# Medical Professional

*WCC*
*Wound Care Certification Examination*

**Questions And Answers PDF Format:**

**For More Information – Visit link below:**
**https://www.certsgrade.com/**

*Version* = **Product**

# Latest Version: 6.0

## Question: 1

When irrigating a wound, what wound irrigation pressure is needed to effectively cleanse the wound while avoiding trauma?

A. <4 psi
B. 20-30 psi
C. 10-15 psi
D. >15 psi

**Answer: C**

Explanation:
Wounds should be irrigated with pressures of 10 to 15 psi. An irrigation pressure of<4 psi does not adequately cleanse a wound, and pressures >15 psi can result in trauma to the wound, interfering with healing. A mechanical irrigation device is more effective for irrigation than a bulb syringe, which delivers about €22 psi. A 250 mL squeeze bottle supplies about 4.5 psi, adequate for low-pressure cleaning. A 35-mL syringe with a 19-gauge needle provides about 8 psi.

## Question: 2

Which type of precautions require that the nurse assistant wear a mask while caring for the patient and that the patient be separated from other patients by at least >3 feet with a curtain separating them and a patient masked during transport to reduce risk of transmission?

A. Standard
B. Contact
C. Airborne
D. Droplet

**Answer: D**

Explanation:
Droplet. Transmission-based precautions include:

| | |
|---|---|
| **Contact** | Use personal protective equipment (PPE), including gown and gloves, for all contacts with the patient or patient's immediate environment.<br>Maintain patient in private room or >3 feet away from other patients. |
| **Droplet** | Use mask while caring for the patient. Maintain patient in a private room or > 3 feet away from other patients with curtain separating them.<br>Use patient mask if transporting patient from one area to another. |
| **Airborne** | Place patient in an airborne infection isolation room.<br>Use ≥N95 respirators (or masks) while caring for patient. |

## Question: 3

A patient with Charcot arthropathy who has had 2 weeks of compression to reduce edema and inflammation will probably next need a

A. total contact cast.
B. half shoe.
C. removable cast walker.
D. foam dressings for cushioning.

**Answer: A**

Explanation:
Charcds arthropathy should be treated with total contact cast for months, with duration depending on the location of the deformity: 12 months for hindfoot, 9 months for midfoot, and 6 months for forefoot. The casts should be changed weekly during the time the volume is changing and then every 2 to 3 weeks. Temperatures should be checked on both sides and should be within 3 degrees Fahrenheit after recalcification. The patient may be allowed gradual weight bearing after skin has resumed normal temperature.

## Question: 4

Which of the following is the most effective to prevent pressure ulcers on the heels?

A. Foam heel pads
B. Heel dressings
C. Heel elevation device
D. Sheepskin heel pads

**Answer: C**

Explanation:
The only way to prevent pressure on the heels is to elevate the heel so that it is not in contact with a surface, such as the bed or wheelchair footrest. A special heel elevation device can be utilized or a pillow may be placed under the legs, to elevate the heels. Additionally, a pillow should be placed between the ankles to prevent pressure ulcers where the feet contact each other. The patients position should be changed frequently with full-body turning to 30-degree lateral position,

avoiding side-lying.

## Question: 5

Which is the best way to move a patient up in bed in order to prevent shear?

A. Place hands under patients axillary region and pull toward the head of the bed
B. Ask patient to use trapeze to pull himself/herself up in bed
C. Use a lift/turning sheet to move patient toward the head of the bed
D. Lower the head of the bed and elevate the knees and ask patient to slide upward

**Answer: C**

Explanation:
Because shear results from a combination of friction and pressure, the only safe way to avoid shear when moving a patient up in bed is to use a lift/turning sheet with two people lifting and moving the patient toward the head of the bed. If possible, the patient can assist by utilizing a trapeze, but the patient should avoid pulling himself/herself toward the head of the bed with the trapeze unless the patient is able to lift completely off the bed with the feet placed flat on the bed to avoid shear on the heels.

## Question: 6

The initial treatment to relieve the itching and prevent excoriation resulting from venous dermatitis is

A. topical antihistamine.
B. compression therapy.
C. topical steroids.
D. topical antibiotics.

**Answer: A**

Explanation:
Venous dermatitis appears on the ankles and lower legs and can cause severe itching and pain, and without treatment to control the dermatitis, it may deteriorate, causing ulcers to form, so treatment is needed to alleviate the symptoms. Initial treatment is usually with topical antihistamines. If this does not relieve symptoms, then low dose topical steroids may be used for short periods only (2 weeks) to reduce inflammation and itching because of the danger of increasing ulceration.

## Question: 7

Which of the following topical treatments is usually the best choice to reduce infection and odor in a fungating necrotic neoplastic lesion?

A. Dakin's solution
B. Yogurt
C. Hydrogen peroxide
D. Metronidazole

**Answer: D**

Explanation:
Metronidazole, in gel or solution, has proven to be an effective topical treatment to control infection and odor in necrotic tumors as it is effective against a wide range of anaerobic bacteria. The solution is used to irrigate the wound and the gel applied directly to the tissue. Hydrogen peroxide may irritate the tissue while Dakin's solution has an odor that some patients dislike although both may reduce tumor odor. Some people have used yogurt and buttermilk topically to reduce odor by reducing wound PH, but there is little research to support their use.

## Question: 8

The primary problem with using the troughing technique to manage a posterior small bowel fistula in an open abdominal wound is

A. adherence.
B. wound contamination.
C. skin excoriation.
D. fungal infection.

**Answer: B**

Explanation:
Troughing is one method of fistula management that is appropriate for fistulas in the posterior aspect of an abdominal wound; however, this technique does not protect the wound from exudate, so the wound can become contaminated. Troughing involves applying skin barrier wafer to the skin surrounding the wound and skin barrier paste to the edges. Then, thin film dressing is applied to the wound down to the fistula opening and an ostomy pouch cut to fit and applied about the fistula opening. This method allows drainage from the wound and the fistula to mix as they both drain into the ostomy appliance.

## Question: 9

What is the primary implication when assessing a surgical wound on postoperative day 9, the nurse finds no evidence of a healing ridge?

A. Wound is healing slowly
B. Wound is infected
C. Wound is at risk of dehiscence or infection
D. Wound is well healed

**Answer: C**

Explanation:
The healing ridge, which is the result of collagen deposition that begins in the inflammatory stage and continues to the proliferation stage, should be evident directly under a suture line between days 5 and 9 after suturing. If the healing ridge is missing, then the wound is at increased risk of dehiscence and infection. The healing ridge appears as an area of induration extending about 1 cm on both sides of the wound.

## Question: 10

What is the primary purpose for applying elbow pads to a patient who exhibits repetitive movement of the arms and legs?

A. Prevent pressure ulcers
B. Promote comfort
C. Reduce shear
D. Reduce friction

**Answer: D**

Explanation:
Elbow and heel pads do not prevent pressure ulcers but they do reduce friction, which can lead to skin breakdown. Friction occurs when body parts rub against the sheet or each other. Elbow pads are especially useful for patients who exhibit repetitive movements of the arms. Other methods to reduce friction include applying transparent film, skin sealant or other protective dressings such as a thin hydrocolloid or other padding, to vulnerable skin sites.

## Question: 11

When cleansing a wound in a shower, how far away from the wound should the showerhead be?

A. 2 inches
B. 6 inches
C. 12 inches
D. 24 inches

**Answer: C**

Explanation:
When cleansing a wound in a shower, the showerhead should be about 12 inches away from the wound. The showerhead may be covered with a clean washcloth or other cloth if necessary, to reduce the water pressure. Showering should usually be done over 5 to 10 minutes to ensure that the wound is adequately clean. The patient may be seated in a shower chair if standing is difficult or the wound is in a hard to reach area.

## Question: 12

When staging tissue damage from irradiation, how would moist, blistering tissue with epidermal tissue loss, serous drainage, and increased pain because of nerve exposure be classified?

A. Stage I
B. Stage II
C. Stage III
D. Stage IV

**Answer: C**

Explanation:
Stage III. Staging of tissue damage from irradiation:

| | |
|---|---|
| **I** | Inflammation results in increased edema and capillary permeability with erythema, itching, burning, and/or pain. |
| **II** | Skin is dry, itchy, and scaly, and epidermis begins to slough because of damage to basal epidermal cells and glands. |
| **III** | Epidermis continues to slough off leaving skin moist and blistering with serous drainage and increased pain because nerves are exposed. |
| **IV** | Tissue changes include hair loss, atrophy, pigment changes, and ulcerations. |

For More Information – Visit link below:

https://www.certsgrade.com/

# PRODUCT FEATURES

- 100% Money Back Guarantee
- 90 Days Free updates
- Special Discounts on Bulk Orders
- Guaranteed Success
- 50,000 Satisfied Customers
- 100% Secure Shopping
- Privacy Policy
- Refund Policy

**16 USD Discount Coupon Code: NB4XKTMZ**