Wound Care Certification Review #8
Assess Cognitive and Functional Status

1. Which assessment finding most directly indicates impaired cognitive function?
A. Slow wound healing
B. Difficulty following multi-step instructions
C. Poor nutritional intake
D. Limited ankle range of motion

2. When a patient demonstrates impulsive behavior and poor insight during wound care, the nurse should prioritize:
A. Teaching wound care steps in written format
B. Assigning a family member to supervise wound care
C. Evaluating decision-making capacity and safety
D. Increasing follow-up visit frequency

3. Which tool best assesses a patient's orientation and memory during a wound care evaluation?
A. Braden Scale
B. Mini-Mental State Examination (MMSE)
C. Norton Scale
D. Glasgow Coma Scale

4. A wound care patient demonstrates unsteady gait and decreased balance. Which assessment is most appropriate to evaluate functional mobility?
A. Timed Up and Go (TUG) test
B. Braden Scale for Pressure Ulcers
C. Confusion Assessment Method (CAM)
D. Functional Independence Measure (FIM)

5. A patient with neuropathy drops wound care supplies due to hand tremors. Which aspect of functional status is most affected?
A. Mobility
B. Dexterity
C. Cognition
D. Orientation

6. During wound care teaching, the patient is unable to recall the steps for applying a dressing. The nurse should next:
A. Increase the complexity of teaching
B. Refer to occupational therapy for memory retraining
C. Simplify instructions and assess short-term memory
D. Document as noncompliant behavior

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7. When assessing a patient's ability to perform ADLs, the nurse should focus on:
A. Nutritional intake
B. Dressing, grooming, and toileting abilities
C. Sleep patterns
D. Support system

8. A patient recovering from a stroke has right-sided weakness and difficulty handling dressing materials. The nurse should recommend:
A. Cognitive retraining exercises
B. Use of adaptive dressing equipment
C. Surgical consultation
D. Increasing protein intake

9. A confused patient repeatedly removes wound dressings. The nurse's best initial intervention is to:
A. Apply restraints
B. Increase supervision and use distraction techniques
C. Administer a sedative
D. Discontinue dressing use

10. Which finding suggests impaired executive functioning during cognitive assessment?
A. Forgetting names of family members
B. Inability to follow logical wound care steps
C. Difficulty recognizing objects
D. Visual hallucinations

11. A patient with Parkinson's disease struggles to open wound care supplies due to tremors. Which professional referral is most appropriate?
A. Physical therapy
B. Occupational therapy
C. Speech therapy
D. Psychiatric services

12. A wound care nurse observes that a patient appears disoriented to time but cooperative and calm. The nurse's best action is to:
A. Reorient the patient and document mental status findings
B. Discontinue wound care until cognition improves
C. Notify the provider of new onset delirium immediately
D. Proceed without addressing orientation

13. When assessing decision-making capacity for wound care consent, which component is most critical?
A. Patient's educational level
B. Patient's ability to understand and reason about care options
C. Patient's emotional response
D. Patient's family agreement with the plan

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14. Which of the following most directly affects a patient's ability to reposition to prevent pressure injuries?
A. Hand-eye coordination
B. Cognitive awareness of skin integrity
C. Lower extremity strength and endurance
D. Appetite and hydration status

15. A patient recovering from hip surgery is mentally intact but unable to reach their lower leg wounds. The most appropriate nursing action is to:
A. Teach the patient to self-apply dressings despite limitations
B. Arrange for home care assistance for wound management
C. Discontinue dressing changes
D. Encourage the patient's spouse to observe wound care only

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Answer Key & Explanations

1. B – Difficulty following instructions indicates cognitive impairment affecting comprehension and memory.
2. C – Impulsive behavior with poor insight suggests impaired judgment; assessing decision-making capacity ensures safety and ethical care.
3. B – The Mini-Mental State Examination (MMSE) is a validated tool to assess orientation, memory, and cognition.
4. A – The Timed Up and Go (TUG) test assesses functional mobility and fall risk.
5. B – Tremors affect dexterity, the fine motor skill required for wound care tasks.
6. C – Simplifying teaching and reassessing short-term memory supports patient learning and identifies cognitive deficits.
7. B – ADL assessment focuses on basic self-care tasks such as dressing, grooming, and toileting.
8. B – Adaptive equipment (e.g., long-handled tools, Velcro closures) compensates for weakness and enhances independence.
9. B – Supervision and distraction help maintain safety while respecting autonomy; restraints are a last resort.
10. B – Executive functioning involves planning, sequencing, and organizing tasks — such as following wound care steps.
11. B – Occupational therapy focuses on improving fine motor skills and adaptive strategies for daily tasks.
12. A – Mild disorientation should be addressed with reorientation and documentation unless acute change suggests delirium.
13. B – Decision-making capacity depends on understanding, reasoning, and communicating a choice — not education level.
14. C – Lower extremity strength directly affects the ability to reposition and relieve pressure.
15. B – Arranging home care ensures proper wound care while acknowledging physical limitations.

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