Free Prometric CNA Practice Test with Answers

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This PDF contains all **12** questions in this exam.

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1. A client's care plan encourages fluids. The nurse aide SHOULD:

A. limit the variety of fluids

B. remove the water pitcher

C. offer fluids between meals

D. provide room temperature fluids

Answer: C. offer fluids between meals

Offering fluids between meals is the best way to encourage fluid intake without interfering with mealtimes.

When a care plan encourages fluids, the nurse aide should look for frequent, low-pressure chances to offer them. Meals can be filling and busy, so a resident may drink little while eating. Offering fluids between meals, in small amounts and often, makes drinking easier and helps prevent dehydration. This also lets the aide observe how much the client drinks and report intake to the nurse, which stays within CNA scope of practice.

A) Limit the variety of fluids

Restricting choices can make drinking less appealing. Many clients drink more when they can pick from familiar or preferred options, so narrowing the variety works against the goal of encouraging fluids.

B) Remove the water pitcher

Taking away the water pitcher removes an easy, visible source of fluids. Keeping water within reach supports independence and reminds clients to drink, so removing it does not fit a plan that encourages fluids.

D) Provide room temperature fluids

Room temperature fluids may suit some clients, but temperature is a personal preference and not a general rule. Some clients prefer cool drinks, and forcing one temperature can reduce how much they drink.

Conclusion

For a client whose care plan encourages fluids, frequent offers between meals are the most reliable approach. Focus on making fluids easy to accept, and remember that choice and availability support intake better than restriction.

2. If a resident starts to fall while walking you should:

A. step out of way

B. let her fall to floor

C. ease yourself down with her

D. try to catch her upright

Answer: C. ease yourself down with her

When a resident begins to fall while walking, ease yourself down with her to control the descent and protect her from injury.

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Falls happen fast, and the safest response is to lower the resident to the floor in a controlled way rather than letting her drop or trying to hold her upright. By easing down with her, you stay close, guide her body down, and protect her head and hips from a hard impact. This approach also protects you from a back or shoulder injury, since catching or holding a falling adult upright puts enormous strain on the aide. After the fall, stay with the resident, check for injury, and call for help according to facility policy.

A) Step out of the way

Moving aside leaves the resident with no support at all and increases the chance of a hard, uncontrolled landing. It may seem like the safe choice for your own body, but abandoning the resident during a fall is not acceptable care.

B) Let her fall to the floor

Simply letting go allows a full-force impact that can cause fractures, head injury, or worse. It can feel like the easiest option, but it ignores your duty to protect the resident as much as you safely can.

D) Try to catch her upright

Trying to hold a falling adult upright is a common instinct, but it can injure both of you and often ends with the resident falling anyway from a greater height. Your body is not built to stop a falling adult, and this effort risks serious strain to your back and shoulders.

Conclusion

Remember that the goal during a fall is a controlled descent, not a catch. Easing down with the resident protects her from injury and protects you too, which is the standard of safe CNA practice.

3. A new nurse aide asks another nurse aide about the importance of the care plan. The nurse aide SHOULD tell the new nurse aide that:

A. following the care plan is very important

B. nurse aides are not involved in the care plan

C. the care plan is the same every day

D. the care plan does not work well

Answer: A. following the care plan is very important

Following the care plan is very important because it guides each resident's individualized care and keeps the whole team consistent.

The care plan is the written roadmap for how a resident's needs are met, built from assessments and updated as the resident's condition changes. Nurse aides spend the most direct time with residents, so following the plan keeps care safe, consistent, and matched to each person's needs, and aides also report changes so the plan can be revised. Explaining this to a new aide sets a professional tone and shows that the aide's role is central to good care.

B) Nurse aides are not involved in the care plan

This may seem believable if a new aide thinks planning happens only in meetings with nurses or therapists. In reality, aides carry out most of the daily care in the plan and contribute observations that shape it, so saying they are not involved misrepresents their role and could lead to ignored instructions.

C) The care plan is the same every day

It is tempting to assume routines stay identical, especially when a resident's day looks similar. Care plans are reviewed and revised as needs, preferences, and conditions change, so treating one as fixed could cause an aide to miss updates and provide outdated care.

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D) The care plan does not work well

A new aide might hear complaints about paperwork and assume plans are useless. The plan is a required, practical tool that coordinates care and protects the resident; dismissing it undermines teamwork and could lead to inconsistent or unsafe care.

Conclusion

Remember that the care plan is the shared guide for individualized, consistent care, and nurse aides both follow it and help keep it current by reporting changes.

4. How can a nurse aide get an answer from a client who is unable to speak because of a recent stroke?

A. Insist that the client try to talk and communicate

B. Ask the client to write or use gestures

C. Tell the client to use sign language

D. Wait for the family to visit

Answer: B. Ask the client to write or use gestures

Ask the client to write or use gestures, since this gives a practical way to communicate when speech is lost after a stroke.

A stroke can damage the areas of the brain that control speech, but the client may still understand language and be able to express needs through other means. Offering paper and pen or encouraging simple gestures respects the client's dignity, reduces frustration, and helps the nurse aide meet care needs safely. The nurse aide should stay calm, allow extra time, ask one question at a time, and confirm understanding by repeating back what the client communicates.

A) Insist that the client try to talk

Pushing a client to speak when speech is impaired can cause embarrassment, anxiety, and a sense of failure. This choice may seem well meaning because practice can support recovery, but forcing speech is not a supportive communication strategy for a recent stroke.

C) Tell the client to use sign language

Sign language is a formal system that many people do not know, and a recent stroke may also affect hand and arm control. This option can sound helpful because it is nonverbal, but it assumes skills the client may not have.

D) Wait for the family to visit

Delaying communication until family arrives leaves the client without a way to express needs, pain, or discomfort and can delay care. It may seem reassuring to rely on family who know the client well, but the nurse aide still needs to interact directly with the client during care.

Conclusion

When speech is affected, offer simple alternative methods such as writing or gestures, allow time, and stay patient and respectful. Communication is a basic care need, and the nurse aide should support it directly rather than waiting or demanding speech.

5. A resident with dementia is crying. Which action by the nursing assistant is most appropriate?

A. Send the resident to her room to be alone

B. Tell the resident that she has dementia

C. Call the resident's family to come in

D. Sit with the resident and reminisce

Answer: D. Sit with the resident and reminisce

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Sitting with the resident and reminiscing gives comfort and connection when a resident with dementia is crying.

When a resident with dementia cries, the behavior is often a form of communication showing fear, loneliness, confusion, or an unmet need. Sitting calmly with the resident and using reminiscence gives reassurance through presence and a familiar, low-pressure activity. Reminiscence taps into long-term memories, which tend to stay intact longer in dementia, so it can soothe the resident and help her feel safe and valued. The aide should also check for basic needs such as pain, hunger, toileting, or overstimulation, and stay within the CNA scope by reporting persistent distress to the nurse.

A) Send the resident to her room to be alone

Isolating a distressed resident can increase fear and confusion, and it may be interpreted as punishment. A person with dementia often cannot self-soothe without support, so leaving her alone risks worsening the crying and missing a treatable cause such as pain.

B) Tell the resident that she has dementia

Reminding a resident of her diagnosis does not ease distress and can add confusion or shame, since she may not understand or remember the condition. This response focuses on facts rather than the resident's feelings and does not meet her emotional need in the moment.

C) Call the resident's family to come in

Family support can be helpful, but calling them is not the first or most direct action for the aide and may not be possible right away. The CNA should first offer comfort and assess for unmet needs, then report to the nurse, who decides whether family should be contacted.

Conclusion

For a crying resident with dementia, the best first step is calm, supportive presence such as sitting and reminiscing, along with checking for unmet needs. Choose the response that comforts the resident and stays within CNA scope rather than isolating, correcting, or immediately escalating.

6. How SHOULD a nurse aide protect a client who wanders?

A. Place the client in bed

B. Apply a restraint to the client

C. Confine the client to an activity room

D. Allow the client to walk within a secure area

Answer: D. Allow the client to walk within a secure area

Allowing the client to walk within a secure area keeps the client safe while still honoring the need to move about.

Wandering is often a sign that a client needs activity, stimulation, or simply movement, so the safest approach is to redirect that energy into a supervised, safe space. A secure area lets the client walk freely while staff keep watch, which lowers the risk of falls, getting lost, or entering unsafe zones without taking away the client's independence. The nurse aide should also use other supportive measures, such as regular checks, meaningful activities, and a calm approach, and should report any changes in wandering behavior to the nurse.

A) Place the client in bed

Keeping a client in bed does not address the restlessness that drives wandering and can lead to weakness, pressure injuries, and increased agitation. It may seem like a simple way to keep the client in one place, but it removes activity the client needs and can make the behavior worse once the client gets up.

B) Apply a restraint to the client

Restraints are not a first-line safety measure and require a provider order, specific indications, and close monitoring; using them to manage wandering can cause injury, distress, and loss of dignity. This option may seem appealing because it appears to stop the behavior immediately, but it carries serious risks and falls outside the aide's independent scope.

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C) Confine the client to an activity room

Locking or confining a client in one room restricts freedom and can feel like punishment, increasing agitation and the chance of unsafe attempts to leave. It may look like a controlled setting, but confinement does not meet the client's need for safe movement and can create new safety hazards.

Conclusion

For a client who wanders, the goal is safe mobility rather than restriction. Choose the option that allows supervised walking in a secure area, and remember that restraints and confinement are not appropriate first responses.

7. Physical problems of AIDS include:

A. weight gain + weak immunity

B. poor nutrition + weak immunity

C. weight loss + good skin

D. swelling + weight gain

Answer: B. poor nutrition + weak immunity

Physical problems of AIDS include poor nutrition and weak immunity.

HIV attacks the body's immune system, gradually destroying the white blood cells that fight infection, so the person becomes vulnerable to many illnesses. Because the body is constantly fighting infections and often has trouble absorbing nutrients, appetite drops and food is not used well, leading to poor nutrition and weight loss. These two problems feed into each other: weak immunity makes infections more frequent, and poor nutrition makes it harder for the body to recover. A CNA should watch for signs of poor intake, weight changes, and frequent infections, and report them to the nurse.

A) weight gain + weak immunity

Weak immunity fits, but weight gain does not match the usual picture. This option may tempt you because a person with a chronic illness might seem to be eating more, yet the typical pattern is loss of weight and muscle, not gain.

C) weight loss + good skin

Weight loss is realistic, but good skin is not a reliable feature. AIDS often brings skin problems such as rashes, sores, and infections, so pairing weight loss with healthy skin misrepresents the condition.

D) swelling + weight gain

Swelling and weight gain are not the hallmark physical problems of AIDS. Some swelling can occur with certain complications, but it is not the main pattern, and weight gain goes against the usual course of the illness.

Conclusion

Remember that AIDS weakens immunity and undermines nutrition at the same time, so poor nutrition plus weak immunity is the best answer. When a question lists physical problems, choose the pair that matches the disease process rather than one plausible word mixed with an unlikely one.

8. A resident with ~6 months to live may be placed in:

A. hospice care

B. subacute care

C. rehabilitative care

D. skilled care

Answer: A. hospice care

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Hospice care is the appropriate placement for a resident with about six months to live, focusing on comfort and quality of life rather than cure.

Hospice is designed for people with a terminal illness and a life expectancy of roughly six months or less. The goal shifts from curing disease to comfort, dignity, and symptom management, with support for both the resident and family. As a CNA, you would provide gentle personal care, help with pain and comfort measures, and offer emotional presence within your scope of practice.

B) Subacute care

Subacute care is short-term, intensive treatment for a person recovering from an acute illness or surgery who is expected to improve. It may sound similar because it happens in a care facility, but it is aimed at recovery and discharge, not end-of-life comfort.

C) Rehabilitative care

Rehabilitative care helps a resident regain function after injury, illness, or surgery, such as through physical or occupational therapy. It is tempting because it also occurs in care settings, but it assumes the person is working toward recovery rather than facing a terminal prognosis.

D) Skilled care

Skilled care provides ongoing medical and nursing services, such as wound care or IV therapy, and can be part of many care plans. It may seem close because hospice often includes skilled nursing, but skilled care alone does not specifically address the comfort-focused, terminal-illness framework that hospice provides.

Conclusion

Remember that hospice equals comfort care for a terminal prognosis of about six months or less. When a question mentions a limited life expectancy and a focus on quality of life, hospice is the answer to look for.

9. A device that restricts body movement is a:

A. physical restraint

B. lap cover

C. over-bed table

D. gait belt

Answer: A. physical restraint

A device that restricts body movement is a physical restraint.

A physical restraint is any device, material, or equipment attached to or near a person's body that limits their freedom of movement or their ability to reach their own body. Common examples include vest restraints, wrist straps, and lap belts used to keep a resident from rising. CNAs must recognize these devices because restraints require a doctor's order, careful monitoring, frequent release checks, and documentation, and they must never be applied as punishment or for staff convenience. Knowing what counts as a restraint helps you protect resident rights and safety.

B) lap cover

A lap cover, such as a lap blanket or tray cover, is used for warmth, privacy, or to hold items and does not attach to the body or limit movement. It can look similar to a lap belt at a glance, which may make it tempting, but it does not restrict the resident's ability to move.

C) over-bed table

An over-bed table is a piece of furniture used for meals, reading, and grooming. It is positioned near the bed and is not attached to the resident, so it does not restrict body movement. Its name may suggest it holds someone in place, but it is simply equipment for comfort and daily care.

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D) gait belt

A gait belt is a safety device worn around the waist to help a CNA support a resident during transfers and walking. It assists movement rather than limiting it, so it does not meet the definition of a restraint. Because it is strapped around the body, it can seem similar, but its purpose is to promote safe mobility.

Conclusion

Remember that a restraint is defined by its effect: it limits a person's freedom of movement or access to their own body. Devices that assist, comfort, or support mobility are not restraints, and recognizing the difference keeps you within CNA scope of practice and protects resident rights.

10. A cause of constipation is:

A. increased fluids

B. high-fiber diet

C. certain medications

D. increased activity

Answer: C. certain medications

Certain medications are a common cause of constipation.

Many medications slow the movement of the intestines or draw fluid out of the stool, making bowel movements harder and less frequent. This is why CNAs should note and report changes in a resident's bowel habits, especially when a new medication has been started, so the care team can address the problem. Knowing which factors help and which factors harm bowel function helps you support residents and communicate useful observations to the nurse.

A) increased fluids

Drinking more fluids usually softens stool and supports regular bowel movements, so it works against constipation rather than causing it. It can seem helpful to think of any fluid change as a possible problem, but adequate hydration is a preventive measure.

B) high-fiber diet

Fiber adds bulk and helps move stool through the intestines, which is why it is recommended to prevent constipation. It may seem related because fiber affects the stool, but its effect is to promote regularity, not cause constipation.

D) increased activity

Physical activity stimulates the muscles of the digestive tract and helps keep bowels moving normally. It can seem reasonable to link activity to body changes, but more movement generally reduces the risk of constipation.

Conclusion

Remember that fluids, fiber, and activity all help prevent constipation, while certain medications can cause it. Watch for changes in bowel patterns and report them promptly to the nurse.

11. Catheter bag urine output unchanged all shift. You should:

A. raise the bag above hips

B. place bag on floor

C. irrigate catheter with water

D. notify the charge nurse

Answer: D. notify the charge nurse

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When the catheter bag shows no change in urine output all shift, notify the charge nurse.

A sudden lack of urine output is a change in the resident's condition that needs to be reported right away. The charge nurse can assess the resident, check the tubing for kinks or blockage, and determine whether the catheter needs attention or the resident needs further evaluation. Your role as a CNA is to observe, report, and document accurately, not to fix catheter problems yourself.

A) Raise the bag above hips

Raising the drainage bag above the level of the bladder lets urine flow backward into the bladder, which can introduce bacteria and cause infection. This option may seem helpful because it appears to encourage drainage, but it actually works against the way a closed drainage system is designed to work.

B) Place bag on floor

The floor is contaminated with germs, and placing the bag there raises the risk of infection. It may seem like a simple way to get urine moving, but it does not address the real concern of no output and creates a new infection risk.

C) Irrigate catheter with water

Irrigation is a sterile procedure outside the CNA scope of practice and must be ordered and performed by licensed staff. It may seem like a direct way to clear a blockage, but doing it yourself can cause injury or infection and delays proper evaluation.

Conclusion

Report changes in urine output to the charge nurse promptly and keep the drainage bag below the level of the bladder and off the floor. Remember that observing and reporting are core CNA duties, while catheter irrigation and troubleshooting belong to licensed staff.

12. When speaking to a resident with a hearing aid you should:

A. face resident & speak slowly

B. turn sideways

C. use long sentences

D. shout into aided ear

Answer: A. face resident & speak slowly

Face the resident and speak slowly so they can see your mouth and follow your speech.

Residents with hearing aids rely on both amplified sound and visual cues like lip reading and facial expressions. Facing the resident directly lets them see your mouth and pick up visual cues, and speaking slowly gives them time to process each word. Keep your voice at a normal volume, reduce background noise, and check that the hearing aid is on and working before you begin.

B) Turn sideways

Turning away hides your face and mouth, so the resident loses lip-reading cues and the sound of your voice travels away from them. It may feel less intense or less awkward to look away, but it makes understanding harder, not easier.

C) Use long sentences

Long sentences carry more words to process and more chances to miss a key word, which is tiring for someone with hearing loss. Short, simple sentences are easier to follow. Longer sentences can seem more polite or complete, but they add to the listening burden.

D) Shout into the aided ear

Shouting sends loud, distorted sound into the hearing aid, which can be uncomfortable or painful and can make speech harder to understand. Speaking at a normal volume while facing the resident works better. Shouting feels like a natural response to hearing loss, but it does not help and may startle or upset the resident.

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Conclusion

For a resident with a hearing aid, face them, speak slowly and clearly at a normal volume, and use short sentences. Avoid turning away, using long sentences, or shouting, and remember to check that the hearing aid is working.

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