Wound Care Certification Review #6
Assess Patient Pain

1. Which of the following is the most complete initial question when assessing a patient's wound-related pain?
A. "How bad is your pain right now?"
B. "What makes your pain better or worse?"
C. "Can you describe where, when, and how your pain feels?"
D. "Does your pain increase with dressing changes?"

2. A 45-year-old patient reports burning and tingling around a healed pressure injury site. Which type of pain is most likely?
A. Nociceptive pain
B. Neuropathic pain
C. Ischemic pain
D. Referred pain

3. Which validated tool would be most appropriate to assess pain in a nonverbal adult patient?
A. Wong-Baker FACES Scale
B. Numeric Rating Scale (NRS)
C. FLACC Scale
D. Visual Analog Scale (VAS)

4. When assessing wound pain, documenting the onset of pain refers to:
A. When the wound first appeared
B. When the pain began or worsened
C. The type of sensation the patient feels
D. The location where the pain is felt

5. A patient with a chronic venous ulcer reports dull aching pain that worsens when standing and improves with elevation. The most likely pain pattern is:
A. Neuropathic
B. Ischemic
C. Venous stasis–related
D. Pressure-induced

6. Which of the following best represents the character of wound pain?
A. Sharp, throbbing, or burning sensations
B. Pain relieved by analgesics
C. Pain that radiates to other areas
D. Pain that occurs intermittently

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7. When using the Numeric Rating Scale (NRS), what instruction should the nurse give the patient?
A. “Point to the face that shows how you feel.”
B. “Rate your pain on a scale from 0 (no pain) to 10 (worst pain imaginable).”
C. “Circle the word that describes your pain best.”
D. “Show me where your pain starts and where it goes.”

8. Which component of pain assessment is described by asking, “Does the pain move or spread anywhere else?”
A. Temporal pattern
B. Radiation
C. Onset
D. Duration

9. Which of the following would best evaluate the temporal pattern of wound pain?
A. “Does your pain change at certain times of day?”
B. “How long have you had this pain?”
C. “Where exactly is your pain located?”
D. “What words describe your pain?”

10. A patient with an ischemic ulcer describes pain that is worse at night and relieved by dangling the leg off the bed. This is consistent with:
A. Neuropathic pain
B. Rest pain from arterial insufficiency
C. Referred pain from spinal compression
D. Psychogenic pain

11. A 6-year-old child with a traumatic wound needs pain assessment. Which scale is most appropriate?
A. Visual Analog Scale
B. FLACC Scale
C. Numeric Rating Scale
D. Wong-Baker FACES Scale

12. A patient reports that their wound pain increases with dressing removal but subsides afterward. The best nursing action is to:
A. Document as chronic pain and notify the provider
B. Administer analgesics prior to dressing changes
C. Change the dressing less frequently
D. Switch to a non-adherent dry dressing

13. Which assessment finding suggests neuropathic wound pain rather than nociceptive pain?
A. Dull, constant ache
B. Sharp, burning, or shooting sensations
C. Pain localized to wound margins
D. Pain relieved completely by rest

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14. The FLACC scale is most appropriate for which patient population?
A. Nonverbal or cognitively impaired individuals
B. Adults with chronic pain
C. Pediatric patients able to verbalize
D. Patients with phantom limb pain

15. During assessment, a patient says, “My wound throbs mostly at night.” Which pain dimension does this describe?
A. Character
B. Temporal pattern
C. Radiation
D. Duration

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Answer Key & Explanations

1. C – This question prompts a multidimensional response covering location, onset, and character of pain — essential for comprehensive assessment.
2. B – Burning and tingling indicate neuropathic pain, often resulting from nerve damage or sensitization.
3. C – The FLACC Scale (Face, Legs, Activity, Cry, Consolability) is validated for nonverbal adults and children.
4. B – "Onset" refers to the time the pain began or worsened, which may differ from the wound's appearance.
5. C – Venous pain typically presents as dull, aching, and relieved by leg elevation due to reduced venous congestion.
6. A – The character of pain refers to the type or quality (sharp, throbbing, burning).
7. B – The Numeric Rating Scale (0–10) is simple, validated, and widely used for verbal, cognitively intact adults.
8. B – Radiation refers to pain that travels or spreads from its original site.
9. A – Temporal pattern describes variations in pain over time, such as day/night or activity-related changes.
10. B – Rest pain relieved by dependency is classic for arterial insufficiency (ischemic) ulcers.
11. D – The Wong-Baker FACES Scale is designed for children who can recognize facial expressions of pain.
12. B – Pre-medicating before dressing changes minimizes procedural pain and supports adherence.
13. B – Neuropathic pain often presents as burning, shooting, or electrical sensations rather than dull aching.
14. A – FLACC is validated for nonverbal and cognitively impaired patients, assessing behavioral indicators of pain.
15. B – Pain that varies with time (e.g., worse at night) reflects the temporal pattern dimension of assessment.

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