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Medication Aide Certification Examination

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Version Demo

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Topic Break Down

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QUESTION NO: 1

When administering several medications at the same time, they must be given in a particular order.

Which of the following is the correct order?

A. Tablets, liquids, syrups, and lozenges

B. Liquids, syrups, tablets, and lozenges

C. Lozenges, tablets, liquids, and syrups

D. Syrups, liquids, tablets, and lozenges

ANSWER: A

Explanation:

Tablets, liquids, syrups, and lozenges is the correct sequence for this medication-aide administration question. Solid oral medications are given first so the individual can swallow each medication safely with an appropriate amount of water and the medication aide can observe that it has been taken. Liquid medications are then administered using the properly measured dose, followed by syrup preparations as directed on the medication record. Lozenges are administered last because they are intended to dissolve slowly in the mouth rather than be swallowed immediately. Giving the lozenge after the medications that require swallowing helps preserve its local effect and avoids interfering with administration of the other oral preparations.

This sequence must always be used together with the medication-administration rights: verify the individual, medication, dose, route, time, documentation, reason, response, and the person's right to refuse. The medication aide should also follow the prescriber's order, the product label, and facility policy, since special instructions such as "with food," "on an empty stomach," or "do not crush" can affect how a medication is administered. Guidance on safe medication administration and observing medication-specific directions is available from the Centers for Medicare & Medicaid Services and the Institute for Safe Medication Practices.

QUESTION NO: 2

If a resident is to have a test that utilizes dye, which medication must be withheld for 24 hours before and 48 hours after the test?

A. Starlit

B. Precose

C. Actos

D. Glucophage

ANSWER: D

Explanation:

Glucophage is the brand name for metformin, a biguanide used to manage type 2 diabetes. In the context of a test using contrast "dye," the concern is iodinated contrast used in many imaging procedures. If contrast-associated acute kidney injury occurs, metformin clearance can fall and the drug may accumulate. This accumulation raises the risk of metformin-associated lactic acidosis, a rare but potentially life-threatening metabolic complication. Temporarily withholding metformin around contrast administration is therefore a safety measure in people whose kidney function may be impaired or who have particular contrast-related renal risk factors.

Current recommendations individualize the timing based on renal function, the route of contrast administration, and clinical circumstances. The U.S. Food and Drug Administration advises stopping metformin at or before iodinated contrast imaging for specified higher-risk patients and reassessing kidney function 48 hours afterward before restarting it. Thus, for the medication-aide exam's stated 24-hour-before and 48-hour-after protocol, Glucophage is the medication identified by the question. See the FDA metformin safety communication and the Glucophage prescribing information.

QUESTION NO: 3

Requiring more of a medication to feel good or to be able to carry out daily activities is called _____.

A. Tolerance

B. Dependence

C. Cumulative effect

D. A drug interaction

ANSWER: B

Explanation:

Dependence is correct because it describes a state in which a person's body and/or mind has adapted to a medication and the person feels unable to function normally, feel well, or manage everyday activities without it. Medication dependence may develop with some drugs that affect the central nervous system, particularly when they are taken regularly over time. A dependent person may experience physical or psychological discomfort when the medication is reduced or stopped, and may feel a compelling need to continue taking it in order to feel normal.

For medication aides, recognizing possible dependence is important because medication use must be observed, documented, and reported according to facility policy and the nurse's directions. A resident who expresses that they cannot get through the day without a medication, requests it unusually often, or appears distressed when it is unavailable should be reported promptly to the supervising nurse. Medication aides must not independently change doses or make clinical judgments about treatment. The National Institute on Drug Abuse explains that dependence can occur when the body adapts to repeated drug exposure: NIDA—Drugs, Brains, and Behavior. Additional patient-focused information is available from MedlinePlus—Drug Use and Addiction.

QUESTION NO: 4

Which of following forms of medication can be cut in half?

A. Non scored tablet

B. Caplet

C. Capsule

D. Scored tablet

ANSWER: D

Explanation:

Scored tablet is correct because its manufacturer has designed and evaluated it to be split along the visible score line. The score is an indentation intended to help produce two portions that contain as close as possible to equal amounts of the active medication. Medication aides should split a scored tablet only when the prescriber's order directs the partial dose and facility policy permits the task. A tablet splitter is generally preferred because it improves accuracy, avoids loss of medication, and reduces handling. Before splitting, the medication aide should verify the drug label, strength, ordered dose, and whether the specific product is appropriate to split. The two portions should be used according to the medication's directions and the facility's procedures; some products may have additional manufacturer-specific instructions regarding storage after splitting. The U.S. Food and Drug Administration explains that scored tablets may be approved for splitting when the manufacturer has demonstrated that each half provides the intended dose. This makes the score line clinically meaningful rather than merely a physical marking. See the FDA's guidance on tablet splitting best practices and its consumer information on safe tablet splitting.

QUESTION NO: 5

What does the term polypharmacy mean?

A. The resident takes many different medications for various medical conditions.

B. The resident or a family member obtains the resident's medications from several different pharmacies.

C. The resident is able to take many different medications without any adverse effects.

D. The resident takes the same medication several times a day.

ANSWER: A

Explanation:

"The resident takes many different medications for various medical conditions." is correct because polypharmacy means the concurrent use of multiple medications by one person. In medication-aide practice, the term commonly describes a resident who has medicines prescribed for several conditions, often by more than one prescriber. Although no single numerical threshold applies in every setting, polypharmacy is frequently defined in clinical literature as taking five or more medications regularly. The important feature is the use of multiple drugs, including prescription medicines, over-the-counter products, vitamins, and herbal supplements when these are part of the resident's medication regimen.

Recognizing polypharmacy helps medication aides remain alert to the increased need for accurate medication records, observation, and timely reporting of changes in condition. Multiple medicines can make a regimen more complex and may increase the potential for medication interactions, duplications, or adverse effects. Medication aides do not independently decide whether a medicine is necessary; they administer medications as authorized, follow facility policy, document appropriately, and report concerns to the nurse. The National Library of Medicine's StatPearls overview of polypharmacy describes it as the use of multiple medications, and the FDA medicine-safety guidance emphasizes maintaining and reviewing a complete medication list.

QUESTION NO: 6

Clarinex is a medication that is available as an over-the-counter drug.

The drug's action is to reduce _____.

A. Allergy symptoms

B. Stomach upset

C. Pain from arthritis

D. Gas

ANSWER: A

Explanation:

"Allergy symptoms" is correct because Clarinex contains desloratadine, a second-generation antihistamine. During an allergic reaction, the body releases histamine, which binds to histamine H1 receptors and contributes to symptoms such as sneezing, runny nose, itchy or watery eyes, and itching of the nose or throat. Desloratadine selectively blocks peripheral H1 receptors, reducing histamine's effects and thereby relieving these allergy symptoms. Its labeled uses include seasonal allergic rhinitis, perennial allergic rhinitis, and chronic idiopathic urticaria (hives). Medication aides should recognize that antihistamines are used to manage manifestations of allergic conditions and should administer them only as ordered, while observing the resident for therapeutic response and any adverse effects. The medication's action is not directed at gastrointestinal gas, arthritis pain, or nonspecific stomach upset. Although the question describes Clarinex as over the counter, Clarinex (desloratadine) is listed in the United States as a prescription product; the pharmacologic action and intended symptom relief remain allergy-related. See the DailyMed Clarinex prescribing information and MedlinePlus information on desloratadine.

QUESTION NO: 7

Which of the following conditions puts the resident at risk when receiving Inderal?

A. Heart attack

B. Hypertension

C. COPD

D. Irregular heart beat

ANSWER: C

Explanation:

COPD is the condition that puts a resident at particular risk when receiving Inderal (propranolol). Propranolol is a nonselective beta-adrenergic blocker, meaning that it blocks both beta-1 receptors in the heart and beta-2 receptors in bronchial smooth muscle. Blocking beta-2 receptors can narrow the airways (bronchoconstriction) and may trigger bronchospasm, wheezing, shortness of breath, or an exacerbation of underlying obstructive lung disease. This is especially important for a medication aide to recognize because a resident with COPD may have limited respiratory reserve; any medication-related decrease in airflow can become clinically significant. The U.S. prescribing information for propranolol lists bronchial asthma as a contraindication and notes that beta blockers may provoke bronchial asthmatic attacks in people with bronchospastic lung disease. In practice, propranolol should be used cautiously or avoided in residents with COPD when a safer alternative is available, according to the prescriber's direction. Medication aides should promptly report new wheezing, increased work of breathing, reduced oxygen saturation if monitored, or other signs of respiratory distress. See the DailyMed propranolol prescribing information and the NCBI StatPearls review of propranolol.

QUESTION NO: 8

A resident who receives warfarin reports black, tarry stools.

What should the Medication Aide do?

A. Report the finding to the nurse immediately

B. Tell the resident to increase fluid intake

C. Give the next dose with food

D. Document the finding at the end of the shift

ANSWER: A

Explanation:

Report the finding to the nurse immediately is correct because black, tarry stools may indicate gastrointestinal bleeding. Warfarin is an anticoagulant that reduces blood clotting, and bleeding is a serious potential adverse effect. The Medication Aide should promptly communicate the resident's report and any other findings, such as weakness, dizziness, abdominal pain, bruising, or bleeding from other sites, to the supervising nurse. The Medication Aide should not independently decide to discontinue or alter the medication. See MedlinePlus warfarin drug information.

QUESTION NO: 9

A resident who is taking antibiotics experiences a rash.

What is this resident experiencing?

A. Adverse effect

B. Anaphylactic

C. Side effect

D. Allergic reaction

ANSWER: D

Explanation:

An **allergic reaction** is the correct answer because a new rash occurring while a resident is taking an antibiotic can indicate that the immune system is reacting to that medication. Drug allergies may cause skin findings such as a rash, itching, or hives; more severe reactions can involve swelling, breathing difficulty, or circulatory symptoms. A medication aide should recognize a suspected allergy promptly, stop administration of the medication if it is being given, and immediately report the finding according to facility policy and the supervising nurse's direction. The resident should also be assessed for signs that the reaction is becoming severe, including facial or throat swelling, wheezing, shortness of breath, dizziness, or faintness, which require urgent emergency response. Accurate documentation and communication are essential so the prescriber and pharmacy can evaluate the reaction and help prevent future exposure. The National Institute of Allergy and Infectious Diseases notes that medication allergies can produce rash and hives, among other symptoms. See NIAID: Drug Allergy and AAAAI: Medication Allergies.

QUESTION NO: 10

For which of the following individuals would you withhold oral medications?

A. A patient who has had a stroke and needs to have liquids thickened.

B. A patient who is unconscious.

C. A patient who is blind.

D. A patient who is awake and alert and has no deficits.

ANSWER: B

Explanation:

A patient who is unconscious is the individual for whom oral medications should be withheld. Safe oral medication administration depends on the patient being able to protect their airway and coordinate swallowing. An unconscious person cannot reliably follow directions, control oral contents, cough effectively, or demonstrate that a tablet or liquid has been swallowed. Giving medication by mouth in this condition creates a substantial risk that the medication, fluid, or saliva could enter the airway, leading to choking or aspiration. Aspiration can cause acute airway obstruction and may also contribute to aspiration pneumonitis or pneumonia.

The medication aide should not attempt to place the medication in the person's mouth or force administration. Instead, follow facility policy, promptly report the patient's condition and the withheld dose to the licensed nurse, and document the medication according to the organization's medication-administration procedures. The nurse or prescriber can assess the patient and determine whether treatment should be delayed, administered by an authorized alternative route, or otherwise revised. This approach reflects standard medication-safety practice: oral medications are administered only when swallowing can occur safely and the patient's level of consciousness supports airway protection. See the NCBI guidance on aspiration risk and MedlinePlus information on aspiration.

QUESTION NO: 11 - (DRAG DROP)

DRAG DROP

Match the following abbreviations with their corresponding terms.

Select and Place:

Answer Area

MAR	Metered dose inhaler
PO	By mouth
MDI	Congestive heart failure
CHF	Medication Administration Record

ANSWER:

Answer Area

MAR	MDI
PO	PO
MDI	CHF
CHF	MAR

Explanation:

These matches use standard medication-administration and clinical documentation abbreviations. MDI means metered dose inhaler, a handheld device that delivers a measured amount of inhaled medication with each actuation. Medication aides may encounter MDIs when assisting with or documenting medications used for respiratory conditions, so recognizing this abbreviation supports accurate medication administration and communication. The National Heart, Lung, and Blood Institute describes inhalers as devices used to deliver medicine directly to the lungs: NHLBI asthma treatment information.

PO is the standard abbreviation for administration by mouth, derived from the Latin phrase *per os*. It identifies the oral route on a medication order and medication administration record. MAR means Medication Administration Record. This is the official record used to document medications that have been administered, including the medication, dose, route, time, and required initials or signature according to facility policy. Accurate MAR documentation helps maintain continuity of care and provides an important medication-safety record. The Centers for Medicare & Medicaid Services discusses medication administration and documentation requirements for long-term-care settings in its nursing home guidance resources.

CHF means congestive heart failure, a condition in which the heart cannot pump blood as effectively as needed, which can lead to fluid buildup and symptoms such as shortness of breath or swelling. The American Heart Association provides clinical patient information about this condition at What Is Heart Failure?. Correctly recognizing these abbreviations promotes safe interpretation of orders, appropriate observation of residents, and reliable documentation.

QUESTION NO: 12

What is the single most important step for the Medication Aide to perform to prevent the spread of infection while administering medications?

A. Wash his or her hands frequently.

B. Wear protective eye wear.

C. Wear gloves.

D. Wash patient hands frequently.

ANSWER: A

Explanation:

“Wash his or her hands frequently.” is correct because hand hygiene is the most important routine action a Medication Aide can take to interrupt the transmission of infectious organisms during medication administration. Hands can pick up microorganisms from surfaces, medication packaging, equipment, or contact with a resident and can then transfer them to another resident, to medication supplies, or to the Medication Aide’s own face. Performing hand hygiene immediately before preparing or administering medications, between residents when indicated, and after completing care reduces this risk. Alcohol-based hand sanitizer is generally appropriate when hands are not visibly soiled; soap and water are required when hands are visibly dirty and in certain infection-control situations, such as suspected or confirmed *Clostridioides difficile* or norovirus. Consistent hand hygiene protects residents, particularly those who are older, medically fragile, or taking medications that affect immune function. The Centers for Disease Control and Prevention identifies hand hygiene as a core practice for preventing healthcare-associated infections and provides clear guidance on when and how to clean hands in healthcare settings. See the CDC’s hand hygiene guidance and its Core Infection Prevention and Control Practices.

QUESTION NO: 13

Which of the following is the responsibility of the Medication Aide?

A. Giving the first dose of a newly ordered medication to the client

B. Converting medication dosage from milligrams to micrograms

C. Withholding a patient medication without reviewing it with the nurse first

D. Giving PRN medications ordered after checking with the resident’s nurse

ANSWER: D

Explanation:

Giving PRN medications ordered after checking with the resident’s nurse is the appropriate responsibility because a medication aide administers medications only under the supervision and delegation of a licensed nurse. PRN means “as needed,” so its administration requires particular attention to the resident’s current symptoms, the ordered indication, the time and amount of prior doses, and the medication’s expected effect. Checking with the resident’s nurse ensures that the nurse can provide the required clinical oversight and confirm that giving the medication is appropriate under the resident’s care plan and the prescriber’s order.

Medication aides play an important role in safe medication administration by following the medication order and facility policy, identifying the resident, documenting administration, observing for response or adverse effects, and promptly reporting relevant findings to the supervising nurse. Delegation does not remove the nurse’s responsibility for assessment and supervision, especially when a medication is requested or needed based on a changing condition. The Centers for Medicare & Medicaid Services recognizes that medication administration in long-term care must be performed in accordance with professional standards and applicable state requirements. See 42 CFR § 483.45, Pharmacy Services and the NCSBN Medication Aide Curriculum Guidelines.

QUESTION NO: 14

A pulse rate that stays below 60 is considered an indication of _____.

A. Hypertension

B. Bradycardia

C. Hypotension

D. Tachycardia

ANSWER: B

Explanation:

Bradycardia is the term for a heart rate that is slower than normal—generally fewer than 60 beats per minute in an adult at rest. Because the pulse reflects the heart rate, a pulse that remains below 60 beats per minute is an indication of bradycardia. Medication aides should measure the pulse accurately, observe the resident for associated symptoms such as dizziness, weakness, fainting, shortness of breath, chest discomfort, or confusion, and promptly report findings according to the care plan and facility policy. A lower pulse can be normal for some people, such as well-conditioned athletes or during sleep, but a persistent low rate or a low rate accompanied by symptoms requires clinical assessment. Certain medicines, including some cardiac medications, can contribute to a slow heart rate, making appropriate observation and reporting especially important when administering medications. The American Heart Association describes bradycardia as a heart rate that is too slow, typically less than 60 beats per minute, and notes that symptoms may occur when the heart does not pump enough oxygen-rich blood to the body. See the American Heart Association's bradycardia overview and the MedlinePlus page on bradycardia.

QUESTION NO: 15

One of your residents complains of a headache, but he has no analgesic ordered.

What then is the best course of action for the Medication Aide?

A. Give two Tylenols tablets and tell the nurse that they have been administered.

B. Call the physician and get an order for an analgesic.

C. Tell the nurse about the resident's request for pain medication and that there is no updated order.

D. Give two Tylenol tablets and record as usual.

ANSWER: C

Explanation:

Tell the nurse about the resident's request for pain medication and that there is no updated order. is the appropriate action because a medication aide administers medications only under the authorized delegation, policies, and medication orders applicable in the facility and jurisdiction. A resident's new complaint of headache requires assessment and clinical follow-up by the licensed nurse. Promptly reporting both the symptom and the absence of an analgesic order enables the nurse to assess the resident, check for relevant history or non-drug interventions, and contact the authorized prescriber if an order is needed. The medication aide should also communicate pertinent observations, such as when the headache began and any symptoms the resident reports, according to facility procedure. Medication administration in long-term-care settings must follow the prescriber's order and the facility's medication-management system; an over-the-counter product is still a medication and is not automatically available for administration simply because it can be purchased without a prescription. This approach protects the resident, keeps the medication aide within the delegated role, and ensures accurate assessment, ordering, documentation, and monitoring. CMS nursing-facility requirements address the need for medication administration to follow professional standards and applicable requirements: 42 CFR § 483.45, Pharmacy Services. The Centers for Medicare & Medicaid Services also provides nursing-facility guidance in its Nursing Homes guidance.

QUESTION NO: 16

Considering the list of medications below, which one would be prescribed for psychoses?

A. 5 FU

B. Chlorpromazine

C. Valium

D. Bactrim DS

ANSWER: B

Explanation:

Chlorpromazine is the correct medication because it is a first-generation (typical) antipsychotic. Antipsychotic medicines are used to treat psychotic disorders and symptoms, including schizophrenia and other conditions in which a person may experience hallucinations, delusions, severely disorganized thinking, or marked agitation associated with psychosis. Chlorpromazine works primarily by blocking dopamine receptors in the brain, which can reduce psychotic symptoms. Its historical brand name is Thorazine, although product availability and brand use can vary by location. A medication aide should recognize that this medicine is administered only under an authorized prescriber's order and according to the medication record, while observing and promptly reporting important adverse effects or changes in condition. Relevant concerns can include excessive sedation, dizziness or orthostatic hypotension, anticholinergic effects, extrapyramidal symptoms, and signs of neuroleptic malignant syndrome. The medication's FDA prescribing information identifies chlorpromazine as an antipsychotic and includes indications related to psychotic disorders. For patient-oriented drug information, see MedlinePlus: Chlorpromazine. For the official labeling and safety information, see FDA prescribing information for chlorpromazine.

QUESTION NO: 17

The resident in room 220 had trouble swallowing breakfast this morning.

The Medication Aide's best course of action is to do _____.

A. change the medication route to rectal instead of by mouth

B. give the medication slowly with ample water

C. hold the medication and tell the nurse of the resident's difficulty swallowing

D. call the provider to report the resident's difficulty swallowing

ANSWER: C

Explanation:

Holding the medication and telling the nurse of the resident's difficulty swallowing is the appropriate action because difficulty swallowing (dysphagia) can make oral medication administration unsafe. A person who cannot swallow reliably may aspirate medication, fluids, or food into the airway, which can lead to choking or aspiration pneumonia. The medication aide should not proceed with an oral dose until the resident's swallowing status and the prescribed medication plan have been assessed by the licensed nurse. Promptly reporting the observation also allows the nurse to determine whether additional assessment, provider notification, swallowing precautions, or a properly ordered alternative formulation or route is needed.

Medication aides must work within their delegated role and follow facility policy, the medication administration record, and instructions from the supervising licensed nurse. Holding a dose when administration appears unsafe and communicating the reason protects the resident while ensuring the nurse can document, assess, and obtain any needed clinical direction. Dysphagia may be associated with acute neurologic changes, medication effects, or other conditions, so it warrants timely attention rather than attempting to work around the problem during the medication pass. Guidance on dysphagia and aspiration risk is available from the American Speech-Language-Hearing Association and medication-administration safety principles are outlined by the Institute for Safe Medication Practices.

QUESTION NO: 18

Residents who are taking PPI should only take them for the following durations:

A. Until symptoms subside.

B. For as long as they are affordable.

C. After they have eaten a bland diet for two weeks.

D. Until discontinued by their healthcare provider.

ANSWER: D

Explanation:

Until discontinued by their healthcare provider is correct because a proton pump inhibitor (PPI) is a medication that must be administered according to the prescriber's order and the resident's individualized treatment plan. The healthcare provider determines the indication, dose, planned duration, response to treatment, and whether therapy should be continued, reduced, or stopped. This is particularly important in long-term-care settings, where medication aides administer medications but do not independently decide when a prescribed medication course ends.

PPIs are often used for a defined therapeutic course, although some residents may need longer treatment for specific conditions. Continued use should be periodically reviewed because prolonged PPI therapy can be associated with clinically important risks, including bone fracture risk in some patients, vitamin and mineral deficiencies, and certain infections. The provider can weigh these risks against the resident's ongoing need for acid suppression and can direct an appropriate taper or discontinuation plan when indicated. Medication aides should therefore follow the current medication administration record and promptly report concerns or changes in symptoms to the nurse according to facility policy. The U.S. Food and Drug Administration describes safety considerations for PPIs at FDA PPI safety information. Additional prescribing information is available through DailyMed.

QUESTION NO: 19

What is the next step after administering a medication to a resident?

A. Record the administration on the MAR.

B. Give the resident a bath.

C. Communicate to the nurse that the resident's medication has been administered.

D. Check the resident's identification.

ANSWER: A

Explanation:

"Record the administration on the MAR." is correct because documentation should occur immediately after the medication has actually been administered. The medication administration record is the resident's official record of drug therapy and must accurately show that the ordered medication was given. Prompt charting provides a reliable account of the medication, including the date and time, and it allows the medication aide or nurse to record required details such as the dose, route, and any pertinent observations according to facility policy. Timely MAR documentation supports continuity of care: the next caregiver can determine what the resident has received and can monitor the intended effect or any adverse response. It also helps prevent an unintended duplicate dose when staff members change shifts or multiple caregivers are involved. Federal nursing-facility requirements require facilities to maintain drug records and ensure that medication errors are kept within acceptable limits; an accurate MAR is central to meeting those care and safety obligations. Documentation must reflect an administration that has occurred, rather than being completed in advance. See the federal nursing-facility pharmacy-services requirements at 42 CFR § 483.45 and the medication-administration guidance from NCBI Bookshelf.

QUESTION NO: 20

A resident is scheduled to receive oral ibuprofen for chronic arthritic pain; however, the resident is unable to swallow.

The nurse must be informed because this is a problem with which of the following rights of medication administration?

A. The right time

B. The right dose

C. The right route

D. The right medication

ANSWER: C

Explanation:

The right route is correct because the prescription specifies oral administration, but the resident cannot safely swallow the medication. Route is a core medication-administration right: it ensures that a medication is given by the method ordered and by a method appropriate to the resident's current condition. An inability to swallow means the ordered oral route cannot be carried out as prescribed and may create a risk of choking, aspiration, or failure to receive the intended dose. The medication aide should not independently choose an alternative route, crush or alter the ibuprofen, or substitute another formulation. Instead, the nurse must be promptly notified so the resident can be assessed and the prescriber can be contacted if a different formulation, route, or treatment plan is needed. This protects the resident while ensuring that any change is authorized and documented. The U.S. Food and Drug Administration advises patients and caregivers to consult a health care professional when swallowing pills is difficult and before altering medications; see FDA guidance on not crushing, breaking, or chewing medicines. Safe medication practice also includes verifying the route as part of medication administration, as described by the NCBI StatPearls overview of medication administration.

QUESTION NO: 21

Many of CNS medications should be taken at night, before bed, to avoid _____.

A. Dizziness

B. Blurred vision

C. Sedation

D. Confusion

ANSWER: C

Explanation:

Sedation is correct because many medications that act on the central nervous system can depress CNS activity and cause drowsiness, sleepiness, slowed reaction time, or reduced alertness. When a prescriber directs that an appropriate CNS medication be administered at bedtime, the timing is intended to place its sedating effect during the resident's usual sleep period. This helps reduce the practical impact of sedation while the person is awake, such as impaired ability to participate in daytime activities or safely ambulate. Medication aides should follow the medication administration record and the prescriber's specific timing instructions; bedtime administration is not appropriate for every CNS medication or every resident. The aide should also observe for excessive sleepiness or other unexpected effects and promptly report concerns according to facility policy. MedlinePlus notes that drugs such as benzodiazepines may cause drowsiness and advises avoiding activities requiring alertness until the person knows how the medication affects them, which supports the rationale for scheduled bedtime dosing when ordered. See MedlinePlus: Benzodiazepines and NCBI Bookshelf: Sedative-Hypnotic Medications.

QUESTION NO: 22

Sharing information with others about the resident that could damage the resident's reputation is the definition of _____.

A. Libel

B. Abuse

C. Neglect

D. Slander

ANSWER: D

Explanation:

Slander is correct because it is a form of defamation involving a communicated statement that harms, or tends to harm, a person's reputation. In a resident-care setting, medication aides must protect residents' privacy, dignity, and personal reputation. Repeating damaging allegations, rumors, or other harmful information about a resident to people who do not need the information for care can create serious ethical and legal concerns. The communication does not need to be made with the intent to be cruel for staff to have an obligation to use professional judgment, maintain confidentiality, and limit resident information to appropriate care-related discussions.

Defamation law generally distinguishes slander as spoken defamation, while written or otherwise fixed defamatory material is commonly treated separately. For exam purposes, the description of sharing reputation-damaging information with others matches slander. This concept reinforces why care personnel should communicate respectfully and disclose resident information only as authorized and necessary. The Legal Information Institute defines slander as a defamatory statement expressed in a transitory form, such as speech: Cornell Law School Legal Information Institute: Slander. Guidance on safeguarding health information is also available from HHS HIPAA Privacy Rule.

QUESTION NO: 23

One important way to note if a resident's behavior is different from the norm is by doing _____.

A. Asking the resident whether this behavior is usual for him or her.

B. Being familiar with the resident's normal behavior.

C. Asking the supervisor about each resident's normal behavior.

D. Checking with the CNA who cared for the resident last week.

ANSWER: B

Explanation:

Being familiar with the resident's normal behavior is correct because recognizing a meaningful behavioral change requires a reliable baseline. A medication aide observes residents routinely and should learn each person's typical communication, alertness, mood, activity level, sleep pattern, appetite, and usual response to care. With this knowledge, the medication aide can identify a new or worsening change—such as unusual confusion, agitation, drowsiness, withdrawal, or decreased responsiveness—and promptly report the observation to the nurse. Changes in behavior may be an early sign of illness, pain, dehydration, delirium, or an adverse medication effect, so timely recognition and reporting support safe resident care. The medication aide should communicate objective details, including what was observed, when it began or was noticed, and how the behavior differs from that resident's established pattern. This allows the nurse to assess the resident, review possible medication-related causes, and determine appropriate follow-up. Federal long-term-care requirements emphasize person-centered care and maintaining each resident's highest practicable well-being, which depends on staff recognizing and communicating changes from the resident's usual condition. See the resident-rights requirements in 42 CFR §483.10 and the National Institute on Aging overview of delirium.

QUESTION NO: 24

True or false: Failure to report a performance error could result in problems with the facility or with an accreditation agency.

A. TRUE

B. FALSE

ANSWER: A

Explanation:

TRUE is correct. A medication aide has a professional duty to promptly report a medication-related performance error, near miss, or unsafe condition according to the facility's reporting procedure and the supervising nurse's direction. Timely reporting allows the resident to be assessed, treated or monitored as needed, enables accurate documentation, and gives the facility an opportunity to investigate the event and improve its medication-use system. It also supports compliance with quality-assurance and resident-safety requirements. A failure to report can prevent the facility from recognizing harm or recurring risks, create incomplete records, and expose the organization to findings during surveys, inspections, or accreditation reviews. Depending on applicable state law, employer policy, and the circumstances of the event, the individual and facility may face corrective action or regulatory consequences. Federal nursing-facility requirements include quality-assurance and performance-improvement obligations to identify and prevent adverse events, including those involving medication processes. The Institute for Safe Medication Practices likewise emphasizes reporting medication errors and hazards so that organizations can learn from them and prevent future harm. See 42 CFR § 483.75, Quality assurance and performance improvement and ISMP: Medication Error Reporting.

QUESTION NO: 25

Which of the following medications is prescribed for hypothyroidism?

A. Synthroid

B. Inderal

C. Metformin

D. Sinemet

ANSWER: A

Explanation:

Synthroid is correct because it is a brand name for levothyroxine sodium, a synthetic form of thyroxine (T4), one of the hormones normally produced by the thyroid gland. Hypothyroidism occurs when the body does not produce enough thyroid hormone. Levothyroxine replaces the missing hormone and helps restore appropriate thyroid hormone activity, supporting normal metabolism, energy use, growth, and body functions. It is standard long-term replacement therapy for most people with primary hypothyroidism.

Medication aides should recognize that levothyroxine is generally administered consistently according to the prescriber's directions, commonly on an empty stomach before breakfast, because food and certain medicines or supplements can reduce absorption. Calcium and iron products in particular may need to be separated from levothyroxine administration. The resident's response is monitored clinically and through thyroid laboratory testing, especially thyroid-stimulating hormone, so the prescriber can determine whether the dose is appropriate. The official product labeling identifies Synthroid as levothyroxine sodium tablets indicated for hypothyroidism. See the Synthroid prescribing information on DailyMed and the National Institute of Diabetes and Digestive and Kidney Diseases overview of hypothyroidism.

QUESTION NO: 26

How long should the MA-C observe client after an antibiotic is given for the first time?

A. 5 minutes to assess any side effects

B. 10 minutes after the first dose is given

C. 20 minutes after the first dose is given

D. 20 to 30 minutes after the first dose and each dose following

ANSWER: C

Explanation:

“20 minutes after the first dose is given” is correct because a client receiving an antibiotic for the first time requires close, immediate observation for an acute medication reaction, including hypersensitivity or anaphylaxis. In medication-aide training, the initial observation period is commonly taught as at least 20 minutes; this focuses attention on the period when a serious immediate reaction is most likely to become apparent. The MA-C should remain alert for symptoms such as rash or hives, itching, swelling of the lips, tongue, or throat, wheezing, shortness of breath, dizziness, or a sudden change in responsiveness. Any suspected reaction must be reported at once and addressed according to the facility’s emergency procedures and the supervising nurse’s directions. The first dose is particularly important because prior tolerance of a different medication does not establish tolerance of a newly prescribed antibiotic. In Washington, medication assistants have a defined and supervised role in medication administration, and medication policies must be followed within that scope; see Washington Administrative Code, medication assistant-certified scope of practice. For clinical context on recognizing and responding to anaphylaxis, consult the CDC guidance on managing anaphylaxis.

QUESTION NO: 27

Which of the following may be a cause for a medication’s failure to elicit the desired effect?

A. The resident’s past history of drug abuse.

B. Using the generic form instead of the brand-name medication.

C. The resident’s diet and nutritional status.

D. Provider orders for several different medications for the resident.

ANSWER: C

Explanation:

The resident’s diet and nutritional status may cause a medication to fail to produce its intended effect because nutrition can substantially influence pharmacokinetics—the absorption, distribution, metabolism, and elimination of a drug. For example, food can alter the rate or amount of a medication absorbed from the gastrointestinal tract. Malnutrition may also reduce serum protein, particularly albumin. Because some medications circulate partly bound to plasma proteins, reduced protein levels can change the amount of active, unbound medication and make the drug response less predictable. In addition, nutritional deficiencies or changes in body composition can affect hepatic metabolism and renal elimination. Medication aides should therefore observe and report relevant concerns such as poor oral intake, significant weight loss, persistent vomiting or diarrhea, use of nutritional supplements, and changes in prescribed diet. They should administer each medication according to its specific directions regarding meals and should not independently alter administration times or dietary restrictions. The clinical importance of food effects and patient-specific factors is reflected in medication labeling and pharmacology guidance from the U.S. Food and Drug Administration and the NCBI StatPearls review of pharmacokinetics.

QUESTION NO: 28

Storing medications is an important responsibility for the medication aide.

Which of the following actions demonstrates the correct storing of a medication?

A. Medications with similar names are stored close together.

B. Mr. and Mrs. Jones’s medications are in the same medication storage bin.

C. All medications are stored in their own original containers.

D. Once medications are opened, they are all kept in the cart, regardless of the directions on the packaging.

ANSWER: C

Explanation:

All medications are stored in their own original containers. This practice preserves the medication's pharmacy or manufacturer label, which identifies the resident, medication name, strength, dosage form, directions, expiration or beyond-use information, and other instructions needed for safe administration. Keeping each medication in its original, properly labeled container also helps ensure that it remains clearly associated with the person for whom it was ordered and supports accurate medication identification during each medication pass. Medication aides should keep resident medications in the designated resident-specific storage area and follow storage conditions stated on the label or package, including any refrigeration, light-protection, or controlled-substance security requirements. In long-term-care settings, federal requirements provide that drugs and biologicals be labeled in accordance with currently accepted professional principles and stored in locked compartments, as appropriate. Proper container and label retention is therefore a central safeguard for medication security, traceability, and safe administration. See 42 CFR § 483.45—Pharmacy Services and the FDA guidance on medicines and their labeling/storage information.

QUESTION NO: 29

Tramadol is a non-narcotic centrally acting analgesic.

Which of the following is the most serious adverse effect listed that may occur when taken?

A. Excessive hunger

B. GI bleeding

C. Seizures

D. Nervousness

ANSWER: C

Explanation:

Seizures is the most serious adverse effect listed. Tramadol can increase seizure risk even when taken within the recommended dosage range, and the risk rises with higher doses or when it is used with medications that lower the seizure threshold. Examples of clinically important interacting drug groups include certain antidepressants, antipsychotics, and other centrally acting medicines. Seizure risk can also be greater in people with epilepsy, a prior seizure history, head trauma, metabolic disorders, alcohol or drug withdrawal, or central nervous system infections.

For medication aides, this risk is important because a resident who develops seizure activity requires immediate emergency response according to facility policy: protect the person from injury, do not restrain them or place anything in their mouth, observe the episode, and promptly notify the nurse or emergency services as directed. Accurate administration, avoidance of unauthorized dose changes, and timely reporting of new neurologic symptoms help reduce harm. The FDA-approved prescribing information specifically warns that seizures have been reported in patients receiving tramadol. See the FDA tramadol prescribing information and MedlinePlus drug information for tramadol.

QUESTION NO: 30

A visitor asks the Medication Aide which medications a resident receives and why they are prescribed.

What is the appropriate response?

A. Tell the visitor the medication names but not the diagnoses

B. Refer the visitor to the nurse and do not disclose the resident's medication information

C. Show the visitor the resident's MAR

D. Ask another resident whether the visitor is family

ANSWER: B

Explanation:

Refer the visitor to the nurse and do not disclose the resident's medication information is correct. Medication information is part of the resident's protected health information and may be shared only with persons authorized to receive it. The Medication Aide should not assume that a visitor, family member, or roommate has permission to know the resident's diagnoses or medications. The nurse can verify whether the visitor is an authorized representative and communicate information through the appropriate process. Protecting confidentiality respects resident rights and supports compliance with privacy requirements. See HHS information on the HIPAA Privacy Rule.

QUESTION NO: 31

The MA-C may be responsible for administering a medication to improve bone density.

Which of the following side effect is most common side effect of the medication Boniva?

A. GI upset

B. Pain in arms or legs

C. Weakness

D. Jaw discomfort

ANSWER: B

Explanation:

Pain in arms or legs is the best answer because Boniva (ibandronate) can commonly cause musculoskeletal symptoms, including pain in an extremity. Boniva is a bisphosphonate used to treat or prevent osteoporosis by slowing bone breakdown and helping preserve bone density. In clinical-trial safety data for the oral monthly tablet, pain in an extremity was among the adverse reactions reported in patients receiving ibandronate. Patients may describe this symptom as aching, soreness, or pain in an arm or leg. The medication aide should observe the patient, document and report symptoms according to the facility's policies, and promptly notify the supervising nurse if the pain is severe, new, persistent, or accompanied by other concerning findings. This supports appropriate assessment and follow-up while the nurse evaluates whether additional clinical action is needed. The official prescribing information lists pain in extremity in its adverse-reaction data; see the FDA Boniva prescribing information. Additional patient-focused medication safety information is available from MedlinePlus: Ibandronate.

QUESTION NO: 32

Which of the following medications are prescribed for the symptoms of asthma?

A. Inderal

B. Spiriva

C. Tussionex

D. Propranolol

ANSWER: B

Explanation:

Spiriva is correct because it is the brand name for tiotropium, an inhaled long-acting muscarinic antagonist bronchodilator. Spiriva Respimat is prescribed as a maintenance treatment for asthma in people aged 6 years and older. By blocking muscarinic receptors in airway smooth muscle, tiotropium helps keep the airways open, reducing bronchoconstriction and helping to improve ongoing asthma control. It is generally used as an add-on maintenance medicine when a person's asthma requires additional long-term control, commonly alongside an inhaled corticosteroid with or without another controller medication.

Maintenance treatment means Spiriva is taken regularly as prescribed to help prevent or reduce persistent asthma symptoms over time; it is not intended to rapidly reverse a sudden asthma attack or acute bronchospasm. Medication aides should recognize the distinction because a resident who has sudden wheezing or shortness of breath needs assessment and the prescribed rescue-treatment plan rather than relying on a maintenance inhaler. The U.S. prescribing information identifies asthma maintenance treatment as an indication for Spiriva Respimat and specifies its age range and limitations of use. See the official DailyMed Spiriva Respimat prescribing information and National Heart, Lung, and Blood Institute asthma treatment guidance.

QUESTION NO: 33

Which of the following medications is not a nasal decongestant?

A. Pseudoephedrine

B. Loratadine

C. Epinephrine

D. Phenylephrine

ANSWER: B

Explanation:

Loratadine is the correct answer because it is a second-generation antihistamine, not a nasal decongestant. It works by selectively blocking peripheral histamine H1 receptors. This reduces allergy symptoms driven by histamine release, such as sneezing, itching of the nose or eyes, watery eyes, and rhinorrhea (runny nose). It may therefore help a person whose nasal symptoms are caused by allergic rhinitis, but its primary action is not to constrict swollen nasal blood vessels or directly relieve nasal congestion.

Nasal decongestants work through sympathomimetic vasoconstriction in the nasal mucosa. Constricting local blood vessels reduces mucosal edema and opens congested nasal passages. Medication aides should distinguish an antihistamine's allergy-symptom role from a decongestant's vascular effect, particularly when assisting with over-the-counter medication use and observing residents for expected therapeutic effects. Loratadine labeling identifies it as an antihistamine for allergy symptoms, while clinical allergy guidance recognizes decongestants as a separate medication class. See the DailyMed loratadine drug information and the American Academy of Allergy, Asthma & Immunology overview of allergy medications.