CNA Practice Test 50 Questions

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1. A resident can brush their teeth independently but asks the CNA to do it because the resident is tired. What is the best approach?

A. Do everything without allowing participation

B. Encourage the resident to do as much as safely possible while providing needed assistance

C. Refuse all assistance

D. Tell the resident oral care is unnecessary

Answer: B. Encourage the resident to do as much as safely possible while providing needed assistance

The best approach is to encourage the resident to do as much as safely possible while providing needed assistance.

CNAs support residents' independence while honoring their need for help. When a resident who can brush their teeth independently asks for help because of fatigue, the aide should promote self-care by encouraging the resident to do what they can and stepping in only where support is needed. This respects dignity, maintains skills, and meets the resident's needs safely.

A) Do everything without allowing participation

Taking over completely removes the resident's chance to stay independent and can lead to loss of function over time. It may seem kind when the resident is tired, but it does not support the resident's abilities or dignity.

C) Refuse all assistance

Declining to help at all ignores the resident's request and their fatigue. CNAs are responsible for providing needed care, so refusing assistance does not meet the resident's needs.

D) Tell the resident oral care is unnecessary

Oral care is an important daily need that supports health and comfort. Dismissing it as unnecessary does not address the resident's request and skips an essential part of care.

Conclusion

Support independence by encouraging residents to do what they safely can while providing help as needed. This balances dignity, function, and safe care.

2. A resident requests privacy while changing clothes. What should the CNA do?

A. Leave the resident completely unattended regardless of safety needs

B. Provide privacy while maintaining appropriate safety and assistance

C. Tell the resident privacy is not permitted

D. Ask another resident to watch the resident

Answer: B. Provide privacy while maintaining appropriate safety and assistance

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Provide privacy while maintaining appropriate safety and assistance respects the resident's right to dignity while keeping the resident safe.

Residents have the right to privacy and dignity, and this includes being given privacy while dressing or changing clothes. At the same time, the CNA is responsible for the resident's safety. The best approach balances both: step back or use a curtain or door to give privacy, while staying close enough to assist if the resident needs help or is at risk of falling. This honors the resident's wishes and keeps them protected.

A) Leave the resident completely unattended regardless of safety needs

Giving privacy does not mean abandoning the resident. Walking away entirely can leave a resident at risk of falling or injury, especially if they need help with balance or clothing. This option may seem appealing because it sounds like full privacy, but it ignores the CNA's duty to keep the resident safe.

C) Tell the resident privacy is not permitted

Refusing a reasonable privacy request goes against the resident's rights to dignity and respect. This choice may come from a wish to keep the resident closely supervised, but supervision can be maintained without denying privacy. Telling a resident privacy is not allowed undermines trust and the care relationship.

D) Ask another resident to watch the resident

Involving another resident in watching someone change clothes violates the resident's privacy and confidentiality. This option may seem like a way to keep the resident safe while giving space, but it exposes the resident to others and is not an appropriate use of another resident. Safety should be provided by staff, not by other residents.

Conclusion

Respecting a resident's right to privacy and maintaining safety go together. Give privacy during dressing while remaining available to assist, and never deny privacy or involve other residents in watching. Choose the answer that protects both dignity and safety.

3. A resident with a prescribed fluid restriction asks for an extra large glass of water. What should the CNA do?

A. Provide the extra water without checking

B. Follow the care plan and consult the nurse about the request

C. Tell the resident fluid restrictions are optional

D. Ask another resident to decide

Answer: B. Follow the care plan and consult the nurse about the request

Following the care plan and consulting the nurse about the request is the right action when a resident on a fluid restriction asks for extra water.

Fluid restrictions are prescribed by the healthcare provider for specific medical reasons, such as heart failure or kidney disease, and the care plan spells out how much fluid the resident may have and how it should be spread out. The CNA's role is to honor that plan and report any request that falls outside it to the nurse, who can assess the resident and decide whether the restriction needs adjusting. This protects the resident's safety while still respecting their wishes and dignity.

A) Provide the extra water without checking

Giving extra fluid on your own may seem kind and responsive to the resident's thirst, but it can upset the balance the provider intended and cause harm such as fluid overload. CNAs are not authorized to change a prescribed restriction, so this choice oversteps the care plan.

C) Tell the resident fluid restrictions are optional

This may feel reassuring in the moment, but it gives the resident inaccurate information and can lead them to drink more than is safe. Restrictions are medical orders, not suggestions, and only the provider or nurse can modify them.

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D) Ask another resident to decide

Turning to another resident may seem like a way to share the decision, but residents have no authority over each other's care plans, and this could breach privacy. The request should go to the nurse, who is responsible for the resident's care.

Conclusion

When a resident on a fluid restriction asks for more to drink, follow the care plan and report the request to the nurse. Knowing your scope of practice and using the chain of communication keeps residents safe and respected.

4. A resident's urine appears unusually dark and the resident reports feeling weak. What should the CNA do?

A. Diagnose dehydration

B. Report the observations promptly to the nurse

C. Give a medication

D. Ignore the change

Answer: B. Report the observations promptly to the nurse

Report the dark urine and weakness to the nurse promptly so the care team can evaluate the resident.

Dark urine and a report of weakness are changes in the resident's condition that fall outside the CNA's role to interpret or treat. The CNA's job is to observe carefully, document what was seen and heard, and communicate it to the licensed nurse right away. The nurse can then assess the resident, check vital signs and hydration status, and decide on any needed interventions. Reporting promptly helps catch possible problems early and keeps the resident safe.

A) Diagnose dehydration

Making a diagnosis requires a nursing assessment and clinical judgment beyond the CNA's scope. Dark urine can have several causes, and labeling it as dehydration could lead others to skip a proper evaluation. It is tempting because dehydration is a common reason for dark urine, but the CNA should describe the findings rather than name a condition.

C) Give a medication

CNAs do not administer medications unless specifically trained and authorized under state rules and facility policy, and never a new or unprescribed treatment. Giving a medication without an order could seriously harm the resident. This option may seem helpful, but any treatment decision belongs to the nurse or provider.

D) Ignore the change

Ignoring a change in urine appearance and new weakness could allow a developing problem to worsen unnoticed. CNAs are the eyes and ears of the care team, and reporting observations is a core responsibility. This option may appeal to someone who feels unsure, but silence is the least safe choice.

Conclusion

When you notice a change such as dark urine or new weakness, observe, document, and report it to the nurse promptly. Stay within your scope: do not diagnose, do not give medications without authorization, and never ignore a change in condition.

5. A resident refuses breakfast and says the resident is not hungry. What should the CNA do?

A. Force the resident to eat

B. Document the refusal objectively and report it according to facility procedure

C. Document that the resident is depressed

D. Hide the refusal from the nurse

Answer: B. Document the refusal objectively and report it according to facility procedure

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Document the refusal objectively and report it according to facility procedure.

When a resident declines a meal, the CNA's role is to observe and report, not to diagnose or force. Record exactly what happened in plain, factual terms (for example, "resident refused breakfast, stated not hungry") and pass this information along through the facility's reporting system so the nurse can assess for causes such as illness, pain, dental problems, medication side effects, or changes in appetite. This keeps the care team informed and supports the resident's right to make choices about eating.

A) Force the resident to eat

Residents have the right to refuse food, and forcing or pressuring someone to eat can cause choking, distress, and loss of trust. This option may seem tempting when a CNA worries about the resident's nutrition, but the proper response is to report the refusal so the nurse can evaluate the situation.

C) Document that the resident is depressed

Depression is a medical diagnosis that falls outside the CNA's scope of practice. A single refused meal does not establish a mood disorder, and charting a diagnosis could be inaccurate and harmful. This may feel like a caring interpretation, but the CNA should record only observable facts and let the nurse or provider assess further.

D) Hide the refusal from the nurse

Withholding information about a refused meal prevents the care team from monitoring nutrition and hydration and could delay needed intervention. This option might seem like a way to avoid conflict or worry, but accurate reporting is a core CNA responsibility and protects the resident's safety.

Conclusion

For meal refusals, stay within your scope: document what you observed in objective terms and report it promptly through facility procedure so the nurse can follow up. Never force food, never chart diagnoses, and never hide changes in intake.

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