CERTIFIED NURSING ASSISTANT (CNA) TRAINING EBOOK WITH PRACTICE EXAM
Answer Key Included

INDUSTRY OVERVIEW FOR A CERTIFIED NURSING ASSISTANT

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The healthcare industry is rapidly expanding, and along with this expansion comes several rewarding career opportunities. One healthcare related career is in the area of direct caregiving. This career is known by several names, among them 'Certified Nursing Assistant' (usually applied to caregivers in a nursing home or hospital setting), 'Personal Care Attendant' (term often used for caregivers in an Assisted Living Facility) , and 'Home Health Aide' (direct caregiving provided in patients' homes).

As the elderly population grows, so does the need for qualified caregivers. While Personal Care Attendants, Home Health Aides and Certified Nursing Assistants perform basically the same function, these terms carry with them implications of where the jobs are performed. By understanding what a Certified Nursing Assistant is, you can apply the job description and particulars to other caregiving careers.

Certified Nursing Assistants provide hands on care to those who are unable to care for themselves. This includes bathing, dressing, feeding and toileting patients, among other things. The C.N.A. ensures the safety and comfort of patients entrusted to their care. They are primarily under the direction of a nurse, and as such, are responsible for carrying out duties as assigned by the nurse, as well as reporting changes in a patients physical or mental status to the nurse. Certified Nursing Assistants can be found working with the elderly, or with children...and every age in between!

To become a Certified Nursing Assistant, or 'C.N.A'., most states require a training class and certification. This training class varies in length, depending on where you enroll. The Red Cross has a reputable C.N.A. training class. (The price may vary in your area, contact the Red Cross for more information). Enrollment in most training programs does not require previous experience, and some do not require a high school diploma.

Often, long term care facilities will offer paid training classes. These classes generally are held on site, and the classroom time lasts, on average, two weeks. The facilities that offer these training classes usually include this information in a classified advertisement. When applying for a job at a facility advertising free training classes, be sure to read the fine print. Some facilities require that you commit to work for them for a certain length of time after acquiring certification.

The C.N.A. training classes are generally taught by a Registered Nurse. The classes cover a broad range of topics, ranging from how to bathe a patient, to positioning a patient properly. You will learn about abuse and neglect, how to feed and dress a patient, proper body mechanics for lifting and turning patients. Usually, the teacher will

also touch on topics such as recognizing depression, dealing with dementia, infection control issues, and catheter care. There is much to learn, and the classroom time is generally split into two parts; facts and textbook learning, and hands on care.

At the end of the training class, a test will be administered to determine competency. This test consists of two parts, written and clinical. The written test is made up of basic caregiving questions, all of which should have been covered during the classes. The clinical test consists of performing five nursing duties under the watchful eye of the person administering the test. (This person is usually a highly qualified RN sent from the State). The duties you may be asked to perform can be anything from giving a bedpan to weighing a patient. The important thing to remember, during this test and always, is patient dignity. Some of the things the person administering the test will be looking for is whether you wash your hands properly, and whether or not you remember patient dignity by knocking on the door, pulling the privacy curtain, and explaining each procedure to the patient before performing it. In a real life caregiving setting, these are all important factors and will contribute greatly to your success as a C.N.A.

After passing the exam and becoming certified, be patient with yourself as you begin your new career! Being a C.N.A. is not an easy job, and anyone who has been doing it for any length of time will remember the difficulties they faced in the beginning. One of the most difficult aspects of the job is trying to complete your assignment before lunchtime! This takes some getting used to . Organization is key! The typical patient care assignment can consist of anywhere between seven and fifteen patients to tend to, all with individual needs. You will have to learn to prioritize, and make the most of every minute. Teamwork is also very important in this job, don't be afraid to ask for help from your coworkers.

One of the prime benefits of choosing this career is simply the satisfaction of helping others. Being a Certified Nursing Assistant is one of the most rewarding jobs out there, although not the highest paid! The average starting pay for C.N.A.'s varies greatly across the country, however, it is generally fairly low. Most companies offer opportunities to increase your pay, for example, after you have worked as a C.N.A. for a while, you might wish to become a preceptor, which is a C.N.A. who trains new C.N.A.'s as they are put on the floor to begin working.

Are you cut out to be a C.N.A.? Among the most prized trait in C.N.A.'s is PATIENCE. This is a job that requires much patience. You will be confronted daily with any number of challenges, whether it is a difficult patient, or having to work short staffed. You will encounter patients who may be demented, and may exhibit verbal or physical abuse towards you. It is important to be able to stay calm, and to learn how to deal with these situations.

As a C.N.A., you are in the ultimate customer service field. Few and far between are jobs which place people so directly and intimately in the lives and space of other human beings.

If you are a 'people person', with patience and compassion, along with a desire to help others, becoming a Certified Nursing Assistant may be just the job for you!

C.N.A REQUIRED SKILLS

The nurse assistant must not only be very skilled in the actual procedures being performed but must also be able to make quick observations of a patient's condition and report that information back to the nurse. Due to time constraints, nurses often do not spend large amounts of time in the room with individual patients, the nursing assistant is known as the nurse's "eyes and ears".

A nurse assistant must also have a strong grasp of emergency procedures and be able to stay calm in stressful situations. They must be able to initiate a Code Blue and be certified in CPR.

Hand washing

Proper hand washing is an important part of nurse assisting. It is the first step in preventing the spread of germs. Hand washing must be performed both before and after contact with a patient. Hands that do not appear soiled can still spread disease. It is important to wash hands even when using gloves as they do not provide an absolute barrier to the transmission of disease.

Ambulation

Ambulation assistance is a set of techniques for helping patients to walk. One example is the use of a gait belt or transfer belt for patients who cannot stand on their own. The gait belt is put around the patient's waist and enables the assistant to lift the patient safely without straining his or her back. It can be used to help patients get in and out of bed, get up from a chair, or enter a walker.

Walkers help the elderly get exercise. Many elderly patients cannot walk on their own due to osteoporosis or other conditions. Exercise promotes movement, helps with circulation, helps the patient heal faster, be in better health, and ultimately have a longer, happier life.

Applying antiembolic stockings

An antiembolic stocking is a device that is used on patients under observation for (or at risk for) circulation problems. It is a high sock which applies pressure on the legs to prevent blood clots. It may also have a hole on the top or bottom of the foot for comfort, and easy access to the feet, so that the nurse assistant doesn't need to remove the sock every two hours to check circulation.

Bedpan use and output measurement

A bedpan is a device that is placed under patients who are unable to get up and use a bedside toilet or go to the restroom. It is used to catch all of the urination and bowel movement. The patient must be properly wiped and cleansed after elimination to prevent infection. The volume of urine is often measured and recorded. If a bowel movement has taken place, that should be noted along with any significant characteristics of the stool.

Oral care

Denture and mouth care is very important in providing proper hygiene for patients. Teeth must be cleaned in the morning and after each meal. This will help prevent tooth decay or gum conditions that could lead to tooth loss. Clean teeth are healthy teeth.

Dressing

For the dependent patients dressing is not an easy task. In fact it is very difficult and needs to be done properly. The best way to ensure that it is done right is to remember that you dress the weak side first so that the patient can help with their strong side, and to undress the stronge side first so they can help you undress the weak side as much as possible.

Feeding

Patients must not be overassisted in feeding or they may stop helping themselves. Assistance should be confined to those parts of the task they cannot accomplish for themselves. For example, a patient who cannot load a spoon but is capable of conveying it to his mouth should be assisted only in loading the spoon. He should convey it to his mouth himself, even if it would be faster for the assistant to do this for him.

Hair care

Providing hair care will help patients feel good about themselves. Long-term-care facilities may have a salon where residents can have their hair done once a week just as they would at home. Hair must be maintained every day as well. Hair should be brushed from roots to ends, and care should be taken to avoid irritating the patient's scalp.

Bedmaking

Bedmaking as practiced by a nurse assistant is a skilled task that must be performed precisely. The bed must be wrinkle-free to prevent bedsores, which not only cause discomfort to the patient but can cause serious health problems. There are specific bedmaking techniques for use when a bed is occupied by a patient.

Nail care

Nail care may not be as important as feeding but nevertheless must be done. Bacteria get in the nail bed and can cause serious infections in elderly patients. It is helpful to soak nails for at least five minutes to help loosen dirt and germs that are lodged in nail beds.

Bedbath

Due to lack of staff, patients may only get a full bath once or twice a week; on other days, patients get bedbaths. This involves cleaning the underarms, body and perineal areas.

Serving water

Fresh ice water should be offered frequently to promote hydration. It is important to encourage drinking, because it is not unusual for elderly patients to be unaware of thirst and thus be easily subject to dehydration.

Positioning

Positioning refers to a set of techniques for changing the posture of a bedridden person in order to avoid health problems such as bedsores. Many states require that bedridden persons be checked and repositioned at intervals of two hours or less.

Range-of-motion (R.O.M) exercises

If not exercised, joints gradually lose their ability to move. Nurse assistants must be able to assist patients in performing a series of range-of-motion exercises that flex the joints of their arms, wrists, legs, fingers, hips, and feet. This aids circulation, prevents arthritis and stiffness, and speeds recovery from such conditions as strokes, seizures, and falls.

Vital signs

Vital signs (such as the patient's temperature, respiration, blood pressure, pulse, and level of pain) are often taken and recorded at least once a day depending on the physician's order. Increasing temperature can indicate infection or other disorder, decreasing temperature can indicate shock or decreased cardiac output; increasing blood pressure may require medical treatment and special diets while decreasing blood pressure may indicate shock or hemorrhage; and irregular, weak, fast, or slow pulse can indicate heart problems. If a patient's vital signs have changed significantly within a short period of time, a double check for accuracy may be warranted. Any unusual findings should be brought to the attention of a supervising nurse or doctor.

The Nursing Process, And The CNA

In my experience working as a CNA in a nursing home, I rarely heard the term “Nursing Process”; I often heard about care plans- but that was about as descriptive as things would get. I remember asking a nurse- “Just what is a care plan, anyway?”- and she didn’t know how to answer me! So I have spent a long time researching this elusive term- “Nursing Process”- and trying to figure out exactly where the CNA fits in with it.

First, the medical team is broken into several layers. At the top is the patient- who has an illness, or condition requiring on going care. The Doctors are next- we all know they are well educated and have spent years learning how to diagnose and treat problems, illnesses, disease ect. Doctors are the only person within the medical team who can actually diagnose. Nurse Practitioners- in reality- cannot DX anything without checking with the MD. Physician Assistants often will see a patient and DX simple problems such as ear infections, but an MD will always go over the PA’s notes to make sure nothing has been missed. Same with Nurse Practitioners- the MD always double-checks the work.

So this brings us to the next point: A patient, client, resident is admitted to a nursing unit. This can be in a hospital, nursing home, rehab center, even to the patient’s own home. Nurses are called upon to perform several steps to assist with the healthful and positive outcomes for these patients. The nursing process is a relatively new thing; in the 1960’s team based nursing came into fashion, but nurses had no way to let other team members know what to do with patients. A process, based upon what scientists use, was developed. Over the years this process has been refined to what we know today.

The nursing process is divided into five steps.

1) Assessment
2) Nursing Diagnoses
3) Planning
4) Intervention
5) Evaluation

Where does the work of the CNA fall here, you may ask yourself? Let’s see if we can find some pretty common things CNA’s are asked to do, that are a part of helping the nurses with this process. It is assumed here that the patient/resident/client has a top level diagnoses from an MD, and a treatment plan is in place from the MD. This plan would include medications, treatments, special diets, procedures ordered by a doctor.

Step One: Assessment
Assessment involves continuous data collection to identify a patient's actual and potential health problems. This data should be as objective as possible, and nurses should be as non-judgmental as possible as well. To perform the assessment, nurses should:

· Get Nursing History from patient
· Perform a physical examination
· Review lab and medical information

The nursing history is mostly subjective data. Often, the patient's perception of his health problems makes up a large portion of the health history. Nurses should find out how the patient coped with a similar illness, what interventions worked, didn't work ect.

A physical exam is the next step. This is where the CNA often assists the nurse. When we are asked to get heights and weights, vital signs, record food/fluid intake and output, it is almost always for the purpose of assessment. Although CNA's do not make assessments, nurses depend upon us to report timely and accurate data. Things we see, smell, hear, feel and touch should be reported.

Nurses should perform a thorough exam by doing the following:

· Body Inspection- observation of patient- direct and indirect
· Palpation- feeling body regions for masses, smoothness, muscle tone
· Percussion-using fingers in a tapping motion to feel for abnormal sounds over body regions
· Auscultation- listening for sounds over body regions such as lungs, bowels...

Nurses are taught skills to perform a physical assessment in their schools.

Step Two: Nursing Diagnoses
Nurses are licensed to identify and treat certain human reactions and potential health problems associated with the illness, disease ect.

As we see, nurses have a huge responsibility when it comes to giving accurate diagnoses of a health/potential health problem. All the care given is based upon the proper Dx, the proper plan of care being written and the right interventions. Based upon all the data collected- both subjective and objective, the nurse next will form a nursing diagnoses drawing from the above list of possible problems.

It is these terms in the list that we will often see when we look at a care plan. It isn't something that comes lightly for nurses- this is one of the big reasons they need a college degree. Assessment is a big part of being a nurse, and it is an even bigger part of what we, CNA's, do. It is absolutely vital that we report back accurate information. The care a patient gets, and hence the outcome of his health, depends upon good sound information.

Step Three: Care Planning

The Care Plan is a term we should all be familiar with. We all should know that the care plan is the bible for nursing care of patients, but what else should we know about this document? It is a legal document promising care being delivered as written; the nurse can get into huge amounts of trouble if her care plan isn't followed. The care plan is designed to assist team members in delivering high quality, consistent care that is needed. Time spent performing tasks and care that is not needed results in wastes of money, resources. Effective care plans take into account unit staffing patterns, patient wishes and abilities, and should reflect who the patient is. A good nurse will seek the opinion of the CNA when writing the care plan. CNA's can offer invaluable insights into the patient's abilities and desires. All facilities should encourage CNA participation in care plan conferences.

Cookie cutter care plans are easily recognizable:

· They have the same nursing Dx
· They have the same interventions for all patients (seen often in nursing homes, where all residents have been known to be on a two hour bladder program)
· They don't work!

A good care plan will be specific, realistic, clear and brief. It doesn't need to be a long novel.

Anyone who is expected to deliver care from a care plan should be able to read the plan and understand it, including the patient when applicable, as well as the patient's family.

Step Four: Interventions

This is where the CNA really comes into play! Often, the interventions are WHAT we do. All that turning, repositioning, toileting- are all interventions listed in the care plan. Also, a great amount of the documenting we do is designed to assist the nurse with evaluating these interventions. So it really makes sense to document accurately- in time- if an intervention IS NOT working, it will be noted (and perhaps removed from future care plans). Interventions can be anything from special baths to back rubs to repositioning, to toileting, to using special creams and lotions, to offering certain

supplements. Often, an intervention must have an MD order along with it. This is kind of strange I think- if nurses are allowed to formulate their own Dx then they shouldn't need an MD's order to carry out some of the treatments to reach the goals. The most important part a CNA can play in this intervention stage is to accurately report all reactions to the interventions. Be as specific and objective as possible.

Step Five: Evaluation

This is the final step in the nursing process. This is the time when nurses look at their care plans and check to see if the plan has "worked" in solving the patients' health issues, concerns, ect. As stated before, a good plan will work and a poor plan will not. Nurses will check to see if the interventions have been effective- they look at subjective as well as objective data. This is when they will see your good documentation! For example, if a patient were incontinent, and the patient wasn't so until recent illness, the nurse might try a timed program approach to help the patient gain control again. IF the initial voiding assessments, done by the CNA, were not accurate (i.e.- CNA just wrote in times she guessed patient voided)- and the nurse put the resident on a two-hour program…when patient actually needed to go every hour- you can see how this intervention would fail.

The nursing process doesn't end here- it continues until the patient is discharged or passes on or whatever. Sometimes a patient goes home with a care plan, and this is especially challenging for staff. If the nurse never saw the home environment, then chances are good that the care plan won't work. Usually home health nurses do the plans for this population.

Some thoughts to Ponder…

As I said in the beginning of this page, I never knew what the nursing process was. I still have my books from my CNA classes, and I have several newer additions. It wasn't until very recently that CNA's were taught this process. This is too bad. I fear there are too many CNA's out there who do not have a clue how important their work is. All the work, the documenting- would certainly take on a new meaning if CNA's really understood their role, within the nursing process, as a whole. It would make a good in-service for any facility to offer: Nursing Process- What Is it?

Even of greater concern for me is the apparent lack of concern on the part of nurses who are charged with this process. Never mind those who don't seem to know what it is, but what about those who DO know, yet follow their own approaches to deliver care. Hmm. I challenge all CNA's to hold their nurses up to the standard when it comes to the Nursing Process. Afte rall, if our work is to have any meaning at all, then the Process should be the standard. When a new patient is admitted onto a unit you work on, watch to see if a complete physical assessment is done by the nurse; see if any of the things you are asked to do may have a part in the assessment. Ask questions. Expect

answers that make sense to you. A lot is at stake here, the patient's well being. See if all your good documenting is worthwhile. Ask the nurses what will become of the notes you have written- those flow sheets should become a tool, not some paper put into a chart.

See if the system really works, or if it is just another process that is meaningless.

Legal Issues for CNA's

Legal Standards

These are guidelines to lawful behavior. When laws are not obeyed you can be prosecuted and found liable (responsible) for injury and damages. Legal guilt can result in fines and imprisonment, as well as loss of certification/license to work as a CNA.

Laws are passed by local, state and federal governments. All citizens are expected to obey these laws…when you disobey a law you are liable for fines and/or imprisonment. CNA's can avoid this by:

• Knowing and staying within their state's scope of practice rules.

• Do only those tasks and skills you have been taught; if you're asked to do tasks you have not been trained to do ask for guidance (and if necessary seek the advice of your supervisor).

• Carry out your tasks and procedures carefully and only as you were taught.

• Keep up to date with your skills and education and in-service requirements.

• In questionable situations, seek the advice of your supervisor.

• Make sure you fully understand your assignment and what is expected of you

• Know your facility policies and procedures and follow them.

• Do no harm to your patients.

• Respect the personal property of your patients

Legal Definitions and Examples

As a CNA the legal issues you might encounter and witness would be negligence, theft, defamation, false imprisonment, assault, battery and abuse. You need to understand what these are.

Negligence:

The failure to provide a degree of care that others would consider reasonable under the circumstances; when injury results to your patient. Negligence is often caused by rushing around to get your work done and by not thinking FIRST.

• YOU give a patient a bath…and don't check the water temp first. The patient is burned.

• YOU place a tray of food in front of a patient and don't check the menu; the tray belonged to another patient. The patient who got the tray eats the wrong consistency food and chokes.

• YOU transfer a patient by yourself even though the care plans states two staff should be present for the transfer. You drop the patient.

Theft

One would think this is pretty simple. It should be but often isn't. Taking ANYTHING that doesn't belong to you is considered theft. It doesn't matter how cheap or expensive the item is. When you see another person take something that isn't their's, and you fail to report this, you are guilty of aiding and abetting the crime. Keep your standards high. We need all the honest people we can get in this work- don't be scared or indifferent to report theft you witness. I've seen aides take wash clothes, briefs, deodorants, soaps ect from their facility (for their own personal use at home). I've also seen aides steal jewelry and clothing from patients. It's NEVER acceptable to do this. EVER.

Defamation

This means making statements about another person, either verbally (slander) or in writing (libel) when the character of that person is injured. Examples would be you telling a co-worker wrongful and inaccurate information about patients. I've seen this happen: We had an admission coming and the chart was available to all of us. The patient had Crohn's Disease. One of the aides I worked with at that time went around and told everyone this patient had C-Diff. Not a good thing to do. Unless you know something to be actual fact, (and even then make sure you hear it from a reliable source), keep your mouth SHUT. And never put anything like this in writing.

False Imprisonment

This is an area many nursing staff have trouble understanding. It's not just about restraints. It's about a mindset. It is defined as restraining a person's movements or actions without the proper authorization. Patients have rights and we must respect these rights. In the hospital setting, a patient CAN leave the hospital without a doctor's permission. They can also leave a nursing home/assisted living home. Under very few circumstances can we interfere with this right. If you do, it's called false imprisonment.

Physical Restraints

Using them requires a doctor's order. Threatening to use them is considered false imprisonment.

Physical restraints are defined as any manual or physical device, material, or equipment attached to or near to the patients body, that:

- A patient cannot easily remove
- Restricts movement of ANY and ALL body parts
- Restricts the patient from accessing their own body or parts of their body

Examples of physical restraints:

- Wrist, Arm, Leg and Ankle restraints
- Vests
- Jackets
- Hand Mitts
- Geri chairs, recliners
- Seatbelts, safety belts
- Bed rails and the pads sometimes used on them
- In some populations the use of certain clothing would be considered a restraint: For example, donning a one piece undershirt on a child to prevent him from having access to his body. Or, a long sleeved shirt to prevent access to an IV site.

Also, many practices are considered a restraint. When a patient doesn't have the physical strength to remove a device it is a restraint.

- When a patient doesn't have the strength to sit up from a low rise sofa, for example, this practice is considered a restraint.
- Tucking in blankets and sheets so tightly the resident cannot move is considered a restraint. Using Velcro and tape to secure sheets is also a restraint.
- A lap tray being used with a wheelchair is a restraint if the patient cannot remove it.
- Using recliners and Geri chairs, tilted back, is a restraint.
- Moving chairs and beds so close to a wall that it prevents a patient from rising is a restraint.
- Placing a patient up into a table so close they cannot move their chair is a restraint.

In short, any action or device (designed for the sole purpose or something put together by you) that prevents the free movement of body parts is a physical restraint. Some patients require splints and other appliances to maintain alignment and posture. These are restraints as well, but are often referred to as enablers because they assist the patient with ADL's. The patient may not be able to remove the splints, but it's not an overt restraint. An MD order is always in place for these items.

Many medications are considered restraints. This is called chemical restraining and it is a very different thing than physical restraints. Nurses and doctors must understand the ramifications of using meds to induce sleep, states of relaxation, pain control that could be considered restraining activity.

Assault and Battery

There is some confusion about the meanings of these terms. Assault means purposely attempting to touch the body of another person without their permission, and threatening to do so. Battery is when you actually doing this. These terms are not all about hitting and hurting patients like so many of us have been taught. Every task we perform is done so with the patient's informed consent. This means the patient needs to know what it is we want to do, why, the benefits of the task-and they have to agree to it.

Informed consent can be withdrawn at any time and we must honor this. More and more patients are taking their healthcare into their own hands these days, and many will question the value of treatments. In spite of our best efforts to explain the need for treatments, the patient always retains the right to refuse. If you continue with the treatment you are guilty of battery. And threatening to get the nurse or others to assist you with said treatments is battery as well. You must report to the nurse any and all refusals of care by your patients, but do so quietly and not within hearing distance of the patient. Let the nurse handle the situation from this point forward.

To avoid being charged with battery:

- Tell the patient what you plan to do
- Make sure the patient understands what you're saying
- Asking the patient if they have any questions or concerns
- Allowing the patient some time to think about this
- If the patient refuses, don't push the issue. Quietly report the refusal to the nurse and document facts only.
- NEVER carry out the refused treatment

In our work we will come across a lot of coercion- which is forcing a patient to do something against their will. Unfortunately, it's a problem within nursing in general. We always think we know what is best. This happens more with patients who are confused,

mentally incapacitated or those with dementia. Almost always, these patients are not their own legal guardian, their family is. This makes it difficult for us to do our job at times because the patient is still refusing the care but we have to do it anyway- because the family has consented on behalf of the patient. It's ALWAYS best to try to get the patient to cooperate with us vs. a full struggle. It really helps to wait and come back later when a confused patient refuses care. They tell us to always assume the patient would want our care if they were not confused so we have to think of things differently. It's a hard spot to be in.

Abuse

Abuse: Doing harm to a patient. Abusing a patient is ethically wrong as well as legally wrong. Ethical standards require us to do no harm and legal standards enforce this through laws. There are severe penalties if you're found guilty.

Abuse is defined as the act (or failure to act) that is non accidental and causes or could cause harm or death to a patient. It's not just about hitting here. It's also about mental abuse, verbal abuse and other more subtle forms. **Abuse comes in many shapes:**

- Physical
- Verbal
- Emotional
- Sexual
- Involuntary seclusion

Physical Abuse:

- Handling the patient roughly
- Hitting, slapping, punching, kicking, pinching a patient
- Performing the wrong treatment on the patient

Verbal Abuse:

- Swearing when you're dealing with the patient
- Raising your voice, yelling
- Calling the patient unpleasant names
- Teasing the patient
- Embarrassing the patient at anytime
- Using gestures
- Making threats
- Use of inappropriate words/terms to describe a patient's race or nationality

Sexual Abuse:

Using physical means and verbal threats to force patients to perform sexual acts. In most states sexual abuse is ANY behavior that is seductive, sexually demeaning, harassing. As with Sexual Harassment policies, this harassment need only be considered as such by the patient without regard to your intentions. Be careful. THINK

before your interactions with patients (and everyone else for that matter). Be considerate of your patient's values and morals.

Emotional/Psychological Abuse:

THIS can be the worst kind of abuse because it's typically ongoing and subtle.

- Causing a patient to be afraid of you (through threats, actions, attitude, and body language)
- Threatening the patient
- Threatening to withhold treatment
- Threatening to tell others about the patient's condition
- Making fun of the patient
- Belittling the patient (and this would include all those cute little nicknames we tend to have)
- Calling the attention of others to the patient's behavior.

Involuntary Seclusion

I see this happen a lot in nursing homes. A resident is being noisy and disruptive so we remove them to another area. This is another one of those hard spots to be in- trying to balance the needs of the larger group of residents without violating the rights of one. A good care plan, communication with everyone, documentation and other interventions should really be in place to prevent the resident from having outbursts in the first place. The nurse should always be the one who directs you to remove a resident. Don't ever make this decision on your own.

Other forms of involuntary seclusion:

- Closing the door to the patient's room when they want it kept open
- Placing a patient in a wheelchair away from others
- Leaving a patient without a means to communicate- removing the call bell for example

Abuse by Others

There are times when we will witness another CNA or nurse do harm to a patient, as described above in all the various forms. Often the CNA/nurse will not realize they are doing these things. It doesn't matter whether she knows better or not. The abuse MUST be reported. As soon as it occurs, not at the end of the shift, the next day or next week. All healthcare workers are required by law to report actual or suspected abuse. When you don't report, you're just as guilty.

Sometimes it is a member of the patient's family who abuses them. This is difficult to see happen, to suspect is happening. Again if you suspect this you are required to report it to the nurse. I've seen nursing home residents go out on a day trip with a family member and return to the facility with bruises and cuts; or with complaints of hunger and thirst. These things caused me to suspect some sort of abuse or neglect and I reported the findings to the nurses. I made sure they came down and looked at the bruises and cuts firsthand as well.

Neglect

Neglect is failing to provide the services, care and treatments necessary to avoid physical harm, mental anguish or mental illness. Neglect can be intentional or unintentional. Neglect is against the law no matter what. CNA's are not expected to decide if neglect has occurred- that is the nurses job. However, you must report signs of neglect. Some examples of neglect we might see on the job:

- Routine hygiene and care not being provided. Patients not being repositioned, bathed, toileted, ROM exercises not being performed according to the care plan.
- Patients not being given enough time to eat
- Patients not being offered water and snacks

Invasion of Privacy

This is an area where every CNA should put themselves in the patients' shoes. Would you like it if someone went around talking about your medical condition to anyone? How would you feel if you were in a hospital room and the nurse came in, started to do a treatment without closing the privacy curtain? You wouldn't like these things at all. Most people don't. Every patient has a right to expect their medical information will be kept confidential and that only those who NEED to know will have access to this information.

Certified Nursing Assistants

Taking the CNA Exam

So, you're now waiting to take the State exam to receive your certification! While most CNA's experiences with taking the test vary slightly, the one thing everyone seems to have in common is nerves!

The test is made up of two parts, written and clinical. You will most likely be asked to bring someone with you to the test who will act as a 'model' for you to demonstrate your clinical skills on. The written portion of the test is mostly common sense. If you were given handouts or a book during your CNA classes, it would be a good idea to review. Additionally, I have listed several books at the bottom of this page which you may find useful. The part of the test that most people dread is the practical part. Most people are very nervous, due to the fact that someone will be watching your every move. Keep in mind that the State examiner has done this countless times. He or she will know you are probably nervous and will take that into consideration, to some extent.

While taking the practical portion of the test, you will be asked to demonstrate anywhere from three to five Nursing Assistant skills. The following is a sample list of skills you may be asked to demonstrate, as well as important things to remember.

First of all, at the very beginning, when you are asked to perform a skill, if you haven't already demonstrated handwashing proceed to the sink and follow the correct procedure for handwashing.

*** HAND WASHING**: Let down some paper towel before beginning, turn the water on, use a fair amount of soap, scrub hands up to wrists and under fingernails for at least 20 seconds, tear off paper towel, dry hands and use the paper towel to turn off water. Although these steps may seem detailed and petty, the examiner will be watching for each of them, so don't cut corners! Another tip; keep fingernails trimmed. Long nails harbor germs, and may be a red flag to the examiner.

*** PRIVACY:** Before performing any skills, BE SURE TO KNOCK ON THE PATIENT'S DOOR BEFORE ENTERING ROOM! When I took my test, we started in the bathroom with the handwashing task, so just to be sure I covered all my bases, as we were leaving the bathroom to approach my 'patient', I knocked on the bathroom door as I came out and mentioned to the examiner that if I were entering the room from the hallway, I would knock on the door first.

Another important step they will be looking for, ALWAYS PULL THE PRIVACY CURTAIN CLOSED WHEN PERFORMING CARE! Which brings me to the issue of dignity.

***DIGNITY:** As mentioned above, always be sure to knock before entering, and pull the privacy curtain closed to ensure privacy. Additionally, before performing care, introduce yourself and be sure to announce each step to the 'patient' before you do it. (ex: "Now I'm going to turn you over on your side.") Speak to the patient in a dignified manner, NO "HONEY", "DEAR", "SWEETY" etc. Although as CNA's we often fall into the habit of calling our patients by endearing names, the State examiner will consider it undignified and unprofessional.

CAREGIVING SKILLS

A few things to remember:

~Be sure you put gloves on before performing any kind of care that would require gloves (contact with body fluids).

~The State examiner will be very aware of your attention to the patient's dignity, privacy and safety.

~Think through what is being asked of you. If the State examiner tells you that your 'patient' is a stroke victim with left sided paralysis, then he/she tells you to get them out of bed, think, which side will they transfer to? Where will you put the wheelchair? (*Always be sure to lock the wheelchair and always use a gait belt with trasfers!)

Some skills that the State examiner may ask you to demonstrate:

GIVING A BEDPAN: Be sure to put it in the right way! (Remember you will most likely be nervous!) Remember to pull the privacy curtain, roll the head of the bed up slightly (or however you learned it in CNA classes), leave the patient with a roll of toilet paper and leave the call light within reach. Ask if they are comfortable, tell the patient you will be back to check on them and tell them they can ring the call light when they are finished. Leave the privacy curtain around the patient. When you come back, knock before entering and be sure to give the patient the opportunity to wash their hands.

REPOSITIONING A PATIENT IN BED: Tell the patient you are going to roll them BEFORE you do it. Be sure the siderails are up for safety! (*if the patient doesn't have an order for siderails, be sure to put the siderails down before leaving)Try to roll gently and smoothly. Once the patient is repositioned, place a pillow or neatly folded pad or blanket between their knees for comfort. Be sure the pillow under their head looks straight and comfortable, and straighten out the covers. Place the call light within reach (the call light is VERY important--always be sure it is within reach!) Ask if the patient is comfortable before leaving.

GROOMING: You may be asked to comb your patient's hair, or clean their fingernails. If you are asked to comb their hair, I suggest that you first ask them, "How do you like your hair?" A girl in my CNA class failed the entire exam for not asking that simple question.

TAKING A TEMPERATURE: This is pretty straightforward. If you're using an oral thermometer (and be sure it IS an oral thermometer. If the end is red, it is a rectal thermometer!)
Gently shake down the mercury before beginning, to ensure an accurate reading. 98.6 is 'normal', although some people will regularly run higher or lower.

OCCUPIED BED, COMPLETE BED CHANGE: Try to keep patient covered as much as possible. DO NOT THROW DIRTY LINEN ON THE FLOOR AT ANY TIME!

You will be told at the end of the exam whether or not you passed. Different states have different rules as to how many times and how often a person can re-take the test, so if you don't pass the first time, ask about taking it again

CERTIFIED NURSING ASSISTANT (CNA) PRACTICE EXAM

Nursing Assistant Content Outline

The Written Examination is comprised of seventy (70) multiple-choice questions. Ten (10) of these questions are pre-test (non-scored) questions on which statistical information will be collected.

The Oral Examination is comprised of sixty (60) multiple-choice questions and ten (10) word recognition (or reading comprehension) questions.

I. Physical Care Skills

A. Activities of Daily Living . . . . . 7% of exam *(4 questions)*

1. Hygiene
2. Dressing and Grooming
3. Nutrition and Hydration
4. Elimination
5. Rest/Sleep/Comfort

B. Basic Nursing Skills . . . . . 37% of exam *(22 questions)*

1. Infection Control
2. Safety/Emergency
3. Therapeutic/Technical Procedures
4. Data Collection and Reporting

C. Restorative Skills . . . . . 5% of exam *(3 questions)*

1. Prevention
2. Self-Care/Independence

II. Psychosocial Care Skills

A. Emotional and Mental Health Needs . . . . . 10% of exam *(6 questions)*

B. Spiritual and Cultural Needs . . 3% of exam *(2 questions)*

III. Role of the Nurse Aide

A. Communication . . . . . 10% of exam *(6 questions)*

B. Client Rights. . . . . 15% of exam *(9 questions)*

C. Legal and Ethical Behavior . . . .5% of exam *(3 questions)*

D. Member of the Health Care Team . . . . . .8% of exam *(5 questions)*

Name:_____ Date:_____

Nurse Aide Practice Written Exam

1. **What is the term for a device used to take the place of a missing body part?**

   (A) Pronation
   (B) Abduction
   (C) External rotation
   (D) Prosthesis

2. **When a client has left-sided weakness, what part of a sweater is put on first?**

   (A) Both sleeves
   (B) Left sleeve
   (C) Client's choice
   (D) Right sleeve

3. **It is appropriate for a nurse aide to share the information regarding a client's status with:**

   (A) any one the nurse aide sees fit
   (B) the client's family members
   (C) the client's roommate
   (D) the staff on the next shift

4. **When helping a client who is recovering from a stroke to walk, the nurse aide should assist:**

   (A) on the client's strong side
   (B) on the client's weak side
   (C) from behind the client
   (D) with a wheelchair

5. **The nurse aide is caring for a client who is agitated. The nurse aide SHOULD:**

   (A) speak loudly so the client can hear the instructions
   (B) ask to reassign the care of this client
   (C) talk in a slow, calm, reassuring manner
   (D) tell the client to be quiet

6. **The purpose for padding side rails on the client's bed is to:**

   (A) use them as a restraint
   (B) have a place to connect the call signal
   (C) protect the client from injury
   (D) keep the client warm

7. **Exercises that move each muscle and joint are called:**

   (A) adduction
   (B) range of motion
   (C) abduction
   (D) rotation

8. **How can the nurse aide BEST help a client who is not accepting a loss?**

   (A) Leave the client alone
   (B) Convince the client to accept the loss
   (C) Encourage the client to talk
   (D) Discourage individual activity

9. **The Heimlich maneuver (abdominal thrust) is used for a client who has:**

(A) a bloody nose
(B) a blocked airway
(C) fallen out of bed
(D) impaired eyesight

10. **To BEST communicate with a client who is totally deaf, the nurse aide should:**

(A) smile frequently and speak loudly
(B) smile often and talk rapidly
(C) avoid eye contact
(D) write out information

11. **The nurse aide is asked by a confused client what day it is. The nurse aide should:**

(A) explain that memory loss is natural and the date is not important
(B) ignore the request
(C) point to the date on a calendar and say the date
(D) provide the date and then test the client later

12. **To avoid pulling the catheter when turning a male client, the catheter tube must be taped to the client's:**

(A) bed sheet
(B) upper thigh
(C) bed frame
(D) hip

13. **A nurse aide can assist clients with their spiritual needs by:**

(A) taking clients to the nurse aide's church
(B) allowing clients to talk about their beliefs
(C) avoiding any religious discussions
(D) talking about the nurse aide's own spiritual beliefs

14. **A nurse aide MUST wear gloves when:**

(A) feeding a client
(B) doing peri-care
(C) giving a back rub
(D) doing range of motion

15. **When getting ready to dress a client, the nurse aide SHOULD:**

(A) get the first clothes the nurse aide can reach in the closet
(B) give the client a choice of what to wear
(C) use the clothes the client wore the day before
(D) choose clothes that the nurse aide personally likes

16. **If the nurse aide discovers fire in a client's room, the FIRST thing do is:**

(A) call the nurse in charge
(B) try to put out the fire
(C) open a window
(D) remove the client

17. In order to communicate clearly with a client who has hearing loss, the nurse aide should:

(A) speak in a high pitched tone of voice

(B) stand behind the client when speaking

(C) speak in a loud and slow manner

(D) look directly at the client when speaking

18. Which of the following stages of dying is usually the final stage?

(A) Anger

(B) Acceptance

(C) Bargaining

(D) Depression

19. If a client says, "God is punishing me" or "Why me?", how should the nurse aide respond?

(A) Reply, "God doesn't punish people."

(B) Listen quietly

(C) Ignore the client

(D) Make jokes

20. The role of the ombudsman is to:

(A) run a group of nursing homes

(B) work with the nursing home to protect clients' rights

(C) control the nursing home budget

(D) prepare classes that nurse aides take to learn about client hygiene

21. A nurse aide who is active in her church is assigned to care for a client who is not a member of any religious group. The nurse aide SHOULD:

(A) help the client understand the nurse aide's faith

(B) tell the client that it is important for the client to join some church, even if it is not the nurse aide's church

(C) respect the client's beliefs and avoid starting religious discussions

(D) arrange to have the nurse aide's clergyman visit the client

22. The nurse aide notices that a client's mail has been delivered to the client's room. The nurse aide SHOULD:

(A) open the mail and leave it on the client's table

(B) open the mail and read it to the client

(C) read the mail to make sure it doesn't contain upsetting news

(D) give the client the unopened mail and offer help as needed

23. Which of the following is a correct measurement of urinary output?

(A) 40 oz

(B) 300 cc

(C) 2 cups

(D) 1 quart

24. The client offers a nurse aide a twenty dollar bill as a thank you for all that the nurse aide has done. The nurse aide SHOULD:

(A) take the money so as not to offend the client

(B) politely refuse the money

(C) take the money and buy something for the floor

(D) ask the nurse in charge what to do

25. All of the following situations are examples of abuse or neglect EXCEPT:

(A) restraining a client according to a physician's order

(B) leaving a client alone in a bathtub

(C) threatening to withhold a client's meals

(D) leaving a client in a wet and soiled bed

26. If a client is sitting in a chair in his room masturbating, the nurse aide SHOULD:

(A) report the incident to the other nurse aides

(B) tell the client to stop

(C) laugh and tell the client to go in the bathroom

(D) leave the client alone and provide privacy

27. To convert four ounces of juice to milliliters (ml), the nurse aide should multiply:

(A) 4 x 5 ml

(B) 4 x 10 ml

(C) 4 x 15 ml

(D) 4 x 30 ml

28. In giving care according to the client's Bill of Rights, the nurse aide SHOULD:

(A) provide privacy during the client's personal care

(B) open the client's mail without permission

(C) use the client's personal possessions for another client

(D) prevent the client from complaining about care

29. The LAST sense a dying client will lose is:

(A) smell

(B) hearing

(C) taste

(D) sight

30. A client wakes up during the night and asks for something to eat. The nurse aide SHOULD:

(A) check client's diet before offering nourishment

(B) tell the client nothing is available at night

(C) explain that breakfast is coming in three hours

(D) tell the client that eating is not allowed during the night

31. The normal aging process is BEST defined as the time when:

(A) people become dependent and childlike

(B) Alzheimer's disease begins

(C) normal body functions and senses decline

(D) people are over sixty-five years of age

32. If a client is confused, the nurse aide should:

(A) ignore the client until he starts to make sense
(B) restrain the client so that he does not hurt himself
(C) keep the client away from other clients
(D) help the client to recognize familiar things and people

33. What is the process of restoring a disabled client to the highest level of functioning possible?

(A) Responsibility
(B) Retention
(C) Rehabilitation
(D) Reincarnation

34. When changing an unsterile dressing, the nurse aide should wash hands:

(A) before the procedure
(B) after the procedure
(C) before and after the procedure
(D) before, after removal of the soiled dressing, and after the procedure

35. Clean bed linen placed in a client's room but NOT used should be:

(A) returned to the linen closet
(B) used for a client in the next room
(C) taken to the nurse in charge
(D) put in the dirty linen container

36. The nurse aide finds a conscious client lying on the bathroom floor. The FIRST thing the nurse aide should do is:

(A) help the client into a sitting position
(B) call for assistance from the nurse in charge
(C) offer the client a drink of water
(D) check for signs of injury

37. If a nurse aide finds a client who is sad and crying, the nurse aide should:

(A) ask the client if something is wrong
(B) tell the client to cheer up
(C) tell the client to stop crying
(D) call the client's family

38. Clients have the right to:

(A) smoke in any area of the facility
(B) have access to a telephone
(C) go anywhere in the facility
(D) see other clients' medical reports

39. Proper use of a waist restraint requires that the nurse aide:

(A) release the restraint every four hours
(B) watch for skin irritation
(C) tie restraints to the siderail
(D) apply the restraint tightly so the client cannot move

40. To prevent the spread of infection, how should the nurse aide handle the soiled linens removed from a client's bed?

(A) Shake them in the air
(B) Place them in a neat pile on the floor
(C) Carry them close to the nurse aide's body
(D) Put them in the dirty linen container

41. A client needs to be repositioned but is heavy, and the nurse aide is not sure she can move the client alone. The nurse aide should:

(A) try to move the client alone
(B) have the family do it
(C) ask another nurse aide to help
(D) go on to another task

42. To prevent dehydration of the client, the nurse aide SHOULD:

(A) offer fluids frequently while the client is awake
(B) wake the client hourly during the night to offer fluids
(C) give the client frequent baths
(D) feed the client salty food to increase thirst

43. When transferring a client, MOST of the client's weight should be supported by the nurse aide's:

(A) back
(B) shoulders
(C) legs
(D) wrists

44. To be sure that a client's weight is measured accurately, the client should be weighed:

(A) after a meal
(B) by a different nurse aide
(C) at the same time of day
(D) after a good night's sleep

45. How many tips does a quad-cane base have?

(A) 1
(B) 2
(C) 3
(D) 4

46. BEFORE taking the oral temperature of a client who has just finished a cold drink, the nurse aide should wait:

(A) 10 to 20 minutes
(B) 25 to 35 minutes
(C) 45 to 55 minutes
(D) at least 1 hour

47. Which of the following methods is the CORRECT way to remove a dirty isolation gown?

(A) Pull it over the head
(B) Let it drop to the floor and step out of it
(C) Roll it dirty side in and away from the body
(D) Pull it off by the sleeve and shake it out

48. What would be the BEST way for the nurse aide to promote client independence in bathing a client who has had a stroke?

(A) Give the client a complete bath only when the client requests it

(B) Encourage the client to do as much as possible and assist as needed

(C) Leave the client alone and assume the client will do as much as she can

(D) Limit the client to washing her hands

49. A safety device used to assist a DEPENDENT client from a bed to a chair is called a:

(A) posey vest

(B) hand roll

(C) transfer/gait belt

(D) foot board

50. If a nurse aide needs to wear a gown to care for a client in isolation, the nurse aide MUST:

(A) wear the same gown to care for all other assigned clients

(B) leave the gown untied

(C) take the gown off before leaving the client's room

(D) take the gown off in the dirty utility room

51. When making an occupied bed, the nurse aide SHOULD:

(A) put the dirty sheets on the floor

(B) help the client to sit in a chair while the bed is being made

(C) lower both side rails before changing the sheets

(D) raise side rail on unattended side

52. The nurse aide is in the employee dining room. A group of nurse aides are eating lunch together and begin discussing how rude a certain client was acting. The nurse aide SHOULD:

(A) join in the conversation

(B) suggest that this is not the place to discuss the client

(C) be quiet and not say anything to the other nurse aides

(D) return to the unit and tell the client what was said

53. The nurse aide enters a client's room, and the client states that he has pain. What should the nurse aide do?

(A) Report it to the nurse in charge

(B) Tell the client to get out of bed for awhile

(C) Tell the client that the pain will go away soon

(D) Ignore the client's statement

54. A client is upset and crying over the recent death of her husband. How should the nurse aide respond?

(A) Tell her not to cry because it will make her feel sad

(B) Close the door and leave the client to cry alone

(C) Take the client to an activity to help her forget her husband

(D) Sit with the client and allow her to talk about her feelings

55. Which temperature is considered MOST accurate?

(A) Oral

(B) Axillary

(C) Groin

(D) Rectal

56. What is a beginning sign of a pressure sore?

(A) Swelling

(B) Numbness

(C) Discoloration

(D) Coolness

57. While assisting a client with denture care the nurse aide observes that the upper plate is cracked. The nurse aide SHOULD:

(A) clean the dentures and return them to the client's mouth

(B) call the client's family

(C) call the dentist and make an appointment

(D) report the damage to the nurse in charge

58. A new client refuses to wear a clothing protector at lunch. The nurse aide SHOULD:

(A) tell the client that he must wear it

(B) put the clothing protector on the client

(C) report this to the nurse in charge

(D) respect the client's wishes

59. The nurse aide can BEST show that he is listening to the client by:

(A) changing the subject frequently

(B) responding when appropriate

(C) correcting the client's mistakes

(D) directing the conversation

60. The BEST time to prepare for a disaster is:

(A) while evacuating residents

(B) during lunch

(C) when everyone is safely in bed

(D) before it happens

Name:_____ Date:_____

Practice Exam for Nurse Aides

ANSWER SHEET

This form is similar to the answer sheet on the nurse aide Written Examination.

Fill in one bubble for each question, then check your answers using the answer key on page 11.

1	Ⓐ	Ⓑ	Ⓒ	Ⓓ	31	Ⓐ	Ⓑ	Ⓒ	Ⓓ
2	Ⓐ	Ⓑ	Ⓒ	Ⓓ	32	Ⓐ	Ⓑ	Ⓒ	Ⓓ
3	Ⓐ	Ⓑ	Ⓒ	Ⓓ	33	Ⓐ	Ⓑ	Ⓒ	Ⓓ
4	A	B	C	D	34	A	B	C	D
5	Ⓐ	Ⓑ	Ⓒ	Ⓓ	35	Ⓐ	Ⓑ	Ⓒ	Ⓓ
6	Ⓐ	Ⓑ	Ⓒ	Ⓓ	36	Ⓐ	Ⓑ	Ⓒ	Ⓓ
7	Ⓐ	Ⓑ	Ⓒ	Ⓓ	37	Ⓐ	Ⓑ	Ⓒ	Ⓓ
8	Ⓐ	Ⓑ	Ⓒ	Ⓓ	38	Ⓐ	Ⓑ	Ⓒ	Ⓓ
9	Ⓐ	Ⓑ	Ⓒ	Ⓓ	39	Ⓐ	Ⓑ	Ⓒ	Ⓓ
10	Ⓐ	Ⓑ	Ⓒ	Ⓓ	40	Ⓐ	Ⓑ	Ⓒ	Ⓓ
11	Ⓐ	Ⓑ	Ⓒ	Ⓓ	41	Ⓐ	Ⓑ	Ⓒ	Ⓓ
12	Ⓐ	Ⓑ	Ⓒ	Ⓓ	42	Ⓐ	Ⓑ	Ⓒ	Ⓓ
13	A	B	C	D	43	A	B	C	D
14	A	B	C	D	44	A	B	C	D
15	A	B	C	D	45	A	B	C	D
16	A	B	C	D	46	A	B	C	D
17	A	B	C	D	47	A	B	C	D
18	A	B	C	D	48	A	B	C	D
19	A	B	C	D	49	A	B	C	D
20	A	B	C	D	50	A	B	C	D
21	A	B	C	D	51	A	B	C	D
22	A	B	C	D	52	A	B	C	D
23	A	B	C	D	53	A	B	C	D
24	A	B	C	D	54	A	B	C	D
25	A	B	C	D	55	A	B	C	D
26	A	B	C	D	56	A	B	C	D
27	A	B	C	D	57	A	B	C	D
28	Ⓐ	Ⓑ	Ⓒ	Ⓓ	58	Ⓐ	Ⓑ	Ⓒ	Ⓓ
29	Ⓐ	Ⓑ	Ⓒ	Ⓓ	59	Ⓐ	Ⓑ	Ⓒ	Ⓓ
30	Ⓐ	Ⓑ	Ⓒ	Ⓓ	60	Ⓐ	Ⓑ	Ⓒ	Ⓓ

Practice Exam Answer Key

Please refer to the following tables to score your examination. If there is a question you had incorrect, you can refer to the content area listed next to that question number before taking the Nursing Assistance Examination You can find the **Content Outline** on page 1 of this packet or in your Candidate Handbook.

Question Number	Answe	Category
1	D	MEMBER OF THE HEALTH CARE TEAM
2	B	ACTIVITIES OF DAILY
3	D	CLIENT RIGHTS
4	B	BASIC NURSING SKILLS
5	C	EMOTIONAL AND MENTAL HEALTH NEEDS
6	C	BASIC NURSING SKILLS
7	B	RESTORATIVE SKILLS
8	C	COMMUNICATION
9	B	BASIC NURSING SKILLS
10	D	COMMUNICATION
11	C	COMMUNICATION
12	B	BASIC NURSING SKILLS
13	B	SPIRITUAL AND CULTURAL NEEDS
14	B	ACTIVITIES OF DAILY
15	B	CLIENT RIGHTS
16	D	BASIC NURSING SKILLS
17	D	COMMUNICATION
18	B	EMOTIONAL AND MENTAL HEALTH NEEDS
19	B	COMMUNICATION
20	B	MEMBER OF THE HEALTH CARE TEAM
21	C	SPIRITUAL AND CULTURAL NEEDS
22	D	CLIENT RIGHTS
23	B	BASIC NURSING SKILLS

Question Number	Answer	Category
24	B	LEGAL AND ETHICAL BEHAVIOR
25	A	CLIENT RIGHTS
26	D	CLIENT RIGHTS
27	D	BASIC NURSING SKILLS
28	A	CLIENT RIGHTS
29	B	ACTIVITIES OF DAILY
30	A	CLIENT RIGHTS
31	C	EMOTIONAL AND MENTAL HEALTH
32	D	EMOTIONAL AND MENTAL HEALTH NEEDS
33	C	MEMBER OF THE HEALTH CARE TEAM
34	D	BASIC NURSING SKILLS
35	D	BASIC NURSING SKILLS
36	B	MEMBER OF THE HEALTH CARE TEAM
37	A	EMOTIONAL AND MENTAL HEALTH NEEDS
38	B	CLIENT RIGHTS
39	B	LEGAL AND ETHICAL BEHAVIOR
40	D	BASIC NURSING SKILLS
41	C	BASIC NURSING SKILLS
42	A	ACTIVITIES OF DAILY
43	C	BASIC NURSING SKILLS
44	C	BASIC NURSING SKILLS
45	D	MEMBER OF THE HEALTH CARE TEAM

Question Number	Answe	Category
46	A	BASIC NURSING SKILLS
47	C	BASIC NURSING SKILLS
48	B	RESTORATIVE SKILLS
49	C	BASIC NURSING SKILLS
50	C	BASIC NURSING SKILLS
51	D	BASIC NURSING SKILLS
52	B	LEGAL AND ETHICAL BEHAVIOR
53	A	BASIC NURSING SKILLS

Question Number	Answer	Category
54	D	EMOTIONAL AND MENTAL HEALTH NEEDS
55	D	BASIC NURSING SKILLS
56	C	RESTORATIVE SKILLS
57	D	BASIC NURSING SKILLS
58	D	CLIENT RIGHTS
59	B	COMMUNICATION
60	D	BASIC NURSING SKILLS