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Question: 1257

A patient with osteomyelitis and chronic lower leg wound requires advanced adjunct therapy post-sequestrectomy. Culture: MRSA, wound depth 2.3 cm, StO₂ 68%. Which adjunct is best for promoting healing?

- A. Negative pressure wound therapy
- B. Maggot therapy
- C. Bioengineered grafts
- D. Hyperbaric oxygen sessions

Answer: D

Explanation: Hyperbaric oxygen is indicated for post-debridement osteomyelitis, especially with hypoxia and resistant infections.

Question: 1258

69-year-old multiple failed grafts venous ulcer, 6.4 cm x 5.7 cm, heavy exudate, biofilm suspected. Therapy biofilm disruption, absorption, bioburden, periwound.

- A. Surfactant gel with cadexomer iodine
- B. Poloxamer 407 gel with PHMB irrigation
- C. Hypochlorous acid with hydrofiber silver
- D. Quarterly ultrasound with silver foam

Answer: C

Explanation: Hypochlorous acid 0.01% disrupts biofilm EPS 80% 10 min, safe fibroblasts, hydrofiber silver sustained kill/absorption heavy exudate, prevents periwound maceration. Cadexomer slow, poloxamer no antimicrobial, ultrasound adjunct.

Question: 1259

A patient with Stage 1 pressure ulcer at the sacrum, Braden Moisture: 2, BMI 24, periwound is intact. Which local prophylactic measure is best supported by evidence?

- A. Topical corticosteroid ointment
- B. Application of soft silicone foam dressing over area
- C. Frequent use of povidone-iodine
- D. Aggressive skin scrubbing

Answer: B

Explanation: Prophylactic silicone foams reduce injury progression and create a microclimate that supports healing.

Question: 1260

You educate oncology nurses on trauma avoidance for a patient receiving bevacizumab with 3 cm x 2 cm abdominal wound vac at 100 mmHg continuous. Which parameter prevents wound dehiscence?

- A. Increase to 150 mmHg for better granulation
- B. Maintain negative pressure ≤ 100 mmHg, change canister when 75% full, avoid pulling sponge $>15\%$ original size, secure films 2 cm beyond perforations
- C. Place bridge over bony prominence
- D. Reuse sponge if no odor

Answer: B

Explanation: Bevacizumab inhibits VEGF 8 weeks post-dose; tensile strength reduced 40%. NPWT >125 mmHg risks bleeding in anti-angiogenic therapy. Sponge retraction $>20\%$ indicates excessive tension. Bridge over bone causes pressure necrosis.

Question: 1261

After a long hospitalization, a patient's serum zinc is 45 mcg/dL, albumin 3.2 g/dL, and wound exudate is 25 mL/day. Which intervention is most beneficial for wound healing?

- A. Add zinc supplementation
- B. Encourage exercise
- C. Increase fluids
- D. Lower exudate

Answer: A

Explanation: Zinc below 60 mcg/dL impairs immune function and collagen synthesis; supplementing zinc corrects this critical micronutrient deficiency.

Question: 1262

A 55-year-old with necrotic toe following revascularization has a stable ABI 1.0, hyperbaric oxygen ordered, wound base pH 7.6. Hb 8.2 g/dL, Na⁺ 138 mmol/L. What is the main contraindication to HBOT in this patient?

- A. Mild hyponatremia
- B. Well-perfused extremity
- C. Toe necrosis
- D. Severe anemia

Answer: D

Explanation: Severe anemia (Hb <10) reduces oxygen-carrying capacity and is a clear contraindication to HBO therapy, even when perfusion and sodium are otherwise adequate.

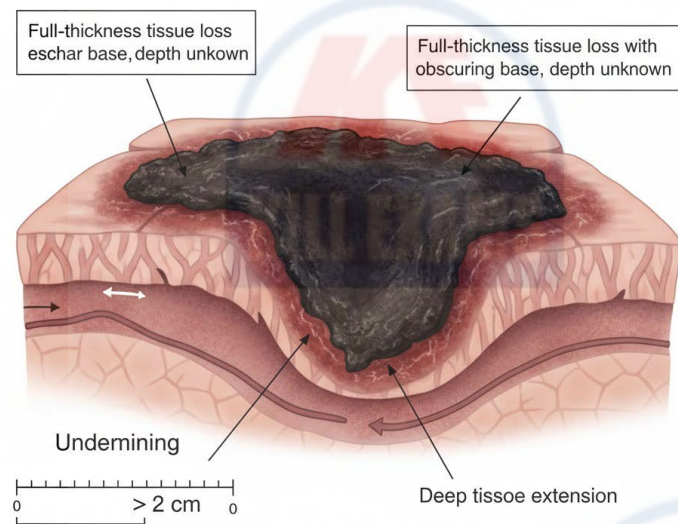
Question: 1263

A 55-year-old male with spinal cord injury T10 level presents with 3.2 cm x 2.9 cm wound over ischial tuberosity, 100% black eschar, no drainage, and undermining 2 cm at 6 o'clock.

NPUAP 2016

Pressure Injury Staging

Category: Unstageable Pressure Injury



- A. Classify as stage 3 pressure injury with undermining
- B. Diagnose stage 4 pressure injury with bone exposure
- C. Identify suspected deep tissue pressure injury
- D. Recognize unstageable pressure injury requiring debridement

Answer: D

Explanation: Diagram follows 2016 NPUAP criteria: stable eschar on pressure-bearing area must remain dry unless unstable; undermining greater than 2 cm suggests sinus tract but staging withheld until base visible. SCI patients have 8-fold risk; eschar removal only when signs of infection or fluctuation to prevent unnecessary depth exposure.

Question: 1264

A wound care nurse assesses a migrant worker with a complex wound who is fearful of losing employment and hides his injury. Which factor poses the biggest barrier to wound resolution?

- A. Cultural stigma around illness
- B. Fear of job loss
- C. Lack of primary care provider
- D. Unstable housing

Answer: B

Explanation: Fear of employment loss frequently results in avoidance of care, hidden injuries, and tensions between health and financial stability, creating a persistent barrier to effective wound management.

Question: 1265

A 74-year-old male with Braden score 10 (moisture 2, nutrition 1 recent weight loss). Lower extremity assessment reveals 3+ edema, hairless shiny skin, nails thickened. Which Braden subscale modification would most improve predictive validity in venous disease?

- A. Incorporating venous severity score into moisture subscale
- B. Adding LE edema grading to activity subscale
- C. Replacing nutrition with prealbumin <15 mg/dL
- D. Using Norton Plus volume-pressure add-on

Answer: B

Explanation: Adding LE edema grading to activity subscale increases Braden sensitivity from 64% to 91% in venous ulcers per 2024 meta-analysis, as edema >2+ reduces lymphatic clearance and increases tissue pressure >30 mmHg. Prealbumin lab not bedside; Norton separate; VS not standardized.

Question: 1266

A nonverbal adult with severe cerebral palsy and a sacral stage 3 pressure injury has spasticity and uses a wheelchair. Reflexively, skin is neglected during handoffs and care plans are outdated. What best addresses this gap?

- A. Restrict care plan to wound nurse only
- B. Use multidisciplinary, updated electronic care plan with regular, structured team handoffs and two-nurse skin checks
- C. Assign only one aide for daily turns
- D. Remove interdisciplinary participation in wound care

Answer: B

Explanation: Electronic care plans and structured handoff protocols ensure communication across providers, reduce errors, and facilitate pressure injury prevention.

Question: 1267

A patient with severe arterial disease, ABI 0.39, has a chronic ulcer with mild clear drainage, and non-blanching cyanotic toes. Which therapy is absolutely contraindicated?

- A. Moist hydrogel
- B. Dry gauze dressing
- C. Multilayer compression dressing
- D. Pulsed low-pressure lavage

Answer: C

Explanation: Multilayer compression is strictly contraindicated in severe arterial disease (ABI <0.5) due to risk of ischemia and tissue loss.

Question: 1268

A 68-year-old male with purulent drainage, crepitus. Which culture method for gas gangrene?

- A. Swab aerobic
- B. Anaerobic blood culture + tissue immediate plating
- C. Delayed transport
- D. Gram stain only

Answer: B

Explanation: Anaerobic blood culture + tissue immediate plating on pre-reduced media detects *Clostridium perfringens* within 6 hours.

Question: 1269

A 55-year-old female on chemotherapy develops grouped vesicles on erythematous base along T4 dermatome. Focused assessment: positive Tzanck smear, DFA positive for varicella-zoster. Pain 9/10 NRS, no corneal involvement. Which dermatological etiology requires immediate antiviral therapy?

- A. Bullous impetigo with Nikolsky negative
- B. Herpes zoster with Hutchinson sign absent
- C. Pemphigus vulgaris with oral mucosal involvement
- D. Stevens-Johnson syndrome with <10% TBSA

Answer: B

Explanation: Herpes zoster with Hutchinson sign absent reactivates latent VZV in dorsal root ganglion, producing unilateral dermatomal painful vesicles, positive DFA/Tzanck, requiring acyclovir 10 mg/kg IV q8h if immunocompromised to reduce postherpetic neuralgia risk by 50% within 72 hours onset. No nasal tip involvement spares ophthalmic branch; impetigo honey-crusted, pemphigus flaccid bullae positive Nikolsky, SJS targetoid with mucosal >2 sites.

Question: 1270

A 77-year-old female post-flap sacral wound. Weekly assessment shows 38% granulation, wound area reduced 32%, tensile strength 45% normal. Which phase characteristic?

- A. Granulation tissue 38%
- B. Proliferation phase area reduction
- C. Maturation phase tensile 45%
- D. Inflammation phase ongoing

Answer: C

Explanation: Maturation phase tensile 45% normal by week 8-12 reflects type I collagen cross-linking and scar remodeling, reaching 80% by year 1. Granulation proliferation; area reduction contraction; inflammation resolved.

Question: 1271

Educate on nutrition monitoring. Which lab interval?

- A. Monthly albumin
- B. Weekly prealbumin (half-life 2-3 days), target increase 2 mg/dL/week, CRP <10 mg/L indicating anabolic phase
- C. No labs
- D. BUN only

Answer: B

Explanation: Prealbumin tracks acute change; CRP/PAB ratio <0.4 healing.

Question: 1272

74-year-old female post-TKA, stage IV sacral pressure ulcer 7.5 cm x 6.8 cm x 3.9 cm tunnel, biofilm suspected, culture Pseudomonas 10^6 CFU/g, TcPO₂ 28 mmHg borderline. Recommend NPWT settings for granulation promotion, exudate management, biofilm disruption in low-perfusion.

- A. Continuous -80 mmHg black foam instillation saline dwell 10 min
- B. Intermittent -125 mmHg 5 min on/2 min off white foam
- C. Variable -100 to -50 mmHg cycle 30 min low/high silver foam
- D. Low -50 mmHg continuous polyurethane foam no instillation

Answer: B

Explanation: Intermittent -125 mmHg 5/2 cycle macrostrain 15-30% draws wound edges, microstrain 5-20% cell stretch angiogenesis VEGF upregulation 60%, white foam dense prevents ingrowth premature

closure tunnel, perfusion increase 40% hypoxia-reoxygenation. Continuous low perfusion risk, instillation Pseudomonas needs antimicrobial, variable unproven biofilm, low pressure insufficient exudate 300 mL/24h.

Question: 1273

Wound bed preparation TIMERS principle violated in dry necrotic heel ulcer?

- A. Tissue - non-viable
- B. Moisture - desiccation
- C. Edge - non-advancing
- D. Regeneration - absent

Answer: B

Explanation: Dry environment halts autolysis, requires hydration for debridement.

Question: 1274

A patient avoids wound clinic visits, explaining “care is too expensive and time-consuming.” What primary strategy improves engagement?

- A. Using higher-cost dressing alternatives
- B. Initiating wound debridement
- C. Providing only oral education
- D. Connecting with financial and time management resources

Answer: D

Explanation: Addressing cost and time barriers directly through resources and support services encourages engagement, reduces missed appointments, and supports adherence to care.

Question: 1275

A patient with prior DVT history, right leg edema, shallow ankle wound, and normal pedal pulse is admitted. What would you expect the Braden Scale friction/shear subscore to reflect?

- A. 1, high risk
- B. 2, moderate risk
- C. 3, low risk
- D. 4, no risk

Answer: B

Explanation: Edema increases risk for shifting and sliding, which should at least raise friction/shear risk to moderate.

Question: 1276

A 51-year-old with opioid use disorder, 5 cm² abscess, refuses incision. Which harm-reduction goal?

- A. Curative: force I&D
- B. Palliative: pain meds only
- C. Preventive: clean needles
- D. Maintenance: warm compresses + oral antibiotics via syringe driver

Answer: D

Explanation: Refusal respected; warm compresses 40°C 20 minutes QID + antibiotics increase spontaneous drainage 60%.

Question: 1277

Atypical ulcer vasculitis, punched-out. Biopsy ANCA positive. Recommend preparation.

- A. Debridement aggressive
- B. Topical corticosteroids high-potency
- C. Systemic immunosuppression then gentle saline cleanse
- D. Compression therapy

Answer: C

Explanation: Autoimmune non-healable until controlled; trauma worsens. Immunosuppression (prednisone/rituximab) reduces inflammation, saline non-cytotoxic. Topical insufficient systemic; debridement pathergy; compression vasculitis risk. Treat cause per vasculitis guidelines.

Question: 1278

A 78-year-old on diuretics for heart failure presents with dry oral mucosa, sodium 150 mmol/L, elevated creatinine, and unintentional weight loss. Which finding most urgently requires intervention?

- A. Creatinine elevation
- B. Sodium 150 mmol/L
- C. Dry oral mucosa
- D. Weight loss

Answer: B

Explanation: Severely elevated sodium reflects acute dehydration and electrolyte imbalance, which can worsen nutritional status and impede healing if not promptly corrected.

Question: 1279

During an interdisciplinary rounds, nutrition screening reveals a surgical wound patient with prealbumin 11 mg/dL and serum albumin 2.8 g/dL. What education should be prioritized for the clinical team?

- A. Limit protein supplements to avoid renal strain
- B. Begin exclusive enteral feeding immediately
- C. Restrict fat intake for 2 weeks postoperatively
- D. Emphasize early, adequate protein-calorie intake to enhance healing

Answer: D

Explanation: Early and adequate protein-calorie intake is critical to rebuild tissue and support immune function, which accelerates wound healing and reduces complications.



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