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# Nursing

## WOCNCB-CWCA

### Certified Wound Care Associate

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## Question: 1

Which method of mechanical debridement may cause damage to granulation tissue and is generally contraindicated?

- A. Wet-to-dry dressings
- B. Whirlpool bath
- C. Irrigation under pressure
- D. Ultrasound treatment

**Answer: A**

Explanation:

In the past, wet-to-dry gauze dressings were frequently used for wound care. but wet-to-dry dressings have little use in current wound care unless the wound is very small, because the gauze adheres to the wound and can disrupt granulation or epithelization. While whirlpool bath may effectively cleanse debris from a wound, concerns about cross-infection have resulted in less frequent use. Ultrasound may effectively débride wounds. Irrigating a wound with pressurized solution can be effective if pressure remains in the optimal range (usually 8 to 12 psi).

## Question: 2

Which of the following is a contraindication to negative pressure wound therapy?

- A. Chronic stage IV pressure ulcer
- B. Wound malignancy
- C. Unresponsive arterial ulcer
- D. Dehiscent surgical wound

**Answer: B**

Explanation:

Contraindications to negative pressure wound therapy (NPWT) include wound malignancy, untreated osteomyelitis, exposed blood vessels or organs, and nonenteric, unexplored fistulas. NPWT uses subatmospheric (negative) pressure with a suction unit and a semi-occlusive vapor-permeable dressing. The suction reduces periwound and interstitial edema, decompressing vessels, improving circulation. stimulating production of new cells, increasing rate of granulation and re-epithelization, and decreasing colonization of bacteria. NPWT is used for a variety of difficult-to-heal wounds. especially those that show less than 30% healing in four weeks of post-debridement treatment or those with excessive exudate.

### Question: 3

Becaplermin (Regranex<sup>®</sup>) gel, a growth factor, is indicated for which type of wound?

- A. Venous stasis ulcer
- B. Pressure ulcer
- C. Sutured/stapled wound
- D. Diabetic ulcer

**Answer: D**

Explanation:

Becaplermin (Regranex<sup>®</sup>) gel is indicated for treatment of peripheral diabetic ulcers extending into subcutaneous tissue or deeper with adequate perfusion. Application follows debridement and usually about three weeks off-loading if healing is not adequate. Becaplermin is a growth factor derived from human platelets but is not approved for use with pressure ulcers and stasis ulcers and should not be used with closed (sutured/ stapled) wounds. Becaplermin is associated with increased risk of developing malignancy and increased risk of death from existing malignancy.

### Question: 4

Which of the following types of dressing is indicated for treatment of a full-thickness infected wound with large amount of exudate?

- A. Alginate
- B. Hydrocolloid
- C. Hydrogel
- D. Semi-permeable film

**Answer: A**

Explanation:

Alginates are effective for infected full-thickness wounds with undermining, tunneling, and large amounts of exudate. They are made from brown seaweed and absorb exudate and form a hydrophilic gel

that conforms to the shape of the wound. Hydrocolloids are effective for clean wounds with granulation and minimal to moderate exudate, but increase risk of anaerobic infection and hypergranulation.

Hydrogels are effective for partial or full-thickness wounds that are dry or have a small amount of exudate and can be used with necrotic and infected wounds. Semi-permeable film is effective over intravenous sites or dry, shallow, partial thickness wounds.

### Question: 5

Which National Pressure Injury Advisory Panel (NPIAP) stage is a pressure ulcer characterized by deep full-thickness ulceration that exposes subcutaneous tissue with possible presence of slough, tunneling, and undermining but without visibility of underlying muscle, tendon, or bone?

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

**Answer: C**

Explanation:

This is a stage III ulcer. NPIAP stages:

Stage I: Skin intact with localized non-blanching reddened area, often over bony prominences.

Stage II: Abrasion, blister, or slightly depressed area with red/pink wound bed but no slough.

Partial thickness skin loss.

Stage III: Deep full-thickness ulceration that exposes subcutaneous tissue with possible presence of slough, tunneling and undermining but without visibility of underlying muscle, tendon, or bone.

Stage IV: Deep full-thickness ulceration with extensive damage, necrosis of tissue extending to muscle, bone, tendons, or joints.

Unstageable: Extent of slough/eschar renders ulcer unstageable before debridement.

Suspected deep tissue injury: Purple/reddish discoloration and boggy, mushy, or firm tissue.



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