Promotion of Safety CNA Practice Test

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1. Transmission modes of infectious disease include:

A. airborne & isolation

B. droplet & disinfection

C. contact & isolation

D. airborne & droplet

Answer: D. airborne & droplet

Airborne and droplet are both recognized transmission modes of infectious disease.

In infection control, germs spread from one person to another through several routes. Airborne transmission happens when tiny particles stay suspended in the air and travel long distances, such as with tuberculosis or measles. Droplet transmission happens when larger droplets from coughing, sneezing, or talking land on nearby surfaces or a person's eyes, nose, or mouth, such as with influenza. Contact transmission is another mode, but it is not paired with airborne in the correct option. Knowing these routes helps the CNA choose the right precautions and protect residents and staff.

A) airborne & isolation

Airborne is a true transmission mode, which makes this option tempting. Isolation, however, is a precaution used to prevent spread, not a way germs travel. Mixing a mode of transmission with a control measure makes this pairing inaccurate.

B) droplet & disinfection

Droplet is a real transmission mode, so this choice can look appealing. Disinfection is a cleaning process that kills germs on surfaces, not a route of transmission. Pairing a mode with a cleaning step does not answer the question.

C) contact & isolation

Contact is a genuine transmission mode, which may draw attention. Isolation is again a precaution rather than a transmission route. This option combines a correct mode with a control measure, so it does not fit the question.

Conclusion

Focus on the word "transmission modes" and look for two routes of spread, not precautions or cleaning methods. Airborne and droplet are both routes, while isolation and disinfection are actions taken to stop spread.

2. When the nurse aide is completing a task that requires gloves, the proper procedure for replacing a client's call light before leaving the room is to:

A. remove the gloves and wash hands before placing the call light within the client's reach

B. clean, dry, and store equipment, and then place the call light within the client's reach

C. place the call light within the client's reach as soon as the task is completed

D. adjust the client's bed to the low position, remove the gloves, and place the call light within the client's reach

Answer: A. remove the gloves and wash hands before placing the call light within the client's reach

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Removing gloves and washing hands before placing the call light within the client's reach keeps the client safe and prevents the spread of germs.

Gloves can carry germs from the task you just finished, so they must come off and hands must be washed before you touch anything the client will use. The call light is something the client handles directly, which makes clean hands especially important. Placing the call light within reach also protects the client from falling or straining while trying to get help. Doing these steps in the right order protects both the client and the aide.

B) Clean and store equipment first

Cleaning and storing equipment is part of good care, but it does not address the germs on your gloves before you handle the call light. This choice may seem organized and thorough, yet it skips the hand hygiene step that protects the client.

C) Place the call light right after the task

Reaching for the call light while still wearing contaminated gloves can transfer germs to a surface the client will touch. It feels efficient because the client gets the call light quickly, but speed does not replace proper infection control.

D) Lower the bed, remove gloves, then place the call light

Lowering the bed is a good safety habit, and removing the gloves is a step in the right direction, but hand washing is missing before the call light is handled. This option looks complete because it includes several safety actions, yet it leaves out the key hygiene step.

Conclusion

Remember the order: remove gloves, wash hands, then handle items the client will touch, and always make sure the call light is within reach before leaving the room.

3. A restraint should be used only:

A. for safety

B. to control hitting

C. with physician order

D. to prevent falls

Answer: C. with physician order

A restraint should be used only with a physician order.

Restraints limit a person's freedom of movement and carry real risks, including injury, circulation problems, and emotional distress, so they are never a casual or routine choice. In nursing facilities, restraints require a specific order from the physician or licensed provider, along with ongoing monitoring, regular release for movement and care, and frequent reassessment. The CNA's role is to follow that order exactly, check on the resident often, and report any changes or problems to the nurse. Keeping residents safe usually means trying less restrictive approaches first, such as meeting unmet needs, adjusting the environment, or increasing supervision.

A) For safety

Safety is a broad goal, not a justification on its own. Many safe alternatives exist, and staff cannot apply a restraint simply because they believe it protects the resident. This option feels tempting because safety is the reason restraints are sometimes considered, but the decision and authorization must come from the provider.

B) To control hitting

Behavior such as hitting is a signal that something is wrong, like pain, fear, or confusion, and it calls for assessment and a care plan rather than automatic restraint. Staff cannot restrain a resident to manage behavior on their own. This choice seems practical in a stressful moment, yet it skips the required order and the search for the underlying cause.

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D) To prevent falls

Restraints do not reliably prevent falls and can actually increase injury risk when residents try to climb out or struggle against them. Fall prevention relies on assessment, environmental changes, and supervision, not on tying a resident down. This option is tempting because falls are a major concern, but it still requires a provider's order and should never be a first response.

Conclusion

Remember that a restraint is a serious intervention that needs a physician's order, frequent monitoring, and regular reassessment. When a question asks when restraints may be used, look for the answer that names proper authorization rather than a general goal like safety or fall prevention.

4. A resident suddenly cannot speak and appears to be choking. What is the most appropriate immediate nursing action?

A. Begin cardiopulmonary resuscitation (CPR) immediately.

B. Deliver four forceful back blows.

C. Perform abdominal thrusts (Heimlich maneuver).

D. Elevate the head of the bed.

Answer: C. Perform abdominal thrusts (Heimlich maneuver).

A resident who suddenly cannot speak and appears to be choking should receive abdominal thrusts (the Heimlich maneuver) right away.

When a resident suddenly cannot speak, cough, or breathe, the airway is likely blocked by a foreign object, and this is a life-threatening emergency. The Heimlich maneuver pushes air out of the lungs to force the object out. As a CNA, you should stay with the resident, call for help or activate the emergency response system, and begin abdominal thrusts according to your training and facility policy. Continue until the object comes out or the resident becomes unresponsive, at which point CPR would begin.

A) Begin CPR immediately

CPR is for a resident who is unresponsive and not breathing normally. This resident is still conscious and showing signs of a blocked airway, so starting chest compressions before the person is unresponsive would not clear the obstruction and could cause harm. CPR becomes the right step only if the resident loses consciousness.

B) Deliver four forceful back blows

Back blows are sometimes used in choking protocols, but they are not the first-line action taught for a conscious adult in most CNA training, and the number and technique vary by protocol. Reaching for back blows instead of abdominal thrusts can delay the most effective maneuver for clearing an adult airway.

D) Elevate the head of the bed

Raising the head of the bed may help with breathing comfort in some conditions, but it does nothing to remove a foreign object blocking the airway. Choosing this action would waste critical seconds during a true choking emergency.

Conclusion

For a conscious resident who suddenly cannot speak and appears to be choking, abdominal thrusts are the priority action. Remember that CPR applies only once the resident becomes unresponsive, and always call for help while you act.

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5. Which of the following requires a primary health care provider's order?

A. Wheelchair cushion

B. Afternoon snack

C. Restraints

D. Hand roll

Answer: C. Restraints

Restraints require a primary health care provider's order before use.

Applying any physical restraint limits a person's freedom of movement and carries real risks, such as pressure injuries, circulation problems, and distress. Because of these risks, restraints are treated as a medical intervention rather than a routine comfort measure. A primary health care provider must assess the resident and write an order, and the care team must follow facility policy, monitor the resident closely, and release the restraint regularly. A CNA never applies a restraint without that order and the required monitoring in place.

A) Wheelchair cushion

A cushion is a comfort and positioning item that helps protect the skin and support posture. Choosing and placing a standard cushion falls within routine nursing care and does not need a provider's order, which makes it an appealing but mistaken choice for this question.

B) Afternoon snack

Offering a snack is part of routine daily care and nutrition support, often guided by the care plan or dietitian rather than a provider's order. It may seem like something that needs approval, but it does not carry the risks that require a medical order.

D) Hand roll

A hand roll is a positioning device used to keep the fingers in a natural, comfortable position and protect the skin. It is a comfort measure carried out under the care plan, so it does not require a provider's order even though it involves positioning the resident's body.

Conclusion

Remember that restraints are a medical intervention with serious risks, so they always need a provider's order and close monitoring. Comfort items and routine care measures, such as cushions, snacks, and hand rolls, do not require that level of authorization.

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