**Skin and Wound Care**

**Competency**

Post Test – Nursing Assistant

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**NURSING ASSISTANT POST TEST FOR SKIN INTEGRITY/PRESSURE ULCER**

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| **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. |  |
| 1. It is important to know what, when, and to whom you report changes in skin condition. |  |
| 1. The following are areas for developing pressure ulcers:  * Heel * Sacrum/coccyx * Elbow * Shoulder/scapula * Ears |  |
| 1. It is not necessary to document the resident’s food and fluid intake related to wound healing. |  |
| 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 |  |

Employee Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_