CNA Georgia Test

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1. A CNA enters a residents room and finds the residents spouse reading the residents medical chart. What should the CNA do?

A. Allow the spouse to continue since they are family

B. Ask the spouse to step out and report the privacy breach to the nurse

C. Take the chart away and scold the spouse

D. Ignore the situation to avoid conflict

Answer: B. Ask the spouse to step out and report the privacy breach to the nurse

The CNA should ask the spouse to step out and report the privacy breach to the nurse.

Residents have a legal right to privacy of their medical information, and a chart is a confidential record. Even a spouse or close family member does not automatically have permission to read it; access is controlled by the resident's consent and facility policy. The CNA's role is to protect the chart, politely ask the visitor to step out, and notify the nurse so the situation can be handled appropriately. This keeps the CNA within scope of practice and preserves the resident's dignity and trust.

A) Allow the spouse to continue since they are family

Family relationships do not automatically grant access to a medical record. It may feel kind or awkward to intervene with a spouse, but letting the chart be read risks a privacy violation and could harm the resident's trust in the care team.

C) Take the chart away and scold the spouse

Removing the chart is reasonable, but scolding is confrontational and unprofessional. The CNA should stay calm and respectful, then involve the nurse rather than discipline a visitor.

D) Ignore the situation to avoid conflict

Avoiding conflict may seem easier in the moment, but ignoring a privacy breach fails to protect the resident's rights. The CNA has a duty to act and report, not to look the other way.

Conclusion

Protecting resident privacy means acting politely but promptly: ask the visitor to step out and report the breach to the nurse. Remember that family status alone does not equal authorization to view a medical chart.

2. A Georgia nurse aide is documenting care. Which entry is appropriate?

A. Resident seemed sad today

B. Resident refused lunch at 12:15 PM

C. Resident was being difficult about bathing

D. Resident probably has a fever

Answer: B. Resident refused lunch at 12:15 PM

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Documenting that the resident refused lunch at 12:15 PM is the appropriate entry because it states an objective, measurable fact with a specific time.

Good documentation in a Georgia nurse aide's charting is factual, specific, and objective. Recording exactly what happened and when it happened, such as a refusal of lunch at a precise time, gives the care team clear information they can act on. Subjective opinions, guesses about diagnoses, and judgmental labels do not belong in the medical record because they can be inaccurate, unfair to the resident, and legally risky.

A) Resident seemed sad today

This entry describes an impression rather than an observable fact, and it lacks specifics about what the aide actually saw or heard. It may feel caring to note a resident's mood, but charting should describe concrete behaviors, such as crying or declining activities, along with the time. Vague emotional labels can be misinterpreted and are not useful for tracking changes in the resident's condition.

C) Resident was being difficult about bathing

Calling a resident difficult is a judgmental label that reflects the aide's frustration rather than the resident's actual behavior. This kind of wording can bias other caregivers and could be seen as disrespectful or unprofessional in a legal record. A better approach would describe exactly what occurred, such as the resident pulling away or saying no to the bath, and the time it happened.

D) Resident probably has a fever

This entry states a guess about a medical condition instead of reporting a measurement. Nurse aides are not responsible for diagnosing, and words like probably introduce uncertainty into the record. The appropriate action is to take the temperature, report the reading to the nurse, and document the actual vital sign and the time it was obtained.

Conclusion

For CNA exam questions on documentation, choose the entry that is objective, specific, and includes a time, and avoid opinions, labels, and diagnostic guesses. This keeps the record accurate and supports safe, respectful care.

3. Which action is an important part of standard precautions when providing direct resident care?

A. Perform hand hygiene at appropriate times

B. Wear gloves for every interaction regardless of the task

C. Reuse disposable gloves when they appear clean

D. Skip hand hygiene when gloves are worn

Answer: A. Perform hand hygiene at appropriate times

Performing hand hygiene at appropriate times is a core element of standard precautions for every resident contact.

Standard precautions treat all blood, body fluids, secretions, and non-intact skin as potentially infectious, so hand hygiene is the single most important step in breaking the chain of infection. CNAs perform hand hygiene before and after resident contact, after removing gloves, after touching contaminated items, and before and after eating or using the restroom. Gloves are a supplement to hand hygiene, not a replacement, and they are worn only when contact with blood, body fluids, or contaminated surfaces is anticipated. Cleaning hands at the right moments protects the resident, the CNA, and other residents from cross-contamination.

B) Gloves for every interaction

Gloves are task-specific and are not needed for routine contact such as taking a pulse, adjusting a pillow, or helping a resident walk. Wearing gloves for every interaction can create a false sense of security, waste supplies, and spread contamination from one surface to another if the gloves are not changed between tasks. This option sounds protective, but it goes beyond what standard precautions require.

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C) Reusing disposable gloves

Disposable gloves are meant for one use and must be discarded after each task or when torn or soiled. Reusing them, even when they look clean, can carry unseen microorganisms from one resident or surface to another. The idea that gloves are fine to reuse if they appear clean is tempting because contamination is often invisible, but appearance is not a reliable sign of safety.

D) Skipping hand hygiene when gloves are worn

Hands can become contaminated while gloves are being removed or if gloves have tiny defects, so hand hygiene is still required after glove removal and at other appropriate times. Gloves do not substitute for clean hands. This option seems efficient, but it leaves the CNA's hands contaminated and increases the risk of spreading infection to residents and staff.

Conclusion

Remember that hand hygiene at the right moments is the foundation of standard precautions, and gloves are used for specific tasks, never reused, and never a substitute for washing or sanitizing your hands.

4. A resident asks the CNA to close the door while the resident is receiving personal care. What should the CNA do?

A. Leave the door open for convenience

B. Close the door when doing so does not conflict with necessary safety requirements

C. Tell the resident that privacy is not part of CNA care

D. Ask another resident to monitor the doorway

Answer: B. Close the door when doing so does not conflict with necessary safety requirements

The CNA should close the door when doing so does not conflict with necessary safety requirements, honoring the resident's request for privacy during personal care.

Resident rights include the right to privacy and dignity during personal care. When a resident asks for the door to be closed, the CNA should respect that request, provided it does not interfere with safety rules such as visual monitoring required for certain residents. Balancing privacy with safety is part of person-centered care, and honoring the request supports trust and dignity.

A) Leave the door open for convenience

Convenience for staff does not outweigh a resident's right to privacy. This choice may seem easier for the CNA's workflow, but it ignores the resident's expressed preference and can make the resident feel exposed or disrespected.

C) Tell the resident that privacy is not part of CNA care

Privacy is a recognized resident right and part of dignified care, so this statement is inaccurate and dismissive. It may seem like a way to avoid a difficult conversation, but it undermines trust and violates the resident's rights.

D) Ask another resident to monitor the doorway

Involving another resident in monitoring exposes the resident's personal care to others and breaches confidentiality. It may seem like a creative way to keep watch while closing the door, but it compromises privacy rather than protecting it.

Conclusion

Respect a resident's request for privacy during personal care whenever safety allows, and remember that dignity and privacy are core resident rights in CNA practice.

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5. A resident who normally walks independently suddenly becomes very unsteady while walking to the bathroom. What should the CNA do?

A. Encourage the resident to walk faster

B. Help the resident to a safe position and report the change to the nurse

C. Leave the resident standing while getting supplies

D. Tell the resident that unsteadiness is normal with aging

Answer: B. Help the resident to a safe position and report the change to the nurse

Help the resident to a safe position and report the change to the nurse.

A sudden change in a resident's ability to walk is a new and important finding. The CNA's first job is to keep the resident from falling, so guide or assist the resident to sit or otherwise stabilize safely, stay with them, and then report the change to the nurse right away. Sudden unsteadiness can point to a new medical problem such as an infection, low blood sugar, medication effect, or a circulation issue, and the nurse needs to know so the resident can be assessed. Reporting a change is a core part of the CNA's role, and it should be done promptly and factually.

A) Encourage the resident to walk faster

Rushing a person who is already unsteady raises the chance of a fall. It may seem like a way to get to the bathroom quickly, but speed does not address the cause of the unsteadiness and adds risk.

C) Leave the resident standing while getting supplies

Leaving an unsteady resident standing alone removes the support and supervision they need at that moment. It might feel efficient to grab supplies first, but the resident could fall while unattended.

D) Tell the resident that unsteadiness is normal with aging

This dismisses a sudden change and delays needed evaluation. Some balance changes can come with aging, but a new, abrupt loss of steadiness is a change in condition that must be reported, not explained away.

Conclusion

When a resident's mobility suddenly changes, protect them from falling first, then report the change to the nurse promptly. Safety and timely reporting are the priorities.

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