CNA Basic Nursing Skills Practice Test

CNA TestBank · Prepared Nov 28, 2026 · Ref VEICFOBS

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1. Which of the following items is disposable?

A. Paper gown

B. Electric razor

C. Commode

D. Bedsheet

Answer: A. Paper gown

A paper gown is a single-use item that is thrown away after one use, making it the disposable item among these choices.

Disposable items are designed to be used once and then discarded, which helps prevent the spread of infection between residents. A paper gown fits this description because it is made of inexpensive material meant for one-time use and is discarded after the task or care episode is finished. Reusable items like razors, commodes, and bedsheets are cleaned, disinfected, or laundered and used again, so they are not disposable. When answering this type of question, think about which item would be thrown in the trash rather than cleaned and reused.

B) Electric razor

An electric razor is a durable piece of equipment that is cleaned and disinfected between residents and reused, so it is not meant to be thrown away after one use. It can seem tempting because razors are personal care items, but proper infection control calls for cleaning shared equipment rather than discarding it.

C) Commode

A commode is a sturdy, reusable piece of equipment that is cleaned and disinfected after each use and then used again. It may seem like a good answer because commodes can carry germs, but the correct infection control response is thorough cleaning, not disposal.

D) Bedsheet

A bedsheet is laundered and reused rather than discarded after a single use. It might seem disposable because it is changed often and can become soiled, but linens are washed according to facility policy and returned to service.

Conclusion

Focus on whether an item is used once and thrown away or cleaned and reused. Paper gowns are single-use and disposable, while razors, commodes, and bedsheets are reusable items that require proper cleaning or laundering.

2. Incontinence may be defined as:

A. loss of bladder control

B. redness of the skin

C. shortness of breath

D. painful leg cramps

Answer: A. loss of bladder control

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Incontinence means a loss of bladder control.

Incontinence is the inability to control urination or bowel movements, and in most CNA exam contexts it refers to the involuntary loss of urine when a person cannot hold it. This matters in daily care because residents with incontinence need frequent checks, prompt toileting, skin cleaning and drying, and regular pad or brief changes to prevent skin breakdown and embarrassment. Recognizing incontinence helps the nursing team plan toileting schedules and protect skin integrity.

B) redness of the skin

Redness of the skin is a sign of irritation or inflammation, such as from moisture, pressure, or infection, not a definition of incontinence. It can be tempting to link redness with incontinence because wet skin often becomes red, but redness is a possible consequence, not the meaning of the term.

C) shortness of breath

Shortness of breath describes difficulty breathing and relates to respiratory or cardiac problems. It has no connection to bladder or bowel control, though it may seem like a general symptom worth noting in a resident's chart.

D) painful leg cramps

Painful leg cramps are muscle spasms often linked to circulation, hydration, or medication effects. They are unrelated to the urinary or bowel systems, even though they are a common complaint in older adults that CNAs report to the nurse.

Conclusion

Remember that incontinence refers to the involuntary loss of urine or stool, and your role is to provide prompt toileting, hygiene, and skin care while reporting changes to the nurse.

3. To promote a client's rest, the nurse aide SHOULD:

A. keep the lights on

B. ask the client questions

C. decrease the noise level

D. position the client upright

Answer: C. decrease the noise level

Decreasing the noise level helps promote the client's rest by creating a calmer environment.

Rest depends on a quiet, comfortable setting. Noise from televisions, hallway traffic, equipment, or conversations can keep a client alert and make it hard to relax or sleep. By lowering the noise level, the nurse aide removes a common barrier to rest and supports the body's need for recovery. This falls within the aide's scope: adjusting the environment is a simple, safe action that supports comfort and healing.

A) Keep the lights on

Bright lighting signals the brain to stay awake and can make resting difficult. It may seem helpful for safety or for monitoring the client, but rest is better supported by dimming lights when appropriate.

B) Ask the client questions

Questions require the client to think and respond, which stimulates rather than settles the person. Conversation may feel friendly and caring, yet it works against the goal of rest.

D) Position the client upright

An upright position is useful for breathing, eating, or certain comfort needs, but it does not by itself create rest and may be uncomfortable for sleeping. Positioning should follow the care plan rather than be used as a rest strategy.

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Conclusion

Remember that rest is promoted by reducing stimulation, and noise control is a key part of a restful environment. Choose the action that calms the setting rather than one that adds activity or stimulation.

4. Pressure sores may be prevented by:

A. moving a client as little as possible

B. giving special care to reddened areas

C. smoothing the bed linens only when necessary

D. keeping the reddened areas moistened

Answer: B. giving special care to reddened areas

Giving special care to reddened areas helps prevent pressure sores from developing.

Reddened skin is an early warning sign that pressure has reduced blood flow to that spot. The CNA should keep the area clean and dry, avoid massaging or rubbing it, relieve pressure by repositioning the client on a regular schedule, and report the redness to the nurse so it can be watched closely. Catching these early changes and protecting the skin gives tissue a chance to recover before an open sore forms.

A) moving a client as little as possible

Keeping a client still seems gentle, but staying in one position concentrates pressure on the same spots and cuts off circulation, which is exactly how pressure sores begin. Regular repositioning, following the care plan, is a core prevention step.

C) smoothing the bed linens only when necessary

Wrinkled sheets create small pressure points and friction against the skin, so linens should be kept smooth and dry as part of routine care. Waiting until it seems necessary leaves the skin exposed to ongoing irritation.

D) keeping the reddened areas moistened

Extra moisture softens and breaks down skin, making it more likely to tear and develop a sore. Reddened areas need to be kept clean and dry, with pressure relieved, rather than kept wet.

Conclusion

Remember that reddened skin is an early warning sign: protect it by relieving pressure, keeping the area clean and dry, and reporting changes to the nurse. Steady positioning, wrinkled linens, and added moisture all increase the risk of skin breakdown.

5. If resident feels pain during range-of-motion you should:

A. continue faster

B. stop and report nurse

C. continue slower

D. pause 1 min then continue

Answer: B. stop and report nurse

Stop the range-of-motion exercise and report the pain to the nurse.

Pain during range-of-motion is a signal that something may be wrong, such as joint inflammation, injury, or an underlying medical problem. The safe action is to stop the movement right away, keep the resident comfortable, and tell the nurse so the resident can be assessed. Continuing to move a painful joint can cause further harm, and CNAs are not responsible for deciding whether pain is normal or how to treat it.

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A) Continue faster

Speeding up would push the joint further into pain and raises the risk of injury. It may seem like finishing quickly would reduce discomfort, but pain is a warning sign that the movement should not continue.

C) Continue slower

Slowing down does not remove the cause of the pain and still forces a painful joint to move. It may seem gentler, but any continued movement against pain can worsen the problem.

D) Pause 1 min then continue

A short pause may let the resident settle, but resuming the same movement without notifying the nurse ignores a possible injury or medical issue. It may seem like a reasonable middle ground, yet the pain still needs to be reported and assessed.

Conclusion

When a resident reports pain during range-of-motion, stop the activity and report to the nurse. Recognizing pain as a warning sign and knowing when to stop and escalate is a core part of safe CNA practice.

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