

# Nebraska SCC CNA State Practice Test (Sample)

## Study Guide



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**SAMPLE**

## **Questions**

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- 1. Which of the following is an important privacy measure during the bedpan procedure?**
  - A. Closing the window**
  - B. Covering the resident with a bath blanket**
  - C. Keeping the door open**
  - D. Using a curtain around the bed**
- 2. What is the primary use of a bedpan?**
  - A. For residents who can walk with assistance**
  - B. For residents who cannot get up and use a toilet**
  - C. For emergency bathroom needs**
  - D. For individuals looking for a temporary toilet solution**
- 3. How should biohazardous waste be handled?**
  - A. Dispose of it in regular trash**
  - B. Place it in marked biohazard containers**
  - C. Flush it down the toilet**
  - D. Burn it on-site**
- 4. How can a CNA ensure medication safety?**
  - A. Randomly select medications for the patient**
  - B. Verify the right patient, medication, dosage, and timing with a nurse**
  - C. Administer medications without checking**
  - D. Delegate medication administration to the patient**
- 5. When should transfer belts be removed?**
  - A. Quickly to save time**
  - B. After reporting observations**
  - C. Slowly and gently to avoid bruising**
  - D. Immediately after use**

- 6. What is the normal temperature range for rectal measurements?**
- A. 96.6-98.6 degrees**
  - B. 98.0-100.0 degrees**
  - C. 98.6-100.6 degrees**
  - D. 99.6-101.0 degrees**
- 7. What is essential to check before using a mechanical lift?**
- A. Ensure the lift is functioning correctly**
  - B. Read the entire manual**
  - C. Make sure the patient is asleep**
  - D. Ask another CNA for their approval**
- 8. What should CNAs do if they notice a sudden change in a patient's condition?**
- A. Document the change and inform the nurse immediately**
  - B. Ignore it if it seems minor**
  - C. Wait for the patient to mention it**
  - D. Ask the patient's family for their opinion**
- 9. What are the common methods for taking vital signs?**
- A. Oral, rectal, axillary, and tympanic**
  - B. Blood pressure, heart rate, breathing rate, and temperature**
  - C. Pulse, respiration, blood sugar, and temperature**
  - D. Rectal, tympanic, digital, and visual**
- 10. Which of the following is an example of a CNA's daily activity?**
- A. Planning patient discharge**
  - B. Administering medications to patients**
  - C. Bathing patients**
  - D. Diagnosing patient conditions**

## **Answers**

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

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## **Explanations**

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**1. Which of the following is an important privacy measure during the bedpan procedure?**

- A. Closing the window**
- B. Covering the resident with a bath blanket**
- C. Keeping the door open**
- D. Using a curtain around the bed**

Covering the resident with a bath blanket during the bedpan procedure is essential for maintaining the resident's privacy and dignity. This action provides a layer of protection, ensuring that the resident feels secure and that their personal space is respected. Privacy is particularly crucial in sensitive situations like using a bedpan, as it can be a source of embarrassment for many individuals. By using a bath blanket, the CNA can help to shield the resident from unnecessary exposure, thus creating a more comfortable environment. The other options do not effectively enhance privacy. For instance, closing the window may prevent outsiders from seeing in but does not address the immediate privacy needs of the resident during the procedure. Keeping the door open can compromise privacy further, exposing the resident to anyone outside the room. While using a curtain around the bed may provide some degree of privacy, it may not offer the same sense of security and covering that a bath blanket does for the resident's comfort.

**2. What is the primary use of a bedpan?**

- A. For residents who can walk with assistance**
- B. For residents who cannot get up and use a toilet**
- C. For emergency bathroom needs**
- D. For individuals looking for a temporary toilet solution**

The primary use of a bedpan is for residents who cannot get up and use a toilet. Bedpans are designed to provide a practical solution for patients who are either bedridden or have limited mobility due to illness, surgery, or other medical conditions. The bedpan allows these individuals to relieve themselves comfortably while remaining in bed, thus maintaining their dignity and ensuring cleanliness when moving to a regular toilet is not feasible. While there are circumstances where individuals in various situations might use a bedpan—like those who need assistance walking or for emergencies—the bedpan's fundamental purpose is to cater specifically to those who are unable to use the toilet independently.

### 3. How should biohazardous waste be handled?

- A. Dispose of it in regular trash
- B. Place it in marked biohazard containers**
- C. Flush it down the toilet
- D. Burn it on-site

The correct answer is placing biohazardous waste in marked biohazard containers. This method is essential for ensuring the safe and appropriate disposal of materials that may pose a risk of infection or contamination. Biohazard containers are specifically designed to contain potentially harmful waste, preventing leaks and exposure to pathogens. These containers are typically puncture-proof, leak-resistant, and are labeled clearly to indicate their contents, ensuring that anyone handling the waste understands its potential dangers. These protocols are in place to comply with health regulations and protect both healthcare workers and the general public from hazards associated with biological waste. Proper disposal in designated containers also makes it easier for waste management services to handle and process the waste safely, often leading to incineration or other appropriate methods of disposal that minimize environmental impact and health risks.

### 4. How can a CNA ensure medication safety?

- A. Randomly select medications for the patient
- B. Verify the right patient, medication, dosage, and timing with a nurse**
- C. Administer medications without checking
- D. Delegate medication administration to the patient

To ensure medication safety, it is essential for a CNA to verify the right patient, medication, dosage, and timing with a nurse. This process is commonly referred to as the "Five Rights" of medication administration: the right patient, the right drug, the right dose, the right route, and the right time. By confirming these elements, the CNA helps prevent medication errors that could lead to serious health consequences for the patient. This verification process typically involves checking the patient's identification against the medication order and ensuring that all aspects of administration are appropriate. Collaborating with the nurse not only reinforces safety protocols but also supports a team approach to patient care, enhancing communication and ensuring that all healthcare professionals involved are on the same page regarding the patient's treatment plan. In contrast, randomly selecting medications or administering them without proper checks significantly increases the risk of errors. Delegating medication administration to the patient could also lead to issues if the patient is uncertain about their medication, leading to misunderstanding or misuse. Therefore, following established protocols and collaborating with nursing staff is crucial in promoting medication safety.

**5. When should transfer belts be removed?**

- A. Quickly to save time
- B. After reporting observations
- C. Slowly and gently to avoid bruising**
- D. Immediately after use

Transfer belts should be removed slowly and gently to avoid bruising because the skin of the patient is often sensitive or fragile, particularly in elderly individuals or those with certain medical conditions. A hasty removal can cause discomfort, trauma, or even injury to the skin, which is not only painful for the patient but can also lead to complications such as skin tears or bruising. The focus during the removal process should be on the patient's safety and comfort. Being mindful about how the transfer belt is taken off ensures the command of body mechanics and allows the caregiver to monitor the patient's reactions, making adjustments as needed for their comfort. This careful approach contrasts with practices that prioritize speed over safety or overlook the patient's condition. Proper technique is crucial in ensuring that the procedure is safe and does not cause harm, thus highlighting the importance of patience in caregiving tasks like this one.

**6. What is the normal temperature range for rectal measurements?**

- A. 96.6-98.6 degrees
- B. 98.0-100.0 degrees
- C. 98.6-100.6 degrees**
- D. 99.6-101.0 degrees

The normal temperature range for rectal measurements is considered to be 98.6 to 100.6 degrees Fahrenheit. This range is slightly higher than oral temperatures due to the rectal method being more reflective of the body's core temperature. Rectal temperatures are often used in clinical settings for their accuracy, especially in children or patients who are unable to communicate effectively. Many parameters can influence body temperature, such as time of day, the individual's activity level, and even the method of measurement. Rectal temperatures tend to be the most reliable method when a precise measurement is needed, which is why understanding this range is significant for healthcare providers. Therefore, the correct answer aligns with the accepted medical understanding of normal rectal temperature ranges, typically reflecting a healthy internal temperature indicative of the body's physiological state.

**7. What is essential to check before using a mechanical lift?**

**A. Ensure the lift is functioning correctly**

**B. Read the entire manual**

**C. Make sure the patient is asleep**

**D. Ask another CNA for their approval**

Ensuring that the mechanical lift is functioning correctly is critical before use, as the safety of both the patient and the caregiver depends on the proper operation of the equipment. This includes checking for any visible signs of wear or damage, making sure that the lift's control mechanisms are responsive, and confirming that the batteries are charged if the lift is powered. A mechanical lift that is not working as intended could lead to accidents or injuries during patient transfers, making it imperative to conduct these checks. While reading the entire manual can provide valuable information about the specific lift, it's not the most immediate priority before operation. Similarly, whether the patient is asleep or asking for approval from another CNA does not impact the lift's functionality and safety directly, which are key considerations in this scenario.

**8. What should CNAs do if they notice a sudden change in a patient's condition?**

**A. Document the change and inform the nurse immediately**

**B. Ignore it if it seems minor**

**C. Wait for the patient to mention it**

**D. Ask the patient's family for their opinion**

When a CNA notices a sudden change in a patient's condition, the appropriate course of action is to document the change and inform the nurse immediately. This response is crucial because sudden changes can indicate that the patient may be experiencing a medical emergency or complication that requires prompt intervention. By documenting the change, the CNA provides a clear record of the patient's condition, which can be vital for the healthcare team in understanding the situation and making informed decisions. Notifying the nurse ensures that a licensed healthcare professional can assess the change and determine the necessary steps to take. This protocol is essential in maintaining patient safety and fostering effective communication within the care team. Ignoring the change, waiting for the patient to mention it, or seeking the family's opinion may lead to delays in treatment that could negatively impact the patient's health. Being proactive in reporting such changes reflects a commitment to quality care and patient advocacy.

## 9. What are the common methods for taking vital signs?

- A. Oral, rectal, axillary, and tympanic**
- B. Blood pressure, heart rate, breathing rate, and temperature**
- C. Pulse, respiration, blood sugar, and temperature**
- D. Rectal, tympanic, digital, and visual**

The choice that identifies common methods for taking vital signs includes oral, rectal, axillary, and tympanic. These methods refer to the different routes used to measure body temperature. - **Oral** involves taking temperature by placing a thermometer in the mouth. This is a common method as it is simple and provides accurate readings for those who can cooperate. - **Rectal** is considered one of the most accurate methods of taking temperature, especially in infants or unconscious patients. It is often used when precise measurements are necessary. - **Axillary** is taken by placing a thermometer in the armpit, which is a less reliable method but is non-invasive and suitable for routine checks. - **Tympanic** involves using a special thermometer to measure temperature in the ear. This method can provide quick results and is also non-invasive. These methods are specifically focused on measuring body temperature, which is one of the four key vital signs. While blood pressure, heart rate, and breathing rate are critical vital signs, they are not methods of taking temperature but rather indicators of overall health. Understanding the specific techniques for measuring temperature is essential for accurately assessing a patient's condition.

## 10. Which of the following is an example of a CNA's daily activity?

- A. Planning patient discharge**
- B. Administering medications to patients**
- C. Bathing patients**
- D. Diagnosing patient conditions**

Bathing patients is a fundamental responsibility of a Certified Nursing Assistant (CNA) and exemplifies their daily activities in a healthcare setting. This task not only involves assisting patients with personal hygiene but also plays a crucial role in maintaining their comfort and dignity. Bathing is an essential part of personal care that helps prevent skin breakdown, infections, and promotes overall well-being. In contrast, activities such as planning patient discharge and diagnosing patient conditions are typically outside the CNA's scope of practice. These tasks require clinical skills and authority that are designated to nurses and other healthcare professionals. Administering medications is also a task reserved for licensed nursing personnel, as it involves a significant level of accountability and clinical judgment. Consequently, bathing patients aligns seamlessly with the CNA's core duties, highlighting their role in providing direct, hands-on care to support patients' daily living needs.