

**CNA EXAM TEST PREP STUDY
GUIDE 2025-2026**

**PRACTICE QUESTIONS &
ANSWER EXPLANATIONS**

**Guia de estudio para el examen CNA 2025 -
2026
ingles y espanol**

**Preguntas de práctica y explicaciones de
respuestas**

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HOW TO USE THIS BOOK

This study guide is organized into 12 comprehensive chapters, each focusing on a specific area of CNA knowledge and skills. Each chapter includes:

1. **Learning Objectives:** Clear goals for what you should understand after studying the chapter
2. **Key Concepts:** Detailed explanations of important topics
3. **Key Terms:** Essential vocabulary you need to know
4. **Practice Questions:** Multiple-choice questions similar to those on the actual exam
5. **Answer Explanations:** Detailed rationales for both correct and incorrect answers
6. **Chapter Summary:** Quick review of main points

For optimal results, we recommend:

- Reading each chapter thoroughly before attempting practice questions
- Taking notes on key concepts and unfamiliar terms
- Reviewing incorrect answers to understand your knowledge gaps
- Completing the final practice exam under timed conditions
- Reviewing all material again before your actual exam date

ABOUT THIS STUDY GUIDE

Welcome to the CNA Exam Test Prep Study Guide 2025-2026. This comprehensive guide is designed to help you successfully prepare for and pass your Certified Nursing Assistant examination. Whether you're a recent graduate from a CNA training program or someone looking to refresh your knowledge before the exam, this book provides everything you need to succeed.

The Certified Nursing Assistant (CNA) exam tests your knowledge and competency in providing basic patient care under the supervision of licensed nurses. This guide covers all major topic areas tested on both the written (or oral) examination and the clinical skills demonstration.

4. **Maintain safety:** Always prioritize resident and personal safety
5. **Stay calm:** Take deep breaths if you feel nervous

TEST-TAKING STRATEGIES

Before the Exam

1. **Get adequate rest:** Ensure you get 7-8 hours of sleep the night before
2. **Eat a nutritious meal:** Have a balanced breakfast to maintain energy
3. **Arrive early:** Plan to arrive at least 30 minutes before your scheduled time
4. **Bring required materials:** Photo ID, admission ticket, and any allowed supplies

During the Written Exam

1. **Read carefully:** Read each question completely before looking at answer choices
2. **Eliminate wrong answers:** Cross out options you know are incorrect
3. **Look for keywords:** Pay attention to words like "first," "best," "except," and "not"
4. **Manage your time:** Don't spend too long on difficult questions
5. **Review your answers:** If time permits, check your work

During the Skills Exam

1. **Listen to instructions:** Pay careful attention to the evaluator's directions
2. **Verbalize actions:** Explain what you're doing as you perform each skill
3. **Follow proper sequence:** Complete steps in the correct order

CHAPTER 1: ROLE AND RESPONSIBILITIES OF THE NURSING ASSISTANT

Learning Objectives

By the end of this chapter, you will be able to:

- Define the role of the Certified Nursing Assistant in healthcare settings
- Identify members of the healthcare team and their roles
- Understand the scope of practice for CNAs
- Recognize the importance of maintaining professional boundaries
- Describe the chain of command in healthcare facilities
- Explain the importance of continuing education for CNAs

ABOUT THE CNA EXAM

The CNA certification exam consists of two parts:

Written (or Oral) Examination

- **Number of questions:** 60-100 multiple-choice questions (varies by state)
- **Time limit:** 90-120 minutes
- **Passing score:** Typically 70-80% (varies by state)
- **Topics covered:** All areas of CNA training curriculum

Clinical Skills Examination

- **Number of skills:** 3-5 randomly selected skills
- **Time limit:** 20-30 minutes
- **Evaluation:** Pass/fail based on critical steps
- **Common skills tested:** Handwashing, vital signs, transfers, personal care

Exam Administration

The exam is administered by state-approved testing organizations such as:

- Pearson VUE
- Prometric
- American Red Cross
- D&SDT-Headmaster

Check with your state's Board of Nursing for specific testing requirements and approved testing sites in your area.

- Provide direct patient care
- Assist with activities of daily living (ADLs)
- Take and record vital signs
- Report observations to nurses
- Provide emotional support to patients

5. Physical Therapists (PTs)

- Help patients regain mobility
- Develop exercise programs
- Teach use of assistive devices
- Prevent physical deterioration

6. Occupational Therapists (OTs)

- Help patients perform daily activities
- Adapt environments for patient needs
- Teach compensatory techniques
- Promote independence

7. Speech-Language Pathologists (SLPs)

- Assess and treat communication disorders
- Help with swallowing difficulties
- Develop communication strategies
- Train patients and families

8. Social Workers

- Coordinate discharge planning
- Connect patients with community resources
- Provide counseling and support
- Advocate for patient needs

9. Dietitians/Nutritionists

- Plan therapeutic diets
- Educate about nutrition
- Monitor nutritional status
- Adjust meal plans as needed

KEY CONCEPTS

The Healthcare Team

The modern healthcare system relies on interdisciplinary teams working together to provide comprehensive patient care. As a CNA, you are a vital member of this team. Understanding each team member's role helps ensure effective collaboration and optimal patient outcomes.

Key Healthcare Team Members:

1. Physicians (Doctors)

- Diagnose medical conditions
- Prescribe medications and treatments
- Perform medical procedures
- Oversee the overall medical care plan

2. Registered Nurses (RNs)

- Develop nursing care plans
- Administer medications
- Perform complex nursing procedures
- Supervise LPNs and CNAs
- Coordinate patient care

3. Licensed Practical/Vocational Nurses (LPNs/ LVNs)

- Provide basic nursing care
- Administer medications (in most states)
- Monitor patients and report changes
- Supervise CNAs in some settings

4. Certified Nursing Assistants (CNAs)

- Perform procedures requiring nursing judgment
- Access or document in medical records (in most facilities)
- Supervise other healthcare workers

Professional Boundaries

Maintaining appropriate professional boundaries is essential for CNAs. These boundaries protect both you and your patients while ensuring professional, therapeutic relationships.

Key Boundary Principles:

1. Keep relationships professional

- Avoid personal relationships with patients
- Don't share personal problems with patients
- Maintain appropriate physical boundaries
- Use professional language

2. Protect patient privacy

- Follow HIPAA regulations
- Don't discuss patients outside of work
- Keep social media separate from work
- Respect patient confidentiality

3. Avoid gifts and money

- Don't accept gifts from patients
- Never borrow from or lend to patients
- Don't become involved in patient finances
- Report offers of gifts to supervisors

4. Maintain ethical standards

- Be honest and trustworthy
- Respect patient autonomy

10. Respiratory Therapists

- Manage breathing treatments
- Maintain ventilators
- Teach breathing exercises
- Monitor oxygen therapy

CNA Scope of Practice

The scope of practice defines what CNAs are legally allowed to do in their role. While specific tasks may vary by state and facility, CNAs generally:

CAN DO:

- Take and record vital signs
- Assist with bathing, dressing, and grooming
- Help with toileting and incontinence care
- Assist with mobility and transfers
- Feed patients and record intake
- Make beds and maintain a clean environment
- Collect specimens (urine, stool, sputum)
- Perform range of motion exercises
- Apply non-medicated lotions
- Provide emotional support
- Report changes in patient condition

CANNOT DO:

- Administer medications (including over-the-counter)
- Insert or remove tubes (catheters, IVs, feeding tubes)
- Perform sterile procedures
- Take verbal or telephone orders from physicians
- Diagnose conditions or prescribe treatments

- Avoid discrimination
- Report unethical behavior

Chain of Command

Understanding the chain of command helps ensure proper communication and problem resolution in healthcare facilities.

Typical Chain of Command (bottom to top):

1. Certified Nursing Assistant
2. Charge Nurse/Team Leader
3. Nursing Supervisor
4. Director of Nursing (DON)
5. Administrator/CEO
6. Board of Directors

When to Use the Chain of Command:

- Reporting patient concerns
- Addressing workplace issues
- Requesting policy clarification
- Reporting safety hazards
- Dealing with ethical dilemmas

Always start with your immediate supervisor unless the situation involves them directly or requires immediate intervention for patient safety.

Documentation and Reporting

Accurate documentation and timely reporting are critical CNA responsibilities. While CNAs typically don't write in official medical records, they must:

Document:

- Vital signs on flow sheets
- Intake and output records
- Activities of daily living completed
- Behavior observations
- Skin condition changes
- Patient complaints or requests

Report Immediately:

- Changes in vital signs
- Changes in mental status
- Signs of pain or distress
- Skin tears, bruises, or pressure areas
- Falls or injuries
- Refusal of care
- Equipment malfunctions
- Suspected abuse or neglect

Continuing Education

Healthcare is constantly evolving, making continuing education essential for CNAs. Benefits include:

1. Maintaining competence

- Stay current with best practices
- Learn new techniques
- Refresh existing skills
- Meet state requirements

2. Career advancement

- Prepare for additional certifications
- Qualify for specialized positions
- Build resume credentials
- Network with other professionals

3. Improving patient care

- Learn evidence-based practices
- Understand new technologies
- Develop cultural competence
- Enhance communication skills

Continuing Education Options:

- In-service training at work
- Online courses and webinars
- Professional conferences
- Community college classes
- Certification programs
- Professional journals and publications

KEY TERMS

Activities of Daily Living (ADLs): Basic self-care tasks including bathing, dressing, eating, toileting, transferring, and walking

Chain of Command: The line of authority and responsibility in an organization

Delegate: To assign a task to another person

HIPAA: Health Insurance Portability and Accountability Act; protects patient privacy

Interdisciplinary Team: Healthcare professionals from different disciplines working together

Scope of Practice: Legal boundaries defining what a healthcare worker can and cannot do

Professional Boundaries: Limits that define appropriate professional relationships

Therapeutic Relationship: A professional, helping relationship focused on patient needs

PRACTICE QUESTIONS

1. Which of the following tasks is within the CNA scope of practice? a) Administering oral medications b) Inserting a urinary catheter c) Taking and recording blood pressure d) Starting an IV line
2. When you notice a patient has developed a new skin tear, you should first: a) Apply a bandage and document it later b) Wait until the end of your shift to report it c) Report it immediately to the nurse d) Ask another CNA what to do
3. A patient offers you \$20 as a thank you for your care. You should: a) Accept it gratefully b) Politely refuse and report to your supervisor c) Accept it but don't tell anyone d) Ask them to donate it to charity instead
4. The healthcare team member responsible for helping patients regain mobility is the: a) Occupational therapist b) Speech therapist c) Physical therapist d) Respiratory therapist
5. When using the chain of command, you should generally start with: a) The administrator b) Your immediate supervisor c) The Director of Nursing d) Human resources
6. Which of the following violates professional boundaries? a) Listening to a patient's concerns b) Sharing your personal phone number with

- a patient c) Providing emotional support d) Respecting patient privacy
7. CNAs are responsible for documenting all of the following EXCEPT: a) Vital signs b) Medical diagnoses c) Intake and output d) Activities of daily living completed
 8. The federal law that protects patient health information privacy is: a) OSHA b) CDC c) HIPAA d) OBRA
 9. Which task can a CNA delegate to another CNA? a) Taking vital signs b) None - CNAs cannot delegate c) Administering medications d) Inserting a feeding tube
 10. Continuing education for CNAs is important because: a) It's required by all states b) It helps maintain current knowledge and skills c) It guarantees a pay raise d) It's only needed for advancement
 11. When a patient refuses morning care, you should: a) Force them to comply b) Skip their care entirely c) Report the refusal to the nurse d) Come back later without asking
 12. The team member who develops the nursing care plan is the: a) CNA b) LPN c) RN d) Physician
 13. Which action demonstrates maintaining professional boundaries? a) Giving a patient your phone number b) Discussing work frustrations with patients c) Keeping conversations focused on patient needs d)

Accepting a small gift from a patient

14. A CNA observes a coworker handling a patient roughly. The CNA should: a) Confront the coworker directly b) Ignore it if the patient doesn't complain c) Report it to the supervisor immediately d) Wait to see if it happens again

15. The primary role of a CNA is to: a) Diagnose patient conditions b) Provide direct patient care c) Develop treatment plans d) Supervise other staff

ANSWER EXPLANATIONS

1. **Correct answer: c) Taking and recording blood pressure**

- Rationale: Taking vital signs, including blood pressure, is a fundamental CNA skill within their scope of practice. CNAs cannot administer medications (a), insert catheters (b), or start IV lines (d) as these require advanced training and licensure.

2. **Correct answer: c) Report it immediately to the nurse**

- Rationale: Any new skin injury must be reported immediately for proper assessment and treatment. Delaying reporting (b) could worsen the condition. CNAs should not independently treat wounds (a) or delay seeking guidance (d).

3. **Correct answer: b) Politely refuse and report to your supervisor**

- Rationale: Accepting gifts from patients (a, c) violates professional boundaries and facility policies. While suggesting donation (d) seems nice, the correct action is to refuse and report the offer to maintain professional standards.

4. **Correct answer: c) Physical therapist**

- Rationale: Physical therapists specialize in mobility, movement, and physical function. Occupational therapists (a) focus on daily

living activities, speech therapists (b) on communication, and respiratory therapists (d) on breathing issues.

5. Correct answer: b) Your immediate supervisor

- Rationale: The chain of command starts with your direct supervisor. Only skip levels (a, c, d) if the issue involves your supervisor or requires immediate action for patient safety.

6. Correct answer: b) Sharing your personal phone number with a patient

- Rationale: Sharing personal contact information crosses professional boundaries. Listening to concerns (a), providing emotional support (c), and respecting privacy (d) are appropriate professional behaviors.

7. Correct answer: b) Medical diagnoses

- Rationale: CNAs document objective observations and care provided but cannot make medical diagnoses. This requires advanced medical training and licensure. CNAs routinely document vital signs (a), intake/output (c), and ADLs (d).

8. Correct answer: c) HIPAA

- Rationale: The Health Insurance Portability and Accountability Act (HIPAA) specifically protects patient health information. OSHA (a) covers workplace safety, CDC (b) is for disease control, and OBRA (d) addresses nursing home regulations.

9. Correct answer: b) None - CNAs cannot delegate

- Rationale: CNAs work under delegation from licensed nurses but cannot delegate tasks to others. They lack the authority to assign work or supervise other healthcare workers.

10. Correct answer: b) It helps maintain current knowledge and skills

- Rationale: Continuing education keeps CNAs current with best practices and maintains competence. While some states require it (a), not all do. It doesn't guarantee raises (c) and is valuable beyond advancement (d).

11. Correct answer: c) Report the refusal to the nurse

- Rationale: Patients have the right to refuse care. CNAs must respect this choice and report it for documentation. Forcing compliance (a) violates patient rights, skipping care (b) neglects duty, and returning without permission (d) disrespects autonomy.

12. Correct answer: c) RN

- Rationale: Registered Nurses develop and modify nursing care plans based on their assessment and nursing diagnosis skills. CNAs (a) and LPNs (b) work under these plans, while physicians (d) create medical treatment plans.

13. Correct answer: c) Keeping conversations focused on patient needs

- Rationale: Professional boundaries require keeping interactions patient-centered. Sharing contact information (a), discussing personal problems (b), and accepting gifts (d) all violate professional boundaries.

14. Correct answer: c) Report it to the supervisor immediately

- Rationale: Suspected abuse must be reported immediately through proper channels. Direct confrontation (a) may escalate the situation, ignoring it (b) enables abuse, and waiting (d) allows potential harm to continue.

15. Correct answer: b) Provide direct patient care

- Rationale: The primary CNA role is hands-on patient care including ADLs and basic nursing tasks. CNAs cannot diagnose (a), create treatment plans (c), or supervise staff (d) as these exceed their scope of practice.

CHAPTER SUMMARY

This chapter established the foundation for understanding the CNA role within healthcare. Key points include:

- CNAs are vital members of the interdisciplinary healthcare team
- The scope of practice defines legal boundaries for CNA tasks
- Professional boundaries protect both patients and healthcare workers
- The chain of command ensures proper communication and problem resolution
- Accurate documentation and timely reporting are critical responsibilities
- Continuing education maintains competence and advances careers

Understanding these concepts helps CNAs provide safe, effective care while working collaboratively with other healthcare professionals. Remember that while CNAs have specific limitations, their direct patient care role makes them essential for quality healthcare delivery.

CHAPTER 2: COMMUNICATION AND INTERPERSONAL SKILLS

Learning Objectives

By the end of this chapter, you will be able to:

- Identify the components of effective communication
- Demonstrate therapeutic communication techniques
- Recognize and overcome communication barriers
- Understand cultural considerations in healthcare communication
- Apply proper telephone and documentation communication
- Use effective communication with special populations

KEY CONCEPTS

Components of Communication

Effective communication involves multiple components working together to convey meaning. Understanding each component helps CNAs communicate more effectively with patients, families, and team members.

Verbal Communication

- **Words:** The actual spoken or written language used
- **Tone:** How something is said (friendly, harsh, caring, impatient)
- **Volume:** Loudness or softness of speech
- **Rate:** Speed of speaking (fast, slow, moderate)
- **Clarity:** How clearly words are pronounced

Nonverbal Communication (comprises about 80% of communication)

- **Facial expressions:** Smiles, frowns, raised eyebrows
- **Body language:** Posture, positioning, movements
- **Gestures:** Hand movements, pointing, waving
- **Eye contact:** Direct gaze, looking away, avoiding eyes
- **Touch:** Therapeutic touch, comforting pat, handshake
- **Personal space:** Physical distance maintained
- **Appearance:** Grooming, dress, hygiene

Therapeutic Communication Techniques

Therapeutic communication promotes healing and helps build trusting relationships with patients. These techniques should be practiced and refined throughout your career.

Active Listening

- Give full attention to the speaker
- Maintain appropriate eye contact
- Nod and use verbal cues ("I see," "Go on")
- Avoid interrupting
- Ask clarifying questions
- Summarize what you heard

Open-Ended Questions

- Encourage detailed responses
- Begin with "what," "how," or "tell me about"
- Examples:
 - "How are you feeling today?"
 - "What concerns do you have?"
 - "Tell me about your pain"

Reflection

- Repeat or rephrase patient statements
- Shows understanding and encourages elaboration
- Example:
 - Patient: "I'm worried about my surgery"
 - CNA: "You're feeling anxious about the upcoming procedure?"

Empathy

- Acknowledge and validate feelings
- Show understanding without judgment
- Example: "It must be difficult being away from your

family"

Clarification

- Ensure accurate understanding
- Ask for more information when needed
- Example: "When you say the pain is bad, can you rate it on a scale of 1-10?"

Silence

- Allow pauses for patient processing
- Don't rush to fill quiet moments
- Gives patients time to formulate thoughts

Summarizing

- Review main points of conversation
- Ensures mutual understanding
- Example: "So you're having sharp pain in your left side that gets worse when you breathe deeply?"

Communication Barriers

Recognizing and addressing communication barriers is essential for effective patient care. Common barriers include:

Physical Barriers

- Hearing impairments
- Vision problems
- Speech difficulties
- Environmental noise
- Physical distance

Solutions:

- Face the person when speaking
- Ensure adequate lighting
- Reduce background noise
- Use assistive devices
- Write key information if needed

Language Barriers

- Different primary languages
- Limited English proficiency
- Medical terminology confusion
- Regional dialects

Solutions:

- Use professional interpreters
- Speak slowly and clearly
- Avoid medical jargon
- Use visual aids
- Verify understanding

Cultural Barriers

- Different communication styles
- Varying concepts of personal space
- Eye contact preferences
- Touch boundaries
- Time orientation differences

Solutions:

- Learn about different cultures
- Ask about preferences
- Respect cultural norms
- Use cultural liaisons
- Avoid assumptions

Psychological Barriers

- Fear and anxiety
- Depression
- Anger or frustration
- Cognitive impairments
- Past traumatic experiences

Solutions:

- Remain calm and patient
- Acknowledge emotions
- Provide reassurance
- Allow extra time
- Involve support persons

Physiological Barriers

- Pain or discomfort
- Medication effects
- Fatigue
- Illness symptoms
- Age-related changes

Solutions:

- Address comfort needs first
- Choose optimal timing
- Keep interactions brief if needed
- Adjust approach based on condition
- Be patient and flexible

Cultural Competence in Communication

Healthcare providers must be culturally sensitive to provide appropriate care to diverse populations. Cultural competence

involves:

Understanding Cultural Variables

1. Communication Patterns

- Direct vs. indirect communication
- Formal vs. informal speech
- Silence interpretation
- Storytelling vs. facts

2. Personal Space

- Intimate distance (0-18 inches)
- Personal distance (18 inches-4 feet)
- Social distance (4-12 feet)
- Public distance (12+ feet)

3. Touch Preferences

- Some cultures encourage touch
- Others find it invasive
- Gender considerations
- Religious restrictions

4. Eye Contact

- Sign of respect in some cultures
- Disrespectful in others
- Gender differences
- Authority considerations

5. Time Orientation

- Present-focused vs. future-focused
- Punctuality importance
- Scheduling flexibility
- Planning preferences

Providing Culturally Sensitive Care

- Ask about cultural preferences
- Avoid stereotyping
- Respect religious practices
- Honor dietary restrictions
- Include family as appropriate
- Use cultural resources

Special Communication Situations

Communicating with Hearing Impaired Patients

- Face the person directly
- Keep your mouth visible
- Speak clearly without shouting
- Use gestures and visual cues
- Write important information
- Ensure hearing aids are working
- Use certified interpreters for sign language

Communicating with Visually Impaired Patients

- Identify yourself when entering
- Announce when you're leaving
- Describe what you're doing
- Use clock positions for locations
- Ask before providing physical guidance
- Keep environment organized
- Use verbal descriptions

Communicating with Aphasic Patients

- Be patient and supportive
- Use simple, short sentences
- Allow extra response time
- Use gestures and pictures
- Avoid finishing their sentences

- Watch for nonverbal cues
- Involve speech therapy

Communicating with Confused or Disoriented Patients

- Remain calm and reassuring
- Use simple, concrete language
- Reorient as needed
- Avoid arguing or correcting
- Redirect when appropriate
- Maintain routine
- Ensure safety

Communicating with Angry or Aggressive Patients

- Stay calm and professional
- Listen to concerns
- Acknowledge feelings
- Set clear limits
- Maintain safe distance
- Get help if needed
- Document incidents

Professional Communication

Telephone Communication

- Answer promptly and professionally
- Identify yourself and unit
- Speak clearly
- Take accurate messages
- Protect patient privacy
- Follow facility protocols

Team Communication

- Use SBAR format for reporting:

- **Situation:** What is happening?
- **Background:** Relevant history
- **Assessment:** Your observations
- **Recommendation:** Suggested actions

Documentation Communication

- Write legibly
- Use approved abbreviations
- Be objective and factual
- Record exact times
- Sign all entries
- Report before documenting

Shift Report Communication

- Be concise but thorough
- Include significant changes
- Mention special needs
- Discuss safety concerns
- Ask clarifying questions
- Take notes

KEY TERMS

Active Listening: Fully concentrating on, understanding, and responding to a speaker

Aphasia: Loss of ability to understand or express speech

Body Language: Nonverbal communication through physical behaviors

Cultural Competence: Ability to interact effectively with people of different cultures

Empathy: Understanding and sharing the feelings of another

Nonverbal Communication: Conveying messages without words

Rapport: A harmonious relationship marked by mutual understanding

SBAR: Standardized communication tool (Situation, Background, Assessment, Recommendation)

Therapeutic Communication: Purposeful communication promoting healing and wellbeing

Verbal Communication: Information conveyed through spoken or written words

PRACTICE QUESTIONS

1. Which percentage of communication is typically nonverbal? a) 20% b) 50% c) 80% d) 95%
2. When communicating with a hearing-impaired patient, you should: a) Shout to ensure they hear you b) Face them directly and speak clearly c) Only use written communication d) Avoid eye contact
3. The best type of question to encourage a patient to share their feelings is: a) Closed-ended question b) Leading question c) Open-ended question d) Yes/no question
4. When a patient says "I'm terrified about my test results," therapeutic response would be: a) "Don't worry, everything will be fine" b) "You seem anxious about getting your test results" c) "The doctor knows what he's doing" d) "My aunt had the same test and was fine"
5. Active listening involves all of the following EXCEPT: a) Maintaining eye contact b) Planning your response while they speak c) Asking clarifying questions d) Summarizing what you heard
6. When using an interpreter, you should: a) Speak directly to the interpreter b) Use long, complex sentences c) Look at and speak to the patient d)

Leave the room for privacy

7. A patient from another culture refuses to make eye contact. This may indicate: a) They are lying b) They are depressed c) Cultural respect d) Hearing problems
8. The 'S' in SBAR communication stands for: a) Summary b) Situation c) Safety d) Symptoms
9. When communicating with an angry patient, you should first: a) Call security immediately b) Argue your point c) Remain calm and listen d) Leave the room
10. Therapeutic touch is appropriate in all situations EXCEPT: a) When comforting a crying patient b) When a patient requests no touching c) During routine care procedures d) When culture permits
11. Which action demonstrates empathy? a) "I know exactly how you feel" b) "This must be very difficult for you" c) "You shouldn't feel that way" d) "I had the same problem last year"
12. When documenting, CNAs should: a) Include personal opinions b) Use creative abbreviations c) Record objective observations d) Wait until the end of shift
13. Personal space in the intimate zone is: a) 0-18 inches b) 18 inches-4 feet c) 4-12 feet d) Over 12 feet
14. When a patient with aphasia struggles to speak,

you should: a) Finish their sentences b) Speak louder c) Be patient and supportive d) Avoid communication

15. Which is a barrier to effective communication? a) Active listening b) Environmental noise c) Eye contact d) Open-ended questions
16. The best way to verify a patient understands instructions is to: a) Ask "Do you understand?" b) Have them demonstrate or repeat back c) Assume they understand if they nod d) Give written instructions only
17. When entering a visually impaired patient's room, you should first: a) Touch them to let them know you're there b) Turn on bright lights c) Announce yourself verbally d) Remain quiet to not startle them
18. Cultural competence requires: a) Treating everyone exactly the same b) Knowing everything about all cultures c) Respecting individual cultural differences d) Avoiding cultural topics
19. Reflection as a communication technique involves: a) Thinking about your day b) Repeating or rephrasing patient statements c) Using mirrors for demonstration d) Avoiding difficult topics
20. When communicating with a confused patient, avoid: a) Using simple language b) Arguing or correcting them c) Maintaining

routine d) Providing reassurance

ANSWER EXPLANATIONS

1. Correct answer: c) 80%

- Rationale: Research shows that approximately 80% of communication is nonverbal, including facial expressions, body language, tone of voice, and gestures. This highlights the importance of being aware of nonverbal cues in patient care.

2. Correct answer: b) Face them directly and speak clearly

- Rationale: Facing hearing-impaired patients allows them to see your lips and facial expressions, aiding comprehension. Shouting (a) distorts speech, written-only communication (c) is impractical, and avoiding eye contact (d) hinders communication.

3. Correct answer: c) Open-ended question

- Rationale: Open-ended questions encourage detailed responses and allow patients to express feelings freely. Closed-ended (a), leading (b), and yes/no questions (d) limit patient responses and may miss important information.

4. Correct answer: b) "You seem anxious about getting your test results"

- Rationale: This response uses reflection to acknowledge the patient's feelings without

dismissing them. Saying "don't worry" (a) minimizes feelings, focusing on the doctor (c) changes the subject, and personal stories (d) shift focus from the patient.

5. Correct answer: b) Planning your response while they speak

- Rationale: Active listening requires full attention to the speaker. Planning responses while they talk means you're not fully listening. Eye contact (a), clarifying questions (c), and summarizing (d) are all components of active listening.

6. Correct answer: c) Look at and speak to the patient

- Rationale: Always address the patient directly, maintaining the provider-patient relationship. The interpreter is a communication tool, not the focus of conversation. Speaking to the interpreter (a) or leaving (d) breaks this relationship.

7. Correct answer: c) Cultural respect

- Rationale: Many cultures consider direct eye contact with authority figures disrespectful. Assuming lying (a), depression (b), or hearing problems (d) without considering cultural factors can lead to misunderstandings and poor care.

8. Correct answer: b) Situation

- Rationale: SBAR stands for Situation, Background, Assessment, and Recommendation. It's a standardized communication framework used in healthcare

to ensure clear, complete information transfer.

9. Correct answer: c) Remain calm and listen

- Rationale: Staying calm and listening helps de-escalate situations and understand the source of anger. Calling security first (a) may escalate, arguing (b) increases conflict, and leaving (d) abandons the patient's needs.

10. Correct answer: b) When a patient requests no touching

- Rationale: Patient preferences and boundaries must always be respected. If a patient requests no touching, this supersedes other considerations. Therapeutic touch is appropriate in the other situations when culturally acceptable.

11. Correct answer: b) "This must be very difficult for you"

- Rationale: This response acknowledges the patient's feelings without claiming to fully understand their unique experience. Saying you know exactly how they feel (a) or sharing personal experiences (d) shifts focus from the patient.

12. Correct answer: c) Record objective observations

- Rationale: Documentation must be factual and objective. Personal opinions (a) are inappropriate, non-standard abbreviations (b) cause confusion, and delayed documentation (d) risks forgetting important details.

13. Correct answer: a) 0-18 inches

- Rationale: Intimate space (0-18 inches) is reserved for close personal relationships and necessary medical care. Understanding space zones helps maintain appropriate professional boundaries while providing necessary care.

14. Correct answer: c) Be patient and supportive

- Rationale: Patients with aphasia need patience and support to communicate. Finishing sentences (a) is frustrating for them, speaking louder (b) doesn't help with aphasia, and avoiding communication (d) isolates them.

15. Correct answer: b) Environmental noise

- Rationale: Environmental noise is a physical barrier to communication. Active listening (a), eye contact (c), and open-ended questions (d) all facilitate rather than hinder effective communication.

16. Correct answer: b) Have them demonstrate or repeat back

- Rationale: Teach-back or demonstration confirms understanding better than verbal confirmation. Patients may say "yes" (a) or nod (c) without truly understanding. Written instructions alone (d) don't verify comprehension.

17. Correct answer: c) Announce yourself verbally

- Rationale: Always verbally identify yourself to visually impaired patients before approaching. Unexpected touch (a) can startle, bright lights (b) don't help blindness, and

remaining quiet (d) leaves them unaware of your presence.

18. Correct answer: c) Respecting individual cultural differences

- Rationale: Cultural competence involves respecting and accommodating individual differences, not treating everyone identically (a). It's impossible to know everything about all cultures (b), and avoiding cultural topics (d) prevents culturally sensitive care.

19. Correct answer: b) Repeating or rephrasing patient statements

- Rationale: Reflection is a therapeutic communication technique where you repeat or rephrase what patients say to show understanding and encourage elaboration. It's not about personal reflection (a), mirrors (c), or avoidance (d).

20. Correct answer: b) Arguing or correcting them

- Rationale: Arguing with confused patients increases agitation and doesn't improve orientation. Simple language (a), routine (c), and reassurance (d) are all helpful strategies for communicating with confused patients.

CHAPTER SUMMARY

Effective communication is fundamental to quality patient care. This chapter covered:

- Communication consists of both verbal (20%) and nonverbal (80%) components
- Therapeutic communication techniques include active listening, open-ended questions, reflection, and empathy
- Common barriers include physical, language, cultural, psychological, and physiological factors
- Cultural competence requires understanding and respecting diverse communication styles
- Special populations require adapted communication approaches
- Professional communication uses standardized tools like SBAR for clarity
- Documentation must be objective, timely, and factual

Mastering these communication skills enables CNAs to build therapeutic relationships, accurately convey information, and provide culturally sensitive care. Remember that effective communication is a skill that improves with practice and conscious effort.

CHAPTER 3: INFECTION CONTROL

Learning Objectives

By the end of this chapter, you will be able to:

- Understand the chain of infection and how to break it
- Identify different types of microorganisms and infections
- Demonstrate proper hand hygiene techniques
- Apply standard precautions in all patient care
- Implement transmission-based precautions appropriately
- Use personal protective equipment (PPE) correctly
- Understand sterilization and disinfection procedures

KEY CONCEPTS

Understanding Microorganisms

Microorganisms are tiny living organisms that can only be seen with a microscope. While many are harmless or beneficial, some can cause infections. Healthcare workers must understand different types to prevent transmission.

Types of Microorganisms

1. Bacteria

- Single-celled organisms
- Can reproduce rapidly
- Examples: Staphylococcus aureus, E. coli, Streptococcus
- Treated with antibiotics
- Can develop antibiotic resistance

2. Viruses

- Smaller than bacteria
- Need living host to reproduce
- Examples: Influenza, HIV, Hepatitis, COVID-19
- Treated with antivirals (limited effectiveness)
- Prevented by vaccines

3. Fungi

- Include yeasts and molds
- Thrive in warm, moist environments
- Examples: Candida (yeast infections), ringworm

- Treated with antifungals
 - Common in immunocompromised patients
- 4. Protozoa**
- Single-celled parasites
 - Often spread through contaminated water
 - Examples: Giardia, malaria
 - Treated with specific antiparasitic drugs
- 5. Prions**
- Infectious proteins
 - Cause degenerative brain diseases
 - Examples: Creutzfeldt-Jakob disease
 - No current treatment
 - Require special sterilization

The Chain of Infection

Understanding the chain of infection helps healthcare workers prevent disease transmission by breaking any link in the chain.

Six Links in the Chain:

1. Infectious Agent (Pathogen)

- The microorganism causing disease
- Break this link: Proper cleaning and disinfection

2. Reservoir (Source)

- Where pathogens live and multiply
- Can be humans, animals, food, water, surfaces
- Break this link: Environmental cleaning, proper food handling

3. Portal of Exit

- How pathogens leave the reservoir
- Examples: Respiratory secretions, blood, feces, urine
- Break this link: Cover coughs, proper waste disposal

4. Mode of Transmission

- How pathogens spread
- Types:
 - Contact (direct/indirect)
 - Droplet
 - Airborne
 - Vector-borne
- Break this link: Hand hygiene, PPE, isolation

5. Portal of Entry

- How pathogens enter new host
- Examples: Breaks in skin, mucous membranes, respiratory tract
- Break this link: Intact skin, PPE, wound care

6. Susceptible Host

- Person who can develop infection
- Factors: Age, immune status, chronic disease
- Break this link: Vaccinations, good nutrition, rest

Hand Hygiene

Hand hygiene is the single most important way to prevent infection transmission. CNAs must master both handwashing and hand sanitizer use.

Handwashing Technique

1. Remove jewelry (except plain wedding band)
2. Turn on warm water
3. Wet hands and wrists
4. Apply soap
5. Lather and scrub for at least 20 seconds:
 - Palms together
 - Back of each hand
 - Between fingers
 - Under nails
 - Wrists
6. Rinse thoroughly under running water
7. Dry with paper towel
8. Use paper towel to turn off faucet
9. Discard towel

When to Wash Hands

- Before and after patient contact
- Before putting on gloves
- After removing gloves
- Before eating or handling food
- After using the restroom
- After blowing nose, coughing, or sneezing
- When visibly soiled
- After handling contaminated items

Alcohol-Based Hand Sanitizer

- Use when hands not visibly soiled
- Apply enough to cover all surfaces
- Rub hands together until dry (15-20 seconds)
- Don't rinse or wipe off

When Hand Sanitizer is NOT Effective

- Visibly dirty hands
- After caring for patients with *C. difficile*

- After caring for patients with norovirus
- Before eating
- After using restroom

Standard Precautions

Standard precautions are infection control practices used for ALL patients, regardless of diagnosis or infection status. They protect both healthcare workers and patients.

Key Components:

1. Hand Hygiene

- Before and after patient contact
- After contact with body fluids
- After touching patient environment

2. Personal Protective Equipment (PPE)

- Gloves for contact with body fluids
- Gowns for splash risk
- Masks for droplet protection
- Eye protection when splash risk

3. Respiratory Hygiene

- Cover coughs and sneezes
- Dispose of tissues properly
- Perform hand hygiene
- Wear mask if coughing

4. Safe Injection Practices

- Never recap needles
- Dispose in sharps containers
- One needle, one patient, one time

5. Environmental Cleaning

- Clean and disinfect surfaces
- Change linens between patients
- Proper waste disposal

6. Patient Placement

- Private room for patients who contaminate environment
- Cohort patients with same infection

Transmission-Based Precautions

Used in addition to standard precautions for patients with known or suspected infections. Three types exist:

Contact Precautions

- **Used for:** MRSA, VRE, C. difficile, scabies, impetigo
- **Requirements:**
 - Private room (or cohort)
 - Gloves and gown for all patient contact
 - Dedicated equipment
 - Hand hygiene critical
- **Key points:** Most common type of isolation

Droplet Precautions

- **Used for:** Influenza, pertussis, mumps, meningitis
- **Requirements:**
 - Private room
 - Mask within 3 feet of patient
 - Patient wears mask during transport
- **Key points:** Droplets travel 3-6 feet

Airborne Precautions

- **Used for:** Tuberculosis, measles, chickenpox, COVID-19

- **Requirements:**
 - Negative pressure room
 - N95 respirator (fit-tested)
 - Door must remain closed
 - Patient wears surgical mask during transport
- **Key points:** Particles remain suspended in air

Personal Protective Equipment (PPE)

Proper use of PPE protects healthcare workers from exposure to infectious materials.

Types of PPE:

1. Gloves

- Choose appropriate size
- Change between patients
- Never wash or reuse
- Remove if torn

2. Gowns

- Cover torso and arms
- Tie securely
- Remove if soiled
- Disposable or reusable

3. Masks

- Cover nose and mouth
- Secure ties or elastic
- Don't touch front
- Change if moist

4. Eye Protection

- Goggles or face shields
- Side protection important

- Clean between uses
- Personal glasses insufficient

5. N95 Respirators

- Require fit testing
- Check seal before entering room
- Special training needed
- Single use only

Donning (Putting On) PPE - Correct Order:

1. Perform hand hygiene
2. Gown
3. Mask/respirator
4. Goggles/face shield
5. Gloves (over gown cuffs)

Doffing (Removing) PPE - Correct Order:

1. Gloves
2. Goggles/face shield
3. Gown
4. Mask/respirator
5. Perform hand hygiene

Key PPE Principles:

- Remove in designated area
- Avoid contaminating yourself
- Discard in appropriate container
- Perform hand hygiene immediately

Healthcare-Associated Infections (HAIs)

HAIs are infections patients acquire while receiving healthcare. Common types include:

Catheter-Associated Urinary Tract Infections (CAUTIs)

- Most common HAI
- Prevention:
 - Insert only when necessary
 - Maintain closed system
 - Keep bag below bladder
 - Empty bag regularly
 - Perform perineal care daily
 - Remove as soon as possible

Central Line-Associated Bloodstream Infections (CLABSIs)

- Serious infections from IV lines
- Prevention:
 - Hand hygiene before handling
 - Keep dressing clean and dry
 - Report signs of infection
 - Never disconnect unnecessarily

Surgical Site Infections (SSIs)

- Infections at surgical incisions
- Prevention:
 - Keep incisions clean and dry
 - Monitor for signs of infection
 - Follow wound care protocols
 - Report drainage or redness

Ventilator-Associated Events (VAEs)

- Lung infections in ventilated patients
- Prevention:
 - Elevate head of bed 30-45 degrees
 - Oral care every 2-4 hours
 - Suction only when needed

- Hand hygiene before care

Cleaning and Disinfection

Proper cleaning and disinfection prevent pathogen transmission through the environment.

Definitions:

- **Cleaning:** Removing visible dirt and debris
- **Disinfection:** Killing most pathogens
- **Sterilization:** Killing all microorganisms

Cleaning Principles:

- Clean from cleanest to dirtiest
- Work from top to bottom
- Use friction when cleaning
- Allow proper contact time for disinfectants
- Change cleaning cloths frequently
- Never double-dip cloths

Levels of Disinfection:

1. **Low-level:** Kills most bacteria and some viruses
 - Used for: Floors, furniture, blood pressure cuffs
2. **Intermediate-level:** Kills bacteria, most viruses, and fungi
 - Used for: Surfaces contaminated with blood
3. **High-level:** Kills all microorganisms except some spores
 - Used for: Respiratory equipment, endoscopes

KEY TERMS

Asepsis: Absence of disease-causing microorganisms

Antimicrobial: Agent that kills or inhibits microorganisms

Colonization: Presence of microorganisms without symptoms

Contamination: Presence of microorganisms on surfaces or objects

Disinfection: Process of killing most pathogenic organisms

Fomite: Inanimate object that can harbor and transmit pathogens

Healthcare-Associated Infection (HAI): Infection acquired during healthcare

Pathogen: Disease-causing microorganism

Personal Protective Equipment (PPE): Barriers worn to prevent exposure

Standard Precautions: Basic infection control for all patients

Sterilization: Complete elimination of all microorganisms

Transmission-Based Precautions: Additional isolation measures for specific infections

PRACTICE QUESTIONS

1. The single most important way to prevent infection transmission is: a) Wearing gloves b) Hand hygiene c) Isolation precautions d) Antibiotics
2. Which link in the chain of infection do gloves primarily break? a) Infectious agent b) Reservoir c) Mode of transmission d) Susceptible host
3. When should you use soap and water instead of alcohol-based hand sanitizer? a) Between all patients b) When hands are visibly soiled c) Before eating lunch d) After removing gloves
4. A patient with MRSA requires which type of precautions? a) Standard only b) Droplet c) Airborne d) Contact
5. The correct order for putting on PPE is: a) Gloves, gown, mask, goggles b) Gown, mask, goggles, gloves c) Mask, gown, gloves, goggles d) Goggles, mask, gown, gloves
6. How far can droplets travel from a cough or sneeze? a) 1-2 feet b) 3-6 feet c) 10-12 feet d) Over 20 feet
7. Which infection requires airborne precautions? a) MRSA b) Influenza c) Tuberculosis d) Hepatitis B

8. The first step in removing PPE is to remove: a) Mask b) Gloves c) Gown d) Goggles
9. Standard precautions should be used: a) Only with infected patients b) Only when blood is visible c) With all patients at all times d) Only in isolation rooms
10. Which type of microorganism is treated with antibiotics? a) Viruses b) Bacteria c) Fungi d) Prions
11. To prevent catheter-associated UTIs, the drainage bag should be: a) Kept at bed level b) Kept below bladder level c) Emptied once daily d) Changed weekly
12. An N95 respirator is required for: a) Contact precautions b) Droplet precautions c) Airborne precautions d) Standard precautions
13. How long should you scrub when washing hands? a) 5 seconds b) 10 seconds c) 15 seconds d) 20 seconds
14. Which patient can alcohol-based hand sanitizer NOT be used with? a) MRSA infection b) C. difficile infection c) Influenza d) Pneumonia
15. The portal of entry in the chain of infection includes: a) Coughing b) Contaminated food c) Broken skin d) Dirty surfaces
16. Which PPE is removed last? a) Gloves b) Gown c) Mask d) Goggles

17. Environmental cleaning should progress from: a) Dirty to clean areas b) Clean to dirty areas c) Bottom to top d) Outside to inside

18. A patient with influenza requires: a) Contact precautions b) Droplet precautions c) Airborne precautions d) No special precautions

19. Sterilization differs from disinfection because it: a) Takes less time b) Kills all microorganisms c) Uses soap and water d) Only kills bacteria

20. Hand hygiene should be performed: a) Only when hands look dirty b) Only after patient contact c) Before and after patient contact d) Only when leaving the unit

ANSWER EXPLANATIONS

1. Correct answer: b) Hand hygiene

- Rationale: Hand hygiene is recognized as the single most important intervention to prevent infection transmission. While gloves (a), precautions (c), and antibiotics (d) play roles, proper hand hygiene is fundamental and universally applicable.

2. Correct answer: c) Mode of transmission

- Rationale: Gloves create a barrier that prevents pathogens from being transmitted via direct contact. They don't affect the infectious agent (a), reservoir (b), or host susceptibility (d), but interrupt the transmission pathway.

3. Correct answer: b) When hands are visibly soiled

- Rationale: Alcohol-based sanitizers don't remove visible dirt or organic material. Soap and water are also needed after using the restroom and before eating, but visible soiling is the key indicator mentioned in guidelines.

4. Correct answer: d) Contact

- Rationale: MRSA (Methicillin-resistant *Staphylococcus aureus*) is transmitted through direct contact with infected wounds or contaminated surfaces. Contact precautions prevent this transmission route

effectively.

5. Correct answer: b) Gown, mask, goggles, gloves

- Rationale: This sequence ensures maximum protection and prevents contamination. Gloves go on last to cover the gown cuffs, creating a complete barrier.

6. Correct answer: b) 3-6 feet

- Rationale: Respiratory droplets from coughs and sneezes typically travel 3-6 feet before falling to surfaces. This distance determines droplet precaution protocols.

7. Correct answer: c) Tuberculosis

- Rationale: TB bacteria can remain suspended in air for extended periods, requiring airborne precautions with negative pressure rooms and N95 respirators. MRSA (a) needs contact, influenza (b) needs droplet, and Hepatitis B (d) needs standard precautions.

8. Correct answer: b) Gloves

- Rationale: Gloves are removed first because they're most likely to be contaminated. This prevents spreading pathogens to other PPE or yourself during removal.

9. Correct answer: c) With all patients at all times

- Rationale: Standard precautions are the foundation of infection control, used universally regardless of diagnosis or suspected infection status. This protects both patients and healthcare workers.

10. Correct answer: b) Bacteria

- Rationale: Antibiotics specifically target bacteria. Viruses (a) need antivirals, fungi (c) need antifungals, and prions (d) have no current treatment.

11. Correct answer: b) Kept below bladder level

- Rationale: Keeping the drainage bag below bladder level prevents urine backflow, which could introduce bacteria into the bladder. The bag should be emptied regularly, not just daily.

12. Correct answer: c) Airborne precautions

- Rationale: N95 respirators filter tiny airborne particles and are required for airborne precautions. Regular surgical masks suffice for droplet precautions.

13. Correct answer: d) 20 seconds

- Rationale: CDC guidelines specify washing hands for at least 20 seconds to effectively remove microorganisms. This is often taught as the time to sing "Happy Birthday" twice.

14. Correct answer: b) C. difficile infection

- Rationale: C. difficile forms spores that alcohol cannot kill. Soap and water physically remove the spores. Alcohol sanitizer is effective against MRSA, influenza, and most pneumonia-causing organisms.

15. Correct answer: c) Broken skin

- Rationale: Portal of entry is how pathogens enter a new host. Broken skin provides direct access. Coughing (a) is portal of exit, while contaminated food (b) and surfaces (d) are

reservoirs.

16. Correct answer: c) Mask

- Rationale: Following proper doffing sequence, the mask is removed after gloves, goggles, and gown to prevent facial contamination from other PPE.

17. Correct answer: b) Clean to dirty areas

- Rationale: Cleaning from clean to dirty prevents spreading contamination to cleaner areas. This principle applies to both room cleaning and patient care.

18. Correct answer: b) Droplet precautions

- Rationale: Influenza spreads via large respiratory droplets, requiring droplet precautions including masks within 3 feet of the patient.

19. Correct answer: b) Kills all microorganisms

- Rationale: Sterilization eliminates all forms of microbial life including spores, while disinfection kills most but not all microorganisms. Sterilization typically takes more time and uses specialized methods.

20. Correct answer: c) Before and after patient contact

- Rationale: Hand hygiene before patient contact prevents bringing organisms to the patient; after contact prevents spreading organisms to others. This is a fundamental principle of infection control.

CHAPTER SUMMARY

Infection control is fundamental to safe patient care. Key concepts from this chapter include:

- The chain of infection has six links, and breaking any link prevents transmission
- Hand hygiene is the single most important infection prevention measure
- Standard precautions are used for all patients, regardless of diagnosis
- Transmission-based precautions (contact, droplet, airborne) supplement standard precautions
- Proper PPE use requires correct donning and doffing sequences
- Healthcare-associated infections are preventable through proper techniques
- Environmental cleaning and disinfection prevent indirect transmission

CNAs play a crucial role in preventing infections through consistent application of these principles. Remember that every interaction with patients and their environment is an opportunity to either prevent or potentially spread infection. Vigilance and proper technique protect both patients and healthcare workers.

CHAPTER 4: SAFETY AND EMERGENCY PROCEDURES

Learning Objectives

By the end of this chapter, you will be able to:

- Identify and prevent common safety hazards in healthcare settings
- Demonstrate proper body mechanics to prevent injury
- Apply fall prevention strategies
- Respond appropriately to various emergencies
- Understand fire safety and RACE/PASS procedures
- Recognize and respond to choking emergencies
- Identify signs of medical emergencies and appropriate responses

KEY CONCEPTS

Environmental Safety

Creating and maintaining a safe environment is a fundamental CNA responsibility. Environmental hazards can lead to injuries for both patients and staff.

Common Environmental Hazards

1. Wet Floors

- Major cause of slips and falls
- Clean spills immediately
- Use "Wet Floor" signs
- Ensure good lighting
- Report leaks promptly

2. Clutter

- Blocks emergency exits
- Creates trip hazards
- Impedes equipment movement
- Keep hallways clear
- Return equipment after use

3. Electrical Hazards

- Frayed cords
- Overloaded outlets
- Equipment near water
- Report damaged equipment
- Never use faulty equipment

4. Poor Lighting

- Increases fall risk
- Causes eye strain
- Affects accurate observation
- Report burned-out bulbs
- Use night lights

5. Temperature Extremes

- Can cause burns or hypothermia
- Check water temperature before bathing
- Monitor room temperature
- Adjust as needed for comfort

General Safety Principles

- Keep call lights within reach
- Lock wheels on beds and wheelchairs
- Keep bed in lowest position when unattended
- Use bed rails appropriately
- Store hazardous materials properly
- Follow facility policies
- Report unsafe conditions immediately

Body Mechanics

Proper body mechanics prevent injury to both CNAs and patients. Back injuries are the most common workplace injury for healthcare workers.

Principles of Proper Body Mechanics

1. Maintain Wide Base of Support

- Keep feet shoulder-width apart
- One foot slightly forward
- Provides stability
- Improves balance

2. Bend at Knees and Hips

- Never bend at waist alone
- Keep back straight
- Use leg muscles (strongest)
- Protect spine

3. Keep Load Close to Body

- Reduces strain on back
- Improves control
- Easier to balance
- Uses less energy

4. Pivot, Don't Twist

- Turn entire body as unit
- Move feet to turn
- Prevents back injury
- Maintains alignment

5. Use Smooth Movements

- Avoid jerky motions
- Count with partner
- Coordinate efforts
- Maintain control

6. Know Your Limits

- Ask for help when needed
- Use mechanical aids
- Don't lift alone if too heavy
- Follow weight restrictions

Safe Lifting Technique

1. Assess the load
2. Get help if needed
3. Stand close to object

4. Bend knees, not back
5. Grip firmly
6. Lift with legs
7. Keep load close
8. Turn by pivoting feet
9. Lower by bending knees

Using Assistive Devices

- **Gait belts:** Provide secure grip for transfers
- **Slide boards:** Reduce friction during transfers
- **Mechanical lifts:** For dependent patients
- **Draw sheets:** For repositioning in bed
- **Wheelchairs:** Lock before transfers
- **Walkers/canes:** Check rubber tips

Fall Prevention

Falls are the leading cause of injury in healthcare facilities. CNAs play a crucial role in fall prevention.

Fall Risk Factors

1. Physical Factors

- Age over 65
- Muscle weakness
- Balance problems
- Vision impairment
- Chronic conditions
- Medication effects

2. Environmental Factors

- Cluttered rooms
- Poor lighting
- Wet floors

- Inappropriate footwear
- Unfamiliar surroundings
- Unstable furniture

3. Behavioral Factors

- Rushing
- Not using assistive devices
- Refusing help
- Confusion
- Poor judgment
- Overestimating abilities

Fall Prevention Strategies

1. Assessment and Identification

- Know who is at risk
- Use fall risk assessment tools
- Identify specific risk factors
- Update assessments regularly

2. Environmental Modifications

- Remove clutter
- Ensure adequate lighting
- Keep frequently used items within reach
- Use non-slip mats
- Ensure clear pathways

3. Patient Interventions

- Answer call lights promptly
- Assist with toileting regularly
- Encourage use of assistive devices
- Provide proper footwear
- Orient confused patients

4. Communication

- Use fall risk identifiers (wristbands, signs)
- Report changes in condition
- Document interventions
- Educate patients and families

Post-Fall Protocol

1. Stay with the patient
2. Don't move them initially
3. Check for injuries
4. Call for nurse immediately
5. Take vital signs if trained
6. Document thoroughly
7. Report to supervisor
8. Complete incident report

Fire Safety

Healthcare facilities must have comprehensive fire safety plans. All staff must know procedures and participate in drills.

RACE Procedure (When Fire Discovered)

R - Rescue

- Remove anyone in immediate danger
- Move to safe area
- Assist those who cannot self-evacuate
- Close doors behind you

A - Alarm

- Activate nearest fire alarm
- Call emergency code
- Give specific location
- Alert others in area

C - Contain

- Close all doors and windows
- Turn off oxygen if safe
- Prevent fire spread
- Never use elevators

E - Extinguish/Evacuate

- Use extinguisher if fire is small
- Evacuate if fire is large
- Follow evacuation plan
- Move horizontally first, then vertically

PASS Technique (Using Fire Extinguisher)

P - Pull

- Pull the pin
- Break tamper seal
- Hold extinguisher upright

A - Aim

- Aim at base of fire
- Not at flames
- Stand 6-8 feet away

S - Squeeze

- Squeeze handle slowly
- Release pressure evenly
- Control discharge

S - Sweep

- Sweep side to side

- Cover base of fire
- Continue until fire out
- Watch for re-ignition

Fire Prevention

- Know location of exits, alarms, and extinguishers
- Keep exits clear
- Follow smoking policies
- Report electrical problems
- Don't overload outlets
- Store flammables properly
- Participate in fire drills

Emergency Response Procedures

CNAs must be prepared to respond to various medical emergencies while staying within their scope of practice.

Choking (Foreign Body Airway Obstruction)

Conscious Adult Choking

1. Ask "Are you choking?"
2. If yes and can't cough/speak:
3. Stand behind victim
4. Make fist with one hand
5. Place thumb side against abdomen (above navel, below ribcage)
6. Grasp fist with other hand
7. Give quick upward thrusts
8. Continue until object expelled or victim unconscious

Unconscious Choking

1. Call for help

2. Lower to floor
3. Begin CPR
4. Check mouth before breaths
5. Continue until help arrives

Seizures

During Seizure:

1. Stay calm
2. Note time seizure started
3. Protect from injury:
 - Move objects away
 - Cushion head
 - Loosen tight clothing
4. Turn on side if possible
5. NEVER:
 - Put anything in mouth
 - Restrain movements
 - Give fluids

After Seizure:

1. Check breathing
2. Keep on side
3. Stay with patient
4. Report to nurse
5. Document details
6. Monitor vital signs

Fainting (Syncope)

Prevention:

- Recognize warning signs (dizziness, pallor, sweating)
- Have patient sit or lie down

- Lower head between knees if sitting

If Patient Faints:

1. Ease to floor/bed
2. Position flat
3. Elevate legs 12 inches
4. Loosen tight clothing
5. Check breathing
6. Apply cool compress
7. Report to nurse

Hemorrhage (Severe Bleeding)

1. Call for help immediately
2. Put on gloves
3. Apply direct pressure with clean cloth
4. Don't remove original cloth if soaked
5. Add more layers
6. Elevate if possible
7. Continue pressure until help arrives
8. Monitor vital signs
9. Treat for shock

Shock

Signs:

- Rapid, weak pulse
- Cold, clammy skin
- Rapid, shallow breathing
- Anxiety or confusion
- Pale or bluish skin
- Dilated pupils

Treatment:

1. Call for help
2. Keep patient lying flat
3. Elevate legs 12 inches (unless head/chest injury)
4. Maintain body temperature
5. Don't give fluids
6. Monitor vital signs
7. Provide reassurance

Disaster Preparedness

Healthcare facilities must be prepared for both internal and external disasters.

Types of Disasters

- Natural: Earthquakes, floods, tornadoes, hurricanes
- Man-made: Chemical spills, terrorism, mass casualties
- Internal: Fire, power failure, water loss

CNA Role in Disasters

1. Know facility's disaster plan
2. Participate in drills
3. Know evacuation routes
4. Follow chain of command
5. Stay calm
6. Protect patients
7. Document actions

General Disaster Response

- Report to assigned area
- Await instructions
- Assist with patient needs
- Maintain patient safety

- Preserve resources
- Communicate clearly
- Document events

Workplace Violence Prevention

Healthcare workers face increased risk of workplace violence. CNAs must recognize and respond to potentially violent situations.

Warning Signs

- Verbal threats
- Aggressive body language
- History of violence
- Substance abuse
- Psychiatric conditions
- Increased agitation

De-escalation Techniques

1. Remain calm
2. Speak slowly and clearly
3. Maintain safe distance
4. Avoid arguing
5. Acknowledge feelings
6. Set limits
7. Offer choices
8. Get help if needed

Personal Safety

- Trust instincts
- Position near exit
- Remove potential weapons
- Work in pairs when possible
- Know emergency codes

- **Report all incidents**

KEY TERMS

Body Mechanics: Using body efficiently and safely during activity

De-escalation: Techniques to reduce tension and prevent violence

Ergonomics: Science of fitting job to worker to prevent injury

RACE: Fire response acronym (Rescue, Alarm, Contain, Extinguish/Evacuate)

PASS: Fire extinguisher use (Pull, Aim, Squeeze, Sweep)

Syncope: Medical term for fainting

Workplace Violence: Physical assault, threatening behavior, or verbal abuse in workplace

PRACTICE QUESTIONS

1. When lifting a heavy object, you should: a) Bend at the waist b) Keep feet together c) Bend at knees and hips d) Twist while lifting
2. The first action when discovering a fire is: a) Activate the alarm b) Rescue anyone in danger c) Get an extinguisher d) Call 911
3. A patient begins choking while eating. They cannot speak or cough. You should: a) Give them water b) Perform abdominal thrusts c) Hit their back d) Wait for them to cough
4. Which increases fall risk? a) Night lights b) Non-slip footwear c) Clutter in room d) Grab bars
5. The "S" in PASS stands for: a) Safety b) Squeeze c) Stop d) Spray
6. To prevent back injury, keep the load: a) At arm's length b) Close to your body c) Above shoulder height d) To one side
7. When a patient has a seizure, you should: a) Put something in their mouth b) Restrain their movements c) Protect them from injury d) Give them water
8. The base of support should be: a) Narrow for stability b) Feet together c) Shoulder-width

apart d) One foot only

9. Signs of shock include: a) Warm, dry skin b) Slow, strong pulse c) Cold, clammy skin d) High blood pressure
10. After a patient falls, first: a) Help them up immediately b) Stay with them and check for injury c) Leave to get help d) Move them to bed
11. To use a fire extinguisher, aim at: a) Top of flames b) Middle of fire c) Base of fire d) Ceiling above fire
12. When using a gait belt: a) Grab patient's clothing b) Hold belt with underhand grip c) Let patient hold belt d) Keep belt loose
13. Fall risk factors include all EXCEPT: a) Age under 65 b) Medication effects c) Poor vision d) Muscle weakness
14. During evacuation, move patients: a) Vertically first b) To parking lot c) Horizontally first d) By elevator
15. For conscious choking, place fist: a) On chest b) Above navel c) On back d) Below ribs
16. When pivoting during transfer: a) Twist at waist b) Move feet to turn c) Keep feet planted d) Bend forward
17. Warning signs of violence include: a) Calm demeanor b) Relaxed posture c) Verbal threats d) Cooperation

18. Post-fall protocol includes: a) Immediate mobilization b) Completing incident report c) Waiting until end of shift d) Not documenting
19. Electrical safety includes: a) Using equipment with frayed cords b) Overloading outlets c) Reporting damaged equipment d) Using equipment near water
20. The strongest muscles for lifting are: a) Back muscles b) Arm muscles c) Leg muscles d) Shoulder muscles

ANSWER EXPLANATIONS

1. **Correct answer: c) Bend at knees and hips**

- Rationale: Bending at knees and hips while keeping back straight uses strong leg muscles and protects the spine. Bending at waist (a) strains back, feet together (b) reduces stability, and twisting (d) can cause injury.

2. **Correct answer: b) Rescue anyone in danger**

- Rationale: RACE prioritizes human life - Rescue comes first. After ensuring immediate safety, then activate alarm (a), contain fire, and extinguish if safe or evacuate.

3. **Correct answer: b) Perform abdominal thrusts**

- Rationale: When someone cannot speak, cough, or breathe, perform abdominal thrusts (Heimlich maneuver) immediately. Water (a) could worsen obstruction, back blows (c) are for infants, and waiting (d) delays critical intervention.

4. **Correct answer: c) Clutter in room**

- Rationale: Clutter creates trip hazards and obstacles. Night lights (a), non-slip footwear (b), and grab bars (d) all reduce fall risk by improving visibility, traction, and support.

5. **Correct answer: b) Squeeze**

- Rationale: PASS stands for Pull, Aim, Squeeze, Sweep. This sequence ensures proper

fire extinguisher use.

6. Correct answer: b) Close to your body

- Rationale: Keeping loads close to body's center of gravity reduces back strain and improves control. Extended arms (a), high loads (c), and side loading (d) all increase injury risk.

7. Correct answer: c) Protect them from injury

- Rationale: During seizures, protect the patient by moving objects away and cushioning their head. Never put objects in mouth (a), restrain (b), or give fluids (d) as these can cause injury.

8. Correct answer: c) Shoulder-width apart

- Rationale: A shoulder-width stance provides optimal stability and balance. Narrow stances (a, b, d) increase fall risk and reduce lifting power.

9. Correct answer: c) Cold, clammy skin

- Rationale: Shock causes poor circulation, resulting in cold, clammy skin, rapid weak pulse, and low blood pressure. Warm dry skin (a), strong pulse (b), and high BP (d) are not shock symptoms.

10. Correct answer: b) Stay with them and check for injury

- Rationale: Never move a fallen patient immediately (a) as this could worsen injuries. Stay with them for safety and assessment. Leaving them (c) is abandonment.

11. Correct answer: c) Base of fire

- Rationale: Aim at the base where fuel meets

oxygen to break the fire triangle. Aiming at flames (a, b) or above (d) is ineffective.

12. Correct answer: b) Hold belt with underhand grip

- o Rationale: Underhand grip provides secure hold and better control. Never grab clothing (a), patient shouldn't hold belt (c), and loose belts (d) are unsafe.

13. Correct answer: a) Age under 65

- o Rationale: Age over 65 increases fall risk. Under 65 (a) is generally associated with lower fall risk, while medication effects (b), poor vision (c), and weakness (d) all increase risk.

14. Correct answer: c) Horizontally first

- o Rationale: Fire evacuation moves patients horizontally to safety on same floor first, then vertically if needed. Elevators (d) are never used during fires.

15. Correct answer: b) Above navel

- o Rationale: For abdominal thrusts, place fist above navel and below ribcage. This location effectively forces air from lungs to expel obstruction.

16. Correct answer: b) Move feet to turn

- o Rationale: Pivoting means turning whole body by moving feet, preventing back injury from twisting (a). Keeping feet planted (c) forces twisting.

17. Correct answer: c) Verbal threats

- o Rationale: Verbal threats are clear warning

signs of potential violence. Calm demeanor (a), relaxed posture (b), and cooperation (d) indicate non-threatening behavior.

18. Correct answer: b) Completing incident report

- Rationale: Falls require thorough documentation including incident reports. Immediate mobilization (a) risks further injury, waiting (c) delays reporting, and not documenting (d) violates policy.

19. Correct answer: c) Reporting damaged equipment

- Rationale: Reporting damaged equipment prevents electrical injuries. Using frayed cords (a), overloading outlets (b), and water exposure (d) all create electrical hazards.

20. Correct answer: c) Leg muscles

- Rationale: Leg muscles are the body's strongest and should be used for lifting. Back muscles (a) are easily injured, while arm (b) and shoulder (d) muscles are weaker than legs.

CHAPTER SUMMARY

Safety and emergency preparedness are critical CNA responsibilities. Key points include:

- Environmental safety requires identifying and eliminating hazards
- Proper body mechanics prevent injury to both staff and patients
- Fall prevention involves assessment, intervention, and environmental modification
- Fire safety follows RACE for response and PASS for extinguisher use
- Emergency responses must be swift and appropriate to the situation
- Choking requires immediate intervention with abdominal thrusts
- Seizure care focuses on protection, not restraint
- Disaster preparedness includes knowing facility plans and participating in drills
- Workplace violence prevention uses recognition and de-escalation

CNAs are often first responders to emergencies in healthcare settings. Proper training, regular practice, and calm response can save lives and prevent injuries. Always work within your scope of practice and seek help when needed.

CHAPTER 5: PERSONAL CARE SKILLS

Learning Objectives

By the end of this chapter, you will be able to:

- Demonstrate proper techniques for bathing and personal hygiene
- Perform safe and dignified perineal care
- Assist with grooming activities including hair, nail, and oral care
- Help patients with dressing and undressing
- Provide appropriate skin care and pressure injury prevention
- Maintain patient dignity and privacy during personal care

KEY CONCEPTS

Principles of Personal Care

Personal care is one of the most intimate aspects of nursing assistant work. These activities require sensitivity, respect, and technical skill to maintain patient dignity while ensuring cleanliness and health.

Universal Principles for All Personal Care:

1. Privacy and Dignity

- Always close doors and curtains
- Keep patient covered except area being cleaned
- Knock before entering
- Explain procedures before starting
- Allow choices when possible

2. Safety

- Check water temperature (105-115°F)
- Use non-slip mats
- Lock wheelchair brakes
- Keep call light within reach
- Never leave confused patients alone with water

3. Communication

- Explain each step
- Ask about preferences
- Encourage participation
- Report concerns or changes

- Document care provided

4. Infection Control

- Perform hand hygiene before and after
- Wear gloves for contact with body fluids
- Change gloves between tasks
- Use clean supplies for each patient
- Work from clean to dirty areas

5. Comfort

- Warm the room
- Gather supplies before starting
- Work efficiently but don't rush
- Pat skin dry, don't rub
- Apply lotion to dry areas

Bathing and Showering

Bathing serves multiple purposes: cleanliness, circulation stimulation, observation opportunity, and comfort. The type of bath depends on patient condition and preferences.

Types of Baths

1. Complete Bed Bath

- For patients who cannot get out of bed
- Wash entire body in bed
- Change water when cool or soapy
- Usually requires 2 basins

2. Partial Bath

- Face, hands, axillae, perineum
- For patients who can do some self-care
- Focus on areas that need daily attention

3. Shower

- For ambulatory patients
- Use shower chair if needed
- Never leave patient alone
- Ensure non-slip surface

4. Tub Bath

- Rarely used in facilities
- Requires special equipment
- High fall risk
- Need mechanical lift often

Complete Bed Bath Procedure

Supplies Needed:

- Bath basin
- Washcloths (at least 4)
- Bath towels (at least 2)
- Soap
- Lotion
- Clean gown/clothes
- Bath blanket
- Gloves
- Linen bag

Steps:

1. Explain procedure and provide privacy
2. Offer bedpan/urinal first
3. Raise bed to working height
4. Remove top linens, cover with bath blanket
5. Fill basin with warm water (test temperature)
6. Put on gloves
7. Make mitt with washcloth
8. Wash eyes from inner to outer corner (no soap)

9. Wash face, ears, neck
10. Remove gown/pajamas
11. Place towel under far arm
12. Wash far arm from fingers to axilla
13. Rinse and dry thoroughly
14. Repeat with near arm
15. Wash chest and abdomen
16. Cover upper body
17. Uncover far leg
18. Place towel under leg
19. Wash from ankle to thigh
20. Wash foot (place in basin if possible)
21. Dry thoroughly, especially between toes
22. Repeat with near leg
23. Change water
24. Turn patient on side
25. Wash back from neck to buttocks
26. Provide back massage with lotion
27. Change water and gloves
28. Perform perineal care
29. Help patient dress
30. Lower bed, ensure safety
31. Document care

Key Points for Bathing:

- Always wash from clean to dirty
- Change washcloths between body parts
- Support joints when washing extremities
- Observe skin for redness, breaks, or changes
- Keep patient warm throughout
- Allow patient to help as able
- Never use soap on eyes

Perineal Care

Perineal care (peri-care) is cleaning the genital and anal areas. It's crucial for preventing infection and maintaining skin integrity.

When to Provide Perineal Care:

- During daily bathing
- After bowel movements
- After urination for incontinent patients
- When catheters present
- Before and after catheter insertion
- As needed for comfort

Female Perineal Care

Position: Supine with knees bent and separated

Procedure:

1. Put on gloves
2. Cover patient with bath blanket
3. Position waterproof pad under buttocks
4. Separate labia with non-dominant hand
5. Using dominant hand, wash from front to back:
 - Use single strokes
 - Clean downward strokes
 - Use clean area of cloth for each stroke
6. Clean from pubis to rectum
7. Rinse thoroughly
8. Dry gently, front to back
9. Turn to side and clean anal area
10. Apply barrier cream if ordered

Male Perineal Care

Procedure:

1. Put on gloves
2. Provide privacy
3. Retract foreskin if uncircumcised
4. Clean tip of penis with circular motion
5. Clean shaft from tip to base
6. Clean scrotum and groin
7. Return foreskin to natural position
8. Turn to side and clean anal area
9. Rinse and dry thoroughly
10. Apply barrier cream if ordered

Important Considerations:

- Always clean from cleanest to dirtiest area
- Use gentle motions to avoid tissue damage
- Never leave foreskin retracted
- Report any unusual discharge, odor, or irritation
- Be matter-of-fact and professional
- Respect cultural preferences

Grooming and Hygiene

Good grooming promotes self-esteem, dignity, and health. CNAs assist with various grooming tasks based on patient abilities.

Hair Care

Daily Hair Care:

1. Ask about preferences
2. Section long hair
3. Brush gently from ends upward
4. Use wide-tooth comb for tangles
5. Avoid pulling
6. Style as patient prefers
7. Use patient's own supplies

Shampooing:

- Bed-bound: Use inflatable basin
- Wheelchair: Roll to sink
- Ambulatory: Assist in shower
- Dry shampoo for quick cleaning

Special Considerations:

- Cultural/religious practices
- Chemotherapy patients (gentle handling)
- Matted hair (never cut without permission)
- Lice or other infestations (report)

Shaving

Safety Razor Shaving:

1. Only if facility allows
2. Check for bleeding precautions
3. Apply warm cloth to soften beard
4. Apply shaving cream
5. Hold skin taut
6. Shave in direction of hair growth
7. Rinse frequently
8. Apply aftershave if desired

Electric Razor:

- Preferred for most patients
- Safer for patients on blood thinners
- Clean after each use
- Check for frayed cords
- Don't use near oxygen

Nail Care

Fingernails:

1. Soak in warm water
2. Clean under nails
3. Trim straight across
4. File rough edges
5. Apply lotion

Important: Many facilities require nurse or podiatrist to trim toenails, especially for diabetic patients

Oral Care

Good oral hygiene prevents infection, maintains comfort, and promotes appetite.

Conscious Patient with Natural Teeth:

1. Gather supplies
2. Elevate head of bed
3. Place towel across chest
4. Apply toothpaste
5. Brush all surfaces:
 - Outer surfaces
 - Inner surfaces
 - Chewing surfaces
 - Tongue
6. Allow patient to rinse and spit
7. Floss if patient desires
8. Apply lip moisturizer

Unconscious Patient:

1. Position on side
2. Open mouth with padded tongue blade
3. Use toothettes with small amount of

mouthwash

4. Clean all surfaces
5. Suction as needed
6. Apply lip moisturizer
7. Never use regular toothbrush (choking risk)

Denture Care:

1. Line sink with towel
2. Remove dentures (lower first, then upper)
3. Rinse under cool water
4. Brush all surfaces
5. Rinse patient's mouth
6. Return dentures (upper first, then lower)
7. Store in labeled container if not wearing

Dressing and Undressing

Assisting with dressing maintains dignity and promotes independence. Always encourage self-care when possible.

General Guidelines:

- Provide privacy
- Let patient choose clothing
- Dress affected/weak side first
- Undress affected/weak side last
- Don't rush
- Ensure proper fit
- Check for skin problems

Dressing Patient with Affected Side:

Putting On:

1. Sleeve on affected arm first
2. Pull garment across back

3. Sleeve on unaffected arm
4. Button/fasten

Taking Off:

1. Unbutton/unfasten
2. Remove from unaffected arm first
3. Remove from affected arm
4. Avoid pulling on affected limb

Special Considerations:

- Adaptive clothing with Velcro
- Front-opening garments easier
- Non-slip socks
- Proper fitting shoes
- Compression stockings as ordered

Skin Care and Pressure Injury Prevention

Skin is the body's largest organ and first defense against infection. CNAs play crucial role in maintaining skin integrity.

Factors Affecting Skin Integrity:

- Immobility
- Moisture (urine, stool, sweat)
- Poor nutrition
- Decreased circulation
- Age-related changes
- Chronic conditions

Pressure Injury Development

Pressure injuries (bedsores, decubitus ulcers) develop when pressure cuts off blood flow to skin.

Common Pressure Points:

- Sacrum/coccyx
- Heels
- Elbows
- Shoulder blades
- Back of head
- Hips
- Ankles
- Ears

Stages of Pressure Injuries:

Stage 1: Non-blanchable redness on intact skin **Stage 2:** Partial thickness skin loss, looks like blister **Stage 3:** Full thickness skin loss, fat visible **Stage 4:** Full thickness with exposed bone/muscle **Unstageable:** Base covered by dead tissue **Deep Tissue:** Purple/maroon intact skin

Prevention Measures:

1. Reposition every 2 hours minimum

- Use turning schedules
- Document position changes
- Use pillows for support

2. Keep skin clean and dry

- Clean immediately after incontinence
- Use barrier creams
- Change wet linens promptly

3. Reduce pressure

- Use pressure-reducing mattresses
- Float heels off bed
- Use cushions in chairs

- Avoid donut cushions

4. Nutrition and hydration

- Encourage adequate intake
- Report poor appetite
- Assist with feeding

5. Inspect skin daily

- During bathing
- During position changes
- Report any changes immediately

6. Avoid friction and shearing

- Lift, don't drag
- Keep head of bed low when possible
- Use draw sheets

KEY TERMS

Axilla: Armpit area

Decubitus Ulcer: Pressure injury/bedsore

Edentulous: Without natural teeth

Perineum: Genital and anal area

Shearing: Skin layers sliding against each other

Toileting: Assisting with elimination needs

PRACTICE QUESTIONS

1. When bathing a patient, you should wash from:
a) Dirty to clean areas b) Clean to dirty areas c) Any direction d) Bottom to top
2. The correct temperature for bath water is:
a) 95-100°F b) 105-115°F c) 120-125°F d) 130-135°F
3. When providing female perineal care, wipe: a) Back to front b) In circular motions c) Front to back d) Side to side
4. For a patient with left-sided weakness, dress the: a) Right side first b) Left side first c) Both sides together d) Upper body first
5. How often should immobile patients be repositioned? a) Every hour b) Every 2 hours c) Every 4 hours d) Once per shift
6. When washing a patient's eyes, use: a) Soap and water b) Water only c) Alcohol wipes d) Hydrogen peroxide
7. Stage 1 pressure injury appears as: a) Open wound b) Blister c) Non-blanchable redness d) Purple intact skin
8. When caring for dentures, use: a) Hot water b) Cool water c) Mouthwash only d) Toothpaste only

9. Electric razors are preferred for patients on: a) Antibiotics b) Blood thinners c) Pain medication d) Vitamins
10. During oral care for an unconscious patient, position them: a) Flat on back b) In high Fowler's c) On their side d) In Trendelenburg
11. The most common site for pressure injuries is: a) Heels b) Elbows c) Sacrum/coccyx d) Shoulders
12. When undressing a patient with right arm weakness, remove the: a) Right sleeve first b) Left sleeve first c) Both sleeves together d) Bottom garments first
13. Perineal care should be provided: a) Weekly b) Daily only c) After each incontinence episode d) Only during full baths
14. Bath water should be changed when: a) Cool or soapy b) After washing face c) Every 5 minutes d) Only once during bath
15. Pressure injuries can develop in as little as: a) 30 minutes b) 2 hours c) 8 hours d) 24 hours
16. When shampooing hair in bed, protect the mattress with: a) Extra blankets b) Waterproof pads c) Bath towels only d) Nothing needed
17. For uncircumcised males, after cleaning you must: a) Leave foreskin retracted b) Apply antibiotic cream c) Return foreskin to natural

position d) Tape in place

18. Fingernails should be trimmed: a) In rounded shape b) Straight across c) To points d) Very short

19. A full thickness wound with visible fat is: a) Stage 1 b) Stage 2 c) Stage 3 d) Stage 4

20. When providing back massage, avoid: a) Lotion b) Long strokes c) Bony prominences d) Muscle areas

ANSWER EXPLANATIONS

1. Correct answer: b) Clean to dirty areas

- Rationale: Always wash from cleanest to dirtiest areas to prevent spreading microorganisms. This principle applies to all patient care to reduce infection risk.

2. Correct answer: b) 105-115°F

- Rationale: This temperature range is warm enough for comfort and cleaning but not hot enough to burn. Always test water temperature before patient contact.

3. Correct answer: c) Front to back

- Rationale: Wiping front to back prevents bringing bacteria from anal area to urethra, reducing UTI risk. This is especially important for female anatomy.

4. Correct answer: b) Left side first

- Rationale: Always dress the affected/weak side first as it requires less movement and is easier when the unaffected side is still free to help. This follows the principle "dress weak side first, undress weak side last."

5. Correct answer: b) Every 2 hours

- Rationale: Repositioning every 2 hours is the minimum standard to prevent pressure injuries. Some high-risk patients may need more frequent turning.

6. Correct answer: b) Water only

- Rationale: Soap can irritate eyes and should never be used. Clean water with separate corners of washcloth for each eye prevents cross-contamination.

7. Correct answer: c) Non-blanchable redness

- Rationale: Stage 1 pressure injuries show persistent redness that doesn't turn white (blanch) when pressed. Skin remains intact but damaged underneath.

8. Correct answer: b) Cool water

- Rationale: Hot water can warp dentures. Cool or lukewarm water is safe and comfortable. Line sink with towel to prevent breaking if dropped.

9. Correct answer: b) Blood thinners

- Rationale: Patients on anticoagulants (blood thinners) bleed more easily from cuts. Electric razors eliminate this risk while still providing grooming.

10. Correct answer: c) On their side

- Rationale: Side-lying position prevents aspiration if fluids accumulate in mouth. Never perform oral care with unconscious patient flat on back.

11. Correct answer: c) Sacrum/coccyx

- Rationale: The sacral area bears the most pressure when lying supine and is the most common site for pressure injuries, especially in bed-bound patients.

12. Correct answer: b) Left sleeve first

- Rationale: When undressing, remove clothing from unaffected side first. This is opposite of dressing (weak side last when undressing, first when dressing).

13. Correct answer: c) After each incontinence episode

- Rationale: Immediate cleaning after incontinence prevents skin breakdown from moisture and bacteria. Daily care alone is insufficient for incontinent patients.

14. Correct answer: a) Cool or soapy

- Rationale: Change water when it becomes cool (uncomfortable) or too soapy (leaves residue). Also change between washing upper/lower body and before perineal care.

15. Correct answer: b) 2 hours

- Rationale: Pressure injuries can begin developing in as little as 2 hours of unrelieved pressure, which is why repositioning every 2 hours is critical.

16. Correct answer: b) Waterproof pads

- Rationale: Waterproof pads protect the mattress from water damage during bed shampooing. Towels alone may allow water to seep through.

17. Correct answer: c) Return foreskin to natural position

- Rationale: Leaving foreskin retracted can cause paraphimosis (medical emergency)

where circulation is cut off. Always return to natural position after cleaning.

18. Correct answer: b) Straight across

- Rationale: Trimming nails straight across prevents ingrown nails. Rounded edges can grow into skin, especially problematic for diabetic patients.

19. Correct answer: c) Stage 3

- Rationale: Stage 3 pressure injuries involve full thickness skin loss with visible fat but no exposed muscle or bone (which would be Stage 4).

20. Correct answer: c) Bony prominences

- Rationale: Avoid massaging over bony areas as this can damage fragile skin and tissues. Massage muscle areas with lotion using long, smooth strokes.

CHAPTER SUMMARY

Personal care forms the foundation of nursing assistant practice. Key takeaways include:

- Privacy, dignity, and safety are paramount during all personal care activities
- Always work from clean to dirty areas to prevent infection
- Bathing provides opportunity for skin assessment and patient interaction
- Perineal care requires meticulous technique to prevent UTIs
- Grooming activities maintain self-esteem and health
- Dress affected side first, undress affected side last
- Pressure injuries can develop in as little as 2 hours
- Prevention through repositioning, skin care, and observation is essential
- Report all skin changes immediately

Personal care tasks offer valuable opportunities to observe patients, provide comfort, and maintain their highest level of independence. These intimate care activities require both technical skill and compassionate delivery.

CHAPTER 6: BASIC NURSING SKILLS

Learning Objectives

By the end of this chapter, you will be able to:

- Accurately measure and record vital signs
- Position patients safely using proper body alignment
- Perform safe transfers and ambulation techniques
- Measure and record height and weight
- Assist with elimination needs
- Provide proper nutrition and hydration support
- Maintain accurate intake and output records

KEY CONCEPTS

Vital Signs

Vital signs are measurements of the body's basic functions and provide crucial information about patient health status. CNAs must measure accurately and recognize abnormal values.

The Four Main Vital Signs:

1. Temperature
2. Pulse
3. Respirations
4. Blood Pressure

Additional Measurements:

- Pain (5th vital sign)
- Oxygen saturation (pulse oximetry)

Temperature

Body temperature reflects the balance between heat production and heat loss. Normal range varies by measurement site.

Normal Temperature Ranges:

- Oral: 97.6-99.6°F (36.4-37.6°C)
- Rectal: 98.6-100.6°F (37.0-38.1°C)
- Axillary: 96.6-98.6°F (35.9-37.0°C)
- Tympanic: 97.6-99.6°F (36.4-37.6°C)

- Temporal: 97.6-99.6°F (36.4-37.6°C)

Factors Affecting Temperature:

- Time of day (lowest in morning)
- Age (elderly have lower temps)
- Exercise
- Emotions
- Illness
- Medications
- Environment
- Menstrual cycle

Types of Thermometers:

1. Electronic/Digital

- Most common
- Quick reading
- Disposable probe covers
- Audible signal when ready

2. Tympanic (Ear)

- Measures infrared heat
- Very quick
- Position properly in ear
- Not for ear infections

3. Temporal Artery

- Scans forehead
- Non-invasive
- Good for children
- Affected by sweating

4. Glass (Mercury)

- Rarely used now

- Safety hazard if breaks
- Must shake down
- Takes longer

Taking Oral Temperature:

1. Wash hands
2. Ensure no hot/cold intake for 15 minutes
3. Cover probe with disposable cover
4. Place under tongue in posterior sublingual pocket
5. Instruct to close lips, not bite
6. Wait for signal
7. Remove and read
8. Dispose of probe cover
9. Record immediately

When NOT to Take Oral Temperature:

- Unconscious patients
- Confused patients
- Seizure risk
- Mouth breathers
- Recent oral surgery
- Children under 5
- Patients on oxygen

Taking Rectal Temperature:

1. Provide privacy
2. Position in Sims' (side-lying)
3. Put on gloves
4. Lubricate probe
5. Separate buttocks
6. Insert 1-1.5 inches in adults
7. Hold in place
8. Wait for signal

9. Remove slowly
10. Clean patient if needed
11. Document as rectal temp

Taking Axillary Temperature:

1. Least accurate method
2. Dry axilla first
3. Place probe in center
4. Lower arm across chest
5. Hold in place
6. Wait for signal (takes longer)
7. Document as axillary

Pulse

Pulse is the wave of blood pushed through arteries with each heartbeat. It indicates heart rate and rhythm.

Normal Pulse Rates:

- Adults: 60-100 beats per minute (bpm)
- Children: 80-120 bpm
- Infants: 120-160 bpm

Pulse Characteristics:

- **Rate:** Number of beats per minute
- **Rhythm:** Regular or irregular pattern
- **Volume:** Strong, weak, thready, bounding

Common Pulse Sites:

1. **Radial** (wrist) - most common
2. **Apical** (heart) - most accurate
3. **Carotid** (neck) - emergencies
4. **Brachial** (inner elbow) - BP/infants

5. **Femoral** (groin) - emergencies
6. **Pedal** (foot) - circulation checks

Taking Radial Pulse:

1. Position arm comfortably
2. Locate pulse with 2-3 fingers
3. Don't use thumb (has own pulse)
4. Count for 60 seconds if irregular
5. Count for 30 seconds x 2 if regular
6. Note rhythm and strength
7. Document findings

Taking Apical Pulse:

1. Position patient supine or sitting
2. Locate 5th intercostal space, mid-clavicular line
3. Place stethoscope diaphragm
4. Count for full 60 seconds
5. Note any irregularities
6. Used for cardiac patients

Factors Affecting Pulse:

- Exercise/activity
- Stress/emotions
- Fever
- Medications
- Blood loss
- Position changes
- Age

Respirations

Respiration involves breathing in (inspiration) and breathing out (expiration). One respiration = one inspiration + one expiration.

Normal Respiratory Rates:

- Adults: 12-20 per minute
- Children: 20-30 per minute
- Infants: 30-60 per minute

Respiratory Characteristics:

- **Rate:** Breaths per minute
- **Depth:** Deep, shallow, normal
- **Pattern:** Regular, irregular
- **Effort:** Effortless, labored

Counting Respirations:

1. Count immediately after pulse
2. Don't tell patient (alters breathing)
3. Keep fingers on pulse site
4. Watch chest rise and fall
5. Count for 60 seconds if irregular
6. Count for 30 seconds x 2 if regular
7. Note any abnormalities

Abnormal Breathing Patterns:

- **Dyspnea:** Difficult breathing
- **Tachypnea:** Rapid breathing (>20)
- **Bradypnea:** Slow breathing (<12)
- **Apnea:** Absence of breathing
- **Cheyne-Stokes:** Alternating deep/shallow with apnea
- **Orthopnea:** Must sit up to breathe

Blood Pressure

Blood pressure is the force of blood against artery walls.

Recorded as systolic over diastolic.

Normal Blood Pressure:

- Normal: <120/80 mmHg
- Elevated: 120-129/<80
- High Stage 1: 130-139/80-89
- High Stage 2: ≥140/90
- Crisis: >180/120

Equipment:

- **Sphygmomanometer:** BP cuff
- **Stethoscope:** To hear sounds
- **Proper cuff size:** Critical for accuracy

Korotkoff Sounds:

1. First sound heard = Systolic
2. Last sound heard = Diastolic

Taking Blood Pressure:

1. Position patient sitting or lying
2. Support arm at heart level
3. Select appropriate cuff size
4. Apply cuff 1 inch above elbow
5. Center arrow over brachial artery
6. Palpate brachial pulse
7. Close valve, inflate 30mmHg above pulse disappears
8. Place stethoscope over brachial artery
9. Slowly release valve (2-3 mmHg/second)
10. Note first sound (systolic)
11. Note last sound (diastolic)
12. Deflate completely
13. Remove cuff

14. Document immediately

Factors Affecting Blood Pressure:

- Stress/anxiety ("white coat syndrome")
- Exercise
- Caffeine/smoking
- Full bladder
- Arm position
- Cuff size
- Medications
- Time of day

Common Errors:

- Wrong cuff size
- Arm not at heart level
- Deflating too fast
- Not waiting between readings
- Taking over clothing

Positioning

Proper positioning maintains body alignment, prevents complications, and promotes comfort. CNAs must understand various positions and their uses.

Common Positions:

1. Supine (Dorsal Recumbent)

- Flat on back
- Pillow under head
- Arms at sides
- Used for: Sleeping, exams

2. Fowler's Positions

- **High Fowler's:** 60-90 degrees
- **Fowler's:** 45-60 degrees
- **Semi-Fowler's:** 30-45 degrees
- **Low Fowler's:** 15-30 degrees
- Used for: Eating, breathing difficulty

3. Lateral (Side-lying)

- On side with pillows for support
- Pillow between knees
- Upper arm supported
- Used for: Sleep, pressure relief

4. Sims' (Semi-prone)

- On side, partially on abdomen
- Lower arm behind back
- Upper knee flexed
- Used for: Rectal procedures, enemas

5. Prone

- On abdomen
- Head turned to side
- Arms at sides or above head
- Rarely used due to breathing difficulty

6. Trendelenburg

- Supine with feet elevated
- Head lower than feet
- Used for: Shock, some procedures

7. Reverse Trendelenburg

- Head elevated higher than feet
- Used for: Some surgeries

8. Lithotomy

- On back, knees flexed
- Feet in stirrups

- Used for: Pelvic exams

Positioning Devices:

- Pillows
- Rolled towels/blankets
- Foam wedges
- Footboards
- Trochanter rolls
- Hand rolls
- Splints

Positioning Guidelines:

- Change position every 2 hours minimum
- Maintain proper body alignment
- Support all body parts
- Prevent pressure on bony prominences
- Check circulation after positioning
- Ensure comfort
- Document position changes

Transfers and Ambulation

Safe patient movement prevents injuries to both patients and staff. Always assess patient ability and use appropriate techniques.

Types of Transfers:

1. Independent

- Patient moves without help
- Standby assistance only
- Verbal cues if needed

2. Assisted

- Patient needs some help
- One or two person assist
- May use assistive devices

3. Dependent

- Patient cannot help
- Mechanical lift required
- Two person minimum

Transfer Principles:

- Assess patient ability
- Explain procedure
- Lock all wheels
- Use gait belt
- Keep back straight
- Pivot, don't twist
- Get help when needed
- Never lift alone if >35 pounds

Bed to Chair Transfer:

1. Lower bed to lowest position
2. Position chair at 45-degree angle
3. Lock wheelchair brakes
4. Remove footrests
5. Apply gait belt
6. Have patient scoot to edge
7. Position feet flat on floor
8. Rock and stand on count of three
9. Pivot toward chair
10. Lower slowly
11. Position properly
12. Replace footrests

Using Mechanical Lifts:

1. Check weight capacity
2. Two person operation
3. Explain to patient
4. Position sling properly
5. Attach hooks facing away
6. Pump slowly
7. Guide, don't push
8. Lower slowly
9. Remove sling if staying up
10. Document use

Ambulation (Walking):

With Gait Belt:

1. Apply belt over clothing
2. Tighten to fit two fingers
3. Stand on weaker side
4. Hold belt with underhand grip
5. Walk slightly behind
6. Match patient's pace
7. Provide encouragement

With Walker:

1. Check rubber tips
2. Adjust to proper height
3. Patient moves walker first
4. Steps into walker
5. Don't let them get ahead of walker

With Cane:

1. Hold on stronger side
2. Move cane with weaker leg
3. Provides support
4. Check rubber tip

With Crutches:

1. Must be properly fitted
2. Support weight on hands, not armpits
3. Various gaits (2-point, 3-point)
4. Requires good balance

Height and Weight

Accurate measurements are essential for medication dosing, nutritional assessment, and monitoring health status.

Measuring Height:

Standing Height:

1. Remove shoes
2. Stand against measuring device
3. Heels together
4. Back straight
5. Look straight ahead
6. Lower bar to crown of head
7. Read at eye level
8. Record in feet/inches or centimeters

Bed Height (Length):

1. Use measuring tape
2. Patient flat in bed
3. Measure from top of head to heel
4. May need to measure in segments
5. Less accurate than standing

Measuring Weight:

Standing Scale:

1. Balance scale before use
2. Remove shoes and heavy clothing
3. Step on center of platform
4. Stand still
5. Read at eye level
6. Record immediately

Chair Scale:

1. For patients who can sit
2. Weigh wheelchair first
3. Subtract wheelchair weight
4. Lock wheels during weighing

Bed Scale:

1. For bedbound patients
2. Built into special beds
3. Follow manufacturer instructions
4. Very accurate

Weight Guidelines:

- Same time of day
- Same amount of clothing
- Same scale if possible
- Before breakfast ideal
- After voiding
- Document any edema

Elimination Needs

Assisting with elimination while maintaining dignity is a fundamental CNA responsibility.

Toileting Options:

1. Bathroom

- Most normal and preferred
- Maintain privacy
- Ensure safety (grab bars)
- Stay nearby if needed

2. Bedside Commode

- For patients who can get up
- Place close to bed
- Lock wheels
- Empty and clean promptly

3. Bedpan

- For bedbound patients
- Regular or fracture pan
- Warm if metal
- Powder for easier placement

4. Urinal

- For male patients
- Can use lying or sitting
- Female urinals available
- Empty promptly

Bedpan Procedure:

1. Provide privacy
2. Lower head of bed
3. Put on gloves
4. Turn patient on side
5. Place bedpan against buttocks
6. Roll patient onto bedpan
7. Raise head of bed
8. Provide toilet paper
9. Give call light

10. Return promptly
11. Lower bed, remove pan
12. Clean perineal area
13. Empty and clean bedpan
14. Remove gloves, wash hands

Catheter Care:

Indwelling Catheter:

- Provide daily perineal care
- Keep bag below bladder
- Never let bag touch floor
- Empty when 2/3 full
- Measure and record output
- Keep tubing free of kinks
- Never disconnect unnecessarily

Condom Catheter (External):

- Males only
- Change daily
- Check circulation frequently
- Keep skin clean and dry

Nutrition and Hydration

Proper nutrition and hydration are essential for health and healing. CNAs play key role in ensuring adequate intake.

Nutritional Needs:

- Proteins: Tissue repair
- Carbohydrates: Energy
- Fats: Energy storage
- Vitamins: Body functions
- Minerals: Various functions

- Water: All body processes

Therapeutic Diets:

1. **Regular:** No restrictions
2. **Mechanical Soft:** Easy to chew
3. **Pureed:** Blended smooth
4. **Clear Liquid:** See-through liquids
5. **Full Liquid:** All liquids
6. **Diabetic:** Controlled carbohydrates
7. **Low Sodium:** Restricted salt
8. **Low Fat:** Reduced fat
9. **High Protein:** Extra protein
10. **NPO:** Nothing by mouth

Feeding Assistance:

1. Check diet card
2. Assist with handwashing
3. Position upright
4. Protect clothing
5. Open containers
6. Season as allowed
7. Offer fluids frequently
8. Allow time to chew
9. Alternate foods
10. Encourage independence
11. Document intake

Dysphagia (Swallowing Difficulty):

- Thickened liquids
- Chin tuck position
- Small bites
- No straws
- Stay upright 30 minutes after

Intake and Output (I&O)

Monitoring fluid balance helps assess kidney function, hydration status, and treatment effectiveness.

Intake Includes:

- Oral fluids
- IV fluids
- Tube feedings
- Ice chips (count as half)
- Soups
- Jello
- Ice cream

Output Includes:

- Urine
- Liquid stool
- Vomitus
- Drainage
- Excessive perspiration

Measurement Guidelines:

- Use graduated containers
- Measure in milliliters (mL)
- 1 ounce = 30 mL
- Record immediately
- Be accurate
- Total each shift

Common Container Amounts:

- Water glass: 240 mL
- Coffee cup: 180 mL

- Soup bowl: 180 mL
- Juice glass: 120 mL
- Ice cream: 120 mL
- Jello: 120 mL

KEY TERMS

Ambulation: Walking

Apical: At the apex (tip) of the heart

Bradycardia: Slow heart rate (<60 bpm)

Diastolic: Bottom number of blood pressure; heart at rest

Dyspnea: Difficulty breathing

Fowler's Position: Semi-sitting position

Gait Belt: Safety device for transfers

NPO: Nothing by mouth (nil per os)

Orthostatic Hypotension: Blood pressure drop with position change

Sphygmomanometer: Blood pressure cuff

Systolic: Top number of blood pressure; heart contracting

Tachycardia: Fast heart rate (>100 bpm)

Trendelenburg: Position with feet elevated above head

PRACTICE QUESTIONS

1. Normal adult respiratory rate is: a) 8-12 per minute b) 12-20 per minute c) 20-30 per minute d) 30-40 per minute
2. The most accurate temperature site is: a) Oral b) Axillary c) Rectal d) Temporal
3. When counting respirations, you should: a) Tell the patient you're counting b) Count immediately after taking pulse c) Count for 15 seconds d) Have patient breathe deeply
4. Normal adult blood pressure is less than: a) 100/60 b) 120/80 c) 140/90 d) 160/100
5. The pulse site used for blood pressure is: a) Radial b) Apical c) Brachial d) Carotid
6. High Fowler's position is: a) 15-30 degrees b) 30-45 degrees c) 45-60 degrees d) 60-90 degrees
7. When ambulating with a cane, it should be held on: a) Weaker side b) Stronger side c) Either side d) Both hands
8. Ice chips count as: a) Full volume b) Half volume c) Don't count d) Double volume
9. Before transferring, always: a) Remove footrests b) Unlock brakes c) Lock wheelchair brakes d) Raise bed

10. Normal adult pulse rate is: a) 40-60 bpm b) 60-100 bpm c) 100-120 bpm d) 120-140 bpm
11. Sims' position is used for: a) Eating b) Sleeping c) Rectal procedures d) Blood pressure
12. When measuring blood pressure, the cuff should be placed: a) Over clothing b) 1 inch above elbow c) At the wrist d) 3 inches above elbow
13. Orthostatic hypotension is: a) High blood pressure b) Low blood pressure with position change c) Irregular heartbeat d) Difficulty breathing
14. One ounce equals: a) 15 mL b) 30 mL c) 60 mL d) 100 mL
15. The apical pulse is located: a) At the wrist b) In the neck c) At the heart d) Behind knee
16. Cheyne-Stokes respirations are: a) Very rapid breathing b) Alternating deep/shallow with apnea c) Constant deep breathing d) Normal breathing
17. When using a mechanical lift: a) One person can operate b) Two people must operate c) Three people needed d) Patient operates
18. Trendelenburg position has: a) Head elevated b) Feet elevated c) Patient on side d) Patient prone
19. A fracture bedpan is used for: a) All patients b)

Patients with hip fractures c) Measuring
output d) Male patients

20. NPO means: a) No visitors b) Nothing by
mouth c) No phone calls d) Normal diet

ANSWER EXPLANATIONS

1. **Correct answer: b) 12-20 per minute**

- Rationale: Normal adult respiratory rate is 12-20 breaths per minute. Rates below 12 (bradypnea) or above 20 (tachypnea) are abnormal and should be reported.

2. **Correct answer: c) Rectal**

- Rationale: Rectal temperature is most accurate as it measures core body temperature. Oral is second most accurate, while axillary is least accurate.

3. **Correct answer: b) Count immediately after taking pulse**

- Rationale: Counting respirations immediately after pulse allows observation without patient awareness, preventing altered breathing patterns. Keep fingers on pulse site as distraction.

4. **Correct answer: b) 120/80**

- Rationale: Normal blood pressure is less than 120/80 mmHg. 140/90 or higher indicates hypertension requiring medical attention.

5. **Correct answer: c) Brachial**

- Rationale: The brachial artery in the antecubital space (inner elbow) is used for blood pressure measurement. The stethoscope is placed over this artery.

6. Correct answer: d) 60-90 degrees

- Rationale: High Fowler's position elevates the head of bed 60-90 degrees, nearly sitting upright. Used for patients with breathing difficulties or during meals.

7. Correct answer: b) Stronger side

- Rationale: Canes are held on the stronger side to provide support for the weaker side. This provides better balance and support during ambulation.

8. Correct answer: b) Half volume

- Rationale: Ice chips melt to approximately half their volume, so they're counted as half when recording intake. This ensures accurate fluid balance calculation.

9. Correct answer: c) Lock wheelchair brakes

- Rationale: Locking wheelchair brakes prevents the chair from moving during transfer, ensuring safety. This is always done before any transfer.

10. Correct answer: b) 60-100 bpm

- Rationale: Normal adult pulse rate is 60-100 beats per minute. Below 60 is bradycardia, above 100 is tachycardia.

11. Correct answer: c) Rectal procedures

- Rationale: Sims' position (side-lying, semi-prone) provides access for rectal procedures like enemas or suppositories while maintaining patient comfort.

12. Correct answer: b) 1 inch above elbow

- Rationale: Proper cuff placement is 1 inch above the antecubital space, with arrow aligned over brachial artery. This ensures accurate readings.

13. Correct answer: b) Low blood pressure with position change

- Rationale: Orthostatic (postural) hypotension is a drop in blood pressure when changing positions, causing dizziness. Common in elderly and with certain medications.

14. Correct answer: b) 30 mL

- Rationale: One ounce equals 30 milliliters. This conversion is essential for accurate intake and output recording.

15. Correct answer: c) At the heart

- Rationale: The apical pulse is taken at the apex of the heart, located at the 5th intercostal space, mid-clavicular line. It's the most accurate pulse measurement.

16. Correct answer: b) Alternating deep/shallow with apnea

- Rationale: Cheyne-Stokes respirations show a pattern of gradually increasing then decreasing depth with periods of apnea. Often seen near death.

17. Correct answer: b) Two people must operate

- Rationale: Mechanical lifts require two people for safe operation - one to operate controls and one to guide patient. This prevents injuries.

18. Correct answer: b) Feet elevated

- Rationale: Trendelenburg position has feet elevated above head level, used for shock or certain procedures to increase blood flow to vital organs.

19. Correct answer: b) Patients with hip fractures

- Rationale: Fracture bedpans are flatter and used for patients who cannot flex their hips, such as those with hip fractures or after hip surgery.

20. Correct answer: b) Nothing by mouth

- Rationale: NPO (nil per os) means nothing by mouth - no food, fluids, or oral medications. Used before surgery or certain tests.

CHAPTER SUMMARY

Basic nursing skills form the core of CNA practice. Essential points include:

- Vital signs provide crucial health information and must be measured accurately
- Normal ranges vary by age and individual factors
- Proper positioning prevents complications and promotes comfort
- Safe transfers require assessment, proper technique, and appropriate assistance
- Ambulation maintains mobility and prevents complications
- Accurate height and weight measurements are essential for treatment
- Elimination needs must be met while maintaining dignity
- Nutrition and hydration support healing and health
- Intake and output monitoring helps assess fluid balance

These skills require practice to develop proficiency. Always prioritize safety, maintain patient dignity, and work within your scope of practice. Report abnormal findings immediately and document all care provided.

CHAPTER 7: MENTAL HEALTH AND SOCIAL SERVICE NEEDS

Learning Objectives

By the end of this chapter, you will be able to:

- Recognize common mental health conditions and their symptoms
- Understand emotional and social needs of patients
- Apply therapeutic communication with mental health patients
- Identify signs of depression, anxiety, and behavioral changes
- Implement appropriate interventions within CNA scope
- Recognize when to report concerns to the nurse

KEY CONCEPTS

Understanding Mental Health

Mental health encompasses emotional, psychological, and social well-being. It affects how people think, feel, and act. Mental health conditions are medical conditions that require professional treatment and compassionate care.

Factors Affecting Mental Health:

- Biological factors (genetics, brain chemistry)
- Life experiences (trauma, abuse)
- Family history
- Physical health problems
- Medications
- Substance abuse
- Social isolation
- Major life changes

Reducing Stigma:

- Mental illness is not a choice or weakness
- Recovery is possible with treatment
- Use person-first language
- Maintain confidentiality
- Show respect and empathy
- Avoid judgmental attitudes

Common Mental Health Conditions

Depression

Depression is more than temporary sadness. It's a persistent condition affecting daily life.

Signs and Symptoms:

- Persistent sad or empty mood
- Loss of interest in activities
- Significant weight change
- Sleep disturbances
- Fatigue or loss of energy
- Feelings of worthlessness
- Difficulty concentrating
- Thoughts of death or suicide
- Physical symptoms (headaches, pain)

CNA Interventions:

- Be patient and supportive
- Encourage participation in activities
- Report any suicidal statements immediately
- Don't minimize feelings
- Maintain routine
- Promote social interaction
- Document mood and behavior

Anxiety Disorders

Anxiety disorders involve excessive fear or worry that interferes with daily activities.

Types:

- Generalized Anxiety Disorder
- Panic Disorder
- Social Anxiety
- Specific Phobias

- Post-Traumatic Stress Disorder (PTSD)

Signs and Symptoms:

- Excessive worry
- Restlessness
- Rapid heartbeat
- Sweating
- Trembling
- Difficulty breathing
- Avoidance behaviors
- Sleep problems
- Irritability

CNA Interventions:

- Remain calm and reassuring
- Use slow, quiet voice
- Reduce environmental stimuli
- Encourage deep breathing
- Don't dismiss fears
- Provide safe environment
- Report panic attacks

Bipolar Disorder

Characterized by extreme mood swings between mania and depression.

Manic Phase:

- Elevated mood
- Increased energy
- Decreased need for sleep
- Rapid speech
- Poor judgment
- Risky behaviors

- Grandiose ideas

Depressive Phase:

- Same as major depression
- May be severe
- Risk of suicide

CNA Interventions:

- Maintain safe environment
- Set limits during manic phase
- Encourage medication compliance
- Monitor for mood changes
- Report significant changes
- Provide consistent routine

Schizophrenia

A chronic brain disorder affecting thinking, perception, and behavior.

Positive Symptoms (additions to normal behavior):

- Hallucinations (false sensory experiences)
- Delusions (false beliefs)
- Disorganized speech
- Disorganized behavior

Negative Symptoms (subtractions from normal behavior):

- Flat affect
- Social withdrawal
- Lack of motivation
- Poor hygiene
- Limited speech

CNA Interventions:

- Don't argue with delusions
- Don't pretend hallucinations are real
- Redirect to reality gently
- Ensure safety
- Encourage self-care
- Report changes in symptoms
- Maintain therapeutic relationship

Substance Use Disorders

Addiction is a chronic disease affecting brain reward, motivation, and memory.

Signs of Substance Abuse:

- Behavioral changes
- Physical symptoms (depends on substance)
- Neglecting responsibilities
- Social isolation
- Continued use despite problems
- Withdrawal symptoms

CNA Role:

- Observe for signs of use or withdrawal
- Report concerns
- Don't enable behaviors
- Support recovery efforts
- Maintain professional boundaries
- Follow facility policies

Behavioral Management

Understanding and managing challenging behaviors

requires patience, skill, and consistency.

Common Challenging Behaviors:

- Aggression (verbal or physical)
- Wandering
- Resistance to care
- Inappropriate sexual behavior
- Hoarding
- Repetitive questions
- Sundowning (increased confusion in evening)

General Behavior Management Strategies:

1. Prevention

- Identify triggers
- Maintain routine
- Meet basic needs
- Reduce stressors
- Provide appropriate activities

2. De-escalation

- Stay calm
- Use non-threatening body language
- Lower voice
- Give space
- Validate feelings
- Offer choices

3. Intervention

- Redirect attention
- Use distraction
- Remove from situation
- Get help if needed
- Ensure safety

4. Documentation

- What happened
- When it occurred
- Possible triggers
- Interventions used
- Outcomes

Specific Behavior Strategies:

For Aggression:

- Stay out of striking distance
- Don't corner patient
- Speak calmly
- Set limits firmly but kindly
- Get help immediately if violent

For Wandering:

- Provide safe walking areas
- Use door alarms
- Redirect to activities
- Check for needs (bathroom, hunger)
- Never use physical restraints

For Resistance to Care:

- Approach calmly
- Explain what you're doing
- Give choices when possible
- Try again later
- Use favorite caregiver if possible

Social and Emotional Needs

Meeting psychosocial needs is as important as physical care

for overall well-being.

Maslow's Hierarchy of Needs:

1. Physiological (food, water, shelter)
2. Safety (security, stability)
3. Love/Belonging (relationships, connection)
4. Esteem (respect, achievement)
5. Self-Actualization (reaching potential)

Emotional Needs:

- Love and affection
- Security and safety
- Recognition and respect
- Independence and control
- Purpose and meaning
- Hope and spirituality

Meeting Emotional Needs:

- Listen actively
- Show genuine interest
- Respect individuality
- Provide choices
- Encourage expression of feelings
- Maintain dignity
- Support relationships

Social Needs:

- Human connection
- Meaningful relationships
- Sense of belonging
- Communication
- Activities and engagement
- Cultural connections

Promoting Social Well-being:

- Encourage participation in activities
- Facilitate family visits
- Support friendships
- Respect privacy for visits
- Include in conversations
- Promote community involvement

Grief and Loss

Patients experience many types of losses requiring emotional support.

Types of Losses:

- Death of loved ones
- Loss of independence
- Loss of health
- Loss of home
- Loss of roles
- Loss of abilities

Stages of Grief (Kübler-Ross):

1. **Denial:** "This isn't happening"
2. **Anger:** "Why me?"
3. **Bargaining:** "If only..."
4. **Depression:** Sadness, withdrawal
5. **Acceptance:** Peace with situation

Supporting Grieving Patients:

- Allow expression of feelings
- Listen without judging
- Don't minimize loss

- Be present
- Respect cultural practices
- Maintain hope
- Report severe depression

Spiritual Needs

Spirituality provides meaning, purpose, and connection for many patients.

Respecting Spiritual Needs:

- Ask about spiritual preferences
- Honor religious practices
- Provide privacy for prayer
- Respect religious items
- Contact clergy if requested
- Don't impose your beliefs
- Support all faiths equally

End-of-Life Spiritual Care:

- Increased importance near death
- May want clergy visits
- Respect rituals
- Support family practices
- Provide quiet environment
- Honor final wishes

Therapeutic Activities

Activities promote mental health, provide structure, and enhance quality of life.

Benefits of Activities:

- Reduce boredom

- Increase self-esteem
- Promote socialization
- Maintain abilities
- Provide enjoyment
- Create routine
- Stimulate mind

Types of Activities:

Physical:

- Exercise groups
- Walking programs
- Dancing
- Balloon volleyball
- Stretching

Cognitive:

- Word games
- Puzzles
- Reading
- Current events
- Trivia

Creative:

- Art projects
- Music programs
- Crafts
- Gardening
- Cooking

Social:

- Group discussions
- Parties

- Outings
- Pet therapy
- Intergenerational programs

Spiritual:

- Religious services
- Meditation
- Prayer groups
- Holiday celebrations

CNA Role in Activities:

- Transport to activities
- Encourage participation
- Assist as needed
- Adapt for abilities
- Report interests
- Document attendance

Suicide Prevention

CNAs must be alert to suicide risk and respond appropriately.

Risk Factors:

- Previous attempts
- Mental illness
- Substance abuse
- Recent loss
- Chronic pain
- Social isolation
- Access to means

Warning Signs:

- Talking about death/suicide

- Giving away possessions
- Saying goodbyes
- Sudden mood improvement
- Increased substance use
- Withdrawing
- Expressing hopelessness

CNA Response:

- Take all threats seriously
- Never leave alone
- Remove dangerous items
- Report immediately
- Document exact words
- Provide support
- Don't promise confidentiality

Supporting Families

Families of mental health patients need support and education.

Family Needs:

- Information about condition
- Coping strategies
- Support resources
- Respite care
- Communication help
- Hope and encouragement

CNA Role:

- Include family appropriately
- Provide emotional support
- Report family concerns
- Respect confidentiality

- Encourage visits
- Support family decisions

KEY TERMS

Affect: Outward expression of emotion

Delusion: Fixed false belief

Hallucination: False sensory perception

Psychosis: Loss of contact with reality

Stigma: Negative attitudes toward mental illness

Therapeutic: Promoting healing or well-being

Trigger: Event that causes symptoms or behaviors

PRACTICE QUESTIONS

1. A patient says "I wish I were dead." You should:
a) Tell them things will get better b) Report immediately to the nurse c) Keep it confidential d) Distract them with activities
2. When caring for a patient with depression, avoid:
a) Encouraging activities b) Being patient c) Saying "cheer up" d) Reporting mood changes
3. A patient with schizophrenia says aliens are controlling him. You should:
a) Agree with him b) Argue it's not real c) Not argue but redirect d) Pretend you see them too
4. Signs of anxiety include all EXCEPT:
a) Rapid heartbeat b) Excessive sleeping c) Sweating d) Restlessness
5. The stages of grief include:
a) Denial, anger, bargaining, depression, acceptance b) Shock, anger, sadness, recovery c) Fear, anger, sadness, joy d) Confusion, anger, depression, hope
6. When a patient is aggressive, first:
a) Call security b) Physically restrain c) Stay calm and give space d) Leave them alone
7. Maslow's hierarchy places which need first?
a) Safety b) Love c) Physiological d) Esteem
8. Positive symptoms of schizophrenia include:

- a) Flat affect b) Hallucinations c) Social withdrawal d) Lack of motivation
- 9. Therapeutic activities help by: a) Keeping patients busy b) Reducing boredom and promoting well-being c) Tiring patients out d) Replacing medications
- 10. Risk factors for suicide include all EXCEPT: a) Previous attempts b) Strong family support c) Chronic pain d) Recent loss
- 11. When supporting grieving patients: a) Tell them to move on b) Share your own losses c) Allow expression of feelings d) Avoid the topic
- 12. Bipolar disorder involves: a) Multiple personalities b) Mood swings between mania and depression c) Only depression d) Only anxiety
- 13. Sundowning refers to: a) Depression at sunset b) Increased confusion in evening c) Fear of darkness d) Sleeping problems
- 14. For wandering behavior: a) Use physical restraints b) Lock all doors c) Provide safe walking areas d) Sedate the patient
- 15. Mental illness stigma can be reduced by: a) Keeping diagnosis secret b) Using person-first language c) Avoiding mental health patients d) Minimizing symptoms
- 16. When patients refuse activities: a) Force participation b) Document refusal and try later

c) Report them as non-compliant d) Take away privileges

17. Negative symptoms of schizophrenia include:

a) Delusions b) Hallucinations c) Social withdrawal d) Agitation

18. Supporting spiritual needs includes: a)

Converting patients b) Sharing your beliefs c) Respecting all faiths d) Avoiding the topic

19. Signs of substance abuse include: a) Improved

hygiene b) Behavioral changes c) Increased responsibility d) Better relationships

20. When documenting behaviors, include: a)

Your opinions b) Other patients' names c) Objective observations d) Diagnoses

ANSWER EXPLANATIONS

1. **Correct answer: b) Report immediately to the nurse**

- Rationale: Any expression of suicidal thoughts must be reported immediately for safety assessment and intervention. Never keep such statements confidential or minimize them.

2. **Correct answer: c) Saying "cheer up"**

- Rationale: Telling depressed patients to "cheer up" minimizes their condition and shows lack of understanding. Depression is a medical condition that can't be fixed by simply cheering up.

3. **Correct answer: c) Not argue but redirect**

- Rationale: Never argue with delusions as it increases agitation, but don't validate them either. Gently redirect to reality or another topic while ensuring safety.

4. **Correct answer: b) Excessive sleeping**

- Rationale: Anxiety typically causes sleep problems like insomnia, not excessive sleeping. Rapid heartbeat, sweating, and restlessness are classic anxiety symptoms.

5. **Correct answer: a) Denial, anger, bargaining, depression, acceptance**

- Rationale: These are the five stages of

grief identified by Kübler-Ross. Not everyone experiences all stages or in this order.

6. Correct answer: c) Stay calm and give space

- Rationale: Remaining calm and giving space helps de-escalate aggression. Physical restraint or leaving them alone could worsen the situation or compromise safety.

7. Correct answer: c) Physiological

- Rationale: Maslow's hierarchy starts with basic physiological needs (food, water, shelter) as the foundation. Other needs can't be met until these are satisfied.

8. Correct answer: b) Hallucinations

- Rationale: Positive symptoms are additions to normal behavior, like hallucinations and delusions. Flat affect and withdrawal are negative symptoms.

9. Correct answer: b) Reducing boredom and promoting well-being

- Rationale: Therapeutic activities serve multiple purposes including mental stimulation, socialization, and maintaining function - not just keeping busy or replacing treatment.

10. Correct answer: b) Strong family support

- Rationale: Strong family support is a protective factor against suicide. Previous attempts, chronic pain, and recent losses all increase suicide risk.

11. Correct answer: c) Allow expression of feelings

- Rationale: Allowing patients to express grief is therapeutic. Telling them to move on or avoiding the topic prevents healthy grieving. Sharing your losses shifts focus from patient.

12. Correct answer: b) Mood swings between mania and depression

- Rationale: Bipolar disorder is characterized by alternating periods of mania (elevated mood) and depression. It's not multiple personalities or single mood states.

13. Correct answer: b) Increased confusion in evening

- Rationale: Sundowning is increased confusion, agitation, or disorientation that occurs in late afternoon/evening, common in dementia patients.

14. Correct answer: c) Provide safe walking areas

- Rationale: Safe walking areas allow wandering without danger. Physical restraints are not allowed, and locking doors or sedation can increase agitation and safety risks.

15. Correct answer: b) Using person-first language

- Rationale: Person-first language (e.g., "person with schizophrenia" not "schizophrenic") reduces stigma by emphasizing the person, not the illness.

16. Correct answer: b) Document refusal and try later

- Rationale: Patients have the right to refuse

activities. Document the refusal and try again later when they might be more receptive. Never force or punish.

17. Correct answer: c) Social withdrawal

- Rationale: Negative symptoms are subtractions from normal behavior like withdrawal, flat affect, and lack of motivation. Delusions and hallucinations are positive symptoms.

18. Correct answer: c) Respecting all faiths

- Rationale: CNAs must respect all spiritual beliefs equally without imposing personal beliefs or trying to convert patients. Support their spiritual practices.

19. Correct answer: b) Behavioral changes

- Rationale: Substance abuse causes behavioral changes, neglect of responsibilities, and relationship problems. It doesn't improve hygiene or responsibility.

20. Correct answer: c) Objective observations

- Rationale: Documentation must be objective and factual. Never include personal opinions, other patients' information, or medical diagnoses which are outside CNA scope.

CHAPTER SUMMARY

Mental health and social needs are integral to overall health and well-being. Key points include:

- Mental health conditions are medical conditions requiring professional treatment
- Common conditions include depression, anxiety, bipolar disorder, and schizophrenia
- Therapeutic communication and patience are essential
- Challenging behaviors require calm, consistent approaches
- Social and emotional needs must be met for quality of life
- Activities provide structure, stimulation, and socialization
- Suicide threats always require immediate reporting
- Grief is a normal process requiring support
- Spiritual needs should be respected and supported
- Family involvement is important when appropriate

CNAs provide crucial support for mental health patients through observation, therapeutic interaction, and creating a safe environment. Always work within your scope, report concerns promptly, and treat all patients with dignity and respect.

CHAPTER 8: CARE OF COGNITIVELY IMPAIRED RESIDENTS

Learning Objectives

By the end of this chapter, you will be able to:

- Understand different types and stages of dementia
- Recognize signs and symptoms of cognitive impairment
- Apply effective communication techniques for dementia patients
- Implement behavior management strategies
- Create safe environments for confused residents
- Provide appropriate activities and stimulation
- Support families dealing with dementia

KEY CONCEPTS

Understanding Dementia

Dementia is an umbrella term for conditions causing decline in mental ability severe enough to interfere with daily life. It's not a normal part of aging.

Key Facts About Dementia:

- Affects memory, thinking, and social abilities
- Progressive and currently irreversible
- Different types have different causes
- Not just memory loss
- Affects whole families
- Requires specialized care approaches

Types of Dementia:

1. Alzheimer's Disease (60-80% of cases)

- Most common type
- Gradual onset
- Affects memory first
- Progresses through stages
- No cure currently

2. Vascular Dementia

- Second most common
- Caused by strokes or blood vessel damage
- Sudden or step-wise decline
- May improve slightly
- Prevention possible

3. Lewy Body Dementia

- Protein deposits in brain
- Visual hallucinations common
- Fluctuating symptoms
- Sleep disturbances
- Sensitivity to antipsychotics

4. Frontotemporal Dementia

- Affects personality first
- Younger onset (40s-50s)
- Behavior changes prominent
- Language difficulties
- Less memory loss initially

5. Mixed Dementia

- Multiple types together
- Common in older adults
- Varying symptoms
- Complex care needs

Stages of Alzheimer's Disease

Understanding stages helps anticipate needs and plan care.

Early Stage (Mild)

- Mild memory loss
- Losing items
- Trouble with names
- Difficulty planning
- Personality changes
- Can still do most ADLs
- May hide problems

CNA Care:

- Encourage independence
- Provide reminders
- Establish routines
- Be patient
- Support dignity

Middle Stage (Moderate)

- Increased memory loss
- Confusion about time/place
- Difficulty recognizing people
- Behavioral changes
- Sleep disturbances
- Wandering risk
- Need help with ADLs

CNA Care:

- Supervise safety
- Assist with care
- Redirect behaviors
- Maintain routines
- Provide structure

Late Stage (Severe)

- Severe memory loss
- Unable to communicate
- Total care needed
- May not recognize anyone
- Difficulty swallowing
- Immobile eventually
- Increased infection risk

CNA Care:

- Provide total care

- Focus on comfort
- Prevent complications
- Support dignity
- Include family

Communication Strategies

Communication becomes challenging as dementia progresses, requiring special techniques.

General Communication Tips:

- Approach from front
- Make eye contact
- Use calm voice
- Speak slowly and clearly
- Use simple words
- One instruction at a time
- Allow time to respond
- Watch body language
- Be patient

Verbal Communication Techniques:

1. Simplify Language

- Short sentences
- Concrete words
- Avoid pronouns
- Repeat if needed
- Don't test memory

2. Positive Phrasing

- Say what TO do
- Avoid "don't" or "no"
- Offer choices

- Use encouraging words

3. Validation

- Accept their reality
- Don't argue or correct
- Acknowledge feelings
- Redirect gently

Examples:

- Instead of "Don't go outside," say "Let's stay inside where it's warm"
- Instead of "That's wrong," say "Tell me more about that"
- Instead of "Remember?" say "Let me help you"

Non-Verbal Communication:

- Friendly facial expressions
- Gentle touch (if accepted)
- Relaxed body posture
- Demonstrate actions
- Use visual cues
- Point to objects
- Maintain eye level

When Communication Fails:

- Stay calm
- Try different approach
- Take a break
- Return later
- Get help if needed
- Document what works

Managing Challenging Behaviors

Behaviors are forms of communication. Understanding triggers helps prevent and manage them.

Common Behaviors and Interventions:

Wandering

- **Triggers:** Boredom, looking for something, restlessness
- **Interventions:**
 - Provide safe walking areas
 - Regular exercise
 - Meaningful activities
 - Door alarms
 - Identification bracelet
 - Never use restraints

Agitation/Aggression

- **Triggers:** Pain, frustration, overstimulation, fear
- **Interventions:**
 - Stay calm
 - Give space
 - Reduce stimuli
 - Check for pain
 - Use soothing voice
 - Redirect attention

Resistance to Care

- **Triggers:** Fear, lack of understanding, loss of control
- **Interventions:**
 - Explain simply
 - Go slow
 - Give choices

- Try different approach
- Return later
- Use favorite caregiver

Repetitive Questions

- **Triggers:** Anxiety, forgetfulness, need for reassurance
- **Interventions:**
 - Answer patiently
 - Provide reassurance
 - Redirect to activity
 - Write down answers
 - Address underlying need

Sundowning

- **Triggers:** Fatigue, shadows, disrupted routine
- **Interventions:**
 - Increase daytime activity
 - Reduce afternoon naps
 - Increase lighting
 - Maintain routine
 - Provide calm activities

Inappropriate Sexual Behavior

- **Triggers:** Confusion, need for intimacy, disinhibition
- **Interventions:**
 - Redirect behavior
 - Provide privacy
 - Don't overreact
 - Cover exposed areas
 - Report to nurse

Hoarding/Hiding

- **Triggers:** Fear of loss, need for control, confusion
- **Interventions:**
 - Check usual hiding spots
 - Don't confront
 - Provide safe items to collect
 - Regular room checks
 - Label belongings

Creating a Safe Environment

Environmental modifications prevent injuries and reduce confusion.

Physical Safety:

- Remove clutter
- Adequate lighting
- Handrails in hallways
- Non-slip surfaces
- Locked hazardous items
- Lower bed height
- Clear pathways
- Secured exits

Reducing Confusion:

- Label rooms and items
- Use pictures/symbols
- Consistent furniture placement
- Calendar and clock visible
- Familiar objects
- Reduce noise
- Simple décor
- Good color contrast

Bathroom Safety:

- Grab bars
- Raised toilet seat
- Non-slip mats
- Good lighting
- Clearly marked
- Warm water only
- Remove razors

Bedroom Modifications:

- Night light
- Clear path to bathroom
- Remove throw rugs
- Bed rails if appropriate
- Personal items visible
- Familiar bedding
- Easy-to-reach call light

Activities for Cognitive Stimulation

Appropriate activities maintain function, provide pleasure, and reduce behaviors.

Activity Principles:

- Match to ability level
- Focus on process, not product
- Build on remaining strengths
- Include familiar activities
- Keep simple
- Provide success
- Be flexible

Types of Activities:

Sensory Activities

- Music therapy
- Aromatherapy
- Pet therapy
- Textured materials
- Hand massage
- Nature sounds

Reminiscence Activities

- Photo albums
- Memory boxes
- Old movies
- Familiar music
- Storytelling
- Life review

Physical Activities

- Walking
- Simple exercises
- Dancing
- Ball toss
- Stretching
- Gardening motions

Cognitive Activities

- Simple puzzles
- Sorting tasks
- Folding washcloths
- Matching games
- Sing-alongs
- Reading aloud

Social Activities

- Small group interactions

- One-on-one visits
- Tea parties
- Simple games
- Holiday celebrations
- Family visits

Daily Living Activities

- Setting table
- Dusting
- Watering plants
- Folding laundry
- Sweeping
- Simple food prep

Nutrition and Dementia

Dementia affects eating abilities and nutritional status.

Eating Challenges:

- Forgetting to eat
- Not recognizing food
- Difficulty using utensils
- Chewing/swallowing problems
- Decreased appetite
- Pacing instead of sitting
- Eating non-food items

Interventions:

- Quiet environment
- Remove distractions
- Use contrasting colors
- Finger foods
- Adaptive equipment
- Verbal cues

- Hand-over-hand assistance
- Small, frequent meals
- Favorite foods
- Monitor weight

Hydration Concerns:

- Often forget to drink
- May not feel thirsty
- Increased dehydration risk
- Offer fluids frequently
- Use colorful cups
- Provide straws
- Offer popsicles
- Monitor intake

Personal Care Considerations

Personal care becomes challenging as dementia progresses.

Bathing Strategies:

- Warm bathroom
- Explain each step
- Cover for privacy
- Use familiar products
- Play soft music
- Allow participation
- Consider bed bath
- Watch for fear

Dressing Tips:

- Simple clothing
- Limit choices
- Lay out in order
- One piece at a time

- Elastic waists
- Velcro fasteners
- Comfortable fit
- Weather appropriate

Toileting Assistance:

- Regular schedule
- Watch for signs
- Clear pathway
- Night light
- Simple clothing
- Dignified approach
- Consider incontinence products
- Maintain skin integrity

Supporting Families

Dementia affects entire families who need education and support.

Family Challenges:

- Grief for person they knew
- Role reversal
- Caregiver stress
- Financial strain
- Difficult decisions
- Guilt feelings
- Family conflicts

CNA Support:

- Listen actively
- Provide information
- Teach care techniques
- Encourage breaks

- Validate feelings
- Include in care
- Report concerns
- Respect decisions

Education Topics:

- Disease progression
- Communication tips
- Behavior management
- Safety measures
- Available resources
- Support groups
- Respite care
- Legal planning

End-Stage Dementia Care

Late-stage dementia requires specialized comfort care.

Common Issues:

- Immobility
- Incontinence
- Eating difficulties
- Communication loss
- Increased infections
- Skin breakdown
- Pain assessment challenges

Comfort Measures:

- Position changes
- Gentle massage
- Soft music
- Familiar voices
- Mouth care

- Pain management
- Spiritual support
- Family presence

Quality of Life Focus:

- Dignity preservation
- Comfort priority
- Sensory stimulation
- Human connection
- Peaceful environment
- Family support
- Honoring preferences

KEY TERMS

Aphasia: Loss of language abilities

Apraxia: Inability to perform learned movements

Catastrophic Reaction: Extreme response to minor stress

Confabulation: Making up stories to fill memory gaps

Perseveration: Repetitive actions or words

Sundowning: Increased confusion in late afternoon/evening

Validation Therapy: Accepting and validating feelings

Wandering: Walking without purpose or destination

PRACTICE QUESTIONS

1. The most common type of dementia is:
a) Vascular dementia b) Alzheimer's disease
c) Lewy body dementia d) Frontotemporal dementia
2. When communicating with dementia patients, use:
a) Complex explanations b) Memory tests c) Simple, clear words d) Abstract concepts
3. A resident with dementia is looking for her mother. You should:
a) Tell her mother is dead b) Validate feelings and redirect
c) Argue she's confused d) Ignore the behavior
4. Sundowning can be reduced by:
a) Afternoon naps b) Dim lighting c) Increased daytime activity
d) Late meals
5. For wandering behavior, appropriate intervention is:
a) Physical restraints b) Locked rooms
c) Safe walking areas d) Sedation
6. Which is NOT a stage of Alzheimer's?
a) Early/mild b) Middle/moderate c) Acute d) Late/severe
7. When a dementia patient resists bathing:
a) Force them to comply b) Skip the bath
c) Try a different approach later d) Call security
8. Appropriate activities for severe dementia include:
a) Complex puzzles b) Sensory

- stimulation c) Learning new skills d) Current events
9. Validation therapy means: a) Testing their memory b) Correcting false beliefs c) Accepting their reality d) Ignoring them
10. Environmental modifications include: a) Busy patterns b) Dim lighting c) Clear labels d) Rearranging furniture
11. Catastrophic reactions are: a) Normal aging b) Extreme responses to minor stress c) Planned behaviors d) Seizures
12. For repetitive questions: a) Tell them they already asked b) Get frustrated c) Answer patiently each time d) Ignore them
13. Which behavior suggests pain in non-verbal patients? a) Smiling b) Sleeping well c) Grimacing d) Eating well
14. Late-stage dementia care focuses on: a) Rehabilitation b) Comfort c) Memory training d) Independence
15. Hoarding behavior may indicate: a) Greed b) Fear of loss c) Spite d) Boredom
16. When dressing a dementia patient: a) Provide many choices b) Rush the process c) Lay out clothes in order d) Use complicated fasteners
17. Dementia affects: a) Only memory b) Only behavior c) Multiple brain functions d) Only old

people

18. Family support includes: a) Taking over completely b) Excluding them c) Education and validation d) Minimizing involvement
19. Safe eating adaptations include: a) TV during meals b) Finger foods c) Complex utensils d) Dark plates
20. Signs of late-stage dementia include: a) Mild forgetfulness b) Total care needs c) Independent ADLs d) Clear communication

ANSWER EXPLANATIONS

1. **Correct answer: b) Alzheimer's disease**

- Rationale: Alzheimer's disease accounts for 60-80% of dementia cases, making it the most common type. Vascular dementia is second most common.

2. **Correct answer: c) Simple, clear words**

- Rationale: Dementia impairs language processing. Simple, concrete words improve understanding. Complex explanations and abstract concepts increase confusion.

3. **Correct answer: b) Validate feelings and redirect**

- Rationale: Validation acknowledges their reality without causing distress. Telling her mother is dead causes renewed grief; arguing increases agitation.

4. **Correct answer: c) Increased daytime activity**

- Rationale: More daytime activity promotes better sleep patterns and reduces evening restlessness. Afternoon naps can worsen sundowning.

5. **Correct answer: c) Safe walking areas**

- Rationale: Safe walking areas allow movement while preventing elopement. Restraints are not allowed and increase agitation. Sedation has serious risks.

6. Correct answer: c) Acute

- Rationale: Alzheimer's progresses through early/mild, middle/moderate, and late/severe stages. "Acute" is not a recognized stage of Alzheimer's.

7. Correct answer: c) Try a different approach later

- Rationale: Resistance often stems from fear or confusion. Trying later with different approach often succeeds. Force traumatizes, skipping neglects hygiene.

8. Correct answer: b) Sensory stimulation

- Rationale: Severe dementia requires simple sensory activities like music, touch, or aromas. Complex activities cause frustration and failure.

9. Correct answer: c) Accepting their reality

- Rationale: Validation therapy accepts the person's reality to reduce distress. Correcting or testing memory increases confusion and agitation.

10. Correct answer: c) Clear labels

- Rationale: Clear labels with pictures help orientation. Busy patterns and dim lighting increase confusion. Rearranging furniture disrupts familiar navigation.

11. Correct answer: b) Extreme responses to minor stress

- Rationale: Catastrophic reactions are disproportionate responses to seemingly

minor triggers, common in dementia due to overwhelm and confusion.

12. Correct answer: c) Answer patiently each time

- Rationale: Repetitive questions reflect anxiety and memory loss. Patient responses provide reassurance. Showing frustration increases distress.

13. Correct answer: c) Grimacing

- Rationale: Non-verbal pain indicators include grimacing, restlessness, and behavior changes. Sleeping well and eating well suggest comfort.

14. Correct answer: b) Comfort

- Rationale: Late-stage dementia care prioritizes comfort over rehabilitation or independence, which are no longer achievable goals.

15. Correct answer: b) Fear of loss

- Rationale: Hoarding often reflects fear of losing possessions or need for control in confusing world, not character flaws.

16. Correct answer: c) Lay out clothes in order

- Rationale: Laying out clothes in order simplifies dressing. Too many choices overwhelm; rushing causes anxiety; complicated fasteners frustrate.

17. Correct answer: c) Multiple brain functions

- Rationale: Dementia affects memory, thinking, behavior, emotions, and physical

abilities - not just memory. It's not part of normal aging.

18. Correct answer: c) Education and validation

- Rationale: Families need education about dementia and validation of their feelings. Including them appropriately supports both patient and family.

19. Correct answer: b) Finger foods

- Rationale: Finger foods enable independent eating when utensil use declines. TV distracts, dark plates reduce contrast needed for vision.

20. Correct answer: b) Total care needs

- Rationale: Late-stage dementia requires total care for all ADLs. Communication is severely impaired or absent, not clear.

CHAPTER SUMMARY

Caring for cognitively impaired residents requires specialized knowledge and approaches:

- Dementia is not normal aging but a group of brain disorders
- Alzheimer's disease is most common, progressing through predictable stages
- Communication must be simplified and non-verbal cues recognized
- Behaviors are forms of communication requiring understanding, not control
- Environmental modifications promote safety and reduce confusion
- Activities should match abilities and provide success
- Personal care requires patience and creative approaches
- Families need education, support, and inclusion
- Late-stage care focuses on comfort and dignity

Remember that behind the dementia is a person with a life history, preferences, and need for connection. Providing compassionate, person-centered care maintains dignity while managing the challenges of cognitive impairment.

CHAPTER 9: BASIC RESTORATIVE SERVICES

Learning Objectives

By the end of this chapter, you will be able to:

- Understand principles of restorative care
- Perform range of motion exercises safely
- Assist with ambulation and mobility devices
- Support bowel and bladder retraining programs
- Promote independence in activities of daily living
- Care for patients with prosthetic and orthotic devices
- Apply restorative techniques to prevent complications

KEY CONCEPTS

Principles of Restorative Care

Restorative care helps patients regain or maintain their highest level of function. It focuses on ability, not disability, and promotes independence.

Goals of Restorative Care:

- Maintain current function
- Prevent decline
- Regain lost abilities
- Promote independence
- Enhance quality of life
- Prevent complications
- Build confidence

Key Principles:

1. Focus on Abilities

- Build on strengths
- Adapt for limitations
- Celebrate progress
- Avoid doing for them

2. Consistency

- Same approach by all staff
- Regular practice
- Daily integration
- Clear communication

3. Patience

- Allow extra time
- Don't rush
- Encourage efforts
- Accept small gains

4. Individualization

- Personal goals
- Tailored approaches
- Consider preferences
- Respect choices

Restorative Programs Include:

- Range of motion exercises
- Walking programs
- Self-care retraining
- Bowel/bladder programs
- Eating/swallowing programs
- Communication enhancement
- Cognitive stimulation

Range of Motion (ROM) Exercises

ROM exercises maintain joint flexibility and prevent contractures. They're essential for immobile patients.

Types of ROM:

1. Active ROM (AROM)

- Patient moves independently
- Builds strength
- Maintains independence
- Encourages participation

2. Active-Assistive ROM

- Patient moves with help
- CNA guides/supports
- Transitional phase
- Builds confidence

3. Passive ROM (PROM)

- CNA moves joints
- For unable patients
- Prevents contractures
- Maintains flexibility

General ROM Guidelines:

- Exercise each joint unless contraindicated
- Move slowly and smoothly
- Stop if pain occurs
- Support joint above and below
- Move through natural range
- Never force movement
- Observe for problems
- Usually done during bathing

Joint Movements:

Shoulder:

- Flexion: Raise arm forward and up
- Extension: Move arm backward
- Abduction: Move arm away from body
- Adduction: Move arm toward body
- Rotation: Turn arm inward/outward

Elbow:

- Flexion: Bend elbow
- Extension: Straighten elbow

- **Supination:** Turn palm up
- **Pronation:** Turn palm down

Wrist:

- **Flexion:** Bend wrist forward
- **Extension:** Bend wrist backward
- **Radial deviation:** Bend toward thumb
- **Ulnar deviation:** Bend toward pinky

Fingers:

- **Flexion:** Make fist
- **Extension:** Straighten fingers
- **Abduction:** Spread apart
- **Adduction:** Bring together

Hip:

- **Flexion:** Bend knee to chest
- **Extension:** Straighten leg back
- **Abduction:** Move leg away from midline
- **Adduction:** Move leg toward midline
- **Rotation:** Turn leg inward/outward

Knee:

- **Flexion:** Bend knee
- **Extension:** Straighten knee

Ankle:

- **Dorsiflexion:** Pull foot up
- **Plantar flexion:** Point foot down
- **Inversion:** Turn sole inward
- **Eversion:** Turn sole outward

ROM Exercise Procedure:

1. Explain procedure
2. Provide privacy
3. Position comfortably
4. Expose only area being exercised
5. Support joints properly
6. Move each joint 3-5 times
7. Observe for pain or resistance
8. Encourage active participation
9. Document exercises completed

Ambulation and Mobility

Progressive mobility maintains strength, prevents complications, and promotes independence.

Benefits of Ambulation:

- Maintains muscle strength
- Prevents contractures
- Improves circulation
- Prevents pneumonia
- Maintains bone density
- Improves mood
- Promotes independence

Progressive Mobility Steps:

1. Bed Mobility

- Rolling side to side
- Scooting up in bed
- Moving to edge of bed

2. Sitting Balance

- Sitting supported
- Sitting at edge of bed
- Sitting unsupported

3. Standing

- Standing with support
- Weight shifting
- Standing balance

4. Walking

- Parallel bars
- Walker
- Cane
- Independent

Gait Training Principles:

- Proper body mechanics
- Appropriate device
- Correct technique
- Safe environment
- Gradual progression
- Regular practice

Common Gait Patterns:

Two-Point Gait (Cane):

- Cane and opposite foot together
- Then other foot
- For mild weakness

Three-Point Gait (Walker):

- Walker forward
- Weak leg forward
- Strong leg follows

- For one weak leg

Four-Point Gait (Walker):

- Right hand forward
- Left foot forward
- Left hand forward
- Right foot forward
- Maximum support

Assistive Devices

Proper use of assistive devices promotes safety and independence.

Walkers:

- Check rubber tips
- Proper height (wrist level)
- All four legs touch ground
- Move walker first
- Step into walker
- Don't get ahead

Canes:

- Hold on strong side
- Rubber tip intact
- Proper height
- Move with weak leg
- Provides balance

Crutches:

- Proper fit essential
- Weight on hands, not armpits
- Check rubber tips

- Various gaits possible
- Requires upper body strength

Wheelchairs:

- Proper positioning
- Feet on footrests
- Lock before transfers
- Check tire pressure
- Regular maintenance

Activities of Daily Living (ADL) Retraining

Helping patients relearn self-care promotes independence and self-esteem.

Dressing Retraining:

- Start with easy items
- Use adaptive equipment
- Seated if needed
- One step at a time
- Verbal cues
- Physical assistance as needed
- Practice daily

Eating Retraining:

- Proper positioning
- Adaptive utensils
- Plate guards
- Non-slip mats
- Built-up handles
- Weighted utensils
- Hand-over-hand guidance

Bathing Retraining:

- Safety equipment
- Long-handled sponges
- Shower chairs
- Grab bars
- Step-by-step instruction
- Gradual independence

Grooming Retraining:

- Built-up handles
- Electric devices
- Organized supplies
- Good lighting
- Seated position
- Mirror at proper height

Bowel and Bladder Retraining

Retraining programs help regain continence and independence.

Bladder Retraining:

Goals:

- Increase bladder capacity
- Establish regular pattern
- Achieve continence
- Reduce infections

Methods:

- Scheduled toileting
- Prompted voiding
- Bladder diary
- Fluid management
- Pelvic exercises

Schedule Example:

- Every 2 hours initially
- Gradually increase intervals
- Before and after meals
- Before bed
- Upon waking

Bowel Retraining:

Goals:

- Regular elimination
- Prevent constipation
- Achieve continence
- Maintain dignity

Methods:

- Consistent timing
- After meals (gastrocolic reflex)
- Privacy provision
- Proper positioning
- Adequate fluids
- High fiber diet
- Activity/exercise

Key Factors:

- Patience required
- Consistency essential
- Team approach
- Positive reinforcement
- Accurate documentation

Prosthetic and Orthotic Care

Many patients use artificial limbs (prosthetics) or supportive devices (orthotics).

Prosthetic Care:

Types:

- Upper extremity
- Lower extremity
- Cosmetic
- Functional

Care Guidelines:

- Clean daily
- Check skin condition
- Proper fit
- Report problems
- Follow wearing schedule
- Protect from damage

Stump Care:

- Daily cleaning
- Inspect for redness
- Proper bandaging
- Avoid lotion on stump
- Exercise as directed
- Report changes

Orthotic Devices:

Common Types:

- Braces
- Splints

- Supports
- Shoe inserts

Care:

- Check skin under device
- Clean as directed
- Proper application
- Report loose/tight fit
- Remove as scheduled
- Skin care important

Preventing Complications

Restorative care prevents common complications of immobility.

Contractures:

- Joint becomes fixed
- Prevention:
 - ROM exercises
 - Proper positioning
 - Splints if ordered
 - Frequent movement

Muscle Atrophy:

- Muscle wasting
- Prevention:
 - Active exercises
 - Resistance training
 - Progressive mobility
 - Adequate nutrition

Foot Drop:

- Foot hangs down
- Prevention:
 - Foot supports
 - ROM exercises
 - Proper positioning
 - High-top sneakers

Pressure Injuries:

- Skin breakdown
- Prevention:
 - Position changes
 - Pressure relief
 - Skin care
 - Nutrition

Communication in Restorative Care

Effective communication motivates and encourages patients.

Motivational Techniques:

- Set achievable goals
- Celebrate progress
- Focus on gains
- Provide choices
- Use positive language
- Involve in planning

Dealing with Frustration:

- Acknowledge feelings
- Provide encouragement
- Break tasks down
- Take breaks
- Adjust goals

- Stay positive

Family Involvement:

- Teach techniques
- Encourage participation
- Share progress
- Set realistic expectations
- Provide resources
- Support efforts

Documentation

Accurate documentation tracks progress and guides care.

Document:

- Exercises completed
- Repetitions/duration
- Patient tolerance
- Progress noted
- Problems encountered
- Pain or discomfort
- Refusals
- Functional improvements

Examples:

- "Assisted with 10 reps of shoulder ROM bilaterally, tolerated well"
- "Ambulated 50 feet with walker, steady gait, no complaints"
- "Participated in dressing upper body independently"

KEY TERMS

Abduction: Movement away from body midline

Adduction: Movement toward body midline

Atrophy: Muscle wasting from disuse

Contracture: Permanent joint flexion

Dorsiflexion: Pulling foot upward

Extension: Straightening a joint

Flexion: Bending a joint

Orthotic: Device that supports body part

Prosthetic: Artificial body part

Range of Motion (ROM): Full movement potential of joint

PRACTICE QUESTIONS

1. The goal of restorative care is to: a) Do everything for the patient b) Help patients reach highest function level c) Speed up care delivery d) Reduce staff workload
2. Passive range of motion is performed when patient: a) Can move independently b) Refuses to participate c) Cannot move the joint d) Is walking
3. Moving a limb away from the body midline is: a) Adduction b) Abduction c) Flexion d) Extension
4. ROM exercises should be done: a) Once weekly b) Only by therapy c) Daily or more often d) Only if ordered
5. A cane should be held on the: a) Weak side b) Strong side c) Either side d) Both hands
6. Bladder retraining involves: a) Catheter use b) Fluid restriction c) Scheduled toileting d) Medications only
7. When exercising joints, stop if: a) Patient is tired b) Patient complains of pain c) It takes too long d) Patient wants to help
8. Foot drop is prevented by: a) Keeping feet flat b) Footboard use c) Crossing legs d) Pointing toes

9. The gastrocolic reflex aids: a) Bladder training b) Bowel training c) Swallowing d) Breathing
10. Prosthetic devices should be: a) Worn continuously b) Cleaned daily c) Shared between patients d) Adjusted by CNA
11. Active ROM means: a) CNA moves joints b) Patient moves independently c) Using machines d) Forced movement
12. Progressive mobility starts with: a) Running b) Bed mobility c) Stair climbing d) Standing
13. Contractures result from: a) Too much exercise b) Lack of joint movement c) Proper positioning d) Good nutrition
14. Walker height should be at: a) Shoulder level b) Hip level c) Wrist level d) Elbow level
15. Restorative care requires: a) Speed b) Patience c) Force d) Restrictions
16. Three-point gait is used with: a) Two canes b) Walker c) Wheelchair d) No device
17. Muscle atrophy is: a) Muscle growth b) Muscle wasting c) Muscle spasm d) Muscle strength
18. During transfers, wheelchairs should be: a) Unlocked b) Moving c) Locked d) Removed
19. ADL retraining includes: a) Advanced skills only b) Self-care activities c) Professional skills d) Medical procedures

20. Orthotic devices: a) Replace body parts b) Support body parts c) Remove body parts d) Exercise body parts

ANSWER EXPLANATIONS

1. Correct answer: b) Help patients reach highest function level

- Rationale: Restorative care aims to help patients achieve and maintain their maximum functional ability, promoting independence rather than dependence.

2. Correct answer: c) Cannot move the joint

- Rationale: Passive ROM is performed by the caregiver when the patient cannot move the joint independently due to weakness, paralysis, or unconsciousness.

3. Correct answer: b) Abduction

- Rationale: Abduction moves a body part away from the midline. Adduction moves toward midline, flexion bends, and extension straightens.

4. Correct answer: c) Daily or more often

- Rationale: ROM exercises should be performed at least daily, often during routine care like bathing, to maintain joint flexibility and prevent contractures.

5. Correct answer: b) Strong side

- Rationale: Holding the cane on the strong side provides better support and balance for the weak side during ambulation.

6. Correct answer: c) Scheduled toileting

- Rationale: Bladder retraining uses scheduled toileting to gradually increase bladder capacity and establish regular voiding patterns without catheters or severe fluid restriction.

7. Correct answer: b) Patient complains of pain

- Rationale: Pain indicates potential injury. Stop immediately if pain occurs and report to the nurse. Never force movement through pain.

8. Correct answer: b) Footboard use

- Rationale: Footboards keep feet at 90-degree angles preventing foot drop. Flat positioning or toe pointing can cause foot drop.

9. Correct answer: b) Bowel training

- Rationale: The gastrocolic reflex stimulates bowel movement after eating, making after meals optimal timing for bowel training programs.

10. Correct answer: b) Cleaned daily

- Rationale: Prosthetics require daily cleaning to prevent skin problems and infection. They shouldn't be worn continuously or shared between patients.

11. Correct answer: b) Patient moves independently

- Rationale: Active ROM means the patient performs movements independently without assistance, maintaining strength and independence.

12. Correct answer: b) Bed mobility

- Rationale: Progressive mobility begins with basic bed movements like rolling and scooting, gradually advancing to sitting, standing, and walking.

13. Correct answer: b) Lack of joint movement

- Rationale: Contractures develop when joints aren't moved through their range of motion regularly, causing permanent flexion and functional loss.

14. Correct answer: c) Wrist level

- Rationale: Proper walker height is at wrist level when arms hang naturally at sides, allowing slight elbow bend during use.

15. Correct answer: b) Patience

- Rationale: Restorative care requires patience as progress may be slow. Rushing or forcing can cause injury and discourage patients.

16. Correct answer: b) Walker

- Rationale: Three-point gait is typically used with a walker when one leg is weak or non-weight bearing. The walker and weak leg move together.

17. Correct answer: b) Muscle wasting

- Rationale: Atrophy is the wasting or decrease in muscle size due to disuse, illness, or nerve damage. Exercise prevents atrophy.

18. Correct answer: c) Locked

- Rationale: Always lock wheelchair brakes

before transfers to prevent the chair from moving and causing falls or injury.

19. Correct answer: b) Self-care activities

- Rationale: ADL retraining focuses on basic self-care activities like dressing, bathing, eating, and grooming to promote independence.

20. Correct answer: b) Support body parts

- Rationale: Orthotic devices support, align, or protect body parts. Prosthetics replace missing parts, while orthotics support existing parts.

CHAPTER SUMMARY

Basic restorative services are essential for maintaining and improving patient function:

- Restorative care focuses on abilities and promotes highest functional level
- ROM exercises prevent contractures and maintain joint flexibility
- Active, active-assistive, and passive ROM serve different patient needs
- Progressive mobility prevents complications and builds strength
- Proper use of assistive devices promotes safe ambulation
- ADL retraining helps patients regain independence in self-care
- Bowel and bladder programs restore continence and dignity
- Prosthetic and orthotic devices require special care
- Prevention of complications is key to restorative success
- Patient motivation and family involvement enhance outcomes

Remember that restorative care requires patience, consistency, and encouragement. Small gains are significant victories. Focus on what patients can do, not what they cannot, and celebrate every achievement toward independence.

CHAPTER 10: RESIDENTS' RIGHTS

Learning Objectives

By the end of this chapter, you will be able to:

- Identify fundamental resident rights in healthcare facilities
- Understand legal protections for residents
- Recognize and prevent abuse and neglect
- Maintain resident privacy and confidentiality
- Support resident autonomy and choice
- Apply residents' rights in daily care
- Report violations appropriately

KEY CONCEPTS

Fundamental Resident Rights

Residents in healthcare facilities maintain all constitutional rights plus additional protections under federal and state law. The Nursing Home Reform Act (OBRA 1987) established comprehensive rights for long-term care residents.

Core Rights Include:

1. Dignity and Respect

- Treated as individuals
- Personal preferences honored
- Cultural needs met
- Individuality maintained

2. Freedom from Abuse and Neglect

- Physical safety
- Emotional well-being
- Financial protection
- Freedom from exploitation

3. Privacy and Confidentiality

- Personal space
- Private communications
- Protected health information
- Dignified care

4. Autonomy and Choice

- Make own decisions
- Choose care options

- Refuse treatment
- Direct own life

5. Quality Care

- Appropriate treatment
- Qualified staff
- Clean environment
- Proper equipment

Right to Information

Residents have the right to be fully informed about their care and facility operations.

Information Rights Include:

- Medical condition and treatment
- Available services and charges
- Facility rules and regulations
- Care plan and changes
- Physician and staff names
- Survey results
- Advance directive information

CNA Responsibilities:

- Answer questions honestly
- Refer medical questions to nurse
- Explain procedures before performing
- Provide information in understandable language
- Use interpreters when needed
- Respect right to refuse information

Right to Make Choices

Residents maintain the right to make decisions about their

daily life and care.

Choice Areas:

- Personal schedule (sleep, meals, activities)
- Clothing selection
- Room arrangement
- Visitors and phone calls
- Activities participation
- Religious practices
- Personal physician
- Roommate selection when possible

Supporting Choice:

- Offer options
- Respect preferences
- Accommodate requests
- Avoid imposing routines
- Document preferences
- Advocate for resident

Privacy Rights

Privacy encompasses both physical privacy and information confidentiality.

Physical Privacy:

- Knock before entering
- Close doors/curtains for care
- Keep body covered except area being treated
- Provide privacy for phone calls
- Allow private visits
- Respect personal space
- Private mail handling

Information Privacy (HIPAA):

- Protected health information
- Limited access to records
- No gossip about residents
- Careful in public areas
- Secure documentation
- Appropriate disclosure only
- Social media restrictions

Confidentiality Exceptions:

- Suspected abuse
- Court orders
- Medical emergencies
- Required reporting
- Team communication for care

Freedom from Abuse and Neglect

Protecting residents from harm is a fundamental responsibility.

Types of Abuse:

1. Physical Abuse

- Hitting, slapping, pushing
- Rough handling
- Inappropriate restraints
- Physical punishment
- Force-feeding

2. Sexual Abuse

- Unwanted touching
- Sexual assault

- Forcing viewing sexual material
- Sexual harassment
- Taking sexual photos

3. Emotional/Psychological Abuse

- Yelling, threatening
- Humiliation
- Isolation
- Intimidation
- Ignoring

4. Financial Abuse

- Stealing money/property
- Forging signatures
- Coercing changes to will
- Misusing funds
- Identity theft

5. Neglect

- Failure to provide care
- Ignoring needs
- Abandonment
- Withholding necessities
- Inadequate supervision

Signs of Abuse/Neglect:

- Unexplained injuries
- Fear of specific people
- Withdrawal or depression
- Sudden behavior changes
- Poor hygiene
- Malnutrition/dehydration
- Untreated medical conditions
- Missing belongings

CNA Response to Abuse:

1. Ensure immediate safety
2. Report immediately to supervisor
3. Document objectively
4. Preserve evidence
5. Support the resident
6. Follow facility protocol
7. Report to state hotline if needed

Right to Visits

Residents have the right to receive visitors and maintain relationships.

Visitor Rights:

- Immediate family anytime
- Others with resident permission
- Private visits
- Refuse visitors
- Intimate relationships (consensual)
- Pet visits per policy
- Children visits

CNA Role:

- Welcome visitors
- Provide privacy
- Assist with visits
- Monitor for exploitation
- Report concerns
- Respect choices

Freedom from Restraints

Restraints (physical or chemical) are strictly regulated and require specific criteria.

Physical Restraints:

- Devices limiting movement
- Include bedrails, belts, mittens
- Last resort only
- Doctor's order required
- Time limited
- Regular monitoring

Chemical Restraints:

- Medications controlling behavior
- Not for staff convenience
- Only for specific conditions
- Lowest dose possible
- Regular review

Alternatives to Restraints:

- Identify underlying needs
- Environmental modifications
- Increased supervision
- Activities and distraction
- Comfort measures
- Family involvement

If Restraints Used:

- Check every 15 minutes
- Release every 2 hours
- ROM exercises
- Toileting
- Skin assessment

- Document thoroughly

Right to Personal Property

Residents may keep personal belongings with reasonable facility requirements.

Personal Property Rights:

- Clothing and jewelry
- Photos and mementos
- Furniture (space permitting)
- Electronics
- Religious items
- Books and magazines
- Grooming supplies

Protecting Property:

- Inventory belongings
- Label items
- Secure valuables
- Report missing items
- Respect belongings
- Handle carefully
- Return promptly

Participation in Care Planning

Residents have the right to participate in planning their care.

Participation Includes:

- Attending care conferences
- Setting goals
- Choosing interventions
- Refusing treatments

- Changing plans
- Involving family

CNA Support:

- Inform about meetings
- Transport to conferences
- Share observations
- Advocate for preferences
- Implement plan
- Report changes

Transfer and Discharge Rights

Residents cannot be transferred or discharged without cause and proper process.

Legal Reasons for Transfer/Discharge:

- Medical needs exceed facility capability
- Safety of self or others
- Nonpayment (after notice)
- Facility closure
- No longer needs services

Required Process:

- 30-day written notice
- Reason stated
- Appeal rights
- Discharge planning
- Safe location
- Medical records transfer

Grievance Rights

Residents have the right to voice complaints without

retaliation.

Grievance Process:

- Make complaints
- Receive response
- Contact ombudsman
- File with state
- No retaliation
- Problem resolution

CNA Response to Complaints:

- Listen respectfully
- Don't take personally
- Report to supervisor
- Document concerns
- Follow up
- Support resolution

Cultural and Religious Rights

Residents have the right to maintain cultural identity and practice religion.

Cultural Rights:

- Language preferences
- Food preferences
- Clothing choices
- Holiday celebrations
- Cultural practices
- Family involvement

Religious Rights:

- Attend services

- Clergy visits
- Religious items
- Dietary restrictions
- Prayer/meditation
- Refuse participation

CNA Support:

- Learn about cultures
- Respect differences
- Accommodate practices
- Avoid judgment
- Facilitate observances
- Protect rights

Voting Rights

Residents maintain full voting rights as citizens.

Supporting Voting:

- Voter registration
- Absentee ballots
- Transportation to polls
- Privacy for voting
- No influence
- Assistance if requested

Financial Rights

Residents have rights regarding their finances and facility charges.

Financial Protections:

- Manage own finances
- Access to funds

- Accounting of charges
- Protection from Medicaid discrimination
- Notice of benefit changes
- Choice of providers

Quality of Life Rights

Beyond basic care, residents have rights supporting quality of life.

Quality of Life Includes:

- Social services
- Activities programs
- Environmental comfort
- Accommodation of needs
- Access to community
- Meaningful relationships

KEY TERMS

Abuse: Willful infliction of harm

Advance Directive: Legal document stating healthcare wishes

Autonomy: Right to make own decisions

Confidentiality: Keeping information private

Exploitation: Taking advantage of vulnerable person

Grievance: Formal complaint

HIPAA: Health Insurance Portability and Accountability Act

Neglect: Failure to provide necessary care

OBRA: Omnibus Budget Reconciliation Act

Ombudsman: Resident advocate

Retaliation: Punishment for exercising rights

PRACTICE QUESTIONS

1. Resident rights are protected by: a) Facility policy only b) State law only c) Federal and state law d) International law
2. A resident refuses a bath. You should: a) Force them to bathe b) Document refusal and try later c) Report them as noncompliant d) Call their family
3. HIPAA protects: a) Facility property b) Staff rights c) Health information privacy d) Visitor access
4. Before entering a room, always: a) Check the schedule b) Announce yourself loudly c) Knock and wait for response d) Enter quietly
5. Physical abuse includes: a) Ignoring requests b) Rough handling c) Taking belongings d) Gossiping
6. Residents can be discharged for: a) Complaining too much b) Being difficult c) Safety concerns with proper process d) Staff convenience
7. Chemical restraints are: a) Cleaning supplies b) Medications controlling behavior c) Physical devices d) Facility policies
8. The ombudsman: a) Owns the facility b) Advocates for residents c) Supervises staff d)

Provides medical care

9. Residents have the right to: a) Smoke anywhere
b) Refuse medications c) Hit staff d) Take others' belongings
10. Signs of neglect include: a) Clean appearance
b) Weight gain c) Untreated bedsores d) Many visitors
11. Visitor restrictions can be imposed: a) Anytime staff wants
b) During meals only c) Only with resident consent or safety issues
d) After 8 PM
12. Financial abuse involves: a) Helping with banking
b) Stealing money or property c) Discussing costs
d) Accepting gifts
13. Restraint alternatives include: a) Medications
b) Locked doors c) Activities and distraction d) Threats
14. Grievances should be: a) Ignored b) Discouraged
c) Addressed without retaliation d) Kept secret
15. Cultural rights include: a) English only b) Standard menu only
c) Language preferences respected d) No religious items
16. Care plan participation is: a) Optional for facilities
b) A resident right c) Staff decision d) Family only
17. Mail should be: a) Opened by staff b) Delivered unopened
c) Read for safety d) Held at desk

18. Residents can choose: a) Staff assignments b) Facility menu c) Daily schedule d) Roommate's activities
19. Abuse must be reported: a) Within a week b) Immediately c) Only if severe d) After investigation
20. Privacy during care means: a) Working alone b) Closing curtains/doors c) No explanations d) Rushing through

ANSWER EXPLANATIONS

1. **Correct answer: c) Federal and state law**

- Rationale: Resident rights are protected by federal laws (like OBRA and HIPAA) and state regulations, not just facility policies or international law.

2. **Correct answer: b) Document refusal and try later**

- Rationale: Residents have the right to refuse care. Document the refusal and attempt again later. Never force care or label as noncompliant.

3. **Correct answer: c) Health information privacy**

- Rationale: HIPAA (Health Insurance Portability and Accountability Act) specifically protects the privacy and security of health information.

4. **Correct answer: c) Knock and wait for response**

- Rationale: Knocking and waiting for permission respects privacy rights and dignity. This is required even in healthcare facilities.

5. **Correct answer: b) Rough handling**

- Rationale: Physical abuse includes rough handling, hitting, or inappropriate use of force. Ignoring is neglect, taking belongings is

financial abuse, gossiping violates privacy.

6. Correct answer: c) Safety concerns with proper process

- Rationale: Residents can only be discharged for specific legal reasons with 30-day notice and proper process. Being "difficult" or complaining aren't valid reasons.

7. Correct answer: b) Medications controlling behavior

- Rationale: Chemical restraints are medications used to control behavior rather than treat medical conditions. They're highly regulated.

8. Correct answer: b) Advocates for residents

- Rationale: The ombudsman is an independent advocate who investigates complaints and protects resident rights, not a facility employee.

9. Correct answer: b) Refuse medications

- Rationale: Residents have the right to refuse treatment including medications. They cannot violate others' rights by hitting or stealing.

10. Correct answer: c) Untreated bedsores

- Rationale: Untreated pressure injuries indicate neglect of necessary care. Clean appearance and appropriate weight indicate proper care.

11. Correct answer: c) Only with resident consent or safety issues

- Rationale: Visitors can only be restricted if the resident wishes or for documented safety/health reasons, not staff convenience.

12. Correct answer: b) Stealing money or property

- Rationale: Financial abuse involves illegal taking or misuse of funds or property. Helping with consent and discussing costs are appropriate.

13. Correct answer: c) Activities and distraction

- Rationale: Appropriate alternatives include activities, distraction, and meeting underlying needs. Medications and threats are forms of restraints.

14. Correct answer: c) Addressed without retaliation

- Rationale: Residents have the right to voice grievances without fear of punishment. Facilities must address complaints appropriately.

15. Correct answer: c) Language preferences respected

- Rationale: Cultural rights include using preferred language, dietary preferences, and religious practices, not forced assimilation.

16. Correct answer: b) A resident right

- Rationale: Participation in care planning is a fundamental right under OBRA, not optional or limited to family.

17. Correct answer: b) Delivered unopened

- Rationale: Mail must be delivered unopened unless the resident requests assistance. Opening mail violates privacy rights.

18. Correct answer: c) Daily schedule

- Rationale: Residents can choose their personal schedule for sleeping, eating, and activities within reason. They cannot control staff or others' choices.

19. Correct answer: b) Immediately

- Rationale: Suspected abuse must be reported immediately to protect the resident. Waiting any time period enables continued abuse.

20. Correct answer: b) Closing curtains/doors

- Rationale: Privacy during care requires closing curtains/doors and keeping the body covered except the area being cared for.

CHAPTER SUMMARY

Protecting and promoting residents' rights is fundamental to ethical healthcare:

- Residents maintain all constitutional and civil rights plus additional protections
- Core rights include dignity, safety, privacy, autonomy, and quality care
- Abuse and neglect in any form are prohibited and must be reported immediately
- Privacy encompasses both physical privacy and information confidentiality
- Residents have the right to make choices about their daily life and care
- Restraints are last resort only with strict regulations
- Cultural, religious, and personal preferences must be respected
- Residents can voice complaints without fear of retaliation
- Participation in care planning is a fundamental right
- Transfer/discharge requires legal cause and proper process

CNAs are frontline protectors of resident rights. Every interaction should promote dignity, respect choices, and protect from harm. When rights are violated, immediate reporting is both a legal and ethical obligation.

CHAPTER 11: LEGAL AND ETHICAL ISSUES

Learning Objectives

By the end of this chapter, you will be able to:

- Understand legal responsibilities and scope of practice
- Identify ethical principles in healthcare
- Recognize legal documents and their purposes
- Apply standards of professional conduct
- Understand documentation requirements
- Identify situations requiring mandatory reporting
- Protect yourself from legal liability

KEY CONCEPTS

Legal Framework

CNAs work within a complex legal framework including federal laws, state regulations, and facility policies.

Key Legislation:

- **Nurse Practice Acts:** State laws defining nursing scope
- **OBRA 1987:** Long-term care standards
- **HIPAA:** Privacy and security rules
- **ADA:** Disability protections
- **OSHA:** Workplace safety
- **Elder Justice Act:** Abuse reporting

Legal Terms:

- **Liability:** Legal responsibility
- **Negligence:** Failure to provide proper care
- **Malpractice:** Professional negligence causing harm
- **Standard of Care:** Expected level of care
- **Tort:** Civil wrong causing harm
- **Assault:** Threat of harm
- **Battery:** Unwanted touching

Scope of Practice

Working within scope of practice protects patients and CNAs from harm and liability.

CNA Scope Includes:

- Basic nursing care
- Vital signs
- ADL assistance
- Specimen collection
- Basic treatments
- Observation and reporting

Outside CNA Scope:

- Medications (including OTC)
- Invasive procedures
- Sterile techniques
- Assessments
- Care planning
- Diagnoses
- IV care
- Tube insertions

Delegation Principles:

- Only accept appropriate tasks
- Know your limitations
- Ask for clarification
- Report inability to complete
- Never exceed scope
- Document appropriately

Ethical Principles

Ethics guide professional behavior beyond legal requirements.

Core Ethical Principles:

1. Autonomy

- Respect for self-determination

- Right to make choices
- Informed consent
- Right to refuse

2. Beneficence

- Do good
- Act in patient's best interest
- Promote wellbeing
- Prevent harm

3. Non-maleficence

- Do no harm
- Avoid causing injury
- Prevent complications
- Safe practice

4. Justice

- Fair treatment
- Equal access
- No discrimination
- Resource allocation

5. Veracity

- Truthfulness
- Honest communication
- Accurate documentation
- No deception

6. Fidelity

- Faithfulness
- Keep promises
- Maintain trust
- Professional loyalty

Professional Boundaries

Maintaining boundaries protects both patients and CNAs.

Boundary Guidelines:

- Keep relationships professional
- Don't share personal problems
- Refuse gifts and money
- Avoid favoritism
- No personal relationships with patients
- Separate work and personal life
- No social media connections
- Maintain therapeutic relationship

Boundary Violations:

- Over-involvement
- Under-involvement
- Personal gain
- Dual relationships
- Sexual misconduct
- Financial exploitation
- Breach of confidentiality

Informed Consent

Patients must give informed consent for treatment.

Elements of Informed Consent:

- Nature of treatment
- Risks and benefits
- Alternatives available
- Right to refuse
- Consequences of refusal
- Voluntary agreement
- Competent to decide

CNA Role:

- Ensure consent exists
- Report concerns
- Stop if consent withdrawn
- Document refusals
- Never obtain consent
- Refer questions to nurse

Advance Directives

Legal documents stating healthcare wishes when unable to communicate.

Types:

1. Living Will

- End-of-life care wishes
- Life-sustaining treatments
- Specific interventions
- Personal values

2. Durable Power of Attorney for Healthcare

- Designates decision maker
- Activates when incapacitated
- Broad healthcare decisions
- Must follow wishes

3. Do Not Resuscitate (DNR)

- No CPR if heart stops
- Various levels
- Must be written order
- Respect wishes

4. POLST/MOLST

- Physician Orders for Life-Sustaining Treatment
- More detailed than DNR
- Portable between settings
- Specific interventions

CNA Responsibilities:

- Know patient's wishes
- Follow facility protocol
- Never decide code status
- Report concerns
- Provide comfort care
- Support family

Documentation Requirements

Documentation is a legal record and communication tool.

Documentation Principles:

- Factual and objective
- Complete and accurate
- Timely
- Legible
- Signed properly
- No erasures or white-out
- Error correction proper
- Approved abbreviations only

What to Document:

- Care provided
- Patient responses
- Observations
- Refusals

- Incidents
- Behavior changes
- Complaints
- Vital signs

Legal Aspects:

- Permanent record
- Legal evidence
- Proof of care
- Communication tool
- Quality monitoring
- Billing support

Documentation Errors:

- Draw single line through error
- Write "error" and initial
- Write correct information
- Never remove pages
- Never alter records
- Report mistakes

Mandatory Reporting

CNAs are mandated reporters with legal obligations.

Must Report:

- Suspected abuse/neglect
- Workplace injuries
- Communicable diseases
- Safety hazards
- Professional misconduct
- Criminal activity
- Substance abuse by staff

Abuse Reporting:

- Immediate to supervisor
- Follow facility protocol
- State hotline if needed
- Document objectively
- Preserve evidence
- Protect resident
- No retaliation protection

Good Faith Reporting:

- Legal protection for reports
- Made honestly
- Reasonable suspicion
- Not proven fact needed
- Better to over-report
- Failure to report illegal

Workplace Safety

Legal requirements protect healthcare workers.

OSHA Requirements:

- Safe work environment
- Proper equipment
- Training provided
- Hazard communication
- Bloodborne pathogen protection
- Violence prevention
- Injury reporting

Worker Rights:

- Refuse unsafe work

- Report hazards
- Receive training
- Access records
- No retaliation
- Workers' compensation

Professional Liability

Understanding liability helps prevent legal problems.

Common Liability Issues:

- Falls due to negligence
- Medication errors
- Failure to report
- Exceeding scope
- Abandonment
- Breach of confidentiality
- Inadequate care

Protecting Yourself:

- Work within scope
- Follow policies
- Document thoroughly
- Report concerns
- Maintain competence
- Professional liability insurance
- Never work impaired

Ethical Dilemmas

Healthcare presents challenging ethical situations.

Common Dilemmas:

- End-of-life decisions

- Religious conflicts
- Family disagreements
- Resource allocation
- Truth-telling
- Cultural conflicts
- Quality vs. quantity of life

Ethical Decision-Making:

1. Identify the problem
2. Gather information
3. Consider options
4. Apply ethical principles
5. Consult others
6. Make decision
7. Evaluate outcome

Resources:

- Ethics committees
- Facility policies
- Nursing supervisors
- Social services
- Chaplains
- Ombudsman

Criminal Background Checks

Healthcare workers undergo extensive screening.

Background Check Components:

- Criminal history
- Sex offender registry
- Abuse registries
- Professional licenses
- Drug screening

- Reference checks

Disqualifying Offenses:

- Patient abuse
- Theft
- Drug offenses
- Violence
- Sexual offenses
- Fraud

Incident Reporting

Proper incident reporting protects everyone involved.

When to Report:

- Patient injuries
- Medication errors
- Equipment failures
- Visitor injuries
- Staff injuries
- Property damage
- Near misses

Incident Report Process:

1. Ensure safety first
2. Provide necessary care
3. Notify supervisor immediately
4. Complete incident report
5. Objective facts only
6. Don't admit fault
7. Don't document in patient record
8. Follow up as required

KEY TERMS

Abandonment: Leaving patients without proper replacement

Advance Directive: Legal document stating healthcare wishes

Assault: Threat of physical harm

Battery: Unwanted physical contact

Defamation: False statements damaging reputation

Ethical Dilemma: Conflict between ethical principles

Informed Consent: Voluntary agreement with understanding

Liability: Legal responsibility for actions

Malpractice: Professional negligence causing harm

Mandated Reporter: Legal obligation to report suspected abuse

Negligence: Failure to provide reasonable care

Scope of Practice: Legal boundaries of practice

PRACTICE QUESTIONS

1. A CNA who performs a task outside their scope of practice may face: a) Promotion b) Legal liability c) Pay increase d) Recognition
2. HIPAA primarily protects: a) Facility property b) Staff rights c) Patient privacy d) Visitor access
3. Informed consent must be obtained by: a) CNAs b) Licensed staff c) Family members d) Administrators
4. A DNR order means: a) Do not disturb b) Do not resuscitate c) Do not record d) Do not release
5. When documenting an error, you should: a) Use white-out b) Remove the page c) Draw a single line through it d) Scribble it out
6. Mandated reporters must report suspected abuse: a) Within 24 hours b) Immediately c) Weekly d) Monthly
7. The ethical principle of "do no harm" is: a) Autonomy b) Justice c) Beneficence d) Non-maleficence
8. Professional boundaries prohibit: a) Caring communication b) Personal relationships with patients c) Empathy d) Advocacy
9. An advance directive becomes effective when:

- a) Signed b) Patient cannot make decisions c) Family requests d) Doctor decides
- 10. Documentation should be: a) Personal opinions b) Objective facts c) Abbreviated heavily d) Completed weekly
- 11. Negligence requires proving: a) Intent to harm b) Failure to meet standard of care c) Criminal action d) Written threats
- 12. Good faith reporting provides: a) Financial rewards b) Legal protection c) Guaranteed anonymity d) Job promotion
- 13. Which is NOT an advance directive? a) Living will b) Insurance card c) Healthcare proxy d) POLST
- 14. Incident reports should: a) Blame someone b) State facts objectively c) Be filed in patient chart d) Admit liability
- 15. The ethical principle of truthfulness is: a) Veracity b) Fidelity c) Justice d) Autonomy
- 16. CNAs can legally: a) Give medications b) Insert catheters c) Take vital signs d) Start IVs
- 17. Patient abandonment occurs when: a) Taking a break b) Leaving without proper coverage c) Ending shift d) Calling in sick
- 18. Background checks include: a) Credit scores b) Political affiliation c) Criminal history d) Social media

19. Assault differs from battery because assault: a) Causes injury b) Is only a threat c) Requires touching d) Is always criminal
20. Ethics committees help with: a) Scheduling b) Payroll issues c) Difficult care decisions d) Hiring decisions

ANSWER EXPLANATIONS

1. Correct answer: b) Legal liability

- Rationale: Working outside scope of practice exposes CNAs to legal liability including loss of certification, lawsuits, and criminal charges.

2. Correct answer: c) Patient privacy

- Rationale: HIPAA (Health Insurance Portability and Accountability Act) specifically protects patient health information privacy and security.

3. Correct answer: b) Licensed staff

- Rationale: Only licensed staff (doctors, nurses) can obtain informed consent. CNAs can witness but not obtain consent.

4. Correct answer: b) Do not resuscitate

- Rationale: DNR orders indicate the patient does not want cardiopulmonary resuscitation if their heart stops.

5. Correct answer: c) Draw a single line through it

- Rationale: Proper error correction involves drawing a single line through the error, writing "error," initialing, and writing correct information.

6. Correct answer: b) Immediately

- Rationale: Suspected abuse must be reported immediately to protect the victim

from further harm. Delays enable continued abuse.

7. Correct answer: d) Non-maleficence

- Rationale: Non-maleficence means "do no harm." Beneficence means "do good," while autonomy and justice are different principles.

8. Correct answer: b) Personal relationships with patients

- Rationale: Professional boundaries prohibit personal/romantic relationships with patients but encourage appropriate caring, empathy, and advocacy.

9. Correct answer: b) Patient cannot make decisions

- Rationale: Advance directives become effective when the patient loses capacity to make their own healthcare decisions.

10. Correct answer: b) Objective facts

- Rationale: Documentation must be factual and objective, not opinions. It should be timely and use only approved abbreviations.

11. Correct answer: b) Failure to meet standard of care

- Rationale: Negligence is unintentional failure to meet the standard of care. Intent to harm would be assault/abuse.

12. Correct answer: b) Legal protection

- Rationale: Good faith reporting laws protect mandated reporters from retaliation or lawsuits when reporting suspected abuse.

13. Correct answer: b) Insurance card

- Rationale: Insurance cards are not advance directives. Living wills, healthcare proxies, and POLST forms are all types of advance directives.

14. Correct answer: b) State facts objectively

- Rationale: Incident reports should contain only objective facts without blame or admitting liability. They're not filed in patient charts.

15. Correct answer: a) Veracity

- Rationale: Veracity is the ethical principle of truthfulness. Fidelity is faithfulness, justice is fairness, and autonomy is self-determination.

16. Correct answer: c) Take vital signs

- Rationale: Taking vital signs is within CNA scope. Medications, catheter insertion, and IVs require advanced training and licensure.

17. Correct answer: b) Leaving without proper coverage

- Rationale: Abandonment occurs when leaving patients without ensuring proper coverage. Taking breaks, ending shifts properly, and calling in sick appropriately aren't abandonment.

18. Correct answer: c) Criminal history

- Rationale: Healthcare background checks include criminal history, abuse registries, and drug screening, not credit scores or political views.

19. Correct answer: b) Is only a threat

- Rationale: Assault is the threat of harm; battery is actual unwanted touching. Assault doesn't require physical contact.

20. Correct answer: c) Difficult care decisions

- Rationale: Ethics committees help resolve ethical dilemmas in patient care, not administrative issues like scheduling or hiring.

CHAPTER SUMMARY

Legal and ethical issues permeate every aspect of CNA practice:

- CNAs must work within their defined scope of practice
- Ethical principles guide professional behavior beyond legal requirements
- Professional boundaries protect both patients and healthcare workers
- Informed consent and advance directives respect patient autonomy
- Documentation serves as legal record and must be accurate
- Mandatory reporting protects vulnerable populations
- Understanding liability helps prevent legal problems
- Incident reporting improves safety for all
- Background checks ensure suitable caregivers
- Ethics committees help resolve difficult dilemmas

CNAs face complex legal and ethical situations daily. Understanding these concepts, maintaining professional standards, and seeking guidance when uncertain protects patients, facilities, and your career. When in doubt, always act in the patient's best interest within your scope of practice.

CHAPTER 12: BODY SYSTEMS AND COMMON CONDITIONS

Learning Objectives

By the end of this chapter, you will be able to:

- Identify major body systems and their functions
- Recognize normal age-related changes
- Understand common diseases and conditions
- Identify signs and symptoms requiring reporting
- Apply knowledge to provide appropriate care
- Support patients with chronic conditions

KEY CONCEPTS

Integumentary System

The integumentary system includes skin, hair, and nails. It's the body's largest organ system.

Functions:

- Protection from infection
- Temperature regulation
- Sensation
- Vitamin D production
- Fluid balance

Age-Related Changes:

- Thinner, more fragile skin
- Decreased elasticity
- Less subcutaneous fat
- Slower healing
- Drier skin
- Gray hair
- Brittle nails

Common Conditions:

Pressure Injuries

- Caused by unrelieved pressure
- Stages 1-4, unstageable, deep tissue
- Prevention crucial
- Report any skin changes

Skin Cancer

- Basal cell (most common)
- Squamous cell
- Melanoma (most dangerous)
- Report unusual moles or lesions

Other Conditions:

- Dermatitis/eczema
- Psoriasis
- Fungal infections
- Shingles
- Burns
- Wounds

CNA Care:

- Daily skin inspection
- Keep skin clean and dry
- Moisturize dry areas
- Reposition frequently
- Protect from injury
- Report changes promptly

Musculoskeletal System

This system provides structure, movement, and protection for organs.

Components:

- 206 bones
- 600+ muscles
- Joints
- Ligaments

- Tendons
- Cartilage

Functions:

- Support and structure
- Movement
- Protection of organs
- Blood cell production
- Mineral storage

Age-Related Changes:

- Decreased bone density
- Loss of muscle mass
- Reduced flexibility
- Slower reflexes
- Joint stiffness
- Height loss

Common Conditions:

Osteoporosis

- Brittle bones
- Fracture risk
- More common in women
- Prevention important

Arthritis

- Osteoarthritis (wear and tear)
- Rheumatoid (autoimmune)
- Joint pain and stiffness
- Decreased mobility

Fractures

- Hip fractures common
- Wrist, spine also frequent
- Slow healing in elderly
- Complications risk

Other Conditions:

- Muscular dystrophy
- Gout
- Bursitis
- Contractures
- Amputations

CNA Care:

- Encourage activity
- ROM exercises
- Proper positioning
- Fall prevention
- Assist with mobility
- Pain monitoring

Nervous System

The nervous system controls all body functions through electrical impulses.

Components:

- Brain
- Spinal cord
- Peripheral nerves
- Sensory organs

Functions:

- Control center

- Communication
- Sensory processing
- Movement coordination
- Thinking and memory

Age-Related Changes:

- Slower reaction time
- Some memory changes
- Decreased sensation
- Balance problems
- Sleep pattern changes

Common Conditions:

Stroke (CVA)

- Blood flow interrupted to brain
- Paralysis/weakness
- Speech problems
- FAST warning signs

Parkinson's Disease

- Movement disorder
- Tremors
- Shuffling gait
- Mask-like face
- Pill-rolling motion

Multiple Sclerosis

- Autoimmune disease
- Myelin damage
- Vision problems
- Weakness
- Variable symptoms

Other Conditions:

- Epilepsy
- Alzheimer's disease
- Peripheral neuropathy
- Brain tumors
- Spinal cord injuries

CNA Care:

- Safety measures
- Fall prevention
- Assist with ADLs
- Communication support
- Seizure precautions
- Skin protection

Cardiovascular System

The cardiovascular system circulates blood throughout the body.

Components:

- Heart (4 chambers)
- Blood vessels
- Blood

Functions:

- Oxygen delivery
- Nutrient transport
- Waste removal
- Temperature regulation
- Immune function

Age-Related Changes:

- Decreased cardiac output
- Arterial stiffening
- Higher blood pressure
- Slower heart rate
- Reduced exercise tolerance

Common Conditions:

Hypertension

- High blood pressure
- "Silent killer"
- Stroke/heart attack risk
- Lifestyle factors

Coronary Artery Disease

- Blocked heart arteries
- Chest pain (angina)
- Heart attack risk
- Leading cause of death

Heart Failure

- Heart can't pump effectively
- Fluid retention
- Shortness of breath
- Fatigue

Other Conditions:

- Arrhythmias
- Peripheral vascular disease
- Deep vein thrombosis

- Anemia
- Valve disorders

CNA Care:

- Monitor vital signs
- Watch for edema
- Position for breathing
- Encourage activity as tolerated
- Low sodium diet support
- Medication compliance

Respiratory System

The respiratory system provides oxygen and removes carbon dioxide.

Components:

- Nose and mouth
- Pharynx and larynx
- Trachea
- Bronchi
- Lungs
- Diaphragm

Functions:

- Gas exchange
- pH balance
- Speech
- Smell
- Protection from pathogens

Age-Related Changes:

- Decreased lung capacity

- Weaker respiratory muscles
- Less efficient gas exchange
- Increased infection risk
- Barrel chest appearance

Common Conditions:

COPD

- Chronic bronchitis
- Emphysema
- Progressive disease
- Smoking related
- Oxygen therapy common

Pneumonia

- Lung infection
- Bacterial or viral
- Serious in elderly
- Preventable with vaccine

Asthma

- Airway inflammation
- Wheezing
- Triggers vary
- Inhaler use

Other Conditions:

- Lung cancer
- Tuberculosis
- Pulmonary embolism
- Sleep apnea
- Influenza

CNA Care:

- Positioning for breathing
- Oxygen safety
- Encourage deep breathing
- Infection prevention
- Monitor respiratory rate
- Report changes

Digestive System

The digestive system processes food for energy and eliminates waste.

Components:

- Mouth and teeth
- Esophagus
- Stomach
- Small intestine
- Large intestine
- Liver, gallbladder, pancreas

Functions:

- Digestion
- Absorption
- Elimination
- Enzyme production
- Nutrient processing

Age-Related Changes:

- Decreased saliva
- Slower digestion
- Reduced absorption

- Constipation tendency
- Tooth loss

Common Conditions:

GERD

- Acid reflux
- Heartburn
- Aspiration risk
- Dietary modifications

Diverticulitis

- Colon pouches inflamed
- Pain and fever
- Dietary changes
- Complications possible

Other Conditions:

- Ulcers
- Hepatitis
- Cirrhosis
- Gallstones
- Colorectal cancer
- Constipation/diarrhea

CNA Care:

- Assist with meals
- Proper positioning
- Oral care
- Monitor bowel patterns
- Encourage fluids
- Diet compliance

Urinary System

The urinary system filters blood and eliminates liquid waste.

Components:

- Kidneys (2)
- Ureters
- Bladder
- Urethra

Functions:

- Waste filtration
- Fluid balance
- Electrolyte balance
- Blood pressure regulation
- Red blood cell production

Age-Related Changes:

- Decreased kidney function
- Reduced bladder capacity
- Increased frequency
- Nocturia
- Incontinence risk

Common Conditions:

Urinary Tract Infections

- Common in elderly
- Confusion in elderly
- Prevention important
- Prompt treatment needed

Chronic Kidney Disease

- Progressive loss of function
- Dialysis may be needed
- Fluid restrictions
- Diet modifications

Other Conditions:

- Kidney stones
- Bladder cancer
- Incontinence
- Retention
- Benign prostatic hyperplasia

CNA Care:

- Encourage fluids
- Toileting schedules
- Perineal care
- Monitor output
- Infection prevention
- Catheter care

Endocrine System

The endocrine system produces hormones regulating body functions.

Components:

- Pituitary gland
- Thyroid
- Parathyroid
- Adrenal glands
- Pancreas

- Reproductive glands

Functions:

- Growth and development
- Metabolism
- Blood sugar control
- Stress response
- Reproduction

Age-Related Changes:

- Slower metabolism
- Glucose intolerance
- Thyroid changes
- Decreased hormones
- Temperature regulation issues

Common Conditions:

Diabetes Mellitus

- Type 1 (insulin dependent)
- Type 2 (most common)
- Blood sugar imbalances
- Multiple complications
- Diet crucial

Thyroid Disorders

- Hypothyroidism (low)
- Hyperthyroidism (high)
- Metabolism effects
- Energy changes

CNA Care:

- Monitor for blood sugar signs
- Assist with diabetic diet
- Foot care important
- Skin inspection
- Report changes
- Medication timing

Reproductive System

The reproductive system enables reproduction and produces sex hormones.

Age-Related Changes:

- Menopause in women
- Decreased hormones
- Prostate enlargement in men
- Vaginal dryness
- Erectile dysfunction

Common Conditions:

- Prostate disorders
- Breast cancer
- Uterine disorders
- STIs still possible
- Vaginal infections

CNA Care:

- Respect privacy
- Maintain dignity
- Proper perineal care
- Report unusual discharge
- Support during exams

Immune System

The immune system protects against disease and infection.

Components:

- White blood cells
- Lymph nodes
- Spleen
- Thymus
- Bone marrow

Age-Related Changes:

- Decreased immune response
- Slower healing
- Increased infection risk
- Reduced vaccine response
- Autoimmune risks

Common Conditions:

- HIV/AIDS
- Autoimmune diseases
- Allergies
- Immunodeficiency
- Cancers

CNA Care:

- Infection prevention
- Standard precautions
- Monitor for infections
- Encourage vaccinations
- Good nutrition support

KEY TERMS

Acute: Sudden onset, short duration

Chronic: Long-lasting or recurring

Hemiplegia: Paralysis of one side

Metastasis: Cancer spread

Nocturia: Nighttime urination

Paralysis: Loss of movement

Pathogen: Disease-causing organism

Sign: Objective, observable finding

Symptom: Subjective complaint

PRACTICE QUESTIONS

1. The largest organ system is: a) Cardiovascular b) Integumentary c) Respiratory d) Nervous
2. Normal age-related changes include: a) Dementia b) Slower reaction time c) Diabetes d) Heart disease
3. FAST stands for stroke signs of: a) Face, Arms, Speech, Time b) Fast, Action, Save, Treatment c) First, Aid, Support, Transfer d) Find, Assist, Stabilize, Transport
4. The most common type of arthritis is: a) Rheumatoid b) Gout c) Osteoarthritis d) Psoriatic
5. COPD includes: a) Asthma only b) Chronic bronchitis and emphysema c) Pneumonia d) Lung cancer
6. Type 2 diabetes is characterized by: a) No insulin production b) Insulin resistance c) Juvenile onset d) Insulin dependence
7. The cardiovascular system includes: a) Lungs b) Kidneys c) Heart and blood vessels d) Brain
8. Osteoporosis causes: a) Joint pain b) Brittle bones c) Muscle weakness d) Skin changes
9. A common sign of UTI in elderly is: a) Chest

- pain b) Confusion c) Vision changes d) Joint pain
10. The endocrine system produces: a) Blood cells b) Hormones c) Antibodies d) Enzymes
 11. Pressure injuries are caused by: a) Infection b) Unrelieved pressure c) Poor diet alone d) Medications
 12. Normal respiratory rate for adults is: a) 8-10 b) 12-20 c) 25-30 d) 35-40
 13. Parkinson's disease affects: a) Memory first b) Movement c) Vision d) Hearing
 14. Heart failure causes: a) Low blood pressure only b) Fluid retention c) Weight loss d) Increased energy
 15. The digestive system does NOT include: a) Liver b) Kidneys c) Stomach d) Pancreas
 16. Age-related changes to skin include: a) Increased thickness b) More elasticity c) Decreased fragility d) Slower healing
 17. Multiple sclerosis affects: a) Bones b) Myelin c) Joints d) Blood vessels
 18. GERD increases risk of: a) Fractures b) Aspiration c) Kidney stones d) Diabetes
 19. The urinary system maintains: a) Temperature only b) Fluid and electrolyte balance c) Hormone production d) Digestion

20. Hypertension is called the "silent killer" because: a) It's not serious b) Often has no symptoms c) Only affects elderly d) Can't be treated

ANSWER EXPLANATIONS

1. Correct answer: b) Integumentary

- Rationale: The integumentary system (skin, hair, nails) is the body's largest organ system, covering the entire body surface.

2. Correct answer: b) Slower reaction time

- Rationale: Slower reaction time is a normal age-related change. Dementia, diabetes, and heart disease are pathological conditions, not normal aging.

3. Correct answer: a) Face, Arms, Speech, Time

- Rationale: FAST helps identify stroke: Face drooping, Arm weakness, Speech difficulty, Time to call 911.

4. Correct answer: c) Osteoarthritis

- Rationale: Osteoarthritis (wear-and-tear arthritis) is most common, especially in older adults. Rheumatoid is autoimmune and less common.

5. Correct answer: b) Chronic bronchitis and emphysema

- Rationale: COPD (Chronic Obstructive Pulmonary Disease) includes chronic bronchitis and emphysema. Asthma is separate, though similar.

6. Correct answer: b) Insulin resistance

- Rationale: Type 2 diabetes involves insulin resistance where cells don't respond properly to insulin. Type 1 has no insulin production.

7. Correct answer: c) Heart and blood vessels

- Rationale: The cardiovascular system consists of the heart and blood vessels. Lungs are respiratory, kidneys are urinary, brain is nervous system.

8. Correct answer: b) Brittle bones

- Rationale: Osteoporosis causes decreased bone density leading to brittle bones and fracture risk. Joint pain suggests arthritis.

9. Correct answer: b) Confusion

- Rationale: In elderly patients, confusion is often the first sign of UTI, even before typical urinary symptoms appear.

10. Correct answer: b) Hormones

- Rationale: The endocrine system produces hormones that regulate body functions. Blood cells are made in bone marrow, antibodies by immune system.

11. Correct answer: b) Unrelieved pressure

- Rationale: Pressure injuries result from unrelieved pressure cutting off blood flow to tissues. While nutrition affects healing, pressure is the primary cause.

12. Correct answer: b) 12-20

- Rationale: Normal adult respiratory rate is 12-20 breaths per minute. Rates outside this range indicate potential problems.

13. Correct answer: b) Movement

- Rationale: Parkinson's disease is primarily a movement disorder causing tremors, rigidity, and slow movement. Memory may be affected later.

14. Correct answer: b) Fluid retention

- Rationale: Heart failure causes fluid backup leading to edema, weight gain, and breathing problems, not weight loss or increased energy.

15. Correct answer: b) Kidneys

- Rationale: Kidneys are part of the urinary system, not digestive. Liver, stomach, and pancreas all play digestive roles.

16. Correct answer: d) Slower healing

- Rationale: Aging skin heals more slowly. It becomes thinner (not thicker), less elastic (not more), and more fragile (not less).

17. Correct answer: b) Myelin

- Rationale: Multiple sclerosis damages myelin, the protective covering of nerve fibers, disrupting nerve signals.

18. Correct answer: b) Aspiration

- Rationale: GERD (acid reflux) increases aspiration risk as stomach acid can enter lungs, especially when lying flat.

19. Correct answer: b) Fluid and electrolyte balance

- Rationale: The urinary system maintains fluid and electrolyte balance through kidney

filtration. Temperature is regulated by integumentary system.

20. Correct answer: b) Often has no symptoms

- Rationale: Hypertension is called "silent killer" because it often has no symptoms while causing serious damage to organs.

CHAPTER SUMMARY

Understanding body systems helps CNAs provide better care:

- Each body system has specific functions vital to health
- Normal aging brings predictable changes to all systems
- Common conditions affect different systems requiring specialized care
- Recognition of signs and symptoms enables early intervention
- System interactions mean conditions often affect multiple systems
- Age-related changes increase vulnerability to disease
- Preventive care can minimize many conditions
- Chronic conditions require ongoing management
- Acute conditions need prompt recognition and response

CNAs observe patients closely and often notice changes first. Understanding how body systems work, recognizing abnormalities, and knowing when to report concerns are essential skills. This knowledge enables provision of appropriate care while working within scope of practice.

FINAL PRACTICE EXAM

This comprehensive exam covers all topics from the study guide. Allow 90 minutes to complete all 100 questions. Choose the BEST answer for each question.

QUESTIONS

1. A resident's temperature is 101.2°F. You should:
a) Give them aspirin b) Report to the nurse immediately c) Apply cold compresses d) Document and monitor
2. When transferring a patient with left-sided weakness, which side moves first? a) Right side b) Left side c) Both together d) Either side
3. The first step in the nursing process is: a) Planning b) Implementation c) Assessment d) Evaluation
4. Standard precautions should be used: a) Only with infected patients b) With all patients c) Only during outbreaks d) When convenient
5. A patient refuses morning care. Your BEST response is: a) "You have to get cleaned up" b) "I'll come back later" c) "That's fine, what would you prefer?" d) "I'll tell the nurse you're being difficult"
6. Normal blood pressure for adults is less than: a) 100/60 b) 120/80 c) 140/90 d) 160/100
7. When providing perineal care for females, wipe:
a) Back to front b) Front to back c) In circles d) Side to side
8. RACE stands for: a) Run, Alert, Call, Evacuate b)

Rescue, Alarm, Contain, Extinguish c) Report, Activate, Control, Escape d) Remove, Announce, Close, Exit

9. Which is a sign of dehydration? a) Increased urination b) Moist skin c) Dark urine d) Weight gain
10. The MOST important infection control measure is: a) Wearing gloves b) Hand hygiene c) Isolation d) Medications
11. When counting respirations, you should: a) Tell the patient b) Count for 15 seconds c) Count after taking pulse d) Have patient breathe deeply
12. A patient with diabetes has cold, clammy skin and is confused. This suggests: a) High blood sugar b) Low blood sugar c) Normal blood sugar d) Infection
13. The Fowler's position has the head elevated: a) 15-30 degrees b) 30-45 degrees c) 45-60 degrees d) Flat
14. Residents have the right to: a) Smoke in their rooms b) Refuse treatment c) Take others' belongings d) Leave without notice
15. When ambulating with a gait belt, hold it: a) From the front b) From behind with underhand grip c) Loosely d) At arm's length
16. Stage 2 pressure injury appears as: a) Non-blanchable redness b) Blister or shallow open

area c) Deep crater d) Exposed bone

17. Objective information is: a) What patient tells you b) What you observe c) What family says d) What you think
18. The medical term for difficulty swallowing is: a) Dyspnea b) Dysuria c) Dysphagia d) Dysrhythmia
19. When a patient is on contact precautions, the CNA must: a) Wear a mask at all times b) Wear gloves and gown for patient contact c) Keep door closed d) Use N95 respirator
20. The pulse site at the wrist is called: a) Apical b) Brachial c) Radial d) Carotid
21. Which nutrient is MOST important for wound healing? a) Carbohydrates b) Fats c) Protein d) Vitamins
22. When lifting, use your: a) Back muscles b) Arm muscles c) Leg muscles d) Shoulder muscles
23. A patient's dentures should be stored in: a) Hot water b) Cool water in labeled container c) Tissue paper d) Dry container
24. Signs of infection include all EXCEPT: a) Fever b) Increased appetite c) Redness d) Swelling
25. When measuring blood pressure, the cuff should be placed: a) Over clothing b) 1 inch above elbow crease c) At the wrist d) 3 inches above elbow

26. Passive range of motion exercises are done: a) By the patient alone b) By the CNA moving joints c) With weights d) Only by therapy
27. A patient with CHF should have their head elevated to: a) Prevent aspiration b) Ease breathing c) Reduce pain d) Improve circulation
28. The first sign of a pressure injury is usually: a) Open wound b) Non-blanchable redness c) Drainage d) Black tissue
29. When communicating with a hearing-impaired patient: a) Shout loudly b) Face them and speak clearly c) Write everything d) Speak to their companion
30. Tuberculosis requires which precautions? a) Contact b) Droplet c) Airborne d) Standard only
31. A fracture bedpan is used for patients with: a) Confusion b) Hip fractures c) Incontinence d) Catheters
32. The normal pulse rate for adults is: a) 40-60 bpm b) 60-100 bpm c) 100-120 bpm d) 120-140 bpm
33. When shaving a patient, you should: a) Shave against hair growth b) Use cold water c) Shave in direction of hair growth d) Dry shave
34. Prone position is lying: a) On the back b) On

the stomach c) On the side d) Sitting up

35. A patient's call light should be: a) Answered within 1 hour b) Answered promptly c) Turned off at night d) Given only to alert patients
36. Which is a normal age-related change? a) Dementia b) Decreased skin elasticity c) Diabetes d) Hypertension
37. When feeding a patient, you should: a) Rush to save time b) Mix all foods together c) Alternate foods and fluids d) Feed dessert first
38. Urinary catheters should be: a) Disconnected for cleaning b) Kept above bladder level c) Emptied when full d) Kept below bladder level
39. HIPAA protects: a) Employee rights b) Patient privacy c) Facility property d) Visitor access
40. Diabetes affects which body system primarily? a) Respiratory b) Cardiovascular c) Endocrine d) Nervous
41. When providing mouth care to an unconscious patient: a) Use regular toothbrush b) Position on back c) Position on side d) Give water to rinse
42. The abbreviation NPO means: a) No visitors b) Nothing by mouth c) No physical activity d) Normal diet
43. Which is an example of neglect? a) Hitting

- a patient b) Taking money c) Not providing needed care d) Yelling at patient
44. Constipation can be prevented by: a) Limiting fluids b) Bed rest c) High fiber diet d) Holding bowel movements
45. When using a mechanical lift: a) One person can operate safely b) Two people must be present c) Patient operates controls d) Family can help
46. Sundowning in dementia patients occurs: a) In the morning b) At noon c) In late afternoon/evening d) At midnight
47. The medical term for high blood pressure is: a) Hypotension b) Hypertension c) Hypoglycemia d) Hyperglycemia
48. Fire extinguishers should be aimed at: a) Top of flames b) Middle of fire c) Base of fire d) Ceiling
49. When a patient is dying, hearing is: a) First sense lost b) Last sense lost c) Not important d) Already gone
50. Handwashing should last at least: a) 5 seconds b) 10 seconds c) 20 seconds d) 60 seconds
51. Which promotes healing? a) Keeping wounds dry b) Removing scabs c) Adequate protein intake d) Limiting movement
52. An ombudsman: a) Owns the facility b)

- Advocates for residents c) Supervises CNAs d)
Provides medical care
53. When should gloves be changed? a) Every hour b) Between patients c) At end of shift d) When convenient
54. Cheyne-Stokes respirations are: a) Very rapid breathing b) Alternating deep/shallow with periods of apnea c) Normal breathing d) Gasping only
55. A patient with COPD should NOT receive: a) Encouragement to breathe deeply b) High concentrations of oxygen c) Emotional support d) Frequent position changes
56. The first step when finding a patient on the floor is: a) Help them up b) Call for help and check for injuries c) Leave to get equipment d) Document the fall
57. Therapeutic communication includes: a) Giving advice b) Active listening c) Sharing personal problems d) Judging choices
58. When caring for a dying patient, you should: a) Leave them alone b) Avoid talking to them c) Provide comfort care d) Restrict visitors
59. Insulin is produced by the: a) Liver b) Kidneys c) Pancreas d) Stomach
60. Which is PPE? a) Stethoscope b) Gloves c) Thermometer d) Blood pressure cuff

61. Confused patients should be: a) Restrained b) Sedated c) Reoriented gently d) Isolated
62. The chain of command starts with: a) Administrator b) Your immediate supervisor c) Director of Nursing d) Medical Director
63. Flexion means: a) Bending a joint b) Straightening a joint c) Rotating a joint d) Extending a joint
64. A sign of dehydration in elderly is: a) Increased appetite b) Tenting skin c) Weight gain d) Frequent urination
65. Droplet precautions require a mask within: a) 1 foot b) 3 feet c) 6 feet d) 10 feet
66. When nail care is refused, you should: a) Force compliance b) Document refusal c) Call family d) Skip documentation
67. The medical abbreviation "BID" means: a) Once daily b) Twice daily c) Three times daily d) Four times daily
68. Which is subjective information? a) Temperature 101°F b) Patient states "I hurt" c) Blood pressure 150/90 d) Pulse 88
69. To prevent foot drop, use: a) Foot board b) Bed cradle c) Trapeze d) Side rails
70. A walker should be at what height? a) Hip level b) Wrist level c) Elbow level d) Shoulder level

71. When caring for a patient with C. diff, hand hygiene requires: a) Hand sanitizer only b) Soap and water c) Nothing special d) Gloves only
72. The medical term for blood in urine is: a) Hematoma b) Hematuria c) Hematemesis d) Hemoptysis
73. Which is a late sign of hypoxia? a) Restlessness b) Cyanosis c) Anxiety d) Increased pulse
74. Validation therapy means: a) Testing memory b) Correcting confusion c) Accepting their reality d) Medication therapy
75. When should side rails be used? a) Always b) Never c) According to care plan d) Night shift only
76. OBRA requires: a) 8 hours training b) 75 hours training c) 120 hours training d) 200 hours training
77. Which is an ADL? a) Managing money b) Bathing c) Driving d) Cooking
78. Orthostatic hypotension is prevented by: a) Rising quickly b) Rising slowly c) Staying in bed d) Increasing fluids
79. The medical term for paralysis on one side is: a) Paraplegia b) Quadriplegia c) Hemiplegia d) Myalgia
80. When should incidents be reported? a) End of

shift b) Immediately c) Next day d) Weekly

81. Which is a sign of approaching death? a) Increased appetite b) Mottled skin c) High blood pressure d) Increased urination
82. Adaptive equipment includes: a) Wheelchairs b) Built-up utensils c) Beds d) Thermometers
83. The most common site for pressure injuries is: a) Heels b) Sacrum c) Elbows d) Shoulders
84. When providing care, knock and wait for response to respect: a) Safety b) Privacy c) Time d) Policy
85. Aspiration risk is highest with: a) Thin liquids b) Pudding c) Mashed potatoes d) Bread
86. The medical term for difficulty breathing is: a) Dysphagia b) Dysuria c) Dyspnea d) Dysphasia
87. A patient's religious items should be: a) Removed b) Hidden c) Respected d) Discouraged
88. Which is within CNA scope of practice? a) Giving medications b) Taking vital signs c) Starting IVs d) Wound assessment
89. Atrophy means: a) Muscle growth b) Muscle wasting c) Muscle spasm d) Muscle strengthening
90. When should you wash your hands? a) Start of shift only b) When visibly soiled only c) Before

and after patient contact d) End of shift only

91. The primary purpose of documentation is: a) Legal protection b) Communication c) Billing d) Evaluation
92. Which is an early sign of skin breakdown? a) Open wound b) Non-blanchable redness c) Black tissue d) Drainage
93. When oxygen is in use: a) Smoking is allowed outside room b) No smoking allowed c) Electric razors preferred d) Candles permitted
94. A patient's weight should be measured: a) After meals b) Same time each day c) With heavy clothes d) Different scales
95. Which promotes dignity? a) Using nicknames b) Providing privacy c) Making decisions for them d) Doing everything for them
96. The abbreviation VS stands for: a) Very Sick b) Vital Signs c) Visitor Services d) Volume Status
97. When should you use standard precautions? a) Only with known infections b) Always with all patients c) Only with blood d) During outbreaks
98. A Glasgow Coma Scale measures: a) Pain level b) Consciousness level c) Blood sugar d) Temperature
99. Which is a barrier to communication? a) Eye contact b) Environmental noise c) Open

questions d) Active listening

100. The most important quality for a CNA is: a) Speed b) Compassion c) Strength d) Intelligence

ANSWER KEY WITH EXPLANATIONS

1. **b) Report to the nurse immediately** - Elevated temperature indicates fever requiring nursing assessment
2. **b) Left side** - Dress/move weak side first for easier manipulation
3. **c) Assessment** - Assessment is always first step to gather information
4. **b) With all patients** - Standard precautions are used universally
5. **c) "That's fine, what would you prefer?"** - Respects autonomy and choices
6. **b) 120/80** - Normal BP is less than 120/80 mmHg
7. **b) Front to back** - Prevents UTI by avoiding contamination
8. **b) Rescue, Alarm, Contain, Extinguish** - Correct RACE sequence
9. **c) Dark urine** - Concentrated urine indicates dehydration
10. **b) Hand hygiene** - Most important infection prevention measure

11. **c) Count after taking pulse** - Prevents altered breathing patterns
12. **b) Low blood sugar** - These are classic hypoglycemia symptoms
13. **c) 45-60 degrees** - Standard Fowler's position
14. **b) Refuse treatment** - Fundamental resident right
15. **b) From behind with underhand grip** - Proper gait belt technique
16. **b) Blister or shallow open area** - Stage 2 characteristics
17. **b) What you observe** - Objective data is observable/measurable
18. **c) Dysphagia** - Medical term for swallowing difficulty
19. **b) Wear gloves and gown for patient contact** - Contact precaution requirements
20. **c) Radial** - Pulse at wrist is radial artery
21. **c) Protein** - Essential for tissue repair and healing
22. **c) Leg muscles** - Strongest muscles for safe lifting
23. **b) Cool water in labeled container** - Prevents

warping and loss

- 24. **b) Increased appetite** - Infections typically decrease appetite
- 25. **b) 1 inch above elbow crease** - Proper cuff placement
- 26. **b) By the CNA moving joints** - Definition of passive ROM
- 27. **b) Ease breathing** - Elevation helps with CHF breathing problems
- 28. **b) Non-blanchable redness** - Stage 1 pressure injury
- 29. **b) Face them and speak clearly** - Best communication method
- 30. **c) Airborne** - TB requires airborne precautions
- 31. **b) Hip fractures** - Fracture pan for those who can't flex hip
- 32. **b) 60-100 bpm** - Normal adult pulse range
- 33. **c) Shave in direction of hair growth** - Prevents irritation and cuts
- 34. **b) On the stomach** - Prone position definition
- 35. **b) Answered promptly** - Safety and customer service
- 36. **b) Decreased skin elasticity** - Normal aging

change

- 37. **c) Alternate foods and fluids** - Aids swallowing and nutrition
- 38. **d) Kept below bladder level** - Prevents backflow
- 39. **b) Patient privacy** - HIPAA protects health information
- 40. **c) Endocrine** - Diabetes is endocrine disorder affecting insulin
- 41. **c) Position on side** - Prevents aspiration
- 42. **b) Nothing by mouth** - NPO medical abbreviation
- 43. **c) Not providing needed care** - Definition of neglect
- 44. **c) High fiber diet** - Promotes regular bowel movements
- 45. **b) Two people must be present** - Safety requirement
- 46. **c) In late afternoon/evening** - Typical sundowning time
- 47. **b) Hypertension** - Medical term for high BP
- 48. **c) Base of fire** - Where fuel meets oxygen
- 49. **b) Last sense lost** - Hearing remains until

death

- 50. **c) 20 seconds** - CDC recommendation
- 51. **c) Adequate protein intake** - Necessary for tissue repair
- 52. **b) Advocates for residents** - Ombudsman role
- 53. **b) Between patients** - Prevents cross-contamination
- 54. **b) Alternating deep/shallow with periods of apnea** - Classic pattern
- 55. **b) High concentrations of oxygen** - Can suppress breathing drive
- 56. **b) Call for help and check for injuries** - Safety first
- 57. **b) Active listening** - Therapeutic communication technique
- 58. **c) Provide comfort care** - Appropriate end-of-life care
- 59. **c) Pancreas** - Produces insulin for blood sugar control
- 60. **b) Gloves** - Personal protective equipment
- 61. **c) Reoriented gently** - Appropriate dementia care
- 62. **b) Your immediate supervisor** - Start of chain

of command

- 63. **a) Bending a joint** - Definition of flexion
- 64. **b) Tenting skin** - Sign of poor skin turgor from dehydration
- 65. **b) 3 feet** - Droplet travel distance
- 66. **b) Document refusal** - Legal requirement
- 67. **b) Twice daily** - BID medical abbreviation
- 68. **b) Patient states "I hurt"** - Subjective data from patient
- 69. **a) Foot board** - Prevents foot drop
- 70. **b) Wrist level** - Proper walker height
- 71. **b) Soap and water** - Required for C. diff spores
- 72. **b) Hematuria** - Blood in urine
- 73. **b) Cyanosis** - Late sign of oxygen lack
- 74. **c) Accepting their reality** - Validation therapy principle
- 75. **c) According to care plan** - Individualized approach
- 76. **b) 75 hours training** - OBRA minimum requirement
- 77. **b) Bathing** - Basic activity of daily living

- 78. **b) Rising slowly** - Prevents sudden BP drop
- 79. **c) Hemiplegia** - One-sided paralysis
- 80. **b) Immediately** - Prompt reporting requirement
- 81. **b) Mottled skin** - Sign of circulation changes near death
- 82. **b) Built-up utensils** - Adaptive equipment example
- 83. **b) Sacrum** - Most common pressure point
- 84. **b) Privacy** - Respects dignity and rights
- 85. **a) Thin liquids** - Highest aspiration risk
- 86. **c) Dyspnea** - Difficulty breathing
- 87. **c) Respected** - Religious freedom right
- 88. **b) Taking vital signs** - Within CNA scope
- 89. **b) Muscle wasting** - Definition of atrophy
- 90. **c) Before and after patient contact** - Standard practice
- 91. **b) Communication** - Primary documentation purpose
- 92. **b) Non-blanchable redness** - Early warning sign

- 93. **b) No smoking allowed** - Oxygen safety
 - 94. **b) Same time each day** - Consistency for accuracy
 - 95. **b) Providing privacy** - Maintains dignity
 - 96. **b) Vital Signs** - Common abbreviation
 - 97. **b) Always with all patients** - Universal application
 - 98. **b) Consciousness level** - GCS purpose
 - 99. **b) Environmental noise** - Communication barrier
 - 100. **b) Compassion** - Essential CNA quality
-

APPENDIX A: MEDICAL TERMINOLOGY

Common Prefixes

- **a-/an-:** without, absence (apnea = without breathing)
- **brady-:** slow (bradycardia = slow heart rate)
- **dys-:** difficult, painful (dyspnea = difficult breathing)
- **hemi-:** half (hemiplegia = paralysis of half body)
- **hyper-:** excessive, above (hypertension = high blood pressure)
- **hypo-:** below, under (hypoglycemia = low blood sugar)
- **poly-:** many (polyuria = excessive urination)
- **tachy-:** fast (tachycardia = fast heart rate)

Common Suffixes

- **-algia:** pain (myalgia = muscle pain)
- **-ectomy:** removal (appendectomy = appendix removal)
- **-emia:** blood condition (anemia = lack of red blood cells)
- **-itis:** inflammation (arthritis = joint inflammation)
- **-oma:** tumor (carcinoma = cancerous tumor)
- **-pathy:** disease (neuropathy = nerve disease)
- **-phagia:** swallowing (dysphagia = difficulty swallowing)
- **-phasia:** speech (aphasia = without speech)
- **-plegia:** paralysis (paraplegia = paralysis of legs)
- **-pnea:** breathing (apnea = no breathing)

Body Position Terms

- **Anterior:** front
- **Posterior:** back
- **Superior:** above
- **Inferior:** below
- **Medial:** toward midline
- **Lateral:** away from midline
- **Proximal:** near point of attachment
- **Distal:** far from point of attachment

APPENDIX B: COMMON ABBREVIATIONS

Frequency

- **QD:** daily
- **BID:** twice daily
- **TID:** three times daily
- **QID:** four times daily
- **QOD:** every other day
- **PRN:** as needed
- **STAT:** immediately

Measurements

- **BP:** blood pressure
- **HR:** heart rate
- **RR:** respiratory rate
- **T:** temperature
- **VS:** vital signs
- **I&O:** intake and output
- **wt:** weight
- **ht:** height

Activities

- **ADL:** activities of daily living
- **AM:** morning care
- **AMB:** ambulate
- **BR:** bedrest
- **BRP:** bathroom privileges
- **OOB:** out of bed
- **ROM:** range of motion

Medical Terms

- **CHF:** congestive heart failure
- **COPD:** chronic obstructive pulmonary disease
- **CVA:** cerebrovascular accident (stroke)
- **DM:** diabetes mellitus
- **HTN:** hypertension
- **MI:** myocardial infarction
- **UTI:** urinary tract infection

Documentation

- **ċ:** with
- **š:** without
- **@:** at
- **↑:** increase/elevated
- **↓:** decrease/low
- **Δ:** change
- **WNL:** within normal limits

APPENDIX C: VITAL SIGNS REFERENCE CHART

Normal Vital Sign Ranges

Temperature

- Oral: 97.6-99.6°F (36.4-37.6°C)
- Rectal: 98.6-100.6°F (37.0-38.1°C)
- Axillary: 96.6-98.6°F (35.9-37.0°C)
- Tympanic: 97.6-99.6°F (36.4-37.6°C)

Pulse

- Adults: 60-100 bpm
- Children: 80-120 bpm
- Infants: 120-160 bpm

Respirations

- Adults: 12-20 per minute
- Children: 20-30 per minute
- Infants: 30-60 per minute

Blood Pressure

- Normal: <120/80 mmHg
- Elevated: 120-129/<80
- High Stage 1: 130-139/80-89
- High Stage 2: ≥140/90
- Crisis: >180/120

When to Report Immediately

Temperature

- Above 101°F (38.3°C)
- Below 96°F (35.6°C)
- Sudden changes

Pulse

- Below 60 or above 100 (adults)
- Irregular rhythm
- Weak or thready

Respirations

- Below 12 or above 20 (adults)
- Difficulty breathing
- Irregular pattern

Blood Pressure

- Systolic >160 or <90
- Diastolic >100 or <60
- Sudden changes

APPENDIX D: STATE-SPECIFIC REQUIREMENTS

CNA Certification Requirements by State (Examples)

Note: Requirements change frequently. Always check with your state's Board of Nursing for current information.

Training Hours

- Federal minimum: 75 hours
- Many states require more (100-180 hours)
- Includes classroom and clinical

Testing

- Written/oral exam
- Skills demonstration
- Both required for certification

Renewal Requirements

- Every 2 years typically
- Continuing education hours vary
- Employment verification may be required

Background Checks

- Criminal background check
- Abuse registry check
- Drug screening (some states)

Important Contacts

National Resources

- National Council of State Boards of Nursing:
www.ncsbn.org
- Pearson VUE: www.pearsonvue.com
- Prometric: www.prometric.com

Finding Your State Requirements

1. Search "[your state] Board of Nursing"
2. Look for "Nurse Aide" or "CNA" section
3. Review current requirements
4. Check approved training programs
5. Verify testing locations

CONCLUSION

Congratulations on completing this comprehensive CNA Exam Test Prep Study Guide! You've covered all essential topics needed to succeed on your certification exam and in your career as a Certified Nursing Assistant.

TEST DAY TIPS

- Get adequate rest the night before
- Arrive early to your testing location
- Bring required identification and materials
- Read questions carefully before answering
- Trust your preparation and knowledge
- Stay calm during the skills demonstration
- Remember that some nervousness is normal

KEY TAKEAWAYS

1. **Patient-Centered Care:** Always prioritize patient safety, dignity, and rights
2. **Scope of Practice:** Work within legal boundaries while maximizing your contribution
3. **Communication:** Effective communication with patients, families, and team members is essential
4. **Observation:** CNAs are the "eyes and ears" - report changes promptly
5. **Continuous Learning:** Healthcare evolves constantly - stay current with best practices

YOUR FUTURE AS A CNA

As a CNA, you'll make a meaningful difference in patients' lives every day. Your compassion, skills, and dedication provide essential care that promotes healing, comfort, and dignity. The healthcare field offers numerous opportunities for growth and advancement, and your experience as a CNA provides an excellent foundation.

Remember that becoming a CNA is not just about passing an exam - it's about committing to a noble profession that requires both technical skill and heartfelt compassion. Take pride in your choice to serve others during their most vulnerable moments.

Best wishes on your exam and in your rewarding career as a Certified Nursing Assistant!

Disclaimer: This study guide is for educational purposes only. Always refer to your state's current requirements and your training program's materials. Healthcare protocols and regulations change frequently, so verify all information with current sources.

GUÍA DE ESTUDIO PARA LA
PREPARACIÓN DEL EXAMEN
DE CNA 2025-2026

**Preguntas de práctica y
explicaciones de respuestas**
