**Skin and Wound Care**

**Competency**

Post Test – Answer Key – Nursing Assistant

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**NURSING ASSISTANT POST TEST FOR SKIN INTEGRITY**

**ANSWER KEY**

|  |  |
| --- | --- |
| **Question: True or False?** | **Answer** |
| 1. It is a requirement to observe resident’s skin for any change both during bath time and with daily cares.
 | TRUE |
| 1. It is important to know what, when, and to whom you report changes in skin condition.
 | TRUE |
| 1. The following are areas for developing pressure ulcers:
* Heel
* Sacrum/coccyx
* Elbow
* Shoulder/scapula
* Ears
 | TRUE |
| 1. It is not necessary to document the resident’s food and fluid intake related to wound healing.
 | FALSE-It is necessary to document intake of both food and fluids as this will assist in decision-making for the IDT including the dietician, nurse and physician in order to determine alternative means of nutrition options for proper wound healing/skin care |
| 1. You should report/communicate with the nurse for any of the following situations:
* Pain
* Change in mood or behavior
* Missing dressing
* Leaking dressing
* Non-compliance with pressure reducing/relieving interventions
 | TRUE |