CNA Exam AZ Practice Test

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1. A CNA observes that a resident ate about half of lunch. What is the best documentation practice?

A. Record the objective amount eaten according to facility procedure

B. Record that the resident has an eating disorder

C. Record that the resident will lose weight

D. Record that the resident was uncooperative

Answer: A. Record the objective amount eaten according to facility procedure

Record the objective amount eaten according to facility procedure.

Documenting the objective amount eaten, such as "ate about half of lunch," follows facility procedure and provides clear, factual information for the care team. This approach supports accurate monitoring of the resident's nutritional intake and helps identify any changes in appetite or eating habits. Objective documentation is essential for continuity of care and allows other staff to make informed decisions.

B) Record that the resident has an eating disorder

A CNA is not qualified to diagnose an eating disorder, and documenting such a label is inappropriate and outside the scope of practice. This option may seem tempting because it attempts to explain the behavior, but it is speculative and not based on objective observation.

C) Record that the resident will lose weight

Predicting future weight loss is not a factual observation and falls outside the CNA's role. Documentation should reflect what is observed, not assumptions about outcomes. This option might appear helpful, but it introduces speculation that could be misleading.

D) Record that the resident was uncooperative

Labeling a resident as uncooperative is subjective and judgmental, and it does not provide useful clinical information. This option may be chosen if the CNA feels frustrated, but it is not objective and can negatively impact the resident's care. Documentation should always be factual and respectful.

Conclusion

Always document objective, measurable observations according to facility policy. Avoid subjective labels or predictions, as they can compromise care and are outside the CNA's scope. Accurate documentation is key to supporting resident health and teamwork.

2. A resident who normally walks independently suddenly becomes weak and unsteady. What should the CNA do?

A. Tell the resident to walk faster

B. Provide appropriate assistance to reduce fall risk and report the change to the nurse

C. Leave the resident standing while obtaining supplies

D. Ignore the change because the resident normally walks independently

Answer: B. Provide appropriate assistance to reduce fall risk and report the change to the nurse

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A sudden change from steady independent walking to weakness and unsteadiness is a warning sign of a new problem, such as illness, medication effects, low blood sugar, or dehydration. The CNA's first job is to keep the resident safe right now by staying close, offering a hand, a gait belt, or a wheelchair as needed, and helping the resident sit down if they seem unstable. Then the change must be reported to the nurse promptly, because only the nurse can assess the cause and decide on further care. Sudden functional decline is not something to wait out or work around.

A) Tell the resident to walk faster

Urging a weak, unsteady resident to hurry increases the chance of a fall and does nothing to address the underlying problem. It may seem like a way to get the resident moving, but speed is the opposite of what an unstable walker needs.

C) Leave the resident standing while obtaining supplies

Leaving an unsteady resident standing alone removes the support and supervision that prevent a fall. It might feel efficient to grab supplies first, but the resident's safety must come before any task.

D) Ignore the change because the resident normally walks independently

Past independence does not cancel out a new, sudden change in condition. Assuming the resident is fine because they usually are can delay needed care and lead to a serious fall or missed illness.

Conclusion

When a resident's ability to walk changes suddenly, protect them from falling first and report the change to the nurse right away. Safety and prompt reporting are always the priority over speed, convenience, or assumptions based on the resident's usual habits.

3. During a transfer, a resident begins to lose balance. What should the CNA do?

A. Pull the resident upward by the arms

B. Use trained transfer techniques to guide the resident safely and obtain assistance as needed

C. Run away to get equipment

D. Tell the resident to regain balance independently

Answer: B. Use trained transfer techniques to guide the resident safely and obtain assistance as needed

During a transfer, when a resident begins to lose balance, the CNA should use trained transfer techniques to guide the resident safely and obtain assistance as needed.

Safety during transfers depends on staying calm and using the body mechanics and transfer methods learned in training. When a resident starts to lose balance, the CNA keeps a firm, supportive hold on the gait belt or approved grip, lowers the resident toward the nearest safe surface such as the bed or chair, and calls for help from coworkers rather than trying to manage the situation alone. This protects both the resident from a fall and the CNA from injury, and it stays within the CNA's scope of practice.

A) Pull the resident upward by the arms

Pulling a resident up by the arms can injure the resident's shoulders and skin and can throw both people off balance, making a fall more likely. It may seem like a quick way to stop the fall, but it is not a safe or trained technique.

C) Run away to get equipment

Leaving the resident alone while they are losing balance removes the support they need at the most dangerous moment and increases the risk of a fall. Getting help is important, but it should be done by calling out or using a call system while staying with the resident.

D) Tell the resident to regain balance independently

A resident who is already losing balance usually cannot recover without physical support, and expecting them to do so ignores the CNA's duty to protect them. This approach may seem respectful of independence, but it leaves the resident at high risk for a fall.

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Conclusion

When balance is lost during a transfer, the safest response is to use trained transfer techniques to support and lower the resident while getting help. Remember that the CNA's role is to protect the resident and themselves, never to pull on arms or leave the resident unsupported.

4. A CNA is wearing gloves while providing personal care. Which practice is correct?

A. Wash and reuse disposable gloves

B. Remove gloves without contaminating bare hands and perform hand hygiene

C. Touch clean supplies with contaminated gloves

D. Wear the same gloves from one resident to another

Answer: B. Remove gloves without contaminating bare hands and perform hand hygiene

Removing gloves without contaminating bare hands and performing hand hygiene afterward is the correct practice.

Gloves are a barrier that protects the CNA and the resident during care, but they do not replace hand hygiene. When care is finished, the CNA should take the gloves off in a way that keeps the outside of the gloves from touching bare skin, dispose of them properly, and then wash hands or use an alcohol-based hand rub. This order matters because gloves can pick up germs during care, and any tiny break or splash during removal can expose the hands. Cleaning hands after glove removal removes anything that slipped through and protects the next person the CNA touches.

A) Wash and reuse disposable gloves

Disposable gloves are made for one use and are not designed to be washed and worn again. Washing them can damage the material, create tiny tears, and leave germs behind, so the barrier no longer works as it should. This option can seem appealing as a way to save supplies, but reusing disposable gloves raises the risk of spreading infection.

C) Touch clean supplies with contaminated gloves

Gloves that have touched a resident, body fluids, or soiled items are contaminated. If those gloves touch clean supplies, the supplies become contaminated and can spread germs to the next resident or to the CNA. This choice may seem harmless when supplies look clean, but germs are invisible, so clean items must be handled with clean or gloved hands that have not been contaminated.

D) Wear the same gloves from one resident to another

Gloves become contaminated during care and can carry germs from one resident to the next. Wearing the same pair between residents spreads infection directly, even if the gloves look clean. This option may seem efficient when care is quick, but each resident needs a fresh pair of gloves along with hand hygiene between residents.

Conclusion

For test-takers, remember that gloves protect during care, but hand hygiene after safe removal is what stops germs from spreading. Disposable gloves are used once, changed between residents, and never used to handle clean supplies after contamination.

5. A resident asks the CNA to keep a necessary care observation secret from the nurse. What should the CNA do?

A. Promise never to tell anyone

B. Explain that necessary information must be communicated to the appropriate care team member

C. Tell other residents instead

D. Ignore the observation

Answer: B. Explain that necessary information must be communicated to the appropriate care team member

The CNA should explain that necessary care information must be shared with the appropriate care team member.

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CNAs are part of the care team, and observations that affect a resident's health, safety, or care plan must be reported to the nurse. When a resident asks for secrecy, the aide can respond kindly and honestly, acknowledging the resident's feelings while explaining that some information has to be passed along so the resident stays safe and receives proper care. This keeps trust intact and follows the CNA's duty to report.

A) Promise never to tell anyone

Agreeing to secrecy may feel like the kind and supportive choice in the moment, but it puts the resident at risk and places the aide outside the care team's communication loop. A promise like this can also damage trust later when the information must be shared anyway.

C) Tell other residents instead

Sharing a resident's care information with other residents violates privacy and confidentiality and does nothing to help the resident's care. It may seem like a way to avoid telling the nurse, but it spreads private information to people who have no role in care.

D) Ignore the observation

Ignoring what was observed leaves the nurse without information needed to assess and respond to the resident's needs. It may feel like a way to honor the request for secrecy, but silence can allow a health or safety problem to go unnoticed.

Conclusion

Respecting a resident's privacy does not mean withholding necessary care information. The CNA should respond with empathy, explain the limits of confidentiality in care settings, and report relevant observations to the nurse.

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