress or agitation. It may look like a fast solution, but it treats the symptom harshly instead of addressing the underlying depression and building rapport.

D) Telling the patient that others have it much worse

Comparing the patient's suffering to others minimizes their experience and can make them feel dismissed or ashamed. It may seem like a way to put things in perspective, but it shuts down communication and does not encourage the patient to take a small step forward.

Conclusion

For test-takers, the therapeutic response in mental health care starts with empathy and respect, followed by a small, supportive invitation to act. Choices that threaten, force, or minimize the patient's feelings undermine trust and are not appropriate for a CNA.

24. When transferring a patient from a bed to a wheelchair, what is the most critical safety step before beginning the transfer?

A. Ensure the wheelchair is locked and footrests are moved aside

B. Pull the patient up by their arms to standing

C. Stand behind the patient to push them forward

D. Have the patient wear only socks on their feet for sliding

Answer: A. Ensure the wheelchair is locked and footrests are moved aside

Before starting a bed-to-wheelchair transfer, the most critical safety step is to lock the wheelchair and move the footrests out of the way.

A locked wheelchair cannot roll away as the patient shifts weight, and moving the footrests aside clears a safe path for the feet and prevents tripping or catching the legs during the move. This simple check protects both the patient and the aide from falls and injury, and it should always come before any lifting or pivoting begins.

B) Pull the patient up by their arms to standing

Pulling a patient up by the arms can strain the patient's shoulders and the aide's back, and it gives poor control of the patient's balance. It may seem like a quick way to get someone upright, but safe transfers rely on the patient pushing up with their own legs and the aide supporting at the gait belt, not on arm pulling.

C) Stand behind the patient to push them forward

Standing behind and pushing gives the aide little ability to guide the patient's footing or catch a forward fall, and it puts the aide off balance. It can feel like a supportive position, but transfers are safer when the aide stands to the side, close to the patient, with a clear view of the movement.

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D) Have the patient wear only socks on their feet for sliding

Socks alone slide easily on floors and offer no grip, which raises the risk of slipping and falling during the transfer. Sliding may look easier, but non-skid footwear keeps the patient's feet planted and stable when they bear weight and pivot.

Conclusion

Always secure the wheelchair and clear the footrests before any transfer. Remember that safe transfers depend on a stable base, proper body mechanics, and non-skid footing, not on pulling, pushing from behind, or sliding.

25. A CNA sustains a needlestick injury from a contaminated sharp. What is the immediate first action?

A. Squeeze the wound to make it bleed

B. Wash the affected area thoroughly with soap and water

C. Apply a sterile bandage and continue working

D. Wait until the end of the shift to report the incident

Answer: B. Wash the affected area thoroughly with soap and water

After a needlestick injury, the immediate first action is to wash the affected area thoroughly with soap and water.

Washing right away helps remove blood and potentially infectious material from the skin surface and reduces the chance that pathogens enter the body. This simple step should be done immediately, before reporting the exposure to a supervisor and seeking follow-up care through the facility's exposure control plan. Prompt washing, followed by proper reporting and medical evaluation, is the standard approach for sharps injuries in the CNA scope of practice.

A) Squeeze the wound to make it bleed

Making the wound bleed may seem like a way to flush out germs, but squeezing or milking the site can damage tissue and is not a recommended first step. The priority is gentle, thorough washing rather than manipulating the wound.

C) Apply a sterile bandage and continue working

Covering the wound without first washing it leaves contaminated material on the skin and delays the most important step. Continuing to work also postpones reporting and evaluation, so this choice skips essential infection control actions.

D) Wait until the end of the shift to report the incident

Delaying report and care can increase risk and may interfere with timely post-exposure evaluation. Sharps injuries need prompt attention, so waiting until the shift ends does not meet the standard of immediate action.

Conclusion

Remember that washing the exposed area with soap and water comes first, then report the injury and follow the facility's exposure protocol right away.

26. A patient is choking and cannot speak, cough, or breathe. What is the CNA's immediate action?

A. Perform abdominal thrusts (Heimlich maneuver)

B. Give the patient a glass of water to wash down the food

C. Slap the patient on the back while they are seated

D. Wait to see if the patient can clear it themselves

Answer: A. Perform abdominal thrusts (Heimlich maneuver)

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Perform abdominal thrusts (Heimlich maneuver) right away when a choking patient cannot speak, cough, or breathe.

A patient who cannot speak, cough, or breathe has a complete airway obstruction, which is a life-threatening emergency. The CNA should call for help or activate the emergency response system while starting abdominal thrusts to force air out of the lungs and dislodge the object. Quick action within the CNA's trained scope can save the patient's life while waiting for the emergency team.

B) Give the patient a glass of water

Offering water to someone with a fully blocked airway cannot reach the lungs and may worsen the blockage or cause aspiration. It may seem like a simple way to help someone who is choking, but a patient who cannot breathe needs thrusts, not fluids.

C) Slap the patient on the back while they are seated

Back blows given to a seated patient are not effective for a complete obstruction and can push the object deeper. This option may seem appealing because back blows are sometimes used for mild choking, but the patient's inability to speak, cough, or breathe calls for abdominal thrusts.

D) Wait to see if the patient can clear it themselves

Waiting is dangerous when the patient cannot speak, cough, or breathe, because the airway is completely blocked and the patient can lose consciousness quickly. It may seem reasonable to give the patient time, but a complete obstruction requires immediate action.

Conclusion

Remember that a patient who cannot speak, cough, or breathe has a complete airway obstruction and needs immediate abdominal thrusts while help is called. Recognizing these signs and acting quickly is the key to answering emergency procedure questions correctly.

27. A patient has a prosthetic leg. What is the CNA's responsibility regarding the prosthetic?

A. Remove it at night and store it in the patient's bedside drawer

B. Inspect the residual limb for redness or breakdown daily and report findings

C. Apply lotion to the residual limb immediately before reapplying the prosthetic

D. Clean the prosthetic with harsh chemical solvents

Answer: B. Inspect the residual limb for redness or breakdown daily and report findings

Daily inspection of the residual limb for redness or skin breakdown, with findings reported to the nurse, is the CNA's responsibility.

The skin under a prosthetic leg is under constant pressure and friction, so it can break down quickly without anyone noticing. Checking the residual limb each day lets you catch redness, blisters, or open areas early and report them so the care team can act before a serious wound develops. This fits within CNA scope: you observe, you report, and you follow the care plan for prosthesis handling.

A) Removing and storing the prosthetic in a drawer

Prosthesis care and removal schedules are set by the care plan and often by the prosthetist or therapy team, not decided by the aide. Storing it loosely in a drawer could damage it or delay the patient's mobility. This option sounds helpful and tidy, but it steps beyond the CNA's role and could harm the device or the patient.

C) Applying lotion right before reapplying the prosthetic

Lotion leaves the skin moist and slippery, which softens tissue and increases friction and slipping inside the socket, raising the risk of skin breakdown. It may seem soothing, but skin under a prosthesis should be clean and dry before the device goes back on.

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D) Cleaning the prosthetic with harsh chemical solvents

Strong solvents can degrade the socket materials, liners, and straps and can irritate the patient's skin. Cleaning should follow the manufacturer's or care plan instructions with mild products. This option sounds thorough, but harsh chemicals damage the device and are not appropriate for aides to use.

Conclusion

Remember that your key job with a prosthetic is to observe the skin it rests on and report changes promptly. Leave decisions about removal schedules and cleaning products to the care plan and the care team.

28. A CNA is measuring a patient's apical pulse. Where should the stethoscope be placed?

A. At the 2nd intercostal space at the right sternal border

B. At the 5th intercostal space at the midclavicular line

C. At the 4th intercostal space at the left sternal border

D. Over the brachial artery in the antecubital fossa

Answer: B. At the 5th intercostal space at the midclavicular line

The stethoscope should be placed at the 5th intercostal space at the midclavicular line to hear the apical pulse.

The apical pulse is heard best over the apex of the heart, which sits at the 5th intercostal space along the midclavicular line on the left side of the chest. This spot places the stethoscope directly over the mitral valve area, where the heartbeat sounds clearest. A CNA counts the apical pulse for a full minute, often before giving certain heart medications, and needs to find this landmark accurately to get a true rate.

A) 2nd intercostal space at the right sternal border

This is the aortic valve area, where sounds from the aortic valve are heard. It can seem like a reasonable heart listening spot, but it does not reflect the apical pulse, so counting here would give an inaccurate rate.

C) 4th intercostal space at the left sternal border

This area overlies the tricuspid valve region and is close to the heart, which makes it tempting. However, it is not the apex, so the apical pulse is not best heard here.

D) Over the brachial artery in the antecubital fossa

This is where a brachial pulse is felt or where a blood pressure cuff is placed. It is a common pulse site, but it is a peripheral artery, not the apex of the heart, so it cannot be used to measure an apical pulse.

Conclusion

Remember that the apical pulse is heard at the heart's apex, the 5th intercostal space at the midclavicular line. Knowing the other chest landmarks as valve areas, not the apex, helps you avoid mixing them up on the exam and in practice.

29. A patient with a valid Do Not Resuscitate (DNR) order stops breathing. What is the CNA's appropriate action?

A. Begin chest compressions immediately

B. Call for the nurse and provide comfort measures, respecting the DNR

C. Shout at the patient to wake them up

D. Leave the room to avoid the situation

Answer: B. Call for the nurse and provide comfort measures, respecting the DNR

Call for the nurse and provide comfort measures while honoring the DNR order.

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A valid DNR order means the patient has chosen not to receive CPR or other resuscitation efforts. When breathing stops, the CNA should notify the nurse promptly and focus on comfort and dignity, staying with the patient as appropriate and following facility policy. The CNA does not start CPR when a valid DNR is in place, and the nurse will confirm the order and guide next steps.

A) Begin chest compressions immediately

Chest compressions are a form of CPR and directly conflict with a valid DNR order. This option may seem tempting because CNAs are trained to act fast in emergencies, but the DNR changes the plan of care, and starting CPR would go against the patient's documented wishes.

C) Shout at the patient to wake them up

Shouting does not help a patient who has stopped breathing and does not address the situation clinically. It might seem like a quick attempt to rouse the patient, but it delays notifying the nurse and providing appropriate comfort care.

D) Leave the room to avoid the situation

Leaving abandons the patient and delays needed nursing assessment and comfort measures. This may feel tempting when a CNA is unsure or uncomfortable, but the professional response is to call for the nurse and remain supportive rather than avoid the situation.

Conclusion

Remember that a valid DNR directs the care team to withhold resuscitation. The CNA's role is to notify the nurse quickly and provide comfort, dignity, and support while respecting the patient's documented wishes.

30. A patient is performing range of motion (ROM) exercises. The patient reports sharp pain when the CNA moves their shoulder. What should the CNA do?

A. Continue the exercise to work through the pain

B. Stop the exercise immediately and report the pain to the nurse

C. Apply ice to the shoulder and continue the exercise

D. Tell the patient that pain is a normal part of rehabilitation

Answer: B. Stop the exercise immediately and report the pain to the nurse

Stop the exercise immediately and report the pain to the nurse.

Sharp pain during range of motion is a warning sign that tissue may be injured or that the movement is beyond what the joint can safely handle. A CNA's role is to support the care plan and protect the patient from harm, not to push through pain. Stopping the activity right away prevents further injury, and reporting the pain gives the nurse the information needed to assess the shoulder and adjust the plan of care. Documenting what happened, when it occurred, and exactly what the patient said is also part of good care.

A) Continue the exercise to work through the pain

Sharp pain is different from mild stiffness or discomfort, and pushing through it can cause tears, strains, or other injury. This option sounds like encouragement and toughness, but CNAs are not trained or authorized to decide that pain should be ignored.

C) Apply ice to the shoulder and continue the exercise

Applying ice is a treatment decision that belongs to the nurse or provider, and continuing the movement after a sharp pain report still risks harm. This option seems caring because ice is often used for soreness, but it does not address the need to stop and report.

D) Tell the patient that pain is a normal part of rehabilitation

Some soreness can occur with activity, but sharp pain is not something to dismiss with reassurance. This response may seem supportive, yet it discourages the patient from reporting symptoms and delays the nurse's assessment.

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Conclusion

When a patient reports sharp pain during ROM, stop the activity and notify the nurse. Protecting the patient and communicating changes promptly is the core of safe CNA practice.

31. A patient is experiencing a hallucination and appears frightened. What is the CNA's best response?

A. Agree with the hallucination to calm the patient down

B. Tell the patient firmly that what they are seeing is not real

C. Acknowledge the patient's fear and gently reorient them to reality

D. Leave the patient alone in the room to calm down

Answer: C. Acknowledge the patient's fear and gently reorient them to reality

Acknowledge the patient's fear and gently reorient them to reality is the CNA's best response.

When a patient with dementia is frightened by a hallucination, the fear is real to them even if what they see is not. The CNA's job is to keep the patient safe and calm, so the first step is to validate the feeling ("I can see this is scary for you") and then gently bring them back to the present with simple, calm statements about where they are and who you are. This approach lowers distress without arguing, and it keeps the patient oriented to reality in a supportive way. Staying calm, using a soft voice, and offering reassurance or a simple distraction after reorienting also helps.

A) Agreeing with the hallucination

Going along with the hallucination may seem kind in the moment, but it reinforces a false belief and can make the confusion worse. It also risks the patient acting on the hallucination in a way that could be unsafe. The CNA should not pretend the hallucination is real.

B) Firmly telling the patient it is not real

Directly correcting or arguing with the patient can increase agitation and fear, because the experience feels real to them. A firm confrontation may damage trust and escalate the situation. Gentle reorientation works better than a blunt correction.

D) Leaving the patient alone

Leaving a frightened patient alone does not address the fear and can increase the risk of falls, wandering, or other harm. The patient needs calm support and supervision, not isolation.

Conclusion

For a frightened patient with dementia, validate the emotion first, then gently reorient to reality while staying calm and present. Avoid arguing, agreeing with the hallucination, or leaving the patient alone.

32. When assisting a patient with a bedpan, what action promotes dignity and proper elimination?

A. Leave the patient uncovered to ensure the bedpan is positioned correctly

B. Provide privacy by closing the door/curtain and covering the patient with a bath blanket

C. Place the bedpan under the patient while they are standing

D. Rush the patient to finish quickly so the CNA can move to the next task

Answer: B. Provide privacy by closing the door/curtain and covering the patient with a bath blanket

Providing privacy by closing the door or curtain and covering the patient with a bath blanket promotes dignity and supports proper elimination.

Elimination is a private and personal activity, and respecting that privacy helps the patient feel safe and respected. Closing the door or curtain and draping the patient with a bath blanket keeps the patient covered while still allowing the CNA to position the bedpan correctly. Feeling

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rushed or exposed can make a patient tense and uncomfortable, which can interfere with relaxing the muscles needed to urinate or have a bowel movement. Giving privacy, keeping the patient warm, and allowing adequate time all support both dignity and normal elimination.

A) Leaving the patient uncovered

Exposing the patient may seem like it makes bedpan placement easier to see, but it removes the patient's privacy and can cause embarrassment and tension. That tension can make it harder for the patient to relax and eliminate, so this approach works against both dignity and proper elimination.

C) Placing the bedpan while the patient is standing

A bedpan is designed to be used while the patient is lying in bed or sitting safely on it, not while standing. Having a patient stand for bedpan placement is unsafe and does not support comfortable, proper elimination.

D) Rushing the patient to finish quickly

It is understandable to feel pressure when there are many tasks to complete, but hurrying a patient interferes with relaxation and normal elimination and takes away the patient's sense of dignity. Allowing adequate, unhurried time is part of respectful care.

Conclusion

Remember that privacy, warmth, and time are essential parts of assisting with elimination. Closing the door or curtain and covering the patient with a bath blanket protects dignity and helps the patient relax enough to eliminate properly.

33. A CNA is disposing of a patient's soiled linens. Which action is correct?

A. Shake the linens in the air to remove debris before placing them in the hamper

B. Hold the linens close to the CNA's uniform to prevent dropping them

C. Roll the linens inward, containing the soiled area, and place them in the designated hamper

D. Place the soiled linens on the floor temporarily while making the bed

Answer: C. Roll the linens inward, containing the soiled area, and place them in the designated hamper

Rolling soiled linens inward to contain the soiled area and placing them directly into the designated hamper keeps infectious material contained and protects everyone in the environment.

Soiled linens can carry blood, body fluids, and germs, so the goal is to move them without releasing germs into the air or onto surfaces. Rolling the linen inward traps the soiled portion inside the bundle, and placing it straight into the designated hamper prevents contamination of the floor, the CNA's clothing, and nearby objects. This follows standard precautions and the general rule of handling linens as little as possible and never shaking them.

A) Shake the linens in the air

Shaking sends droplets and particles from the soiled linen into the air and onto nearby surfaces, which can spread germs to the CNA, the patient, and other residents. It may seem like a quick way to remove loose debris, but it creates an infection control hazard.

B) Hold the linens close to the uniform

Pressing soiled linen against the uniform transfers germs onto clothing that can then be carried to other patients and areas. Holding a bundle close may feel like a safe way to avoid dropping it, but it increases the risk of contaminating yourself.

D) Place soiled linens on the floor temporarily

The floor is heavily contaminated, and setting linens there spreads germs onto the linen and the floor area, and picking them back up can contaminate hands and gloves. It may seem convenient while making the bed, but linens should go directly into the hamper without touching the floor.

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Conclusion

Remember to keep soiled linens contained, avoid shaking them, and never place them on the floor or against your uniform. Rolling them inward and putting them straight into the designated hamper is the safest habit for infection control.

34. A patient's oxygen saturation drops to 88% and they appear short of breath. What is the CNA's first action?

A. Increase the oxygen flow rate on the regulator

B. Immediately report the findings to the licensed nurse

C. Encourage the patient to take deep breaths and wait 10 minutes to recheck

D. Document the finding and continue with other tasks

Answer: B. Immediately report the findings to the licensed nurse

Report the low oxygen saturation and shortness of breath to the licensed nurse right away.

A saturation of 88% with visible shortness of breath signals that the patient is not getting enough oxygen, which can worsen quickly. The CNA's role is to recognize the change, stay with the patient, keep them safe and comfortable, and notify the licensed nurse immediately so the nurse can assess and decide on treatment. Quick reporting allows the care team to act before the patient deteriorates.

A) Increase the oxygen flow rate on the regulator

Adjusting oxygen settings is outside the CNA's scope of practice; oxygen orders and flow rates are set and changed by licensed staff based on assessment. This option feels tempting because it seems like a fast fix, but acting beyond your training can harm the patient and delays proper evaluation.

C) Encourage deep breaths and wait 10 minutes to recheck

Waiting and rechecking delays needed care when the patient is already showing signs of low oxygen. Encouraging breathing may seem harmless and supportive, but a 10-minute delay can allow the patient's condition to worsen, and the nurse should be told about the change right away.

D) Document the finding and continue with other tasks

Documentation matters, but it does not replace immediate reporting of a serious change. This option seems efficient because charting is part of the job, yet recording the finding without telling the nurse leaves the patient without timely intervention.

Conclusion

When a patient shows signs of low oxygen, the CNA's priority is to recognize the change and report it promptly to the licensed nurse while keeping the patient safe. Remember that adjusting oxygen or delaying care falls outside the CNA's role.

35. A patient has a cast on their right leg. Which observation by the CNA should be reported immediately?

A. The patient complains of mild itching under the cast

B. The patient's right toes are pale, cool, and swollen

C. The cast feels warm and dry to the touch

D. The patient requests an extra pillow to elevate the leg

Answer: B. The patient's right toes are pale, cool, and swollen

Pale, cool, and swollen toes on a casted leg signal impaired circulation and must be reported immediately.

When a cast is too tight or swelling builds up inside it, blood flow to the foot can be reduced. Pale color, cool skin, and swelling in the toes are warning signs that circulation is being compromised, which can lead to serious tissue damage if not addressed quickly. The CNA's role is to notice these changes, compare the casted leg with the other leg when possible, and report the findings to the nurse right away so the cast or

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the patient's positioning can be evaluated. Quick reporting protects the patient from permanent injury.

A) Mild itching under the cast

Some itching is common as the skin under a cast becomes dry or as healing occurs, and it usually does not point to an emergency. It can seem concerning because the patient is uncomfortable, but mild itching alone does not suggest a circulation problem and can be noted and monitored rather than treated as an immediate emergency.

C) The cast feels warm and dry to the touch

A cast that is warm and dry is generally expected, especially after it has fully hardened, and this finding does not suggest a complication. It may seem reassuring or worth mentioning, but it is not a sign of compromised circulation or infection that requires immediate reporting.

D) The patient requests an extra pillow to elevate the leg

Elevating a casted leg is often encouraged to help reduce swelling, so this request reflects a normal comfort measure rather than a danger sign. It can seem like a change in condition, but helping the patient elevate the leg within care plan guidelines is appropriate and does not require urgent reporting.

Conclusion

For a patient in a cast, changes in color, temperature, sensation, or swelling of the toes are the key warning signs of circulation problems. Remember to check the toes regularly and report pale, cool, or swollen toes to the nurse without delay.

36. A CNA is measuring a patient's blood pressure and hears the first tapping sound at 130 mmHg and the sounds disappear at 80 mmHg. How should this be recorded?

A. 130/80 mmHg

B. 80/130 mmHg

C. 130 mmHg systolic only

D. 210 mmHg

Answer: A. 130/80 mmHg

The blood pressure should be recorded as 130/80 mmHg, with the first tapping sound as the systolic and the point where sounds disappear as the diastolic.

When measuring blood pressure, the first clear tapping sound you hear through the stethoscope marks the systolic pressure, which is the pressure in the arteries when the heart contracts. The point at which the sounds fade and disappear marks the diastolic pressure, the pressure when the heart relaxes between beats. In this case, the first tapping sound at 130 mmHg is the systolic value and the disappearance of sounds at 80 mmHg is the diastolic value, so the reading is written as systolic over diastolic: 130/80 mmHg. Recording in this standard format keeps the reading clear and consistent for the care team.

B) 80/130 mmHg

This reverses the order of the numbers. The systolic value always goes on top and the diastolic value on the bottom, so placing 80 first misrepresents the reading. It can seem tempting if you simply write the numbers in the order you noticed them, but the standard format requires systolic first.

C) 130 mmHg systolic only

This records only half of the measurement and leaves out the diastolic pressure, which is just as important for assessing the patient's condition. Both values are needed for a complete and useful blood pressure reading, so reporting only the systolic number gives an incomplete picture.

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D) 210 mmHg

This number comes from adding the two readings together, which has no meaning in blood pressure measurement. Adding systolic and diastolic values does not produce a valid pressure reading, and reporting it could cause confusion or unnecessary alarm. Blood pressure is always recorded as two separate values, not a sum.

Conclusion

Remember that blood pressure is written as systolic over diastolic, with the first tapping sound as the top number and the point where sounds disappear as the bottom number. Keeping this order straight helps you report accurate vital signs that the care team can rely on.

37. A patient asks to read their own medical record. What is the CNA's appropriate response?

A. Tell the patient that only doctors are allowed to read medical records

B. Inform the patient that they have the right to review their record and assist them in contacting the nurse or medical records department

C. Hand the patient the chart immediately

D. Refuse the request because the patient might misinterpret the information

Answer: B. Inform the patient that they have the right to review their record and assist them in contacting the nurse or medical records department

Inform the patient that they have the right to review their record and assist them in contacting the nurse or medical records department.

Patients have a legal right to access their own medical information, and the CNA's role is to support that right within the proper channel. The CNA does not own the record and should not release it directly, but acknowledging the request and connecting the patient with the nurse or medical records staff keeps the process safe, documented, and respectful. This response protects patient autonomy while staying inside the CNA's scope of practice.

A) Only doctors may read records

This statement is false and could discourage a patient from exercising a legal right. It may seem protective of confidentiality, but confidentiality does not mean hiding a patient's own information from them.

C) Hand the patient the chart immediately

This feels helpful and patient-centered, but the CNA is not authorized to release or manage the medical record. Charts can be misplaced or altered, and the proper staff must handle access and documentation.

D) Refuse because the patient might misinterpret

Concern about confusion is understandable, but it does not justify denying a legal right. The better approach is to route the request to the nurse or medical records staff, who can explain the information clearly.

Conclusion

Remember that patients have the right to see their records, and the CNA supports that right by referring the request to the appropriate staff rather than releasing or refusing it personally.

38. A patient is wearing anti-embolism (TED) stockings. What is the CNA's responsibility regarding these stockings?

A. Remove them once a week for washing

B. Ensure they are wrinkle-free and remove them daily to assess skin integrity

C. Apply them tightly enough to cut off circulation to prevent swelling

D. Roll them down at the top if they are uncomfortable for the patient

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Answer: B. Ensure they are wrinkle-free and remove them daily to assess skin integrity

Ensure TED stockings stay wrinkle-free and are removed daily so you can check the skin underneath.

TED stockings help blood flow back toward the heart and reduce the risk of clots, but they only work safely when they fit smoothly and the skin is checked regularly. Wrinkles or bunched fabric can press into the skin and cause irritation or pressure damage, so smoothing them out is part of good care. Removing the stockings daily gives you a chance to look at the skin for redness, breakdown, or changes in color and temperature, and to clean and dry the legs. Report any skin problems to the nurse and follow the care plan for how long the stockings should stay on.

A) Remove them once a week for washing

Waiting a full week leaves the skin unchecked for too long, so early signs of pressure or irritation could be missed. It may seem like a simple schedule, but daily skin assessment is a core part of safe stocking care.

C) Apply them tightly enough to cut off circulation to prevent swelling

Stockings that are too tight can squeeze blood vessels and actually reduce circulation, which is the opposite of the goal. The idea that tighter means better compression is tempting, but TED stockings should fit smoothly and firmly without pinching or restricting blood flow.

D) Roll them down at the top if they are uncomfortable for the patient

Rolling down the top creates a tight band that can interfere with circulation and cause pressure on the skin. It may seem like a quick comfort fix, but the right response is to reposition the stocking properly or tell the nurse about the discomfort.

Conclusion

Remember that TED stockings must be smooth and wrinkle-free and removed daily so the skin can be checked. When something does not fit or feel right, report it rather than adjusting the stockings in ways that could harm circulation.

39. A patient with anxiety is hyperventilating. What is the most appropriate initial action by the CNA?

A. Have the patient breathe into a paper bag

B. Stay with the patient, speak in a calm, slow voice, and encourage slow, deep breaths

C. Administer the patient's prescribed anti-anxiety medication

D. Tell the patient to stop overreacting

Answer: B. Stay with the patient, speak in a calm, slow voice, and encourage slow, deep breaths

Staying with the patient, speaking calmly and slowly, and encouraging slow, deep breaths is the most appropriate first action for a patient who is hyperventilating from anxiety.

Hyperventilation during anxiety is often driven by fear and a feeling of losing control. A calm, reassuring presence helps lower the patient's arousal, and coaching slow, deep breathing helps restore normal carbon dioxide levels and ease symptoms. This approach is safe, within CNA scope, and addresses the immediate distress without delay.

A) Paper bag breathing

This method is outdated and carries risks such as low oxygen levels and is not recommended for routine anxiety-related hyperventilation. It can seem appealing because it was once widely taught, but it is not a safe first step for a CNA to initiate.

C) Administering prescribed anti-anxiety medication

Giving medication is outside CNA scope; CNAs may remind or assist only as allowed by facility policy and delegation, and medication is not the immediate first response to hyperventilation. It can seem helpful because the patient has a prescription, but the CNA should focus first on calming measures and report to the nurse.

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D) Telling the patient to stop overreacting

This dismisses the patient's distress and can worsen anxiety and breathing. It may seem like a quick way to redirect the patient, but it damages trust and does not address the physiologic symptoms.

Conclusion

For anxiety-related hyperventilation, the CNA's best first action is a calm presence and coaching slow, deep breaths, then reporting to the nurse if symptoms persist or worsen.

40. When providing oral care to an unconscious patient, what is the most critical safety measure?

A. Use a large amount of water to ensure the mouth is clean

B. Position the patient in a side-lying position with the head of the bed elevated

C. Brush the teeth vigorously to remove all plaque

D. Leave the patient supine to keep the airway open

Answer: B. Position the patient in a side-lying position with the head of the bed elevated

Positioning the patient in a side-lying position with the head of the bed elevated is the most critical safety measure during oral care for an unconscious patient.

An unconscious patient cannot swallow or cough to protect the airway, so secretions, water, and debris can easily slide into the lungs and cause aspiration. Turning the patient to the side lets fluids drain out of the mouth by gravity, and raising the head of the bed keeps the airway higher than the stomach and mouth. This positioning protects breathing while still allowing you to clean the mouth safely. Always stay with the patient, work with small amounts of fluid, and keep suction or a way to clear the mouth nearby.

A) Use a large amount of water

More water increases the risk that fluid will pool in the mouth and be breathed into the lungs, which is especially dangerous when the patient cannot swallow. It may seem like extra water would clean better, but safety comes first, and only small amounts of fluid should be used.

C) Brush the teeth vigorously

Vigorous brushing can injure delicate gum tissue and cause bleeding, and it does nothing to protect the airway. It may seem like strong scrubbing removes more plaque, but gentle, thorough cleaning is both safer and effective.

D) Leave the patient supine

Lying flat on the back allows fluids and debris to collect at the back of the throat and drain toward the airway, raising aspiration risk. Keeping the patient supine may seem like it keeps the airway open, but it actually makes aspiration more likely.

Conclusion

For an unconscious patient, the priority in oral care is protecting the airway. Side-lying positioning with the head of the bed elevated lets fluids drain safely, and this principle should guide your answer on exam questions about patient safety.

41. Which of the following is the most effective way for a CNA to prevent the spread of infection in a healthcare facility?

A. Wearing gloves for all patient interactions

B. Performing proper hand hygiene before and after every patient contact

C. Keeping patients isolated in their rooms at all times

D. Spraying air fresheners in patient rooms

Answer: B. Performing proper hand hygiene before and after every patient contact

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Performing proper hand hygiene before and after every patient contact is the single most effective action a CNA can take to prevent infection spread.

Germs travel most often on the hands of healthcare workers as they move from one resident to the next. Cleaning hands at the right moments, before touching a resident and after any contact with the resident or their surroundings, breaks that chain of transmission. This practice is simple, fast, and proven to reduce infections in every care setting, which is why it is emphasized so heavily in CNA training and facility policy.

A) Wearing gloves for all patient interactions

Gloves feel protective and are an important part of standard precautions, so this option can seem like the safest choice. However, gloves do not replace hand hygiene; hands can become contaminated while putting gloves on or taking them off, and gloves are not needed for every interaction. Relying on gloves alone can actually lead to skipped handwashing.

C) Keeping patients isolated in their rooms at all times

Isolation is used only for specific transmission-based precautions ordered by a provider, and routine isolation of all residents would harm their physical and emotional well-being. This option sounds like it would block infection, but it is not a general prevention strategy and is outside the CNA's role to decide.

D) Spraying air fresheners in patient rooms

Air fresheners may mask odors, which can make a room seem cleaner, but they do not remove or kill infectious germs. Some residents also have respiratory conditions that fragrances can irritate, so this is not an infection control measure.

Conclusion

Remember that hand hygiene before and after every patient contact is the cornerstone of infection prevention. Gloves, isolation, and room sprays each have limited roles, but none replaces clean hands.

42. A CNA notices a frayed electrical cord on a patient's bed control unit. What is the appropriate action?

A. Tape the frayed area and continue using the bed

B. Unplug the device, tag it as 'Out of Order', and report it to maintenance

C. Ignore it as long as the bed still moves

D. Attempt to repair the cord with a staple gun

Answer: B. Unplug the device, tag it as 'Out of Order', and report it to maintenance

Unplug the device, tag it as 'Out of Order', and report it to maintenance to remove the hazard from use.

A frayed electrical cord can expose wires, cause shocks, or start a fire, so the safe response is to take the equipment out of service right away. Unplugging the bed control unit cuts the power at the source, tagging it warns others not to use it, and reporting it sends the problem to the people trained to fix it. This keeps the patient and staff safe while staying within the CNA's role, which is to identify hazards and report them rather than make repairs.

A) Tape the frayed area and continue using the bed

Tape does not restore the insulation or make the wiring safe, and damage can continue under the tape where no one can see it. This option feels tempting because it is quick and keeps the bed in use, but it leaves a shock and fire hazard in place.

C) Ignore it as long as the bed still moves

A device can work normally and still be dangerous, since the risk comes from the exposed wiring rather than from whether the motor runs. It seems easy to overlook damage when nothing has gone wrong yet, but ignoring a hazard allows a serious injury to happen later.

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D) Attempt to repair the cord with a staple gun

Driving a staple into a cord can pierce the insulation, create a short circuit, and cause shock or fire, and electrical repair is outside the CNA's scope. It looks like a practical fix, but it makes the hazard worse and puts the patient and staff at risk.

Conclusion

When equipment is damaged, the CNA's job is to stop its use, warn others, and report it. Unplug it, tag it, and notify maintenance so trained staff can handle the repair safely.

43. A patient has difficulty swallowing (dysphagia). Which action by the CNA is most appropriate during mealtime?

A. Provide thin liquids to help wash down the food

B. Ensure the patient is sitting upright at a 90-degree angle

C. Talk to the patient extensively during meals to keep them entertained

D. Place the food on the unaffected side of the mouth, but keep the head tilted back

Answer: B. Ensure the patient is sitting upright at a 90-degree angle

Ensuring the patient sits upright at a 90-degree angle is the most appropriate action during mealtime for someone with dysphagia.

Sitting fully upright allows gravity to help move food and fluid safely down the throat and reduces the chance that material will enter the airway. This position also supports a clear, straight pathway for swallowing, which lowers the risk of choking and aspiration. CNAs should confirm the patient is positioned properly before offering any food or drink and should follow the care plan for any specific positioning or diet instructions.

A) Provide thin liquids to help wash down the food

Thin liquids move quickly and are often harder for a person with dysphagia to control, so they can raise the risk of choking or aspiration. It may seem helpful to wash food down, but thickened liquids or specific textures are usually ordered instead. The CNA should follow the prescribed diet consistency rather than offering thin liquids on their own.

C) Talk to the patient extensively during meals to keep them entertained

Frequent conversation during meals can distract a patient who needs to focus on chewing and swallowing, increasing the chance of choking. A calm, quiet mealtime with limited talking is safer. Keeping the patient company is kind, but it should not interfere with safe swallowing.

D) Place the food on the unaffected side of the mouth, but keep the head tilted back

Placing food on the stronger side can be helpful, but tilting the head back opens the airway and makes swallowing less safe by allowing food to slip down too quickly. A neutral or slightly chin-down position is often recommended. The head-back position works against the goal of protecting the airway.

Conclusion

For a patient with dysphagia, upright positioning at about 90 degrees is the key safety measure during meals. Remember to follow the care plan for diet texture and liquid consistency, keep mealtime calm, and avoid positions or practices that make swallowing harder.

44. A CNA is measuring a patient's radial pulse and notes it is irregular. What is the best next step?

A. Record the irregular pulse and move on to the next patient

B. Count the apical pulse for a full minute

C. Estimate the pulse rate based on the irregular rhythm

D. Tell the patient their heart is skipping beats and they should be worried

Answer: B. Count the apical pulse for a full minute

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When a radial pulse feels irregular, the best next step is to count the apical pulse for a full minute.

An irregular radial pulse can signal a heart rhythm problem, and the radial site may not reflect the true rate or rhythm accurately. Listening at the apex with a stethoscope for a full minute gives a more reliable count and lets you note the pattern of irregularity. This is within CNA scope when your facility policy allows it, and the finding should be reported to the nurse promptly so the patient can be properly evaluated.

A) Record the irregular pulse and move on

Documenting an abnormal finding without further assessment or reporting leaves an important change unaddressed. An irregular pulse deserves a more accurate measurement and communication with the nurse, not just a note in the chart.

C) Estimate the pulse rate

Guessing at a rate when the rhythm is irregular produces unreliable information that could mislead the care team. A full-minute count, ideally at the apical site, is needed for accuracy.

D) Tell the patient their heart is skipping beats and they should be worried

Sharing alarming interpretations goes beyond the CNA role and can cause unnecessary fear. The CNA should gather accurate data and report it to the nurse, who explains findings to the patient.

Conclusion

An irregular radial pulse calls for a full-minute apical count and prompt reporting to the nurse. Stay within your scope, measure accurately, and let the care team handle interpretation and patient teaching.

45. A patient's religious beliefs prohibit blood transfusions. The patient is scheduled for surgery. What is the CNA's role?

A. Try to convince the patient that the transfusion is medically necessary

B. Document the patient's wishes and ensure the care team is aware of the advance directive

C. Ignore the request because it is a life-threatening situation

D. Tell the patient that the hospital will force the transfusion if needed

Answer: B. Document the patient's wishes and ensure the care team is aware of the advance directive

The CNA should document the patient's wishes and make sure the care team knows about the advance directive.

Respecting a patient's religious beliefs is a core part of resident rights and patient autonomy. When a patient refuses blood transfusions for religious reasons, the CNA's role is to honor that choice, record it accurately, and communicate it to the care team so the advance directive is followed. The CNA does not make medical decisions, persuade the patient, or override the patient's wishes; the job is to advocate for and protect the patient's expressed preferences within the care team.

A) Trying to convince the patient

Persuading a patient to change a deeply held religious belief oversteps the CNA's role and can feel coercive. It may seem helpful to push for what looks medically necessary, but respecting autonomy means not pressuring the patient.

C) Ignoring the request

Ignoring a patient's stated wishes violates resident rights and undermines trust. A life-threatening situation can make staff want to act quickly, but the CNA still must respect the patient's documented choices and let the care team handle the clinical decisions.

D) Telling the patient the hospital will force treatment

Threatening a patient is inappropriate and frightening, and it misrepresents how care works. This option may seem like a way to emphasize urgency, but it damages trust and does not reflect the CNA's supportive role.

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Conclusion

For resident rights questions, remember that the CNA protects and communicates the patient's wishes rather than trying to change them. Documenting and informing the care team is the safe, respectful action.

46. A patient is using a walker for ambulation. Which observation indicates the patient is using the walker correctly?

A. The patient lifts the walker, moves it forward, and then steps into the walker

B. The patient pushes the walker forward like a shopping cart while walking

C. The patient holds the walker by the side rails for better balance

D. The patient takes large, running steps to keep up with the walker

Answer: A. The patient lifts the walker, moves it forward, and then steps into the walker

The patient lifts the walker, moves it forward, and then steps into the walker, which is the proper technique.

Standard walkers are designed to be lifted and placed ahead of the body, then the patient steps forward into the walker while keeping it stable. This sequence keeps the walker as a steady base of support and helps prevent falls. The patient should stand upright, grip the handles, lift and set the walker down a short distance ahead, then step in without letting the walker get too far away. This pattern gives the patient a reliable support point with each step and matches the way the device was built to be used.

B) Pushing the walker like a shopping cart

Pushing a standard walker along the floor can cause it to slide or tip, especially on smooth or uneven surfaces, and it does not provide the same stable support as lifting and placing it. This option can seem appealing because it looks smooth and fast, but it does not match how a standard walker is meant to be used.

C) Holding the walker by the side rails

The side rails are not the intended gripping point for ambulation, and holding them can make the walker unstable and reduce the patient's control. This may look like a way to improve balance, but the handles are designed for a secure, balanced grip.

D) Taking large, running steps

Large, fast steps can cause the patient to outrun the walker and lose support, raising the risk of a fall. This option may seem efficient, but safe walker use calls for short, controlled steps that stay close to the device.

Conclusion

For a standard walker, remember the sequence: lift, place forward, then step into it with short, steady steps. Recognizing this pattern helps you confirm safe technique and protect the patient from falls.

47. A patient with schizophrenia tells the CNA, 'The government is poisoning my food.' What is the CNA's best response?

A. Taste the food first to prove it is safe

B. Say, 'I understand you feel that way, but I assure you the food is safe to eat.'

C. Agree with the patient to build rapport

D. Tell the patient that their delusion is ridiculous

Answer: B. Say, 'I understand you feel that way, but I assure you the food is safe to eat.'

The CNA should acknowledge the patient's feelings while calmly stating that the food is safe to eat.

When a patient with schizophrenia expresses a delusion, the CNA should not argue with or endorse the false belief. Instead, the CNA acknowledges the patient's emotional experience and offers gentle, factual reassurance. This approach preserves trust, reduces distress, and keeps the patient safe without reinforcing the delusion. The CNA should also report the delusion to the supervising nurse so the care team can

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monitor the patient's mental status and safety.

A) Taste the food first to prove it is safe

Tasting the food may seem like a caring way to ease the patient's fear, but it engages directly with the delusion and implies the concern deserves a test. It also sets a precedent that staff will act out delusional thinking, which can strengthen the belief over time.

C) Agree with the patient to build rapport

Agreeing may feel like a quick way to avoid conflict, but confirming a false belief reinforces the delusion and can increase the patient's fear and distrust later. Rapport is built through calm, honest support, not by joining the delusion.

D) Tell the patient that their delusion is ridiculous

Calling the belief ridiculous may seem like a direct way to correct a false idea, but it dismisses the patient's feelings and can cause anger, withdrawal, or loss of trust. The CNA's role is to respond with respect and report concerns, not to confront or shame the patient.

Conclusion

For delusions, acknowledge the feeling, give calm factual reassurance, and report to the nurse. Avoid arguing, agreeing, or acting on the false belief.

48. When collecting a clean-catch midstream urine specimen, what instruction should the CNA give the patient?

A. Collect the very first urine that comes out into the cup

B. Clean the perineal area, start urinating into the toilet, then collect the middle portion in the cup

C. Fill the specimen cup to the very top to ensure there is enough for testing

D. Touch the inside of the cup to ensure a secure grip

Answer: B. Clean the perineal area, start urinating into the toilet, then collect the middle portion in the cup

Clean the perineal area, begin urinating into the toilet, then collect the middle portion of the stream in the cup.

A clean-catch midstream specimen is collected this way to keep the sample free of bacteria and cells from the skin and the first part of the urine stream. Cleaning the perineal area reduces contamination from normal skin flora. Letting the first urine flow into the toilet flushes out organisms that normally sit near the urethral opening. Catching the middle portion gives the most accurate sample of what is actually in the bladder, which helps the lab identify a true urinary tract infection rather than a contaminated specimen. The CNA should explain these steps clearly, provide the collection supplies, and allow privacy while the patient collects the sample.

A) Collect the very first urine into the cup

The first urine carries skin bacteria and cells from the urethra, so it can make the lab result look like an infection when there is none, or hide the real organism. It feels quick and simple, which makes it tempting, but it defeats the purpose of a clean-catch specimen.

C) Fill the specimen cup to the very top

Only a small amount of urine is needed for testing, and overfilling can cause spills and contamination of the outside of the container. A full cup may seem like it guarantees enough sample, but the collection method matters far more than the volume.

D) Touch the inside of the cup

Fingers carry bacteria, so touching the inside of the cup or lid introduces germs directly into the specimen. Holding the cup by the outside only feels less secure, but it protects the sample and keeps the result reliable.

Conclusion

Remember the clean-catch midstream sequence: clean the area, void the first part into the toilet, then collect the middle portion into the cup without touching the inside. This protects specimen quality and supports accurate diagnosis and treatment.

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49. A patient is placed on Droplet Precautions. Which PPE must the CNA wear when entering the room?

A. N95 respirator only

B. Surgical mask upon entering the room

C. Gown and gloves only

D. No special PPE is required, only standard precautions

Answer: B. Surgical mask upon entering the room

A surgical mask must be worn upon entering the room for a patient on Droplet Precautions.

Droplet Precautions are used for germs spread by large respiratory droplets from coughing, sneezing, talking, or procedures. These droplets travel only a short distance, so a surgical mask worn when entering the room blocks them from reaching the CNA's nose and mouth. Standard precautions still apply, so hand hygiene and gloves or gowns are added when contact with body fluids is likely. The key point is that the mask is the required barrier for droplet spread, and it should be put on before stepping into the room.

A) N95 respirator only

An N95 respirator is reserved for airborne precautions, such as tuberculosis or measles, where tiny particles stay suspended in the air and require a fit-tested mask. It may seem tempting because it offers more protection, but it is not the standard requirement for droplet precautions and does not replace the need for a surgical mask in this situation.

C) Gown and gloves only

Gowns and gloves protect against contact with body fluids and surfaces, but they do nothing to stop respiratory droplets from being breathed in. This option can seem reasonable because PPE often includes gown and gloves, yet it leaves the mouth and nose unprotected, which is the main route of droplet transmission.

D) No special PPE is required, only standard precautions

Standard precautions apply to every patient, but transmission-based precautions like Droplet Precautions require extra protection beyond the basics. This choice may seem appealing if the CNA thinks standard precautions cover everything, but it ignores the specific risk of droplet spread and would leave the CNA unprotected when entering the room.

Conclusion

Remember that Droplet Precautions call for a surgical mask when entering the room, while N95 respirators belong to Airborne Precautions. Knowing which precaution matches which PPE keeps both the CNA and the patient safe.

50. A patient with a history of fainting (syncope) states they feel dizzy and 'see spots' while standing in the bathroom. What is the CNA's immediate action?

A. Tell the patient to take deep breaths and finish using the bathroom

B. Assist the patient to sit or lie down on the floor immediately to prevent a fall

C. Run to get the nurse while leaving the patient standing

D. Give the patient a glass of cold water

Answer: B. Assist the patient to sit or lie down on the floor immediately to prevent a fall

Assist the patient to sit or lie down on the floor immediately to prevent a fall.

Dizziness and seeing spots are warning signs that the brain is not getting enough blood flow and a fainting episode may be seconds away. When a patient with a history of syncope reports these symptoms while standing, the safest move is to lower them to the floor or a seated position right away, before they lose consciousness and fall. Getting the patient down in a controlled way protects the head and body from striking hard surfaces and keeps the CNA in control of the situation. Once the patient is safe on the floor or seated, the CNA stays with them, checks for responsiveness and breathing, and calls for the nurse.

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A) Deep breaths and finish in the bathroom

Encouraging the patient to stay standing and finish in the bathroom keeps them upright during a moment when blood flow to the brain may already be dropping. Deep breathing does not reverse a fainting episode that is already starting, and the patient could collapse onto the bathroom floor or fixtures. This option sounds calm and reassuring, which makes it tempting, but it delays the one action that prevents injury.

C) Run to get the nurse while leaving the patient standing

Leaving an unsteady patient alone and upright removes the person who could guide them safely to the floor if they faint. The patient could fall and hit their head in the time it takes to find help. Getting help matters, but the CNA should first stabilize the patient and then call for the nurse using a call light or by calling out, rather than abandoning them mid-symptom.

D) Give the patient a glass of cold water

Cold water does not stop an impending faint, and a patient who is dizzy and seeing spots may not be able to hold a glass safely. There is also a choking risk if the patient's level of consciousness drops while drinking. Offering water seems like a kind, practical response, but it does nothing to prevent the fall that is the real danger here.

Conclusion

When a patient reports dizziness or visual changes while standing, treat it as a warning of an imminent faint and lower them to the floor or a safe seated position first. Preventing the fall comes before everything else, and the nurse can be called once the patient is secure.

51. A nursing assistant is caring for a resident with Clostridioides difficile (C. diff). Which hand hygiene method is most effective for this pathogen?

A. Alcohol-based hand rub

B. Antimicrobial soap and water

C. Chlorhexidine gluconate

D. Sterile saline rinse

Answer: B. Antimicrobial soap and water

Plain soap and water, ideally antimicrobial soap and water, is the most effective hand hygiene method after caring for a resident with C. difficile because the mechanical action of washing physically removes the spores.

C. difficile forms spores that are resistant to alcohol, so alcohol-based rubs do not reliably kill or remove them. Washing with soap and water works by friction and rinsing, lifting spores off the skin and sending them down the drain. Standard precautions plus contact precautions, including gown and gloves, are used, and handwashing with soap and water is performed after glove removal and after contact with the resident or contaminated surfaces. Antimicrobial soap adds a chemical agent, but the key element is the soap-and-water wash itself.

A) Alcohol-based hand rub

Alcohol rubs are quick and convenient and are the usual choice for many organisms, which makes this option tempting. However, alcohol does not destroy C. difficile spores, and rubbing without rinsing does not physically remove them from the hands. Relying on a rub can leave spores on the skin and contribute to spread.

C) Chlorhexidine gluconate

Chlorhexidine is an antiseptic used in some surgical scrubs and skin preps, and it sounds like a strong choice. It is not the routine hand hygiene product for routine resident care, and it is not the recommended approach for removing C. difficile spores from hands. Its use here would not match standard hand hygiene practice.

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D) Sterile saline rinse

Sterile saline is used for wound cleansing and irrigation, not hand hygiene. Rinsing with saline alone does not have the soap and friction needed to lift and remove spores, and it is not a recognized hand hygiene method for resident care.

Conclusion

For C. difficile, remember that spores resist alcohol, so wash hands with soap and water using good friction and rinsing. Save alcohol rubs for situations where they are appropriate, and follow contact precautions with gloves and gowns to limit spread.

52. During a fire in the facility, a CNA finds a resident in the hallway coughing and confused. According to the RACE acronym, what is the CNA's immediate first action?

A. Close the resident's door

B. Evacuate the resident to a safe zone

C. Rescue the resident from immediate danger

D. Activate the fire alarm

Answer: C. Rescue the resident from immediate danger

According to RACE, the CNA's immediate first action is to rescue the resident from immediate danger.

RACE stands for Rescue, Alarm, Contain, and Extinguish/Evacuate, and the letters are listed in the order they should be performed. A resident who is coughing and confused is showing signs of smoke exposure and is in the hallway where the fire hazard is present, so the first priority is to move that person away from the danger before doing anything else. Once the resident is out of harm's way, the CNA can pull the alarm, help contain the fire by closing doors, and follow the facility's evacuation plan. The CNA should stay calm, use a safe route, and get help from coworkers if the resident cannot be moved alone.

A) Close the resident's door

Closing doors is part of the Contain step, which comes after rescue and alarm. This step matters for slowing the spread of smoke and fire, so it can seem like a smart first move, but it does nothing to remove the resident from the smoke-filled hallway right now.

B) Evacuate the resident to a safe zone

Evacuation is the final step of RACE and happens after the resident has been rescued and the alarm has been activated. Moving straight to a full evacuation can seem thorough, but it skips the alarm step, which brings trained help and protects everyone else in the building.

D) Activate the fire alarm

Pulling the alarm is the second step, Alarm, and it is essential for notifying staff and emergency responders. It can feel like the most responsible first action, but a resident who is coughing and confused needs to be removed from the immediate danger before the CNA turns attention to the alarm.

Conclusion

Remember that RACE follows a set order: Rescue first, then Alarm, Contain, and Extinguish/Evacuate. When a resident is in the path of smoke or fire, getting that person to safety is always the first move, and the other steps follow once the immediate danger has been addressed.

53. A CNA is measuring a resident's blood pressure. Which of the following findings requires immediate reporting to the charge nurse?

A. Systolic pressure of 118 mmHg

B. Diastolic pressure of 76 mmHg

C. Systolic pressure of 170 mmHg

D. Pulse pressure of 42 mmHg

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Answer: C. Systolic pressure of 170 mmHg

A systolic pressure of 170 mmHg is significantly elevated and requires immediate reporting to the charge nurse.

Blood pressure is recorded as systolic over diastolic. A systolic pressure of 170 mmHg is well above the normal range (typically 90–120 mmHg) and may indicate hypertension or another serious condition. CNAs are responsible for accurately measuring vital signs and promptly reporting any abnormal findings to the charge nurse for further assessment and intervention.

A) Systolic pressure of 118 mmHg

This value falls within the normal range for systolic blood pressure, so it does not require immediate reporting. It might seem concerning if you are unsure of normal parameters, but it is actually a healthy reading.

B) Diastolic pressure of 76 mmHg

A diastolic pressure of 76 mmHg is within the normal range (typically 60–80 mmHg) and does not necessitate immediate reporting. This is a common and acceptable value.

D) Pulse pressure of 42 mmHg

Pulse pressure is the difference between systolic and diastolic pressures. A value of 42 mmHg is within the normal range (about 30–50 mmHg) and is not typically a cause for immediate concern. It might seem important because it is a calculated value, but it does not indicate an urgent issue in this context.

Conclusion

Always report significantly elevated blood pressure readings, such as a systolic pressure of 170 mmHg, to the charge nurse promptly. Knowing normal ranges helps distinguish which findings require immediate attention.

54. When providing oral care to an unconscious resident, what is the most critical safety intervention to prevent aspiration?

A. Using a hard-bristled toothbrush

B. Placing the resident in a supine position

C. Positioning the resident on their side with the head turned

D. Using a large amount of toothpaste

Answer: C. Positioning the resident on their side with the head turned

Positioning the resident on their side with the head turned allows fluids to drain out of the mouth instead of entering the airway.

An unconscious resident cannot cough, swallow, or protect their airway, so secretions, water, and toothpaste foam can easily slide down the throat into the lungs. Turning the resident onto their side and turning the head lets gravity carry fluids out of the mouth rather than back toward the throat. This side-lying position is a standard safety step during oral care for any resident who cannot swallow or respond, and it should be combined with using small amounts of fluid, a soft toothbrush, and suction or gauze at the bedside if available.

A) Using a hard-bristled toothbrush

A hard-bristled brush can injure delicate gums and oral tissue, but it does not address the path that fluids take into the airway. The bristle type affects comfort and tissue safety, not aspiration risk, so it does not solve the core danger in this situation.

B) Placing the resident in a supine position

Lying flat on the back leaves the mouth directly above the throat, so fluids pool at the back of the mouth and drain downward toward the airway. This position increases aspiration risk rather than reducing it, even though it may seem like a natural way to keep the resident still.

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D) Using a large amount of toothpaste

More toothpaste creates more foam and fluid in the mouth, which is harder to clear and easier to aspirate. The amount of toothpaste affects cleanliness and comfort, but it does not protect the airway and can actually add to the risk.

Conclusion

For an unconscious resident, the priority in oral care is protecting the airway. Side-lying positioning with the head turned lets fluids drain safely from the mouth, and this should guide your answer whenever aspiration prevention is the focus.

55. Which body mechanic principle should a CNA apply when moving a heavy box of supplies?

A. Bend at the waist and keep legs straight

B. Twist the torso while lifting to gain momentum

C. Hold the box as far from the body as possible

D. Bend at the knees and hold the load close to the body

Answer: D. Bend at the knees and hold the load close to the body

Bend at the knees and hold the load close to the body is the body mechanic principle a CNA should apply when moving a heavy box of supplies.

Bending at the knees uses the large, strong muscles of the legs to do the lifting instead of the smaller, weaker muscles of the back. Keeping the load close to the body shortens the lever arm and reduces the strain on the spine, which lowers the risk of back injury. This approach protects both the CNA and the supplies being moved, and it reflects safe body mechanics taught in standard CNA training.

A) Bend at the waist and keep legs straight

Bending at the waist places the stress of the lift on the lower back rather than the legs, which is a common cause of back strain and injury. It can feel natural when reaching for something low, but it is not a safe lifting technique for heavy loads.

B) Twist the torso while lifting to gain momentum

Twisting while lifting adds rotational force to the spine at the same time it is bearing weight, which increases the risk of injury. Momentum may seem helpful for getting a heavy object moving, but it does not make the lift safer.

C) Hold the box as far from the body as possible

Holding a load away from the body lengthens the lever arm and multiplies the strain on the back and shoulders. Reaching out may feel like it gives better control, but it actually makes the load harder to manage safely.

Conclusion

For test-takers, remember that safe body mechanics means using the legs to lift and keeping the load close. Avoid bending at the waist, twisting during a lift, or holding weight away from the body.

56. A resident is learning to walk with a standard cane. Which instruction should the CNA provide?

A. Move the cane forward, followed by the weaker leg, then the stronger leg

B. Move the weaker leg forward, followed by the cane, then the stronger leg

C. Move the stronger leg forward, followed by the cane, then the weaker leg

D. Move the cane and both legs forward simultaneously

Answer: A. Move the cane forward, followed by the weaker leg, then the stronger leg

Move the cane forward first, then the weaker leg, then the stronger leg for safe, stable walking.

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Using a cane for walking follows a simple pattern that protects the weaker side and keeps the body balanced. The cane acts as an extra support point on the side that needs help, so it moves forward before the weaker leg. Placing the cane down first lets the resident shift weight onto it while stepping with the weaker leg, and then the stronger leg follows to complete the step. This sequence spreads the body weight over the cane and the stronger leg, which lowers the risk of stumbling or falling. The CNA should remind the resident to keep the cane close to the body, look ahead, and take small, steady steps while staying nearby for safety.

B) Weaker leg first

Leading with the weaker leg before the cane removes the support the resident needs at the moment of weight bearing, which can cause a loss of balance. It may seem logical to focus on the weak side first, but the cane must be in place before that leg takes weight.

C) Stronger leg first

Stepping with the stronger leg first leaves the weaker side without the cane's support and disrupts the natural rhythm of a supported gait. This option can look appealing because the stronger leg feels more reliable, yet the cane needs to lead so it can share the load.

D) Cane and both legs together

Moving the cane and both legs at the same time is not a controlled walking pattern and gives no clear point of support during the step. It may sound efficient, but it removes the staggered timing that keeps the resident steady.

Conclusion

Remember the cane-first order: cane, weaker leg, stronger leg. This pattern keeps the resident supported and steady, and it reflects safe, standard mobility practice for CNAs.

57. A resident is prescribed a mechanical soft diet. Which of the following food items is appropriate to serve?

A. Raw carrots and celery sticks

B. Ground meat and mashed potatoes

C. Chewy steak and crusty bread

D. Whole apples and popcorn

Answer: B. Ground meat and mashed potatoes

Ground meat and mashed potatoes are appropriate for a mechanical soft diet because they are moist, tender, and easy to chew and swallow.

A mechanical soft diet is prescribed for residents who have difficulty chewing or swallowing but who do not need a fully pureed diet. Foods should be soft, moist, and cut or ground into small pieces so they are easy to manage. Ground meat provides protein without tough fibers, and mashed potatoes are smooth and soft, making both good choices. The CNA should also confirm the diet order, check the tray against it, and report any concerns about swallowing to the nurse.

A) Raw carrots and celery sticks

Raw vegetables are hard, fibrous, and require strong chewing, which makes them difficult and unsafe for someone on a mechanical soft diet. They may seem healthy and familiar, but texture is the key factor here, not nutritional value.

C) Chewy steak and crusty bread

Tough meat and hard bread crusts demand vigorous chewing and can be hard to break down, raising the risk of choking or poor intake. These foods may seem like a normal meal, but they do not meet the soft, moist texture requirements of this diet.

D) Whole apples and popcorn

Whole apples are firm and popcorn has small, dry, easily aspirated pieces, both of which are unsafe for a resident with chewing or swallowing difficulty. They may seem like light snacks, but their texture and choking risk make them unsuitable.

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Conclusion

For a mechanical soft diet, choose foods that are soft, moist, and easy to chew, such as ground meat and mashed potatoes. Always check the tray against the prescribed diet and report any swallowing concerns to the nurse.

58. A resident with Alzheimer's disease is experiencing 'sundowning' and becoming increasingly agitated in the late afternoon. What is the best approach for the CNA?

A. Turn on the television to distract the resident

B. Confront the resident about their inappropriate behavior

C. Provide a quiet, calm environment and use gentle redirection

D. Administer a PRN sedative medication

Answer: C. Provide a quiet, calm environment and use gentle redirection

Providing a quiet, calm environment and using gentle redirection is the best approach for a resident experiencing sundowning.

Sundowning is a common pattern in Alzheimer's disease where agitation, confusion, and restlessness increase in the late afternoon or early evening. The CNA's role is to reduce stimulation and create a soothing atmosphere, because a calm setting helps lower the resident's anxiety and prevents escalation. Gentle redirection—such as guiding the resident toward a quiet activity, a snack, or a familiar routine—respects the resident's dignity and avoids confrontation. This approach stays within CNA scope of practice and supports safety without the use of force or medication decisions.

A) Turn on the television to distract the resident

Television can add noise, flickering light, and confusing content, which may increase agitation rather than settle it. Distraction can be useful, but it needs to be calm and low-stimulation, so this choice works against the goal of reducing environmental stress.

B) Confront the resident about their inappropriate behavior

Confrontation tends to increase fear, frustration, and agitation in a person with dementia, who may not understand or remember the behavior being addressed. The resident is not acting out on purpose; the behavior reflects brain changes and unmet needs, so correction is not helpful.

D) Administer a PRN sedative medication

Giving medication is outside the CNA's scope of practice; CNAs do not administer PRN sedatives or decide when they are needed. The CNA can report changes to the nurse, but the first response should be non-drug comfort measures and environmental adjustments.

Conclusion

For sundowning, remember that calm, low-stimulation surroundings and gentle redirection are the CNA's first-line tools. Avoid confrontation and remember that medication administration belongs to licensed nursing staff.

59. How should a CNA communicate effectively with a resident who has severe hearing impairment?

A. Shout loudly into the resident's ear

B. Speak clearly, face the resident, and use a normal tone of voice

C. Use complex medical terminology to ensure accuracy

D. Speak to the resident's family member instead of the resident

Answer: B. Speak clearly, face the resident, and use a normal tone of voice

Speak clearly, face the resident, and use a normal tone of voice to communicate effectively with a resident who has severe hearing impairment.

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Residents with severe hearing impairment often rely on visual cues such as lip reading, facial expressions, and gestures to understand speech. Facing the resident allows them to see your mouth and expression, while speaking clearly at a normal volume keeps words distinct without distortion. Shouting can distort sound and appear aggressive, and using complicated medical terms creates confusion rather than clarity. The resident has the right to be addressed directly, so involving family instead of the resident takes away their independence and dignity. Good communication means making sure the resident can see you, keeping your tone natural, and checking that they understood the message.

A) Shout loudly into the resident's ear

Shouting can distort speech, sound harsh, and startle or upset the resident, and it does not improve understanding for someone with hearing loss. It may seem helpful to raise your voice when someone cannot hear, but volume alone does not solve the problem and can even make words harder to understand.

C) Use complex medical terminology to ensure accuracy

Complex medical terms confuse most residents and do not help someone with hearing impairment understand the message. Accuracy comes from clear, simple words, not technical language, so this approach works against effective communication.

D) Speak to the resident's family member instead of the resident

Speaking only to family members ignores the resident and takes away their right to be included in their own care. It may feel easier to get information across through a relative, but it undermines the resident's dignity and independence, and the resident should always be addressed directly when possible.

Conclusion

For a resident with severe hearing impairment, face them, speak clearly in a normal tone, and confirm understanding. Avoid shouting, jargon, or talking around the resident, and always treat them as the primary person in the conversation.

60. To prevent pressure ulcers, how often should a CNA reposition a bedbound resident?

A. Every 1 hour

B. Every 2 hours

C. Every 4 hours

D. Only when the resident requests to be moved

Answer: B. Every 2 hours

Repositioning a bedbound resident at least every 2 hours is the standard practice to prevent pressure ulcers.

Pressure ulcers form when constant pressure on one area cuts off blood flow to the skin and underlying tissue. Turning and repositioning the resident at least every 2 hours relieves that pressure and lets circulation return to the skin. CNAs should follow the care plan, which may call for more frequent turns for residents at higher risk, and should check the skin at each turn for redness or breakdown.

A) Every 1 hour

Turning every hour is more often than needed for most residents and can disturb rest and sleep. It may seem like extra caution, but routine turning schedules are based on tissue tolerance, and hourly turns are usually reserved for specific high-risk situations ordered by the care team.

C) Every 4 hours

Waiting 4 hours leaves pressure on the same areas long enough for skin damage to begin. This option can seem reasonable because it is less disruptive, but the interval is too long for routine prevention in a bedbound resident.

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D) Only when the resident requests to be moved

A bedbound resident may not feel pressure or may be unable to communicate discomfort, so relying on requests allows harmful pressure to build up unnoticed. This choice seems respectful of the resident's wishes, but prevention requires a scheduled turning routine.

Conclusion

Remember that routine repositioning at least every 2 hours, along with skin checks, is a core CNA responsibility for preventing pressure ulcers in bedbound residents.

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