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# Medical Tests

## NAWCO-WCC

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# Latest Version: 6.0

## Question: 1

A moderate output enterocutaneous fistula is one with a daily output of

- A. 100-200 mL
- B. <200
- C. 200-500 mL
- D. >400mL

**Answer: C**

Explanation:

A moderate output enterocutaneous fistula (CECF) is one with a daily output of 200-500 mL:

Low output: <200 mL per day

Moderate output: 200-500 mL per day

High output: >500 mL per day

Output is only one way of categorizing ECFs as they may also be categorized according to the origin and the etiology. Most ECFs are iatrogenic with some resulting from leak of an anastomosis and others from trauma associated with surgery.

## Question: 2

Over-inflation of a viscous fluid-filled support surface may result in

- A. bottoming out.
- B. increased pressure.
- C. increased immersion.
- D. increased envelopment.

**Answer: B**

Explanation:

Over-inflation of a viscous fluid-filled support surface may result in increased pressure while under-inflation may result in bottoming out so the pressure must be carefully monitored so that it remains in an optimal range for the patient. Additionally, the fluid may shift, leaving some areas of the support surface without adequate support, so the fluid distribution must be monitored as well, depending on the size of the fluid-filled chambers in the support surface,

## Question: 3

With low-level laser therapy for wound care, which of the following must be done immediately before treatment?

- A. Wound cleansed with NS and left open and exposed
- B. Wound cleansed with NS and covered with semipermeable film
- C. Wound cleansed with povidone-iodine and covered with gauze dressing
- D. Wound cleansed with NS and protective gel applied

**Answer: B**

Explanation:

With low-level laser therapy for wound care, immediately before treatment the wound must be cleansed with normal saline and a semipermeable film applied over the wound. The laser probe should be cleansed with 70% isopropyl alcohol and placed in direct contact with the semipermeable film for the prescribed duration of treatment. The duration of treatment (generally measured in seconds) depends on the laser intensity, but excessive exposure may impair healing. When treatment is completed, the semipermeable film should be removed and the wound again cleansed with saline and redressed.

#### Question: 4

If a patient scheduled for hyperbaric oxygen therapy presents with a severe upper respiratory infection, the treatment should generally be

- A. withheld.
- B. given for a shorter period of time.
- C. given for a longer period of time.
- D. given as usual.

**Answer: A**

Explanation:

If a patient scheduled for hyperbaric oxygen therapy presents with a severe upper respiratory infection, the treatment should generally be withheld because an upper respiratory infection increases the risk of developing barotrauma. URIs are considered a relative contraindication. Other relative contraindications include lung disorders (such as COPD and asthma), high fever, pregnancy, seizure disorders (the threshold for seizures may be lowered), medical devices (may malfunction unless approved for hyperbaric oxygen therapy), abnormalities of the eustachian tube, and claustrophobia.

#### Question: 5

If a patient has been stung by a jellyfish, the wound should be neutralized to prevent undischarged nematocysts from continuing to fire by

- A. heat immersion.

- B. ice packs.
- C. irrigation with water.
- D. irrigation with acetic acid (vinegar).

**Answer: D**

Explanation:

If a patient has been stung by a jellyfish, the wound should be neutralized to prevent undischarged nematocysts from continuing to fire by irrigation with acetic acid (vinegar). When nematocysts fire, they release toxins, and application of hot water or ice or rubbing the area may cause firing. It's important to wear gloves when using forceps or tweezers to remove any adherent tentacles in order to prevent inadvertent contact with toxin. Shaving the area with shaving cream or baking soda paste and a safety razor may help to remove remaining nematocysts.

### Question: 6

Excessive collagen production at the site of a wound leads to

- A. inflammation.
- B. dehydration of wound.
- C. abnormal scarring.
- D. rapid healing.

**Answer: C**

Explanation:

Excessive collagen production at the site of a wound leads to abnormal scarring. This often results from dehydration of the tissue, which stimulates keratinocytes to produce cytokines. These in turn cause fibroblasts to release collagen. Hydrating agents, such as silicone sheets/gels (dimethicone) should be applied to the scar to maintain hydration and prevent transepidermal water loss (TEWL). TEWL increases when the barrier function of the skin is impaired. TEWL can be affected by both intrinsic factors (inadequate intake of fluids, fever) and environmental factors (temperature, humidity).

### Question: 7

Hydrocolloid dressings with silver are appropriate for

- A. dry infected wounds.
- B. dry clean wounds.
- C. infected wounds without heavy exudate.
- D. infected wounds with mild exudate.

**Answer: D**

Explanation:

Hydrocolloid dressings with silver are appropriate for infected wounds with mild exudate. The silver requires exudate in order to be released, but hydrocolloid dressings are inappropriate with heavy exudate. The silver has antimicrobial action. The hydrocolloid dressing can be left in place for up to a week before changing the dressing. but this may depend on the amount of exudate. Hydrocolloid dressings with silver deactivate enzymatic agents used for debridement.

### Question: 8

A patient has been prescribed becaplermin gel (Regranex®) according to standard protocol for wound treatment. How many hours out of 24 should the gel be in place on the wound?

- A. 6
- B. 12
- C. 18
- D. 24

**Answer: B**

Explanation:

If a patient has been prescribed becaplermin gel (Regranex®), a growth factor derived from platelets, according to standard protocol for wound treatment, the gel should be left in place for 12 out of 24 hours. The wound is cleansed with saline or water, becaplermin gel applied, and the wound covered with a saline-moistened gauze dressing. After 12 hours, the dressing and gel is removed and the wound covered with saline-moistened gauze only for the remaining 12 hours.

### Question:9

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:

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

## Question: 10

If a patient has a full-thickness ulcer of the foot that extends down to the tendon but with no indications of abscess or osteomyelitis, this would be classified according to the Modified Wagner's Foot Ulcer Classification as

- A. Grade 2.
- B. Grade 3.
- C. Grade 4.
- D. Grade 5.

**Answer: A**

Explanation:

Grade 2. Modified Wagner's Foot Ulcer Classification:

<b>Grade 0</b>	Pre-ulcerative but at risk. Healed ulcers or bony deformities may be present.
<b>Grade 1</b>	Superficial ulcer, extending into subcutaneous tissue; superficial infection with/without cellulitis.
<b>Grade 2</b>	Full-thickness ulcer to tendon or joint but no abscess or osteomyelitis.
<b>Grade 3</b>	Full-thickness ulcer may extend to bone with abscess, osteomyelitis, or sepsis of joint and may include deep plantar infections, abscesses, fasciitis, or infections of tendon sheath.
<b>Grade 4</b>	Gangrene of the forefoot only, but the rest of foot is able to be salvaged.
<b>Grade 5</b>	Gangrene of entire foot, requiring amputation.

## Question: 11

What is a major symptom of plantar fasciitis?

- A. Foot pain in the middle of the night
- B. Foot pain when standing after periods of rest
- C. Foot pain with exercise
- D. Foot pain in the afternoon

**Answer: B**

Explanation Details

The clinical features of plantar fasciitis include subjective symptoms of pain and discomfort. The pain can be described as a slow, dull ache; intense achiness; or a burning sensation. The pain can be sharp, pinpoint, or knifelike.

Patients will often complain of pain in the heel when standing after periods of rest, especially on their first step in the morning. This pain diminishes with each successive step but can return late in the afternoon (after prolonged weight-bearing). It is usually described as non-radiating and localized to the medial aspect of the heel pad. The symptoms are predominantly unilateral, but bilateral involvement occurs in 10% of cases.

**Question: 12**

Regranex Gel (becaplermin) is indicated for the treatment of what type of wound?

- A. Venous stasis ulcers
- B. Infected surgical incisions
- C. Pressure ulcers
- D. Diabetic ulcers

**Answer: D**

Explanation Details

Regranex Gel (becaplermin) is the first FDA-approved recombinant human growth factor (platelet-derived) used in the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue and beyond with an adequate blood supply.

**Question: 13**

Which of the following methods of obtaining a wound culture is the gold standard?

- A. Levine technique
- B. Tissue biopsy
- C. Needle aspiration
- D. Quantitative swab technique

**Answer: B**

Explanation Details

Tissue biopsy is the removal of a piece of tissue with a scalpel or by punch biopsy. It is considered the gold standard for wound culturing.

Needle aspiration and the swab technique are other methods of obtaining a wound culture. The Levine technique is recommended as the primary method of swabbing a wound for culture.

## Question: 14

Lower extremity edema that has a visible depression in the skin of approximately 2 mm is categorized as what level of pitting edema?

- A. 1+
- B. 2+
- C. 3+
- D. 4+

**Answer: A**

### Explanation Details

Edema is the presence of abnormally large amounts of fluid in the intercellular tissue spaces of the body, usually with demonstrable amounts in the subcutaneous tissues. It can be localized (venous or lymphatic obstruction or increased vascular permeability) or systemic (heart failure or renal disease). Edema is another example of moisture imbalance.

There are two types of edema: nonpitting and pitting. The extent of pitting edema is assessed by pressing firmly but gently with an index finger for several seconds on the dorsum of each foot (behind the medial malleolus and over the shins). Edema is "pitting" when there is a visible depression that does not rapidly refill and resume its original contour. Pitting edema is often observed with the dependence of a limb and with tissue congestion associated with CHF, venous insufficiency, and lymphedema. It is measured on a severity scale of 0-4+, and bilateral edema of the lower extremities can be a sign of a systemic problem.

0 = not present

1+ = minimal (2 mm indentation that persists for 10-15 seconds)

2+ = moderate (4 mm indentation that persists for 10-15 seconds)

3+ = moderate severe (6 mm indentation that persists for >1 min)

4+ = severe (8 mm indentation that persists for 2-5 min)

## Question: 15

Slough can be described as which of the following?

- A. Viable tissue
- B. Granulation tissue
- C. Collagen
- D. Necrotic tissue

**Answer: D**

### Explanation Details

Slough is soft, moist, avascular (nonviable) tissue (necrotic/devitalized). It may be white, yellow, tan, or green and loosely or firmly adherent to the wound bed. It is composed of fibrin debris and has a moderate to high water content.

Granulation tissue is pink/red moist tissue composed of new blood vessels, connective tissue, fibroblasts, and inflammatory cells that fill an open wound when it starts to heal. Granulation tissue typically appears deep pink or red with a granular surface that is berry-like or cobblestone.



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