# CNA Exam California Practice Test

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**1. A CNA in California is caring for a resident who suddenly reports chest pain and has difficulty breathing. What should the CNA do first?**

A. Give the resident their prescribed nitroglycerin

B. Stay with the resident and call for the licensed nurse immediately

C. Ask the resident to walk to the nurses station

D. Document the complaint and check on the resident in 15 minutes

**Answer: B. Stay with the resident and call for the licensed nurse immediately**

**Stay with the resident and call for the licensed nurse immediately, since sudden chest pain with trouble breathing needs urgent licensed assessment.**

Chest pain combined with difficulty breathing can signal a life-threatening emergency such as a heart attack. A CNA's role is to recognize the danger, remain with the resident so they are not left alone and can be monitored, and get the licensed nurse right away. The nurse can then assess the resident, start emergency protocols, and call for additional help such as EMS. Staying calm, keeping the resident still, and reporting clear details like when the pain started and how it feels are all within CNA scope and help the care team respond quickly.

**A) Give prescribed nitroglycerin**

Giving medication is outside CNA scope of practice, and this resident has not been assessed for this new symptom. It may seem helpful because the medication is already prescribed, but the nurse must decide whether it is appropriate and safe right now.

**C) Ask the resident to walk to the nurses station**

Walking during chest pain and shortness of breath can strain the heart and worsen the situation. It may seem like a fast way to get help, but the resident should stay still while the nurse comes to them.

**D) Document and check back in 15 minutes**

Delaying action for 15 minutes is dangerous when chest pain and breathing trouble can signal a heart attack. Charting is important, but it comes after the resident is safe and the nurse has been notified.

**Conclusion**

For sudden chest pain with difficulty breathing, remember that the CNA's first job is to stay with the resident and alert the licensed nurse immediately. Recognizing an emergency and acting quickly, without stepping outside your scope, protects the resident's safety.

**2. Which task is within the California CNA scope of practice?**

A. Inserting a urinary catheter

B. Administering oral pain medication

C. Measuring and recording a residents blood pressure

D. Changing a sterile dressing on a surgical wound

**Answer: C. Measuring and recording a residents blood pressure**

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**Measuring and recording a resident's blood pressure is a routine monitoring task that falls within the California CNA scope of practice.**

CNAs are trained to gather basic vital signs and report them to the nurse. Taking a blood pressure and writing it down does not involve deciding treatment or breaking the skin, so it fits safely within the aide's role. The nurse uses these numbers to assess the resident and plan care.

**A) Inserting a urinary catheter**

This is an invasive procedure that enters the body and carries a risk of infection and injury, so it requires a licensed nurse or other qualified professional. It can seem like a basic bedside task, but the skill and judgment involved place it outside the aide's scope.

**B) Administering oral pain medication**

Giving medication involves knowing the drug, the dose, and the resident's response, which is a nursing responsibility. A CNA may remind a resident or report pain, but handing over the medication itself goes beyond the aide's training and legal limits.

**D) Changing a sterile dressing on a surgical wound**

Sterile technique and wound assessment require a licensed clinician who can judge healing and watch for infection. The task looks simple, yet any break in sterile practice could harm the resident, so it stays with the nurse.

**Conclusion**

For scope-of-practice questions, choose the task that is routine, non-invasive, and reported to the nurse. Vital signs fit that pattern, while procedures that break the skin, enter the body, or involve medication belong to licensed staff.

**3. A CNA is asked by a nurse to insert a urinary catheter for a resident. What is the CNA's most appropriate response?**

A. Insert the catheter because a nurse delegated the task

B. Refuse because catheter insertion is outside the CNA scope of practice

C. Insert the catheter only if the resident consents

D. Ask another CNA to assist with the insertion

**Answer: B. Refuse because catheter insertion is outside the CNA scope of practice**

**The CNA should refuse because inserting a urinary catheter is outside the CNA scope of practice, even when a nurse requests it.**

Nurse aide training and legal scope of practice focus on basic personal care, safety, observation, and reporting. Catheter insertion is an invasive procedure that requires a licensed nurse's training, judgment, and legal authority. A nurse's request does not expand what a CNA is allowed to do, and accepting the task would put the resident at risk and expose the aide to legal and professional consequences. The right action is to politely decline, explain that the task is outside the CNA role, and report the request to the supervising nurse or charge nurse so the resident still receives proper care.

**A) Insert because a nurse delegated it**

Delegation only applies to tasks that fall within the aide's training and legal scope. A nurse cannot transfer authority for a procedure the CNA is not licensed or trained to perform, so this choice confuses following directions with lawful delegation.

**C) Insert only if the resident consents**

Resident consent is important for any care, but it does not change what a CNA is permitted to do. Consent cannot make an out-of-scope procedure acceptable, so this option mixes up two separate issues.

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**D) Ask another CNA to assist**

Involving another aide does not solve the problem, since both CNAs share the same scope limits. This choice may feel like teamwork, but it would still result in an unqualified person performing an invasive procedure.

**Conclusion**

Know your scope of practice and stay within it. When asked to perform a task outside your role, decline respectfully and report the situation so a licensed nurse can provide the care safely.

**4. A CNA is caring for a resident on contact precautions. Which personal protective equipment is required before entering the room?**

A. Gloves only

B. Gown and gloves

C. Mask and eye protection

D. No PPE is needed if the door is closed

**Answer: B. Gown and gloves**

**Contact precautions require putting on a gown and gloves before entering the resident's room.**

Contact precautions are used to stop the spread of germs that travel by direct or indirect touch, such as on hands, clothing, or surfaces. Because a CNA will have close physical contact with the resident and the room environment, both a gown and gloves form the barrier that keeps germs from moving from the resident to the CNA and on to other residents. PPE is put on before entering the room and removed carefully before leaving, with hand hygiene right after.

**A) Gloves only**

Gloves protect the hands, but they leave the arms, clothing, and uniform exposed to germs that can cling to fabric and travel to the next resident. It can seem like gloves cover the main risk since hands touch so much, but contact precautions call for a gown as well to block that route of spread.

**C) Mask and eye protection**

Masks and eye protection guard against droplets or splashes and are tied to droplet or airborne precautions, not contact precautions. This option can feel thorough because more protection sounds safer, but the type of precaution should match how the germ spreads, and contact spread is stopped mainly by covering skin and clothing.

**D) No PPE is needed if the door is closed**

A closed door does not stop germs that spread by touch, since the CNA still goes in and has contact with the resident and the room. It can seem logical that a shut door contains the risk, but the door does nothing to protect the person providing hands-on care.

**Conclusion**

Match the PPE to the precaution type: contact precautions mean a gown and gloves before entering the room. Remember that PPE is only effective when it is put on before contact and removed safely afterward with good hand hygiene.

**5. A CNA is charting resident care. Which entry is written correctly?**

A. Resident was in a bad mood all morning

B. Resident ate 75% of breakfast at 8:15 AM

C. Resident probably has a urinary tract infection

D. Resident refused care because they are stubborn

**Answer: B. Resident ate 75% of breakfast at 8:15 AM**

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**Charting "Resident ate 75% of breakfast at 8:15 AM" is the correctly written entry because it is objective, specific, and measurable.**

Good documentation records what the CNA actually observed and did, using facts, numbers, and times rather than opinions or guesses. "Ate 75% of breakfast at 8:15 AM" tells the next caregiver exactly what happened and when, and it can be verified. This kind of entry protects the resident and the care team, supports continuity of care, and stays within the CNA's scope of practice by reporting observations instead of making diagnoses or judgments.

**A) "Bad mood"**

This entry describes a personal interpretation of the resident's behavior rather than a specific observation. "Bad mood" means different things to different people and cannot be measured or verified. It may seem tempting because it captures the CNA's concern, but charting should describe what was seen or heard, such as the resident refusing to talk or staying in bed, rather than labeling feelings.

**C) "Probably has a UTI"**

This entry states a possible medical diagnosis, which is outside the CNA's role. Only a licensed provider can diagnose an infection. The CNA's job is to report signs and symptoms, such as burning on urination or confusion, to the nurse. It may seem helpful to note a suspicion, but charting a guess can mislead others and is not appropriate documentation.

**D) "Refused care because they are stubborn"**

This entry mixes a fact (refusing care) with a judgment about the resident's character. Words like "stubborn" are subjective and can be seen as disrespectful or biased. It may seem tempting because it explains the refusal, but the chart should simply state what happened, when, and what was done, such as notifying the nurse of the refusal.

**Conclusion**

For CNA charting, remember the rule of objective facts: record what you saw, did, and when, using measurable details and avoiding opinions, labels, or diagnoses. Entries like "ate 75% of breakfast at 8:15 AM" are clear, accurate, and useful to the whole care team.

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