EXAM CRAM

# CNA

## Certified Nursing Assistant

### Second Edition

**Linda Whitenton, Marty Walker**

**Pearson**
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**CNA Certified Nursing Assistant Exam Cram, Second Edition**

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# About the Authors

**Marty Walker** has practiced nursing for the past 39 years at the vocational nursing level as a registered nurse, and at the master's level. Marty began her nursing career as a licensed practical nurse, receiving her vocational education certificate from Atlantic Vocational School in Pompano Beach, Florida, in 1979. In 1982, she earned the associate degree in nursing from Broward Community College in Davie, Florida. She worked for more than 10 years as a staff nurse in telemetry, critical care, and emergency nursing before completing a bachelor of science degree in nursing from Florida International University in Miami, Florida. In 1995, she began teaching medical-surgical nursing at Ivy Tech State College in Sellersburg, Indiana.

After relocating to Miami, Marty accepted a position as Nurse Clinical Educator for three cardiac units at Jackson Memorial Hospital. She attained a Master's in Nursing Science in Nursing Education from Barry University in Miami Shores, Florida, in 2003. Marty's love of teaching led her to Mercy Hospital's School of Practical Nursing, along with adjunct teaching positions at Florida International University and Barry University. In Miami, Marty added pediatrics to her teaching expertise. She taught medical-surgical nursing for a short time at Pensacola State College in Pensacola, Florida, before accepting a full-time associate professor position at Northwest Florida State College, where she taught in the RN-BSN program as well as the associate degree nursing program. She is now the director for both programs. Marty's expertise also includes test construction. She has led the faculty at NWF State College in improving the success rates of students enrolled in the program as well as their success on the NCLEX-RN. Marty's versatility extends to her clinical practice as she completed the family nurse practitioner certificate program at the University of South Alabama in Mobile, Alabama, where she also completed her Doctorate in Nursing Practice in 2014. Marty has volunteered as the director of nursing services, as a nurse practitioner, and as board president for the Crossroads Medical Center Clinic in Valparaiso, Florida, since 2007.

**Linda Whitenton** began a 45-year nursing career in 1967 as a nursing assistant in Paducah, Kentucky. Following her graduation from Murray State University's BSN program in 1970, she practiced in mental health, pediatrics, and medical-surgical nursing. Teaching nursing assistants, emergency medical technicians, and unit secretaries in a Mississippi hospital cemented her love for teaching in her role as a hospital in-service education director in the early 1970s. She accepted her first teaching position at Northeast Mississippi Community College in 1975. While at NEMC, she taught fundamentals, medical-surgical nursing, management, and psychiatric nursing and served as assistant director and director of the program for seven years. In 1977, Linda earned her master's of science degree in nursing at the Mississippi University for Women, which also afforded her the family nurse clinician credential. In 1987, she relocated to Florida and accepted a position as associate director of nursing for the associate degree nursing program at St. Petersburg College in St. Petersburg.

While at SPC, she designed curriculum for more than 1,000 employees of the Pinellas County EMS, taught LPN transitional students at night, and practiced part time at the Bayfront Medical Center Trauma Center.

During her 35 years of teaching, Linda continued to practice in emergency nursing, urological nursing, and as a nurse clinician. Linda also earned 30 hours of post-masters work in anthropology and educational psychology. In 2004, she returned to clinical practice as the director of nursing/vice president for a Mississippi community hospital. While there, she received a national award for outstanding nursing leadership. She returned to Florida in 2000 to design and direct a new AD nursing program for Northwest Florida State College, formerly Okaloosa-Walton College, the first of seven health programs now in place at the college. Linda served as associate dean of Health Technology for three years, adding administrative oversight for the health programs she launched during her eight-year tenure at NWFSC. In 2008, she retired from the college, receiving the honor of Emeritus Associate Dean and Director of Nursing. In 2015, Linda accepted an interim position as campus dean at Pensacola State College, where she now serves as director of Nursing and Emergency Medical Services, overseeing the nursing programs, the emergency medical service programs, the surgical technology, and the newly designed patient care technician program. Linda has worked with Rinehart and Associates Nursing Review, a nurse-owned company that offers review courses for graduates preparing for their examination to become licensed RNs or LPNs. Linda is a Certified Nurse Educator, CNE, and a member of Sigma Theta Tau International Nursing Society.

# About the Technical Editor

**Steven M. Picray** is a medical surgical registered nurse in a major metropolitan hospital. He has also been a Baptist pastor and a computer programmer. He has a bachelor's and a master's degrees in theology, a B.S.N., and is currently pursuing his master's degree in nursing to become a nurse practitioner.

# Dedication

*We dedicate this book to the compassionate and caring nursing assistants everywhere, who dedicate their lives to caring for our precious elders.*

# Acknowledgments

We wish to thank Kathy McNair for her superlative technical assistance, her encouragement, caring, and expertise in all she does for nursing education.

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We also thank our families for their love and patience.

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- Study Mode
- Practice Exam Mode
- Flash Card Mode

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CHAPTER FOUR

# Promotion of Function and Health of Residents

**Medical Term Hotlist**

Abduction
Adduction
ADEs
AM care
Ambulation
Ambulation assistive device
Analgesia
Apical pulse
Aspiration
Atrophy
Autonomy
Axilla
Blood pressure
Body alignment
Body mechanics
Body temperature
Braden scale
Calorie
Cerebral vascular accident (CVA)
Coccyx
Commode
Contracture
Convalescence
Dangling
Defecate
Dehydration
Delirium
Dentition
Dentures
Diastolic pressure
Dorsiflexion
Dysphagia
Dyspnea
Ecchymosis
Emesis
Extension
Fecal impaction
Fever
Flatus
Flexion
Fowler's position
Gait-transfer belt

Geri chair
Graduate
HS care
Hydration
Hygiene
Hypertension
Immobilize
Intake and output (I & O)
Lateral position
Logroll
Malnutrition
Mechanical lift
Noncompliance
NPO
Nutrient
Oral hygiene
Perineal care
PO
Podiatry
Pressure ulcer
Prone position
Radial pulse
Range of motion (ROM)
Rapport
Respirations
Restorative care
Rotation
Self-actualization
Sim's position
Stool
Supination
Sphygmomanometer
Stethoscope
Supine position
Syncopy
Systolic pressure
Tympanic membrane
Urinate
Void

Nearly half of the written exam (WE) contains questions about your nursing skills. This chapter focuses on the key principles involved in providing resident care, organized into the following categories:

- Personal Care Skills
- Restorative Skills
- Psychosocial Skills
- Recording and Reporting

You must also review all skills as outlined in the performance checklists in Chapter 6, "Clinical Skills Performance Checklists." Critical steps for safe skills performance often reflect the key principles reviewed here; these critical steps must be met to successfully pass the Clinical Skills Test (CST), which tests your competencies in the following categories.

# Personal Care Skills

The focus of this category is a review of direct care you provide residents on a daily basis to promote their health and well-being.

## Activities of Daily Living

Assisting residents with activities of daily living (ADLs) is one of your primary responsibilities. The sections that follow describe the skills involved with ADLs.

### Hygiene

It is important for residents to feel clean and fresh. Equally important is to keep the residents free from disease due to harmful bacteria that can enter the body through any skin break, which includes mucous membranes that line any body cavity. With aging, the skin produces less oil, which makes it dry, requiring less frequent bathing. This does not mean that a daily partial bath is not needed to freshen the mouth and *perineal* area (area of the body that includes the male and female genitalia and the anus). Cleanliness also removes body sweat, odors, and other secretions. Morning care (*AM care*) that includes washing the resident's face and hands followed by tooth brushing or denture care before eating breakfast helps decrease harmful bacteria, maintain a pleasant appearance, and increase a sense of well-being for the resident. Hygiene care before bedtime, often called *HS* (hour of sleep) *care*, accomplishes the same goals and promotes rest and sleep. HS care also might include a back rub or other form of massage to relax the resident.

### Bathing

The resident's bath schedule as determined by the care plan might require a complete bath, shower, or a partial bath. Remember the general goals of skin care when bathing the resident; that is, to remove pathogens and promote comfort. Bathing promotes cleanliness, helps improve circulation by stimulating the muscles, provides exercise for the joints and limbs, and gives you the opportunity to inspect the resident's skin, mobility, and other signs of health and well-being. It also provides a time for personal interaction with residents that helps increase their self-esteem.

Safety, security, and privacy are key considerations with each type of bath. Allow the resident to participate in all aspects of personal care and grooming to promote self-control. Residents have taken care of themselves all of their lives and need to feel they can be independent as

much as possible. Independence, decision making, and self-control are also known as having *autonomy*. Feeling secure is second only to being safe from harm. Protect residents from accidents while bathing, which includes falls, and from undue exposure due to failure to provide privacy during the bathing procedure. Posting privacy signs, using a privacy curtain, or closing the door, as well as shielding the body while bathing, are all essential steps to ensure privacy.

**EXAM ALERT**

**For residents who are high risk for falls while bathing in the tub or shower, use an assistive device to help secure them in the shower chair or tub. Follow agency policy and accepted procedure when using any assistive device. Unauthorized use of these assistive devices could be considered a restraint.**

Skin care involves keen observation of any breaks in the skin or other abnormalities that might indicate injury or disease. Keeping the skin moist but not wet, dry in the *axilla* (armpits) and *perineum*, and free from pressure are very important steps to protect the resident. Be sparing with lotions or other emollients for keeping skin supple. Avoid talcs, powders, or other products that can cake within skin folds. Areas, such as the *axilla*, beneath the breasts, the genitalia, buttocks, and other skin creases, are warm and moist, which can encourage bacterial growth.

**EXAM ALERT**

**Only a licensed nurse can apply prescription ointments, lotions, or other products in any form to the skin; however, you are responsible for reporting any redness, pain, tenderness (signs of *inflammation*), open sore, or other skin abrasion immediately to the licensed nurse.**

A skin break can result in a *pressure ulcer* (also called a bedsore, or *decubitus ulcer*) found over any bony part, such as the tailbone (*coccyx*), hip, back, elbow, breasts, spine, shoulder, or the back or side of the head. The term bedsore is misleading because a pressure ulcer can occur outside of bed by prolonged sitting or any pressure on the skin that decreases the blood supply to that area. Follow the facility's protocol for care of residents who are high risk, often evaluated according to the *Braden scale*, a guide used by the licensed nurse for describing the skin's risk for breakdown. Residents who are *immobile* (cannot move or walk), have a poor nutrition status, or have trouble healing are considered high risk for pressure ulcers and must be observed closely for any skin breakdown. Pressure ulcers are very painful and difficult to heal, leading to other complications and misery for the resident. The best approach to bedsores is prevention. Additional steps to prevent bedsores are incorporated into personal skills, such as positioning and turning the immobile resident, protecting bony prominences from undue pressure, using protective devices and equipment, and keeping the resident dry, comfortable, well nourished, and hydrated, as outlined in Chapter 5, "Specialized Care."

The following are other general principles that apply to bathing and grooming:

- Use standard precautions for personal care.
- Keep bathwater temperature at a safe level.
- Use mild soaps or other cleansers per facility policy, watching for resident allergies to bath products.
- When cleansing the body, wash from the cleanest area to the dirtiest area.
- For the complete bed bath, change water, wash cloth, and gloves prior to bathing the lower body and extremities.
- If assisting the resident to bathe, provide for rest so as not to overly tire the resident.

**CAUTION**

Be alert for residents who become weak, dizzy, or faint (*syncope*) during the bath, taking steps to protect them from falls or other accidents. If such a situation occurs, stop the bath process, stay with the resident, and call for assistance; report the incident to the licensed nurse immediately.

- Avoid touching the floor with bath towels, the remote shower spray head, or other bath equipment, because the floor is considered contaminated.
- Disinfect the tub, shower, and other bath articles following the bath or shower.
- Promptly remove soiled bath linens.
- Report and record the bath/grooming procedure and the resident's response.

## Oral Care

Residents might need assistance with oral care, which can include brushing the resident's teeth or denture care. Dentures are false teeth, which might replace all or part of the resident's own teeth; they are necessary for proper eating, to retain the shape of the face, and to promote a positive self-image. With gloved hands, hold dentures over the sink to clean them. Pad the sink area with paper towels or a washcloth and water to provide safety against breakage in case the dentures are dropped during cleaning. Breaking dentures without taking those precautions can result in charges of negligence against you or the agency.

**CAUTION**

Do not use a regular toothbrush on dentures because the toothbrush will scratch the dentures, creating places for harmful bacteria to grow. Bacteria growth can cause mouth infections and bad breath.

With gloved hands, use a denture brush, a toothette, or washcloth to remove obvious particles on the dentures. Handle them gently, and wash and rinse them in warm (*tepid*) water to avoid damaging the dentures. Cover them with water and add an effervescent denture tablet to complete the cleaning process. After cleaning, store the dentures in a designated container labeled with the resident's name.

**CAUTION**

Take every precaution to prevent accidental loss of residents' dentures because this incident is costly, disposes the resident to nutritional problems, and is emotionally upsetting. Report lost dentures immediately.

In addition to teeth brushing, keep the mouth moist and free of debris. Dry mucous membranes in the mouth encourage bad breath and skin breakdown along with tooth decay. Depending on the resident's condition, you might need to provide oral care hourly or every two hours.

**EXAM ALERT**

**When giving oral care to a comatose resident (one who is unconscious), turn the resident's head to the side and gently swab his or her mouth and mucous membranes with the recommended equipment and supplies while being careful not to cause the resident to aspirate, which means accidentally drawing food or fluid into the air passage.**

Because the comatose resident breathes through the mouth, frequent oral care is needed to help clear secretions and keep the mouth and membranes well hydrated.

### Grooming

Grooming includes hair care, shaving, nail care, and eyeglasses and hearing aid care. A resident who is well-groomed feels better and has a more positive outlook and self-esteem. Grooming principles mirror those for ADLs in general regarding standard precautions, providing privacy for the resident, and encouraging the resident to participate in ADLs as much as possible, which includes making choices that will increase satisfaction and compliance with the daily care plan. Remember to dress residents appropriately and comfortably in their own clothing. Consider weather and environmental changes for each resident; make clothing adjustments accordingly to maintain a comfortable body temperature. Because some residents might lose body fat, they can become chilled more easily, requiring a light wrap, sweater, or extra bed covering. Always check with the residents to determine their clothing and comfort needs.

## Shaving

Shaving residents requires careful technique to avoid accidental nicking of the skin, which can create an entry for pathogens. Residents who have prolonged blood clotting for any reason

might be required to shave with an electric razor. Check the resident's care plan for directions on how to manage his shaving needs.

# Nail Care

Like skin care, nail care requires careful cleansing, frequently accomplished when washing the resident's hands. Keeping nails trimmed and clean can improve appearance while preventing injury or infection transmitted by dirty, unkempt nails. Soaking the resident's hands and feet in warm water helps loosen debris and eases nail trimming and cuticle care.

**NOTE**

In most states, CNAs may not trim resident's nails because of the possibility of exposing the resident to injury/infection. Risk for infection is especially related to residents with diabetes mellitus. If you assess that the resident's toenails need trimming, notify the nurse, who will make arrangements for a podiatry consult.

**CAUTION**

Dry between the resident's fingers and toes to prevent skin breakdown; avoid lotion between the fingers and toes to prevent bacterial growth.

Aging can cause the toenails to become thick and difficult to manage. Despite the need to keep nails trimmed, special consideration must be made for residents with diabetes because their toenails must be trimmed very carefully to avoid cuts on the foot that, due to poor circulation or diabetes, might not heal properly. Consult the facility's policy for nail care required for residents with special conditions such as diabetes. Refer to Chapter 5 for more information on foot care for the diabetic resident.

*Hair Care* Clean hair that is neatly combed helps improve the self-image of residents and contributes to their general well-being. Each facility has a policy for hair care, including shampooing. In some facilities, shampooing the hair might require a doctor's order. Many residents might have their hair washed, set, and combed by a beautician who provides cosmetology services in the long-term care facility. Being sensitive to each resident's unique grooming needs is the hallmark of effective nursing assistant practice. Consult with the resident and family to learn the best approach for hair care, realizing that not all hair can be managed in the same way by different races or cultures. Consult with the licensed nurse when deciding the most effective approach.

## Nutrition

Food is necessary for life. The fuel needed for adequate life functions comes from calories in food, defined as units of heat measurement. Caloric intake through foods gives the body the

energy it needs. Elders, like younger adults, need the same kinds of nutrients, including vitamins and minerals. However, in the long-term care setting, residents must depend on caregivers for their nutritional needs. Although the diet of each resident must contain a balance of proteins for cell growth and healing, carbohydrates for ready energy, and fats for fueling the cells, the caloric needs of residents vary according to their activity level and their health status. Nutrition also includes fluid intake to maintain adequate hydration needed for all cellular functions in the body, especially digestion of foods. Fluid intake is required to replace losses through perspiration, respirations, evaporation, and normal elimination. Fluid intake also helps regulate body temperature as well as the moisture in the skin and mucous membrane. Aging can affect the sense of taste, smell, and thirst, which can cause a decrease in solid food and fluid intake. Other factors can affect resident nutrition, such as level of awareness, dentition, and the ability to chew properly; cultural considerations (religion, personal preferences, and family traditions); emotional well-being (depression, isolation, frustration, and anger); and the long-term care environment. If the resident's care plan specifies a special diet, the resident might not be satisfied with the diet and refuse to follow it. This is an example of noncompliance, meaning the resident does not adhere to the diet order. Noncompliance with diet can lead to malnutrition (inadequate consumption or absorption of food) or dehydration, meaning there is not enough fluid in the body that can cause serious problems in all body systems.

Edema, the opposite of dehydration, occurs when there is too much fluid in the body from excessive fluid intake or nutritional imbalances (such as too much salt or protein imbalance), certain medications, or disease processes. Edema, from accumulation of fluid in the body tissues, is often seen as swelling of the ankles, puffiness around the resident's eyes or all over the face, swelling of fingers, which causes rings to be excessively tight, or an increase in the diameter (roundness) of the abdomen. With edema, socks, sleeves, rings, or other clothing may leave a deep imprint on the skin where edema exists. Unless relieved, the local edema may decrease blood flow to the affected area, causing pain or inability to use the body part(s) affected.

**CAUTION**

Notify the nurse if a resident develops edema as previously described.

Remember these factors when assisting the resident with meals, fluids, and snacks to help maintain adequate nutritional status. The following guidelines can help achieve this goal:

- Diet permitting, offer the resident choices in the menu to encourage independence and sense of control.
- Make mealtime as pleasant an experience as possible. If the resident is dining in his or her room, remove noxious odors, bedpans, urinals, and anything that could negatively affect the resident's appetite. In the dining room, seat residents together who encourage pleasant social interaction.

- If the resident is dining alone, encourage social interaction, offering assistance as needed and conversation that helps increase resident satisfaction with the dining experience.
- Converse with the resident during the meal. Conversation, even when one-sided, helps to make the dining experience more pleasant.
- Present food as attractively as possible.
- Keep hot foods hot and cold foods cold.
- Offer fluids as often as possible according to the diet order.
- Assist with feeding as needed to encourage adequate nutrition.

**EXAM ALERT**

**Review the feeding skills in Chapter 5, focusing on the critical steps to prevent choking and aspiration.**

- Be patient with slow eaters and praise progress as needed to help increase motivation.
- Encourage physical activity to help improve the appetite.
- Individualize approaches to meals that recognize cultural needs—for example, offering a kosher diet, involving family or friends to assist with meals or feeding, praying before eating, and so on.
- If diet permits, encourage family members or friends to bring favorite foods from home or the community that appeal to the resident.

As with other nursing skills, accurately record and report all dietary intake, including fluids. Review the I & O skill in Chapter 6, "Clinical Skills Performance Checklists," for critical steps regarding charting meal consumption.

**NOTE**

Record I & O using the metric system or the measurement as specified in the I & O skill checklist in Chapter 6.

## Toileting

Aging can affect the nervous system that controls elimination of body wastes like urine and feces (also known as *stool* or solid waste). The urge or need to *void*, or urinate (pass urine from the body) or *defecate* (pass feces from the body) decreases with age, often meaning that the resident is not aware of voiding or defecating until it actually happens. Decreased appetite and thirst, coupled with less food and fluid intake as well as slower digestion of foods, contribute to

elimination problems. Infirmity or being unable to get to the toilet in time to avoid accidental soiling of clothing by urine or feces is not only potentially dangerous due to the increased risk of falls but also embarrassing for the resident.

Other factors might interfere with normal elimination, such as certain medications that could cause constipation or diarrhea, inactivity, pelvic muscle weakness due to aging, and nervous disorders. Small, watery leakage of stool could indicate a *fecal impaction*, a condition in which hard feces is trapped in the large intestine and rectum and cannot be pushed out by the resident. *Diarrhea*, on the other hand, results when food wastes pass too quickly through the intestine so that water is not reabsorbed adequately. This causes a watery brown liquid to be expelled, which leads to local skin irritation and a dangerous imbalance in the resident's fluid and electrolyte status. Both conditions require immediate reporting to the licensed nurse as well as prompt intervention to prevent further complications.

Remember the following principles when assisting the resident with toileting:

- Assisting the resident to void or defecate on a routine, timely basis to maintain normal elimination pattern and avoid accidents
- Being alert to individual toileting needs and prepare accordingly to help prevent accidents
- Observing standard precautions when handling urine or stool
- Using a bedpan, urinal, or bedside commode (portable toilet), and other procedures to maintain a normal elimination schedule
- Performing careful skin care following voiding or defecating
- Assisting the resident to wash his or her hands after toileting
- Observing, reporting, and recording excess or decreased output

Chapter 5 reviews guidelines for special care regarding elimination (for example, catheter care, ostomy care, enema procedure, and so on).

## Rest, Sleep, and Comfort

Elders need as much sleep as other adults. Their ability to sleep might be influenced by the long-term care environment, especially when newly admitted, their activity level, their general state of health, and their individual habits. Naps or rest periods are essential for health and well-being and should be included in the resident's care plan. However, excessive napping during the day can interfere with sleep as well as signal a febrile illness or neurological complication. Residents might also awaken from sleep confused or *delirious*, meaning a state of agitated confusion. This situation is a sign of decreased oxygen to the brain that leads to the confusion. Report any change in *consciousness* (the awakened state), awareness or alertness, sleepiness for no obvious reason, and the inability to respond verbally.

Pain or discomfort can also interfere with rest and sleep. Pain might go unreported by the resident whose pain tolerance (ability to carry out activities or rest despite pain) is high or who has lost the ability to perceive pain. Likewise the resident might deny pain but act in other ways that indicate discomfort, which might include loss of appetite, refusal to participate in recreational activities, inability to sleep (*insomnia*), or withdrawing from social contact. Residents might also be less likely to report pain if they believe they will be labeled as complainers.

**NOTE**

Be careful to accept a resident's report of pain or discomfort at face value.

Physical signs of pain include increased pulse (*tachycardia*), increased respirations (*tachypnea*), difficulty breathing (*dyspnea*), and high blood pressure (*hypertension*). Sweating, crying, grunting, moaning, and other indicators of distress can indicate pain as well. The nurse can assess the resident's pain on a scale of 0–5 (zero meaning no pain to a score of five, which means it hurts enough to cry). The nurse might administer an analgesic, a drug to relieve pain. If the resident receives analgesia, you must assist the nurse in observing the resident's response to the medication, any dramatic change in the resident's vital signs after receiving the medication, and the resident's report of pain relief. Any abnormal reactions (known as *ADE*s, or adverse drug effects) to analgesia can include a sudden drop in blood pressure or respirations, dyspnea (rapid breathing), a rash on the body, and emotional distress. These signs require immediate intervention, so report them immediately to the nurse. Skills related to respiratory distress or cardiac emergencies are discussed in Chapter 5. You can assist the resident to rest more comfortably by changing the resident's position, offering diversion activities (reading, listening to music, meditation, and so on), providing a massage, and creating a quiet environment.

The following are general principles of care to promote rest and sleep:

- Maintaining the individual resident's routine to promote safety and security that encourages rest and sleep
- Arranging the resident's environment to decrease noise and confusion
- Pacing resident activities to arrange for rest periods during the day and an effective sleep schedule
- Using positioning devices to increase comfort
- Offering emotional support when the resident is experiencing pain and discomfort
- Promoting safety by keeping the bed in the lowest position; locking the wheelchair when the resident is sitting; keeping the urinal, bedpan, or bedside commode near the bed; and keeping a night light on for the resident when visiting the restroom during the night

- Arranging care routines to encourage rest; for example, spacing ADLs, recreational activities, and visiting times
- Refraining from judging the resident who reports pain. Residents may be less likely to report pain if they believe they will be labeled as complainers.
- Teaching the resident to avoid caffeine-free beverages at least three to four hours prior to bedtime, because caffeine acts as a stimulant, which promotes wakefulness.

# Restorative Skills

*Prevention* is one of the most important approaches you use with residents. The steps you take to help prevent complications of immobility, for example, are critical for the resident. Other skills you perform include observing changes in the resident's status and reporting your findings so that immediate interventions can be made to ward off infection or infirmity. Restorative skills are those nursing duties you perform to help the resident function as normally as possible that goes beyond rehabilitation, a process of therapeutic treatments or approaches to restore and maintain the highest possible level of functioning a resident can possess. For example, physical therapists might assist the resident to walk, but the resident chooses to sit in a wheelchair all day and not ambulate, even though he or she is able; refusing to ambulate can result in a setback in his or her rehabilitation progress. Your encouragement and assistance to help motivate the resident to walk is preventive in nature because you are committed to maintaining the resident's restored function. It is also considered restorative because it involves more than physical therapy but emotional and psychological support. Feeding, assisting with toileting, and turning immobile residents are examples of preventive measures you take every day to prevent complications that can occur from inactivity, failure to maintain adequate nutrition, and skin breakdown from toileting problems.

# Self-Care and Independence

The Omnibus Budget and Reconciliation Act (*OBRA*) of 1987 requires all long-term facilities to use every resource to help residents reach or maintain their highest level of physical, psychological, and mental functioning. The act requires that all residents have a right to make as many choices about their lives, their care, and their life style routines as possible. It is not only a legal requirement determined by OBRA but an ethical principle as well. Care guidelines discussed thus far have included self-care and independence. Adhering to residents' rights helps meet the letter of the law as well as the spirit of the law; that is, to protect residents' rights of a comfortable and caring environment in which they can live as safely and happily as possible.

**NOTE**

Unless their self-care decisions are dangerous to themselves or others, residents should be allowed and encouraged to make them.

The principles covered in the sections that follow apply to restorative skills.

# Mobility/Immobility

*Mobility* is being able to move by one's self, to walk, and to exercise to help maintain muscle function and improve a sense of independence and self-worth. Moving, ambulating, and exercising help improve blood circulation and proper musculoskeletal functioning. *Immobility*, the opposite of being mobile, affects the total well-being of the resident; that is, by exposing the resident to alterations in almost every body system:

- In the circulatory system, an increased risk of blood clots (*thrombi*) and edema in the lower extremities, causing undue stress on the heart.
- Respiratory complications such as pneumonia, other infections of the respiratory tree, or failure to expand the lungs.
- In the digestive system, *anorexia*, or decreased appetite, and constipation.
- The musculoskeletal system suffers due to loss of calcium in the bones (called osteopenia), *atrophy*, or muscle wasting and *contractures* (deformities of the limbs due to immobility). The inability to walk also adds to an increased thinning and weakening of the bones, leading to osteoporosis, a chronic condition putting the resident at risk for fractures.
- Pressure ulcers on the skin.

Mentally and emotionally, the immobile resident might feel frustrated, isolated, depressed, and hopeless due to loss of autonomy and the need to rely on others. Socially, the resident loses self-esteem, has poor body image, and feels separated from social interaction.

Assisting the resident to maintain normal functional movement might include range of motion (*ROM*), which means freely moving all limbs and joints. If the resident cannot perform range of motion independently, you must perform passive range of motion exercises (*PROM*), which move the joints to protect the muscles from atrophy, increase circulation, and joint motion.

**CAUTION**

Follow the care plan instructions for PROM as well as the facility's policy for exercising the neck. Remember to avoid pushing the joint past the point of resistance or the point where pain occurs.

Range of motion includes *abduction* (moving the extremity away from the body), *adduction* (moving the extremity toward the body), *flexion* (bending the extremity), and *extension* (opposite of flexion). Report and record the PROM procedure and the resident's response to the exercises. Physical therapists or massage therapists might also provide exercises for the residents as part of the rehabilitation plan. Your care helps to restore the resident to normal functioning and support the plan.

When you assist the immobile resident with lifting, moving, or transferring, remember to:

- Use proper body mechanics.
- Explain what you are going to do.
- Ask for the resident's help as much as possible.
- Face the resident.
- Place your feet apart in line with your shoulders.
- Bend your knees.
- Keep your back straight.
- Reach close to the resident, protecting your balance, posture, and internal girdle (contract abdominal muscles and buttocks to protect the spine).
- Use both hands when lifting.
- Avoid twisting at the waist.
- When moving the resident's entire body, move the top first, the middle (torso) second, and then the legs; in certain situations, *logrolling* might be necessary, which is moving the body from side to side as one unit.
- Ask for assistance from another nursing assistant as needed to keep you and the resident safe.
- Use a mechanical lift, lift sheet, or other device as needed to promote safe lifting.

Positioning the immobile resident requires using the previous principles to keep the body in proper alignment. For immobile residents, use positioning devices (hand rolls, wedges, splints, shoes, or boots) to provide *dorsiflexion* (pointing toes of the foot toward the knee) and to prevent contractures, pressure ulcers, and discomfort. Review body positioning—for example, prone, supine, Sim's position, and Fowler's position, as well as using a mechanical lift discussed in Chapter 6.

**EXAM ALERT**

**Critical steps in these procedures will most likely be included on the WE.**

*Transferring*, or moving the resident from bed to chair, from bed to wheelchair, and from bed to stretcher requires proper body mechanics and the use of a *gait belt* or other assistance to prevent falling. Assisting the resident to walk is another important skill involved in ADLs. These skills are outlined in Chapter 6.

**EXAM ALERT**

**Proper body mechanics is of utmost importance to protect yourself and the residents when lifting, moving, transferring, and ambulating residents.**

# Health Maintenance and Restoration

Health maintenance and restoration includes measuring vital signs, height, and weight. Vital signs include the temperature, pulse, respiration, and blood pressure—all essential elements of life; thus the term *vital*. Accurate measurement and recording are important skills in determining the overall health of the resident.

Careful attention to vital signs can save a life. Age-related factors that affect vital signs include age, sex, time of day in which vital signs are measured, illness, emotions, activity and exercise, food intake, and medications. Often, a change in one vital sign will affect the other vital signs. For example, when the resident has a fever (temperature over 101 degrees), the pulse rate and respirations will also increase.

It is important to weigh residents carefully as ordered. Consider clothing, shoes, and other articles when weighing the resident because weight can be affected by clothing. Report any dramatic changes in weight because these changes might indicate a nutritional deficiency, fluid retention, or a serious illness.

Determining resident height is an important measure when admitting a resident; record subsequent measurements at least annually or as required by facility protocols. Changes in posture due to problems in the musculoskeletal system can be determined by monitoring resident height.

General guidelines that apply to measuring vital signs are as follows:

- Explain the procedure to the resident.
- Delay measuring the oral (PO) temperature at least 15 minutes for residents who have recently smoked or who have had a hot liquid.
- Arrange the steps of measuring vital signs, height, and weight to conserve energy and increase efficiency.

**EXAM ALERT**

**Follow product guidelines for use of tympanic thermometers, sphygmomanometers (blood pressure cuff), and stethoscopes to ensure accuracy in vital signs measurement.**

- If taking an axillary temperature, make sure the axilla is dry; record the reading with an *A*, indicating the method used; and follow other facility guidelines for use of approved medical abbreviations or terms.
- If unsure of any reading, repeat the procedure and report your findings.

**NOTE**

Blood pressure measurements should be taken in the arm that records the highest reading with the resident sitting or lying. The initial blood pressure reading should be taken in both arms with the resident lying supine, sitting, and standing; record each measurement. Remember, when the resident is sitting, both feet should be flat on the floor. Do NOT take blood pressure in an arm if

- The arm is on the same side as a mastectomy.
- The arm has been affected by stroke or other debilitating injury or is malformed.
- The arm has a current IV infusion or a shunt in it.

- The radial pulse (pulse felt at the wrist) should be measured for at least one minute if the resident has heart disease. When taking the apical pulse (listening to the heartbeat at the apex, or tip of the heart), listen for at least one minute and record the reading. Review the apical-radial pulse procedure in Chapter 6. Report an irregular pulse (heartbeat), because the resident might be experiencing an abnormal heart condition.
- Respirations (includes inspiration and expiration) should be counted for one minute, noting any difficulty in breathing (dyspnea) or pauses in the rhythm of the respirations or the pulse.
- Review the facility's procedure for using a wheelchair scale or other equipment for immobile residents who cannot stand on a scale.
- Record and report vital signs, height, and weight promptly.

**TIP**

Carry a small pad or other means of recording the vital signs at the bedside so you will remember them; this is especially important when completing vital signs for multiple residents.

- Clean all vital sign equipment after each use, especially stethoscope heads, to prevent cross-contamination.

# Psychosocial Care Skills

Assisting residents to meet their basic needs includes their emotional and mental well-being, also called *psychosocial needs*. These needs are as important as the physiological needs discussed previously. All residents living in a long-term care facility are no different from other people who need to feel worthwhile, loved, and secure in their relationships with others. Having these needs at least partially met can contribute to their overall health and welfare.

## Emotional and Mental Health Needs

Being mentally and emotionally healthy means being able to cope with the effects of aging, adjusting to life changes such as being dependent on others, losing loved ones and friends, as well as changes in social life. Those who feel good about the past will often cope well with aging, remaining hopeful, and optimistic about the future. Adjusting to aging is a difficult time for some residents who might long for those more productive years, who have lost a spouse or significant other, and who must now face the future alone and in a strange environment. Memories for them might be painful, especially if they did not achieve their life goals or if they regret past experiences. Leaving the familiar surroundings of home, past friendships, and past lifestyle can be depressing for the resident who feels lonely and isolated. Equally, residents might also become depressed in the long-term care environment and feel resentment toward family who, in their opinion, abandoned them. Elders, especially widows and widowers, are at high risk for suicide because they can fall deeper and deeper into depression that might go unnoticed by family, friends, or caregivers.

Caring about residents as well as for them is a key ethical component of nursing assistant practice. It is often easier to meet the physical needs of residents than to address their psychosocial and emotional needs. Actions, however, speak louder than words, such as spending time with residents, listening to them, showing interest in them and their lives, and encouraging social interaction with others. Being kind, considerate, and compassionate are attributes described in Chapter 1, "What You Need to Know to Prepare for the Exam"; they bear repeating here as well. Demonstrate your genuine concern and acknowledgement of each resident as a worthwhile person who deserves your respect and positive regard. Remember that, despite regional influences, you must always address residents by title and name, not "Grandma," "Mamma," "Honey," "Sweetie," or other forms of address that may be perceived by the resident as disrespectful and/or demeaning. When residents request to be called by their first name, add Mr., Mrs., or Miss to the first name to show respect.

You can encourage residents to participate in their care and activities, which will help improve their sense of independence, self-control, mood, and outlook. Encouraging family members and friends to visit and involving residents in activities helps to meet their social needs. Being observant when working with residents by watching and listening for cues to their mood is

very important because you will spend more time with them than any other caregiver. Report any signs or symptoms of depression to the nurse so that interventions can be made to protect the resident and improve his or her quality of life in the long-term care facility.

# Cultural Needs

Be aware of residents' unique needs, desires, and meaning in life based on their cultural practices. This is particularly important when planning care for residents that will satisfy them and build their trust. Table 4.1 is a review of views on health, illness, and caring by various cultural groups that might influence how you approach their care.

**TABLE 4.1 Cultural Views of Health and Illness**

| | Western Cultures | Non-Western Cultures |
|---|---|---|
| **Illness Causes** | Biological or medical sources (germs, viruses, bacteria, body system malfunctions, and cancers) | Supernatural<br>Religious<br>Magical<br>Supernatural |
| **Illness Diagnosis** | Scientific, system-specific pathology, use of technology | Naturalistic<br>Holistic |
| **Treatment of Illness by Practitioners/Healers** | Medicine<br>Surgery<br>Educated according to established standards and qualifications for practice | Herbal<br>Supernatural<br>Magical/religious practices<br>Learned through apprenticeship<br>Reputation in the community as healer |
| **Responsibility for Health or Illness** | Self | Care provided by others;<br>Rely on cultural group |

Residents' cultural beliefs affect how they view illness or infirmity and, more importantly, how they respond to health problems. For example, people from certain non-western cultures believe that seizures result from the wandering of the soul, a supernatural cause. They might seek treatment from a shaman, or community healer who can perform a ritual to restore their soul. This is different from western cultural beliefs in the scientific explanation of seizures as being caused by a neurological abnormality. This cultural conflict could impact the resident's acceptance of traditional medication to treat a seizure.

Another example of cultural differences is the value in North American society in individualism, or the ability to take care of self and remain independent of others. Asians, Africans, and

Hispanics, however, rely on active family and community support and involvement in their care. This might be seen, for example, in an Asian elder who refuses rehabilitative care after hip surgery until her family can be present.

Many Southeast Asians use folk remedies, and Haitians and South Americans might use herbals, or potions, and wear jewelry (amulets) to ward off evil spirits that cause illness. Native Americans use prayers, chanting, and herbs to treat illness, often thought to stem from supernatural as well as physical causes.

Certain cultures also respond differently to pain and suffering. Asians might become stoic and choose not to report pain, whereas Hispanics might complain quite vocally when distressed.

These are only a few examples of how cultural differences of residents might affect their health and illness behavior. You must be able to understand each resident in light of his or her culture, being careful not to dismiss his or her beliefs or minimize the role that culture plays in health and well-being. Accepting cultural differences demonstrates your ability to truly accept all residents with dignity and care.

# Spiritual Needs

*Spirituality* is defined as finding the inner meaning, or essence of life. Spiritual health refers to the wholeness of a person and the ability to connect with something larger than self. This sense of completeness or self-fulfillment is called *self-actualization* and, according to psychology, meets the highest level of basic human needs. Spirituality might be expressed by residents who find meaning in nature, music, or other expressions that reflect their beliefs of a supreme being or higher power. Healthy people have a positive spirit, meaning they find hope and confidence in the future. They view life with a sense of humor. The human spirit is also a powerful force when a person faces difficulties or life crises. The opposite of spiritual health in this case is called *spiritual distress*, or the feeling that the future is hopeless. Spiritual distress can lead to or increase the severity of illness or infirmity. Research describes elders who lose the will to live due to spiritual distress and, despite interventions to the contrary, die soon after hopelessness occurs.

Spirituality is often linked with an organized, formal religion that includes rituals and other behaviors that express faith; however, spirituality is not directly connected to religion. The freedom and opportunity to observe religious practices enables the resident to meet his or her spiritual needs and, thus, is important to maintain.

The best way to support resident's spiritual needs is to find out what matters most to them. Listen to what they say about spirituality and their spiritual needs. Establishing a caring relationship with residents, known as *rapport*, will help residents more openly talk about their

spiritual needs and how you can support them. The following principles apply when addressing residents' spiritual needs:

- Organize care to enable residents the opportunity to practice their own religion.
- Handle any religious objects used by the resident with care and respect.

**EXAM ALERT**

**Praying with residents or participating in their religious practices is appropriate but not required.**

- If you are uncomfortable with participating in the resident's religious practices, consult with the licensed nurse who can refer the resident to a religious counselor or volunteer to assist with making religious services or other forms of spiritual expression possible.
- Stay open to residents whose beliefs and spiritual practices might differ from your own.
- Be careful not to ignore, disapprove of, or judge a resident's spiritual practices.

**EXAM ALERT**

**Do not impose your own religious beliefs on residents. This is a form of prejudice, which is unacceptable in a health-care environment.**

- Respect the resident's choice not to participate in religious activities.
- Encourage residents to express other forms of spirituality that do not include religious activities.
- Express your own spirituality to impart hope and a sense of humor when relating to residents.

# Sexual Needs

Sexuality or expressing one's sexual needs for intimacy is important to residents and should not be ignored. Physical sexual expression involves more than lovemaking and includes touching, caressing, cuddling, and other forms of human touch. Psychologically, love and affection and a sense of belonging also involve sexual expression. Contrary to popular belief, sexual desire does not decrease with aging. However, the physical response to desire can be affected by neurological and circulatory changes due to conditions such as diabetes, cardiovascular disease, or chronic illness. It is important for you to be aware of your own feelings about sexuality to help residents meet their sexual needs.

Equally important is your knowledge that residents have a right to express their sexual feelings and must be given such opportunities as are appropriate in the long-term care setting. It is important to provide privacy for residents who need to express their sexual desires. Displays of affection toward you or other residents are normal according to the customs of common courtesy and social etiquette. However, you must frankly and clearly confront sexual behavior that is unacceptable to you or others. For example, if a resident makes unwanted sexual advances toward you or another resident, firmly and specifically state your objection to the advance. The resident may also refer to you as a "girlfriend" or "boyfriend," which is also unacceptable and presents an opportunity for misunderstanding should you tolerate the reference. Other unwelcome behavior may include flirting, which the resident might defend as merely teasing. Such defense is unacceptable, even if prompted or aided by illness, medication, or mental state. Kindly inform the resident that the behavior must stop immediately. Be as specific as possible, for example, "I need you to remove your hand from my breast immediately." Serious breaches of etiquette related to sexuality should be reported immediately to your supervisor in order to protect yourself and other residents.

## Data Collection and Reporting

Your ability to observe residents while caring for them is an essential skill you bring to work. Collecting data and reporting changes in residents' conditions can be life saving. You spend the majority of your shift providing direct care to residents, which is a good time to learn from them what is happening to them and how they are progressing with their plan of care. Small changes in condition can make a big difference in a resident's well-being. For example, noticing a resident not talking with you as much as the day before might signal a developing infection or change in neurological status or mood. Changes in vital signs that might not seem alarming to others might alert you that the resident needs further assessment by the nurse. Assisting the resident with ADLs gives you the opportunity to use your sense of smell, touch, sight, and hearing to detect changes in the resident that warrant follow up. Using your senses helps validate what you can directly observe, also known as *objective assessment*. Subjective findings are those observations you conclude from what the resident reports to you that cannot be seen directly; these are also referred to as *symptoms*. Resident's statements of pain, distress, or general health belong to this category of observation and can be as significant as your direct observations. Be careful not to underestimate subjective reporting; take the resident's report at face value. Ignoring the resident's statements can cause you to miss important clues to health changes that could become life threatening if left unattended.

**NOTE**

*Following your gut*, which means your intuition or hunch, is actually based on past experience with residents and can serve you well in your work to keep residents safe and secure; don't ignore your intuition, but act on it.

General guidelines for data collection and reporting resident health status are as follows:

- When reporting changes in a resident's condition, use his or her own words as much as possible to promote objectivity and accuracy.
- Ask the resident to repeat any statements regarding his or her condition to be sure you understand what is being reported to you.
- Report any change in
  - Vital signs, including weight changes
  - Skin changes, including, but not limited to, cyanosis (blue skin color); size or appearance of moles or other skin lesions; skin temperature; and rashes or redness
  - Weakness or dizziness; syncope (fainting)
  - Signs or symptoms of abuse or neglect
  - Edema anywhere in the body
  - Mood changes or any change in resident behavior
  - Coughing or spitting up blood
  - Vomiting
  - Diarrhea or constipation
  - Environmental hazards
  - Any suspicions that cannot be verified but that still cause you to feel concern for the resident's welfare

Recording resident information is another important task you perform daily. Recent changes in technology now might require a basic ability to use the computer or other electronic devices for documenting/recording care and observations. It is important to use correct grammar and spelling as well as acceptable medical terms and abbreviations.

**EXAM ALERT**

**Review medical terms and abbreviations on the Cram Sheet to help you prepare for the WE.**

If recording your observations and care on a written form, be sure to document in blue or black ink only and print legibly, accurately, and completely to ensure proper documentation of what occurred while working your shift. Sign your name and title to all entries. Record your work promptly to ensure accuracy and completeness; make corrections as needed according to the facility's guidelines. Never erase, scratch out, or use a liquid eraser to correct your charting.

If you record in error, strike it out with one line and your initials. Do not leave empty spaces. Remember that the resident's chart is a medical record and, as such, is a legal document and can be used in court.

**TIP**

Always record your work as though an attorney is reading it.

Be objective and descriptive in recording; never record your opinion. For example, when describing a reddened area on the heel of a resident, describe the size of the area (1×1-inch; dime-sized), color, whether the area is at or above the level of the skin and whether the area is warm to the touch. Refrain from stating your opinion as to why it is reddened, such as "the area is red because the last shift did not turn the resident." Expressing your opinion is not only opinion, it may jeopardize the agency by stating an observation with an opinion that implies negligence. You may, however, use resident direct quotes, but be careful to use quotation marks and not your interpretation of what the resident said.

Seek help from the nurse or your supervisor in charting situations that require consultation to ensure that your documentation is thorough, concise, and as objective as possible.

# Exam Prep Questions

1. What are two general goals for a.m. care?

   - ❍ **A.** Remove soil and promote an increase in skin moisture.
   - ❍ **B.** Promote relaxation of the resident and decrease need for mobility.
   - ❍ **C.** Increase circulation and decrease incidence of pressure ulcers.
   - ❍ **D.** Remove harmful bacteria and promote well-being.

2. The nurse hands the nurse assistant a tube of medication and asks her to apply it after she has completed the resident's bath. Which of the following would be the nursing assistant's best response?

   - ❍ **A.** "I will gladly apply the medication as soon as I dry the skin."
   - ❍ **B.** "I don't have the time to do your job and mine too."
   - ❍ **C.** "As a nursing assistant, I can't apply medication without a nurse present in the room."
   - ❍ **D.** "As a nursing assistant, applying medication is beyond my scope of practice."

**3.** Which statement about taking an oral temperature is false?

- ❍ **A.** The thermometer is placed in the mouth under the tongue in the sublingual pocket.
- ❍ **B.** Wait 10 minutes if the resident has consumed any hot or cold liquids.
- ❍ **C.** The normal oral temperature is 96.6°F.
- ❍ **D.** Thermometer covers are used on all residents.

**4.** When should an apical pulse rate be repeated?

- ❍ **A.** A pulse rate of 84 beats per minute
- ❍ **B.** A pulse rate of 54 beats per minute
- ❍ **C.** A pulse rate of 76 beats per minute
- ❍ **D.** A pulse rate of 66 beats per minute

**5.** Which of the following definitions is true?

- ❍ **A.** Tachycardia is a slow heart rate.
- ❍ **B.** An irregular heart rate should be taken for at least 30 seconds.
- ❍ **C.** The carotid site is used most often to obtain the pulse.
- ❍ **D.** Bradycardia is a slow heart rate.

**6.** Which blood pressure should the nursing assistant repeat before reporting it to the nurse?

- ❍ **A.** 90/60 mm Hg
- ❍ **B.** 120/74 mm Hg
- ❍ **C.** 140/68 mm Hg
- ❍ **D.** 130/70 mm Hg

**7.** All of the following steps are part of the procedure for weighing residents, except what?

- ❍ **A.** Residents are to remove shoes before weighing.
- ❍ **B.** Residents are to void before being weighed.
- ❍ **C.** Weights are obtained when the nursing assistant has time in the day's schedule.
- ❍ **D.** Scales are to be calibrated to zero each day or routinely.

**8.** A resident who was very talkative earlier in the day is now difficult to awaken for his bath. The most appropriate action for the nursing assistant is which of the following?

- ❍ **A.** Ask another nursing assistant if this has ever happened before.
- ❍ **B.** Report the change in condition to the charge nurse immediately.
- ❍ **C.** Realize he does not want his bath now and come back later.
- ❍ **D.** Reposition the resident and make sure he is comfortable.

9. The nurse assistant might expect to find pressure ulcers in all of the following locations except where?

   ❍ **A.** Heels

   ❍ **B.** Nose

   ❍ **C.** Elbows

   ❍ **D.** Knees

10. Which of the following is false regarding assisting a resident with his or her bath?

   ❍ **A.** Have the room free from drafts.

   ❍ **B.** Assure the resident's privacy.

   ❍ **C.** Warm the bath water to between 110 and 115 degrees.

   ❍ **D.** Use only one washcloth and towel.

11. According to psychology, the highest basic need a person is able to obtain to promote health and well-being is

   ❍ **A.** Cultural needs

   ❍ **B.** Physical needs

   ❍ **C.** Sexual needs

   ❍ **D.** Spiritual needs

12. The CNA should always be instructed on equipment before using it.

   ❍ **A.** True

   ❍ **B.** False

# Answer Rationales

1. **D.** The two primary goals of bathing are protection from harmful bacteria and promoting the well-being of the residents. Removing soil and promoting an increase in skin moisture (A) is incorrect because bathing might increase skin dryness, not decrease it. Promoting relaxation of the resident and decreasing need for mobility (B) is incorrect because residents require mobility to decrease morbidity. Increasing circulation and decreasing incidence of pressure ulcers (C) is incorrect because pressure ulcers are decreased by cleanliness and frequent change of position along with proper nutrition.

2. **D.** Nursing assistants are not to apply medications because they do not have a license, training, or knowledge to administer medications. The statements in choices A and C are incorrect because the nursing assistant is planning to administer the medication, which is not part of his or her role. The statement in choice B is incorrect due to the use of improper communication.

3. **C.** Normal oral temperatures are between 96.8°F and 100.4°F. Placing the thermometer in the mouth under the tongue in the sublingual pocket (A), waiting 10 minutes if the resident has consumed any hot or cold liquids (B), and using thermometer covers on all residents (D) are all steps used to determine the oral temperature.

4. **B.** The normal adult heart rate is between 60 to 100 beats per minute. A pulse rate of 84 (A), 76 (C), and 66 (D) are within the normal range.

5. **D.** Bradycardia is the heart rate below 60 beats per minute. Answer A, "Tachycardia is a slow heart rate," is incorrect; tachycardia is the heart rate above 100 beats per minute. Answer B, "An irregular heart rate should be taken for at least 30 seconds," is incorrect because irregular heart rates are to be obtained for one full minute. Answer C, "The carotid site is used most often to obtain the pulse," is incorrect; the radial site is used most often to obtain a resident's pulse.

6. **A.** Normal blood pressure for an adult is less than 120/80 and pre-hypertensive is less than 139/89. The blood pressure readings of 120/74 mm Hg, 140/68 mm Hg, and 130/70 mm Hg in choices B, C, and D are within normal limits.

7. **C.** Residents should be weighed at approximately the same time each day. Having the resident remove shoes (A), voiding (B) before being weighed, and calibrating the scales to zero each day or routinely (D) are part of the procedure for assuring accurate weighing of the residents.

8. **B.** Change in a resident's condition is serious and should be communicated to the nurse immediately. Answer A is not correct because assessment of the resident is not part of the nursing assistant's role. Answer C involves assumptions that might lead to harm of the resident. Answer D is incorrect because the first and most important action of the nursing assistant in this situation is to communicate immediately to the nurse the change in the resident's condition.

9. **B.** Pressure ulcers are more prone to develop in bony areas. The heels (A), elbows (C), and knees (D) are areas with the highest incidence of pressure ulcers, which are located on bony surfaces.

10. **D.** At least two washcloths and towels will be needed. One is for clean areas and the other for areas considered dirty. This is done to prevent spread of organisms. Keeping the room free from drafts (A), assuring the resident's privacy (B), and warming the bath water to between 110 and 115 degrees (C) are correct. The room is to be free of drafts, and the room temperature should be between 68°F and 74°F to prevent chilling. The resident's privacy is to be maintained at all times. Bath water temperature should be warm to promote comfort, help relaxation of muscles, and prevent chilling but should not be hot, which risks injury to the resident.

11. **D**. This sense of completeness or self-fulfillment is called  and, according to psychology, meets the highest level of basic human needs. Answers A, B, and C are basic spiritual needs and are important to a patient's well-being; these needs must be met first before a person can reach the highest need of spirituality.

12. **A**. True. To operate any equipment, the CNA should first be instructed on the correct use so as not to harm the patient or themselves.

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