Colorado CNA Practice Exam (Sample)

Study Guide

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Questions

1. When performing range of motion (ROM) exercises on a client, the nurse aide should:

A. Ask the client to do the exercises themselves

B. Move the joints slowly and gently

C. Stop immediately if the client complains of pain

D. Work through any pain the client feels

2. Under which of the following conditions should a nursing assistant not take an oral temperature on a person?

A. The person is asleep

B. The person is confused or disoriented

C. The person has a cough

D. The person is underweight

3. One dietary habit that a nursing assistant can encourage to help residents sleep better is:

A. Drinking water before bed

B. Eating a large meal before bed

C. Having a sugary snack before bed

D. Limiting caffeine intake

4. All of the following are types of ostomies except:

A. Colostomy

B. Craniostomy

C. Gastrostomy

D. Ileostomy

5. One reason that the Health Insurance Portability and Accountability Act (HIPAA) was passed was to:

A. Encourage advance directives

B. Ensure staff competency

C. Protect privacy of health information

D. Regulate long-term care facilities

6. Which of the following is a normal age-related change for the male reproductive system?

A. Increased production of testosterone

B. Number and capability of sperm decreases

C. Development of new reproductive organs

D. Enhancement of libido

7. Weakening, wasting away, and decrease in size of a muscle is called:

A. Atrophy

B. Contracture

C. Hypertrophy

D. Myopathy

8. Which is a sign of dehydration?

A. Dizziness

B. Fluid retention

C. Increased appetite

D. Swollen ankles

9. Adduction is:

A. Flexing a body part

B. Moving a body part away from the body

C. Moving a body part toward the body

D. Rotating a body part

10. What is the normal range for rectal temperature?

A. 96.6 - 99.7 F

B. 96.6 - 98.6 F

C. 97.2 - 100.1 F

D. 98.6 - 100.6 F

Answers

1. A
2. A
3. A
4. B
5. A
6. B
7. A
8. A
9. A
10. A

Explanations

1. When performing range of motion (ROM) exercises on a client, the nurse aide should:

A. Ask the client to do the exercises themselves

B. Move the joints slowly and gently

C. Stop immediately if the client complains of pain

D. Work through any pain the client feels

ROM exercises should be done by the client themselves, not by the nurse aide. A client should be able to do their own exercises for a few reasons. It encourages independence and control over their own body, it promotes self-care and autonomy, and it reduces the risk of injury. Additionally, it is important to remember that any exercise that causes pain should be stopped immediately, rather than working through it. This ensures that the client does not sustain any further injury and allows for proper assessment of their pain threshold. Moving joints slowly and gently is also important to ensure that the client is comfortable and does not experience any pain or discomfort during the exercises. Therefore, options B, C, and D are incorrect because they go against the best practice of having the client perform ROM exercises themselves.

2. Under which of the following conditions should a nursing assistant not take an oral temperature on a person?

A. The person is asleep

B. The person is confused or disoriented

C. The person has a cough

D. The person is underweight

The condition under which a nursing assistant should not take an oral temperature is when the person is confused or disoriented. This is because individuals who are confused may not fully understand the instructions or may have difficulty keeping their mouth closed around the thermometer, leading to inaccurate readings or discomfort. Additionally, the risk of aspiration or injury increases when someone is disoriented, making it unsafe to take an oral temperature. Taking an oral temperature while a person is asleep may not be ideal, but it doesn't pose the same level of risk as with someone who is disoriented. However, it's essential to ensure that the temperature-taking process does not disturb their rest unnecessarily. Similarly, a cough might influence the comfort level but does not inherently restrict the ability to measure temperature effectively. Underweight status does not typically affect the appropriateness of taking an oral temperature either.

3. One dietary habit that a nursing assistant can encourage to help residents sleep better is:

A. Drinking water before bed

B. Eating a large meal before bed

C. Having a sugary snack before bed

D. Limiting caffeine intake

Drinking water before bed can be beneficial as it ensures adequate hydration, which is important for overall health. However, the timing of fluid intake is important to consider. While staying hydrated is crucial for all bodily functions, consuming too much liquid right before sleeping may lead to nighttime awakenings for bathroom trips, which could disrupt sleep. In the context of promoting better sleep, limiting caffeine intake is especially important. Caffeine is a stimulant found in coffee, tea, soda, and chocolate, which can interfere with the ability to fall asleep and stay asleep. Therefore, encouraging residents to avoid caffeine, particularly in the hours leading up to bedtime, can significantly improve their sleep quality. While drinking water has its benefits, it's advisable to focus on the impact of caffeine intake when discussing dietary habits that promote better sleep. This consideration recognizes the broader implications of dietary choices on sleep cycles and overall well-being.

4. All of the following are types of ostomies except:

A. Colostomy

B. Craniostomy

C. Gastrostomy

D. Ileostomy

The correct answer is B Craniostomy. A Colostomy, Gastrostomy, and Ileostomy are all types of surgical procedures that create an opening in the abdomen for the temporary or permanent diversion of fecal matter, urine, or stomach contents, respectively. A Craniostomy, on the other hand, is a type of surgical procedure that involves creating an opening in the skull to access the brain for neurological examinations or procedures. Therefore, it is not considered a type of ostomy.

5. One reason that the Health Insurance Portability and Accountability Act (HIPAA) was passed was to:

A. Encourage advance directives

B. Ensure staff competency

C. Protect privacy of health information

D. Regulate long-term care facilities

HIPAA was passed to enhance patient control over personal health information. Choice A is correct because an advance directive is a legal document that allows an individual to specify what actions should be taken for their health if they are no longer able to make decisions for themselves. Choices B, C, and D are incorrect because while they may relate to patient rights and healthcare regulations, they are not the primary reason for the passing of HIPAA. HIPAA does not specifically mention staff competency or long-term care facilities, and though it does protect privacy of health information, this is not its primary purpose.

6. Which of the following is a normal age-related change for the male reproductive system?

A. Increased production of testosterone

B. Number and capability of sperm decreases

C. Development of new reproductive organs

D. Enhancement of libido

One normal age-related change for the male reproductive system is the decrease in both the number and capability of the sperm. This is due to the natural decline in testosterone production as men age, which can lead to a decrease in sperm production and quality. While testosterone production may initially increase in older men, it typically levels off and can even decrease over time. Option A is incorrect because increased testosterone production is not a normal age-related change. Option C is incorrect because no new reproductive organs develop in males as they age. Option D is incorrect because while libido may fluctuate in older men, it is not necessarily enhanced.

7. Weakening, wasting away, and decrease in size of a muscle is called:

A. Atrophy

B. Contracture

C. Hypertrophy

D. Myopathy

Atrophy refers to the weakening, wasting away, and decrease in size of a muscle. This can occur due to various reasons such as lack of use, nerve damage, or poor nutrition. Contracture is the abnormal shortening of muscle tissue, leading to a reduced range of motion at a joint. Hypertrophy is the increase in size of a muscle due to increased muscle fiber size. Myopathy refers to a disease or abnormal condition of skeletal muscle tissue.

8. Which is a sign of dehydration?

A. Dizziness

B. Fluid retention

C. Increased appetite

D. Swollen ankles

Dizziness is a common sign of dehydration because when the body lacks sufficient fluids, it can lead to reduced blood volume and changes in the balance of electrolytes, which can affect blood flow to the brain. This can result in feelings of lightheadedness or dizziness, especially when standing up quickly. Recognizing dizziness as a symptom is crucial, as it indicates that the body is not maintaining adequate hydration levels to support normal functioning. In contrast, fluid retention is often a result of the body holding onto excess fluid, which differs from dehydration. An increased appetite is not typically associated with dehydration, as the body usually reacts to lack of fluids with reduced thirst or appetite. Likewise, swollen ankles can signify conditions unrelated to hydration levels, such as heart or kidney problems, rather than dehydration itself. Understanding these distinctions helps in recognizing dehydration effectively and responding appropriately.

9. Adduction is:

A. Flexing a body part

B. Moving a body part away from the body

C. Moving a body part toward the body

D. Rotating a body part

Adduction refers to the movement of a body part toward the midline of the body. This means that when you adduct a limb, such as bringing your arms back to your sides or your legs closer together, you are moving them closer to the central axis of your body. This is an important concept in anatomy and physical movement, particularly in the context of understanding how different muscles work during various activities. Flexing a body part typically involves reducing the angle between two parts, such as bending an elbow or knee. While this is a common movement, it is distinct from adduction, which specifically focuses on the lateral positioning of limbs. The focus of adduction is to bring parts together, rather than bending or reducing angles.

10. What is the normal range for rectal temperature?

A. 96.6 - 99.7 F

B. 96.6 - 98.6 F

C. 97.2 - 100.1 F

D. 98.6 - 100.6 F

The normal range for rectal temperature is generally accepted to be around 98.6 to 100.6 degrees Fahrenheit. This range reflects the typical variation observed in body temperature when measured rectally, which is considered one of the most accurate forms of temperature measurement due to its close proximity to core body temperature. While the option indicates a slightly broader span from 96.6 to 99.7 degrees, this does not account for the more specific and accepted range that rectal readings typically fall within. The ideal normal range for rectal temperature is specifically more focused around the higher end, recognizing that these readings are generally higher than oral or axillary measurements. Understanding the ranges for different types of temperature readings is crucial for assessing a patient's health, especially since temperature can be an important indicator of infection or other medical conditions.