CNA SKILLS TEST QUICK-CHECK

All 20 skills + Handwashing + Indirect Care · Built on the Prometric checklist used in CT

SIDE 1 · SKILLS TEST
Damon C. Davis Sr., RN

5 skills scored
Handwashing (once, at the start) + Indirect Care (all through) + 3 assigned

Pass all 5
Fail one skill and you retake the skills test

31–40 min
Total time depends on your 3 skills. Announced at the start

Handwashing
Not prompted. Wash first, before anyone tells you

Self-correct
Tell the NAE, then do it. Not after the skill ends; never for a safety error

★ **Key scored checkpoint or safety rule** · **Supplies:** look during orientation; collect only after your test begins · A–T = skill letters in the CT bulletin · Evaluator = NAE (Nurse Aide Evaluator)

INDIRECT CARE — SCORED IN EVERY SKILL

OPEN EVERY SKILL

1. Knock. Greet by name. Say your name and title.
2. Explain the care *before* and *as* you do it.
3. Ask preferences (which arm, how warm).
4. **Privacy: close curtain, keep body covered.** ★
5. Clean hands. Gloves for any body fluid.

CLOSE EVERY SKILL

1. **Bed low, wheels locked.** ★
2. **Call light within reach.** ★
3. Rails per care plan (not graded on the test).
4. Ask, "Are you comfortable? Need anything?"
5. Linen in hamper, trash out, table dry. Clean hands.

Throughout every skill: safe distance from the bed edge, gentle movement, Standard Precautions.

HANDWASHING — ALWAYS SCORED · NOT PROMPTED

SUPPLIES sink, soap, paper towels, trash can

1. Wet hands and wrists. Apply soap.
2. Lather palms, backs, between fingers, around cuticles, under nails, and wrists.
3. **Scrub with friction at least 20 seconds. Counting out loud helps.** ★
4. Rinse hands and wrists, fingertips pointing down.
5. Dry with a clean paper towel. Throw it away.
6. **Turn off faucet with a new dry towel. Clean hands never touch the sink.** ★

Scored once, at the start. Still clean your hands before and after resident contact in every skill.

MEASUREMENTS — H · I · F · G

H RADIAL PULSE

SUPPLIES watch with second hand, Measurement Form, pen

1. Rest the arm so it does not dangle.
2. 2–3 fingertips on the thumb side of the wrist. Never your thumb.
3. **Count one full minute.** ★
4. **Record on the Measurement Form within ±4 beats of the NAE.** ★

Report under 60 or over 100 to the nurse.

F EMPTY URINARY DRAINAGE BAG

SUPPLIES gloves, graduate, paper towel barrier, alcohol wipe, I&O form

1. Gloves on. Graduate on a barrier on the floor.
2. **Open drain. Tip touches nothing: not graduate, not floor.** ★
3. Close drain, wipe tip, return it to its holder.
4. Graduate on a flat surface with a barrier. Read at eye level.
5. Empty into toilet. Rinse, dry, store graduate.
6. Bag stays below bladder, hung on the bed frame (not the side rail), off the floor.
7. **Gloves off, hands clean, then record on the I&O form within ±50 mL, as urine, with the time.** ★

G FEED A RESIDENT IN A CHAIR

SUPPLIES tray + diet card, spoon, clothing protector, hand wipe, napkin, Food & Fluid Intake form

1. Diet card matches resident and tray.
2. Resident sits upright in the chair.
3. Clean resident's hands. Offer clothing protector.
4. Sit at eye level. Feed with a spoon, small bites.
5. **Wait for each swallow. Offer fluid every 2–3 bites.** ★
6. Talk with the resident. Wipe mouth as needed.
7. **Record food (%) and fluid (mL), each within 25% of the NAE.** ★

Coughing or pocketing food: stop and tell the nurse. Can't breathe or speak: call for help now.

I RESPIRATIONS

SUPPLIES watch with second hand, Measurement Form, pen

1. Keep fingers on the wrist as if still taking the pulse.
2. **Never tell the resident how to breathe.** ★
3. One rise + one fall of the chest = 1 breath.
4. **Count one full minute. Record within ±2 breaths.** ★

Report under 12 or over 20, or labored breathing.

MOVING & POSITIONING — T · A · D · C · Q · R · S

T TRANSFER: BED TO WHEELCHAIR (PIVOT)

SUPPLIES wheelchair, gait/transfer belt, nonskid shoes

1. Chair beside bed on the stronger side. Footrests swung away.
2. Bed low, bed wheels locked. Nonskid shoes on.
3. Help to sit at edge (never pull arms). Pause; ask about dizziness. Feet flat.
4. **Lock wheelchair brakes before standing.** ★
5. **Belt at waist over clothing, clear of breasts and skin folds; flat fingers fit under.** ★
6. Cue: "On three, we stand." Grip belt at sides/back.
7. Brace their knees with yours. Bend your knees, not back.
8. Pivot together; resident takes no steps. Stop when legs touch the seat.
9. Lower gently. Hips to back of seat, feet on footrests. Remove belt.

A AMBULATE WITH GAIT BELT

SUPPLIES gait/transfer belt, nonskid shoes, chair at the finish

1. Bed low, wheels locked, nonskid shoes on.
2. Sit at edge, feet flat; ask about dizziness.
3. **Belt at waist over clothing, clear of skin folds; flat fingers fit under.** ★
4. Cue, then stand them, gripping belt at sides/back.
5. Walk slightly behind, on the weaker side, hand on belt.
6. **Walk at least 10 steps. Ask how they feel.** ★
7. Turn until backs of legs touch the chair. Lower gently.
8. Remove belt. Hips back in the seat.

C CHANGE AN OCCUPIED BED

SUPPLIES bottom sheet, top sheet, pillowcase, hamper (clean linen never on floor)

1. **Wheels locked. Far side protected (rail up, or a helper) before you roll the resident away.** ★
2. Roll resident away; roll dirty sheet to their back.
3. Clean sheet on your half; tuck at head and side.
4. Roll resident over the hump; pull dirty sheet out.
5. **Resident always lies on a bottom sheet.** ★
6. Pull clean sheet through: smooth, no wrinkles. Don't drag skin.
7. Dirty linen held away from uniform. Never shake it.
8. Top sheet to shoulders; tucked loosely at the foot (toe room); sides untucked.
9. Pillow stays under head except to change the case.

Q·R·S PASSIVE RANGE OF MOTION

SUPPLIES none · **RULES FOR ALL ROM**

- Only the named joint, only the named side.
- Support the limb above and below the joint.
- **Each movement 3 times. Slow, smooth, never forced.** ★
- **Ask about pain. Stop if it hurts.** ★

SKILL	MOVEMENTS (3 EACH)
R · Shoulder	Arm up toward head of bed, then down. Arm out from side, then back.
Q · Elbow, wrist	Bend and straighten elbow. Bend wrist down, then back.
S · Hip, knee, ankle	Bend hip and knee toward chest, return; heel never drags. Foot up toward head, then down.

D SUPPORTED SIDE-LYING POSITION

SUPPLIES 4 pillows or positioning devices

1. Wheels locked. Bed flat if allowed.
2. **Turn first, then place pillows. Never near the edge.** ★
3. Pillow rolled and tucked against the back.
4. Upper knee bent, in front of the lower leg.
5. Pillow between legs; knees and ankles do not touch.
6. **Not lying on the lower arm, shoulder, or hand.** ★
7. Head pillow supports neck and chin. Pillow under upper arm.

PERSONAL CARE — N · J · P · B (E ON SIDE 2)

N PERINEAL CARE (FEMALE)

SUPPLIES gloves, basin, soap, 4+ washcloths, towel, bath blanket, clean underpad

1. **Water checked on your inner wrist; resident agrees it's comfortable.** ★
2. Gloves on. Remove soiled pad; place a protective pad under hips.
3. Soapy cloth: inside labia, genitals, groin folds.
4. **Front to back, a clean spot of cloth for every stroke.** ★
5. Rinse with a soap-free cloth, front to back. Pat dry.
6. Change water if it turns cool or soapy.
7. Turn to side: wash, rinse, dry buttocks and rectal area, front to back.
8. Remove wet pad. Leave resident on a clean, dry underpad.

J CATHETER CARE (FEMALE)

SUPPLIES gloves, basin, soap, washcloths, towel, underpad, bath blanket

1. Water temperature checked; underpad under hips.
2. Clean inside labia front to back, clean spot each stroke.
3. **Hold catheter near the body so it never pulls.** ★
4. **Clean 3–4 inches of tubing, moving away from the body.** ★
5. Rinse with a clean, soap-free cloth, new area each stroke, same direction. Dry.
6. Bag below bladder, off floor. Tubing free of kinks.

P PARTIAL BED BATH & BACK RUB

SUPPLIES basin, soap, washcloths, 2 towels, bath blanket, lotion, clean gown

1. **Water temperature checked by you and the resident.** ★
2. Eyes first, no soap: inner to outer corner, a clean cloth area for every stroke.
3. Face without soap (unless preferred). Pat dry.
4. Uncover only the part you wash. Washcloth folded into a mitt; towel under each part.
5. Wash, rinse, dry: neck, arm, hand, underarm, chest, abdomen. Support the arm.
6. Change water when cool or soapy.
7. Turn to side. Wash, rinse, dry back.
8. Warm lotion; long gliding and circular strokes.
9. Clean gown, tied in back.

B ASSIST WITH A BEDPAN

SUPPLIES bedpan, gloves, underpad, toilet paper, hand wipe

1. Gloves on. Underpad under hips.
2. Resident rolls to side or lifts hips. Never push the pan.
3. **Standard pan: wide end under buttocks. Fracture pan: narrow end under.** ★
4. Raise head of bed once on pan. Toilet paper + call light in reach.
5. Lower head of bed before removing. Hold pan steady.
6. Note urine/stool; measure if on I&O. Empty, rinse into toilet, dry, store.
7. Offer hand wipe. Remove underpad.

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Study aid only. Your state's current Candidate Information Bulletin and Prometric Clinical Skills Checklist are the final word. Follow facility policy and the care plan.

SKILLS, CONT. + TEST-DAY REFERENCE

Last 5 skills · Written-test essentials · Ranges · Safety · Test-day checklist

SIDE 2 · SKILLS + WRITTEN
Read it the morning of. Leave it in the car.

60 questions
Multiple choice, 90 minutes

Oral option
Request it on your application. Not on test day

Arrive 30 min
Late? You may be turned away and lose your fee

2 IDs
Both valid and signed. One current government photo ID; name matches exactly

Not allowed
Phones, bags, notes, study materials

PERSONAL CARE, CONTINUED — E

E DRESS A RESIDENT WITH A WEAK ARM

SUPPLIES 2 outfit choices, shirt with sleeves, pants, socks

1. Let the resident choose. Gather all clothes before the gown comes off.
2. Gown off the strong arm first, then the weak arm.
3. **Weak arm in first. Gather sleeve; ease it over the hand.** ★
4. Support the weak arm. Never force or overextend.
5. Pants and socks on. Front faces front; fasten and straighten.

Memory hook: weak in first, out last.

GROOMING — M · L · O · K

M MOUTH CARE (TEETH)

SUPPLIES gloves, toothbrush, toothpaste, cup of water, emesis basin, towel

1. **Sit resident upright, 60–90°, before any fluid or brushing.** ★
2. Towel or protector over chest. Gloves on.
3. Wet brush, add toothpaste.
4. Brush all surfaces and the gum line gently. Brush tongue.
5. Offer water to rinse; basin to spit. Mouth clean and dry.

L MOUTH CARE (DENTURES)

SUPPLIES gloves, denture cup, denture brush + paste, towel, foam swabs, cup of water, emesis basin

1. **Line the sink with a towel or water, or hold over a basin.** ★
2. **Cool or lukewarm running water. Never hot.** ★
3. Brush every surface. Rinse.
4. Store in a labeled cup with cool water.
5. Protect clothing. Clean gums and tongue with a moist foam swab. Offer rinse; mouth left clean and dry.

O HAND & NAIL CARE

SUPPLIES basin, washcloth, towel, orangewood stick, emery board, lotion

1. **Water temperature checked. Soak the hand.** ★
2. Wash all surfaces, including between fingers.
3. **Flat edge of orangewood stick under nails. Wipe it between nails.** ★
4. Rest hand on a towel. Dry well, between fingers too.
5. File smooth with emery board. Never cut nails.
6. Warm lotion; wipe off excess. Support the arm.

K FOOT CARE (RESIDENT IN CHAIR)

SUPPLIES basin, floor barrier, soap, washcloth, towel, lotion, clean sock

1. Basin on a barrier on the floor. Water temperature checked.
2. Support the leg. Soak foot. Soap goes on the cloth, not in the basin.
3. Wash top, bottom, and between toes. Rinse.
4. Dry well, especially between the toes.
5. **Warm lotion in your hands. Top and bottom only, never between toes. Wipe excess.** ★
6. **Sock and shoe on. Bare foot never touches the floor.** ★

Never cut toenails. Report cracks, sores, or color changes.

THE 4-STEP FRAMEWORK — WHEN YOU'RE UNSURE

1. **Safety:** which answer keeps the resident SAFEST?
2. **Rights:** which answer RESPECTS dignity and choice?
3. **Procedure:** which follows the care plan, not personal judgment?
4. **Report:** does this need the NURSE? CNAs observe and report; they don't diagnose.

Still stuck? Pick the answer that protects the resident. Be wary of "always" and "never," and of answers where the CNA acts outside their role.

CONVERSIONS & I&O MATH

- 1 oz = **30 mL**
- 8 oz cup = **240 mL**
- 1 tsp = **5 mL** · 1 Tbsp = **15 mL**
- 1,000 mL = 1 L
- 1 kg = **2.2 lb**
- 1 inch = 2.54 cm
- **Intake:** all fluids, soup, gelatin, ice cream; ice chips count as half
- **Output:** urine, emesis, drainage, liquid stool

24-hour clock: from 1:00 pm on, add 12. 12:30 pm = 1230 · 1:00 pm = 1300 · 6:30 pm = 1830 · midnight = 0000 (or 2400).

POSITIONS

Supine	flat on back
Prone	on stomach
Lateral	on side, supported with pillows
Sims'	left side, top knee bent toward chest (enemas)
Semi-Fowler's	head of bed 30–45°
Fowler's	45–60°
High Fowler's	60–90° (eating, breathing trouble)

Keep residents upright at least 30 minutes after meals.

REPORT TO THE NURSE RIGHT AWAY

- Chest pain, trouble breathing, choking
- **Stroke (F.A.S.T.):** Face droop, Arm weakness, Speech trouble, Time: get help now and note when it started
- Any fall, injury, or bruise, even if they say they're fine
- Vital signs outside care-plan limits, or a big change
- Open skin, new swelling; blood in urine, stool, or vomit
- Refusal of food, fluid, or care
- Any sign or report of abuse or neglect

INFECTION CONTROL

- **Hand hygiene** is the #1 way to stop infection.
- **Standard Precautions:** treat all blood and body fluids as infectious, for every resident.
- Work clean to dirty. Hold linen away from your uniform.

PPE ON	PPE OFF
1 Gown	1 Gloves
2 Mask	2 Goggles / shield
3 Goggles / shield	3 Gown
4 Gloves	4 Mask, then wash hands

Hands contaminated while removing PPE? Clean them right away.

Contact	gown + gloves (C. diff: soap and water preferred)
Droplet	mask on entering the room (flu)
Airborne	N95, door closed (TB)

RESIDENT RIGHTS & ABUSE

- Privacy, dignity, choice, and confidentiality (HIPAA).
- The right to **refuse** care: respect it, then report it.
- Keep personal belongings; voice complaints without fear.
- **Abuse:** physical, verbal, emotional, sexual, financial, neglect, involuntary seclusion.
- **CNAs are mandated reporters. Report suspected abuse to the nurse immediately. CT law also requires a state report; follow facility policy.** ★

COMMUNICATION

- **Hearing loss:** face them, speak clearly in a lower pitch; don't shout.
- **Vision loss:** say who you are; describe food by clock position.
- **Dementia:** short sentences, one step at a time; don't argue, redirect.
- **Aphasia:** yes/no questions, picture boards, patience.

NORMAL ADULT RANGES

MEASURE	NORMAL	TELL THE NURSE
Pulse	60–100 /min	under 60, over 100, irregular
Respirations	12–20 /min	under 12, over 20, labored
Temp (oral)	97.6–99.6 °F	outside range
Blood pressure	under 120/80	top 140+ or bottom 90+; or under 90/60
Oxygen (SpO_2)	95–100%	below 95% or care-plan limit
Urine output	about 1,500 mL/day	under 30 mL/hr; dark, bloody

Axillary reads about 1 °F lower than oral; rectal about 1 °F higher.

SAFETY & EMERGENCIES

- **Falling:** don't catch. Ease to the floor, protect the head, call for help. Don't move them until the nurse checks.
- **Choking** (can't speak or cough): call for help; back blows and abdominal thrusts as your CPR training teaches. Unresponsive: start CPR.
- **Fire RACE:** Rescue, Alarm, Contain, Extinguish/Evacuate.
- **Extinguisher PASS:** Pull, Aim, Squeeze, Sweep.
- **Restraints:** never for discipline or convenience; only with an order. Check every 15 min; release every 2 hours.
- **Body mechanics:** wide stance, bend knees, load close, turn your feet. Don't twist.

SKIN & PRESSURE INJURIES

- Reposition at least every 2 hours in bed, every hour in a chair. Keep skin clean and dry. Lift, don't drag.
- **Never rub a red area. Report redness that doesn't fade.** ★

ABBREVIATIONS

ADL	activities of daily living	**PRN**	as needed
NPO	nothing by mouth	**q2h**	every 2 hours
I&O	intake and output	**BID / TID**	2 / 3 times a day
HOB	head of bed	**amb**	ambulate
ROM	range of motion	**VS**	vital signs

4 SKILLS-TEST INSIDER TIPS

1. **Talk as you work.** Say each step out loud. The NAE can't score what they can't see or hear.
2. **The "Are you sure?" check.** When doubt hits, one breath: did I do that step? If not, say "I need to go back and complete a step," then do it.
3. **Gather smart.** Look for supplies during orientation; collect them once your test begins.
4. **The foot-of-the-bed pause.** When you think you're done, stand at the foot of the bed for 10–15 seconds and scan: bed low, wheels locked, call light, rails, resident comfortable.

NIGHT BEFORE & MORNING OF

- ☐ Admission letter
- ☐ Both IDs signed ahead of time
- ☐ Watch with a second hand
- ☐ Flat, nonskid, closed-toe shoes
- ☐ Scrubs (suggested)
- ☐ Hair tied back, nails short
- Eat a light, familiar meal
- Plan for traffic and parking
- Use the restroom before check-in
- Walk each skill through in your mind
- Mind goes blank? One slow breath. Your training will catch up.

REMEMBER WHY YOU'RE HERE

You said you wanted to help people. That is your difference. Not everyone in healthcare brings that. You do. Now go prove it.

— Damon C. Davis Sr., RN

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Sources (checked Nov 2026): Prometric Clinical Skills Test Checklist (2018) and General Instructions; CT CNA Candidate Information Bulletin (rev. 08/2019), prometric.com/exams/nurseaide-ct. Ranges are general adult guidelines; follow the care plan.

Practice free on your phone
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No sign-up · Side 2 of 2