

Nursing

*WOCNCB-CWCN
Certified Wound Care Nurse*

Questions And Answers PDF Format:

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Latest Version: 6.0

Question: 1

A solid skin barrier wafer with a pouch is applied to a copiously draining wound, but the skin beneath the wafer has become denuded. The BEST initial solution is to

- A. apply a skin barrier powder to the denuded skin under the wafer.
- B. discontinue use of the pouch and apply topical dressing.
- C. apply a moisture barrier paste under the wafer.
- D. apply a moisture barrier ointment to the skin and absorbent dressings.

Answer: A

Explanation:

A skin barrier powder is used as an initial barrier on denuded skin to provide an adherent base for ointments, pastes, or solid skin adhesive barriers. The powder is sprinkled over the denuded area and excess removed before application of a second barrier. The powder should be applied thinly because excess will impair adhesion of other barrier products, and it should not be used on intact skin because it will not properly adhere. Skin barrier powders contain powder pectin, karaya, gelatin, carboxymethyl cellulose, or combinations. Skin barrier powders are frequently used with ostomy products when the skin has become weepy.

Question: 2

Which of the following biological skin substitutes would be appropriate for repair post- Mohs procedure for a large facial squamous cell carcinoma?

- A. Apligraf
- B. TransCyte
- C. Integra
- D. Dermagraft

Answer: C

Explanation:

Integra, with a protective silicone outer layer over a collagen and chondroitin-6-sulfate layer, is FDA approved for a wide variety of uses, including full-thickness or partial-thickness burns, pressure ulcers, venous ulcers, diabetic ulcers, and surgical wounds, such as post-Mohs procedure. It is also used to resurface scars and keloids and for contracture release. Integra is usually meshed (1:1 ratio) to allow for drainage and penetration of antimicrobials. After application, Integra is secured with compression dressing or negative pressure.

Question: 3

During the phases of healing, which cell is responsible for beginning angiogenesis?

- A. neutrophil
- B. fibroblast
- C. macrophage
- D. myofibroblast

Answer: B

Explanation:

During the inflammation phase, macrophages release growth factors, which attract fibroblasts to the wound. Fibroblasts are responsible for beginning angiogenesis and are critically important during the proliferation phase of healing, which usually begins at about day 3 after trauma. In addition to angiogenesis, fibroblasts initiate formation of collagen (type III) and initiate epithelialization, which begins from the basement membrane of the skin or from the wound edges if the basement membrane is compromised.

Question: 4

Which wound dressing type is most likely to result in pain during dressing change?

- A. gauze
- B. hydrocolloid
- C. hydrogel
- D. alginates

Answer: A

Explanation:

Gauze dressings cause the most pain during dressing change because they tend to adhere to the wound when dry. Even though wet-to-dry gauze dressings are frequently prescribed, they may result in trauma to the wound, damaging granulating tissue, and should be avoided in favor of dressing types that maintain a moist environment. The primary considerations when choosing a dressing type should be those that cause the least wound trauma and the least pain while promoting healing.

Question: 5

A basic principle of wound care with occlusive dressings is to keep the wound

- A. cool and dry
- B. warm and dry

- C. warm and moist
- D. cool and moist

Answer: C

Explanation:

Occlusive dressings should keep the wound warm and moist. Reasons include:

- Reduction in dehydration allows cells such as neutrophils and fibroblasts to carry out their functions in wound repair, This also results in less cell death.
- Angiogenesis requires a moist environment and low oxygen tension.
- Autolytic debridement with proteolytic enzymes is enhanced.
- Re-epithelization of tissue occurs because the epidermal cells are able to spread across the surface of the wound.
- Reduction in microorganisms because the seal provided by occlusive dressings decreases infection.
- Pain reduction results from protection of the nerve endings and the need for fewer dressing changes.

Question: 6

The potency of topical corticosteroids may be increased by

- A. air drying.
- B. covering with a gauze dressing.
- C. covering with water-impermeable barrier.
- D. applying heat to the area the steroid is applied to.

Answer: C

Explanation:

The potency of topical corticosteroids may be increased by covering with a water-impermeable barrier, such as plastic wrap or gloves (if on the hands). The covering should be kept in place for at least 4 hours. Alternately, wet wraps may be used for large areas, such as having the patient wear damp pajamas covered with dry pajamas. Topical steroids have very little systemic absorption, so they have fewer adverse effects than oral steroids. Ointments are more potent than creams.

Question: 7

Patients who are sitting in wheelchairs should be advised to shift weight every

- A. 60 minutes.
- B. 45 minutes.
- C. 30 minutes.
- D. 15 minutes.

Answer: D

Explanation:

Patients who are sitting in wheelchairs should be advised to shift weight every 15 minutes. Additionally, they should reposition, if possible, every hour. If patients are unable to shift weight, then alternating pressure support surfaces are recommended. Wheelchairs should contain support surfaces that are pressure mapped for the individual in different positions, such as when sitting upright, leaning forward, and reclining, to ensure that the support surfaces provide adequate reduction in pressure.

Question: 8

Intertrigo is most likely to occur in patients that are

- A. elderly.
- B. diabetic.
- C. obese.
- D. malnourished.

Answer: C

Explanation:

Intertrigo is most likely to occur in patients that are obese, especially in humid conditions. It results from the interaction of friction, moisture, and heat and often occurs in body folds with erythema, maceration, and fissures. Patients may experience pain, itching, and burning and may develop a secondary bacterial or fungal infection. The area must be kept clean and dry. Treatment includes topical steroids (hydrocortisone 1 and an antifungal, such as clotrimazole 1

Question: 9

With cellulitis, blood testing usually shows leukocytosis with increased

- A. neutrophils.
- B. 'basophils.
- C. lymphocytes.
- D. monocytes.

Answer: A

Explanation:

With cellulitis, blood testing usually shows leukocytosis with increased neutrophils. Cellulitis is most common on the lower extremities but can occur elsewhere. Cellulitis typically initially appears as a small reddened edematous area that expands over the next 6 to 36 hours and is often accompanied by increasing fever and chills. In some cases, septicemia and hypotension

may occur. Treatment is with IV or parenteral antibiotics. Cellulitis is usually caused by gram-positive cocci, such as group A beta-hemolytic streptococci, *Staphylococcus aureus*, and MRSA.

Question: 10

Which of the following is the first treatment for a chemical burn to the skin?

- A. flush the area with water
- B. administer pain medication
- C. wash the area with soap and water
- D. apply cold compresses to the area

Answer: A

Explanation:

The first treatment for a chemical burn to the skin is to flush the area with copious amounts of water, usually for at least 10-20 minutes. The flushing should be carried out so that the water running off of the burned area does not flow onto other body parts as this may spread contamination. Any clothing, jewelry, shoes, or other items worn by the person and contaminated should be removed. The healthcare provider should utilize PPE to avoid inadvertent exposure to the chemicals.

Question: 11

Which of the following are the three wound factors that most often lead to social isolation?

- A. pain, malodor, and impaired mobility
- B. pain, drainage, and infection
- C. infection, size of wound, and malodor
- D. malodor, drainage, and visible wound

Answer: D

Explanation:

The three wound factors that most often lead to social isolation are:

Malodor: Patients may feel embarrassed or ashamed if the wound has a foul odor and may avoid contact with others when they encounter negative attitudes. In turn, others may avoid contact with the patients, increasing their isolation.

Trying to cope with drainage in social situations can be difficult, especially if patients are worried that the dressing may become saturated and leak and that drainage may soak into clothing and furnishings.

Visible wound: Wounds that are disfiguring or easily seen, especially wounds on the face or other visible parts of the body often result in negative responses from others.

Question: 12

If a patient with peripheral arterial disease develops an ulcer on the foot, which of the following is indicated to help determine if the ulcer resulted from ischemia or pressure?

- A. documentation regarding positioning and pressure reduction
- B. assessment of wound character
- C. vascular laboratory/imaging studies
- D. assessment of wound location

Answer: C

Explanation:

If a patient with peripheral arterial disease develops an ulcer on the foot, vascular laboratory/imaging studies (such as arteriograms and Doppler ultrasounds) are indicated to help determine if the ulcer resulted from ischemia or pressure, since both may be implicated to some degree. The degree of circulatory impairment must be assessed in order to determine the best approach to treatment and to prevent further breakdown of tissue. If circulatory impairment is severe, prevention of pressure ulcers is challenging.

Question: 13

If a patient with diabetes has a healing diabetic ulcer and an inflamed great toe, which the patient says resulted from using scissors to cut his nails, the nurse should recommend that the patient

- A. use clippers instead of scissors.
- B. cut the nails under a good light.
- C. visit a podiatrist.
- D. ask the spouse to cut the toenails.

Answer: C

Explanation:

If a patient with diabetes has a healing diabetic ulcer and an inflamed great toe, which the patient says resulted from using scissors to cut his nails, the nurse should recommend that the patient visit a podiatrist on a routine basis for nail care. Because of impaired sensation, cutting the nails can be dangerous for a diabetic patient who may also have impaired vision. Additionally, the podiatrist will examine the foot and note any issues of concern.

Question: 14

If a 65-year-old patient's zinc level is 60 mcg/dL, the anticipated effect on the patient's wound is

- A. no effect.
- B. accelerated healing.
- C. impaired circulation.
- D. delayed healing.

Answer: D

Explanation:

If a 65-year-old patient's zinc level is 60 mcg/dL, the anticipated effect on the patient's wound is delayed healing. Zinc is essential to the enzymes involved in metabolism of proteins and carbohydrates and is also involved in DNA replication. About 20% of the body's zinc is stored within the skin. Normal values for adults are 70 to 120 mcg/dL. Zinc levels must be monitored, especially with large wounds such as burn injuries, and supplementation provided if levels fall below normal.

Question: 15

If, during the patient's physical assessment, the patient's ankle-brachial index (ABI) was 0.35, the nurse anticipates

- A. no symptoms.
- B. 'borderline perfusion.
- C. severe disease with ischemia.
- D. critical limb-threatening condition.

Answer: C

Explanation:

If, during the patient's physical assessment, the patient's ankle-brachial index (ABI) was 0.35, the nurse anticipates severe disease with ischemia:

Ankle-brachial index score

>1.4	Abnormally high, may indicate calcification of vessel wall.
1 to 1.4	Normal reading, asymptomatic.
0.9 to <1.0	Indicates narrowing of one or more leg blood vessels; borderline PAD
0.7 to <0.9	Indicates peripheral artery disease; often associated with intermittent claudication during exercise.
0.4 to 0.7	Moderate PAD
<0.4	Severe PAD; pain even at rest, limb threatened.
0.25	Critical limb-threatening condition.

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