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# CWOCN

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**Question: 1010**

A 70-year-old male with a pressure ulcer on his sacrum has a wound culture positive for methicillin-resistant Staphylococcus aureus (MRSA). His white blood cell (WBC) count is 12,000/μL, C-reactive protein (CRP) is 50 mg/L, and erythrocyte sedimentation rate (ESR) is 60 mm/hr. Which diagnostic study should be ordered to assess for underlying osteomyelitis?

A. Bone biopsy
B. X-ray of the sacrum
C. Computed tomography (CT) scan
D. Magnetic resonance imaging (MRI)

Answer: D

Explanation: MRI is the most sensitive and specific imaging modality for detecting osteomyelitis, showing bone marrow edema and soft tissue involvement. A bone biopsy is definitive but invasive and typically follows imaging. X-ray is less sensitive, missing early osteomyelitis. CT is useful for bony destruction but less effective for early changes. The elevated WBC, CRP, and ESR suggest infection, supporting the need for MRI.

**Question: 1011**

A 63-year-old patient with a colostomy and peristomal candidiasis reports embarrassment due to odor. The patient's goal is to attend religious services. Which intervention is most effective?

A. Recommend stoma revision
B. Initiate oral fluconazole and standard pouch
C. Apply nystatin powder and use an odor-neutralizing pouch
D. Use a high-output pouch with barrier cream

Answer: C

Explanation: Peristomal candidiasis requires nystatin powder, and an odor-neutralizing pouch addresses embarrassment, supporting attendance at religious services. Oral fluconazole is unnecessary, stoma revision is invasive, and high-output pouches are irrelevant.

**Question: 1012**

A Wound Ostomy Continence Nurse is teaching about repositioning for pressure injury prevention. Which schedule is most effective for a high-risk patient?

A. Every 2 hours with 30-degree tilts
B. Every 4 hours with full turns
C. Every 6 hours with minimal adjustments
D. Once daily with prolonged elevation

Answer: A

Explanation: For high-risk patients, repositioning every 2 hours with 30-degree tilts minimizes pressure while reducing shear forces, optimizing prevention. Longer intervals (4 or 6 hours) increase risk, and daily repositioning is insufficient.

**Question: 1013**

During a handoff communication for a patient with a complex sacral pressure injury, which piece of information is most critical to include to ensure continuity of multidisciplinary care?

A. Current dressing type and change frequency
B. Braden Scale score of 12
C. Patient's dietary preferences
D. Wound culture results pending

Answer: A

Explanation: The current dressing type and change frequency are essential to maintain consistent wound management across care teams, directly impacting healing. While the Braden Scale score, dietary preferences, and pending culture results are important, they are less immediately actionable for ensuring continuity of wound care during handoff.

**Question: 1014**

A 60-year-old female with a stage 2 pressure injury has a history of multiple sclerosis and uses a wheelchair. Her wound shows minimal exudate, and her serum vitamin D is 18 ng/mL. Which factor is most likely delaying wound healing?

A. Immobility from multiple sclerosis
B. Pain from wound pressure
C. Vitamin D deficiency
D. Wheelchair-related shear forces

Answer: C

Explanation: Vitamin D deficiency (18 ng/mL, normal 30–100 ng/mL) impairs wound healing by reducing immune response and collagen formation, critical for a stage 2 pressure injury. While immobility and shear forces contribute, the low vitamin D level is the most specific factor based on the lab value and clinical context.

**Question: 1015**

A 68-year-old patient with a sacral pressure injury and type 2 diabetes mellitus has poor wound healing despite optimal wound care. Which intervention should the nurse prioritize to educate the patient and caregiver about to enhance wound healing?

A. Initiating a daily walking program to improve circulation
B. Starting a high-dose antibiotic regimen for infection prevention
C. Maintaining strict glycemic control with insulin therapy
D. Using a low-air-loss mattress for pressure redistribution

Answer: C

Explanation: Strict glycemic control is critical for wound healing in diabetic patients, as hyperglycemia impairs immune response, collagen synthesis, and angiogenesis. While a walking program, antibiotics, and pressure redistribution are important, glycemic control directly addresses the systemic factor most impacting this patient's wound healing.

**Question: 1016**

A 65-year-old patient with a venous leg ulcer has a wound with 70% granulation tissue and a serum ferritin of 20 ng/mL. Which education point should the Wound Ostomy Continence Nurse emphasize to support healing?

A. Explaining iron supplementation benefits
B. Demonstrating compression therapy techniques
C. Teaching leg elevation for 20 minutes daily
D. Reviewing moist dressing application

Answer: A

Explanation: Low ferritin indicates iron deficiency, impairing oxygen delivery and healing in venous ulcers. Iron supplementation addresses this systemic barrier. Compression and elevation are critical but secondary to iron status. Moist dressings support healing but don't correct deficiency.

**Question: 1017**

A patient with a surgical wound dehiscence has a deep wound with heavy exudate and no infection. Which intervention best promotes healing?

A. Alginate rope with a secondary foam dressing
B. Negative pressure wound therapy
C. Hydrogel with a transparent film
D. Wet-to-dry gauze packing

Answer: B

Explanation: Negative pressure wound therapy effectively manages heavy exudate in a deep surgical wound dehiscence, promotes granulation tissue formation, and fills dead space. Alginate rope is less effective for deep wounds with heavy exudate, hydrogels are unsuitable, and wet-to-dry gauze is non-selective and outdated.

**Question: 1018**

A 64-year-old patient with a venous leg ulcer (7 $cm^2$) has a history of obesity and lymphedema. The patient refuses compression due to discomfort but wants to reduce exudate. Which intervention is most effective?

A. Apply a foam dressing and elevate legs
B. Initiate NPWT with diuretics
C. Prescribe antibiotics and use a hydrogel
D. Recommend surgical lymph node transfer

Answer: A

Explanation: Foam dressings manage exudate, and leg elevation reduces edema, addressing the patient's goal without compression. NPWT and diuretics are inappropriate, antibiotics are unnecessary without infection, and surgical lymph node transfer is overly invasive.

**Question: 1019**

A patient with an arterial ulcer has a wound with 90% eschar and an ABI of 0.5. The patient's erythrocyte sedimentation rate (ESR) is 50 mm/hr. Which teaching point should the Wound Ostomy Continence Nurse emphasize to the vascular team?

A. Initiate statin therapy for plaque stabilization
B. Apply a dry gauze dressing to protect eschar
C. Monitor ESR to assess inflammation
D. Refer for revascularization to improve perfusion

Answer: D

Explanation: An ABI of 0.5 indicates severe arterial insufficiency, and revascularization is critical to restore blood flow and enable healing of the eschar-covered ulcer. Dry gauze maintains eschar but doesn't address perfusion. ESR is nonspecific, and statins are not the priority intervention.

**Question: 1020**

A 70-year-old patient with a stage IV pressure ulcer and limited mobility is at risk for moisture-

associated skin damage (MASD). Which educational intervention best prevents MASD and promotes skin health?

A. Refer the patient to a dermatologist for topical treatment options
B. Instruct the patient to avoid all moisture exposure by limiting bathing
C. Provide a pamphlet on MASD and recommend daily skin inspections
D. Teach the caregiver to use a barrier cream and change absorbent pads every 2 hours

Answer: D

Explanation: Teaching the caregiver to use a barrier cream and change absorbent pads frequently directly addresses moisture management, preventing MASD. Avoiding bathing is impractical and unhygienic, a pamphlet alone does not ensure action, and a dermatologist referral is unnecessary without first implementing preventive measures.

**Question: 1021**

A 75-year-old male with an arterial ulcer on the lower leg presents for initial assessment. His medical history includes smoking (30 pack-years), COPD, and atorvastatin use. Ankle-brachial index (ABI) is 0.6, indicating severe arterial insufficiency. What is the most critical initial assessment to prioritize?

A. Pain assessment using the Wong-Baker FACES scale
B. Smoking cessation counseling
C. Wound culture for infection
D. Vascular consultation for revascularization

Answer: D

Explanation: Prioritizing a vascular consultation for revascularization is critical. An ABI of 0.6 indicates severe arterial insufficiency, which severely limits perfusion to the arterial ulcer, impeding healing and increasing amputation risk. Revascularization may restore blood flow, addressing the primary barrier to healing. While smoking cessation, pain assessment, and infection screening are important, they are secondary to correcting the underlying vascular compromise, which is the most immediate threat to wound healing and limb preservation.

**Question: 1022**

A patient with a chronic wound seeks advocacy resources. Which option best supports patient empowerment?

A. General health website with basic wound care tips
B. National wound care organization with patient advocacy programs
C. Local clinic with limited wound care expertise
D. Social media group with unverified advice

Answer: B

Explanation: A national wound care organization with patient advocacy programs offers evidence-based resources, support networks, and policy advocacy tailored to chronic wound patients. This empowers patients with reliable information and community support, unlike generic or unverified sources.

**Question: 1023**

A 75-year-old patient with a stage III pressure injury has a wound with minimal exudate, 40% necrotic tissue, and dry periwound skin. The wound measures 6 cm x 4 cm x 0.8 cm. Which topical therapy is most appropriate to promote autolytic debridement?

A. Calcium alginate dressing
B. Hydrogel dressing
C. Hydrocolloid dressing
D. Silver foam dressing

Answer: B

Explanation: Hydrogel dressings donate moisture to dry wounds with necrotic tissue, promoting autolytic debridement while protecting dry periwound skin. Calcium alginate is too absorbent for minimal exudate. Hydrocolloid dressings may cause maceration in fragile skin. Silver foam dressings are unnecessary without infection and may dry the wound bed.

**Question: 1024**

A patient with a chronic pressure injury is being evaluated by the Wound Ostomy Continence Nurse for referral to a dermatology specialist. What clinical finding would most likely prompt this referral?

A. Evidence of undermining in the wound bed
B. Thick eschar covering the wound
C. Signs of localized wound infection
D. Presence of atypical wound characteristics

Answer: D

Explanation: Atypical wound characteristics, such as irregular borders, unusual pigmentation, or failure to heal despite optimal care, warrant a dermatology referral to rule out malignancy or other dermatologic conditions. Undermining, infection, or eschar may require surgical or infectious disease input but are less specific to dermatology expertise.

**Question: 1025**

A 58-year-old patient with a traumatic wound (6 cm x 4 cm x 1.5 cm) has 70% eschar and 30% slough. The patient is on heparin therapy (PTT 80 seconds). Which debridement modality is most appropriate to minimize bleeding risk?

A. Autolytic debridement with a hydrogel dressing
B. Surgical debridement with excision
C. Conservative sharp debridement
D. Chemical debridement with collagenase

Answer: D

Explanation: The patient's elevated PTT (80 seconds) indicates a high bleeding risk, making conservative sharp and surgical debridement contraindicated due to the potential for uncontrolled hemorrhage. Autolytic debridement is safe but too slow for a wound with extensive eschar. Chemical debridement with collagenase is non-invasive, selective, and minimizes bleeding risk while effectively removing necrotic tissue.

**Question: 1026**

A 68-year-old patient with a lower extremity wound has a capillary refill of 3 seconds, palpable posterior tibial pulse (+2), and mild edema. The skin is warm with hemosiderin staining. Monofilament testing shows reduced sensation. What is the most likely wound etiology?

A. Arterial insufficiency
B. Neuropathic ulceration
C. Pressure injury
D. Venous stasis

Answer: D

Explanation: Hemosiderin staining, mild edema, and warm skin are classic signs of venous stasis. Reduced sensation suggests neuropathy, but the vascular findings prioritize venous insufficiency as the primary etiology. Arterial insufficiency would show prolonged capillary refill and weak pulses, while pressure injuries require prolonged pressure.

**Question: 1027**

When applying a bioengineered skin substitute, which wound preparation step is essential?

A. Debridement to remove all granulation tissue
B. Maintenance of a moist wound environment
C. Irrigation with high-pressure saline
D. Application of a thick antimicrobial ointment

Answer: B

Explanation: A moist wound environment is essential for bioengineered skin substitute integration, promoting adherence and healing. Debridement removes necrotic tissue, not granulation; high-pressure irrigation may damage the wound bed; and thick ointments interfere with substitute adherence.

**Question: 1028**

A patient with a venous leg ulcer has a wound bed with 80% yellow slough, irregular wound edges, and moderate serous exudate. The periwound skin is hyperpigmented and edematous. Which phase of wound healing is predominantly stalled in this wound?

A. Hemostasis
B. Inflammation
C. Maturation
D. Proliferation

Answer: B

Explanation: The presence of yellow slough and persistent exudate indicates a prolonged inflammatory phase, where the wound is unable to progress to proliferation, which would involve granulation tissue formation. Hemostasis occurs immediately post-injury and is not relevant here. Proliferation would show healthy granulation, not slough. Maturation involves remodeling and occurs after proliferation, not in a slough-covered wound.

**Question: 1029**

A patient with a surgical wound (9 cm x 4 cm x 2.5 cm) has moderate exudate, 35% slough, and a strong odor. The wound culture is positive for Escherichia coli. Which topical therapy is most appropriate to reduce bioburden and control odor?

A. Silver-impregnated foam dressing
B. Honey-based dressing
C. Mupirocin ointment
D. Charcoal-impregnated dressing

Answer: A

Explanation: Silver-impregnated foam dressings manage moderate exudate and provide antimicrobial action against Escherichia coli, reducing bioburden and controlling odor. Charcoal dressings manage odor but not bioburden. Honey dressings have limited efficacy against E. coli. Mupirocin is for localized infections, not large wounds.

**Question: 1030**

A patient with a stage 4 pressure injury is scheduled for surgical debridement. How should the nurse educate the caregiver about the purpose of this invasive intervention?

A. It removes necrotic tissue to reduce infection risk
B. It promotes granulation tissue formation

C. It enhances blood flow to the wound bed
D. It stimulates collagen synthesis for wound closure

Answer: A

Explanation: Surgical debridement removes necrotic tissue, which reduces infection risk and prepares the wound bed for healing. It does not directly enhance blood flow, promote granulation, or stimulate collagen synthesis.

**Question: 1031**

A 55-year-old patient with a chronic arterial ulcer is being evaluated for hyperbaric oxygen therapy (HBOT). Which factor would most likely preclude the use of HBOT?

A. Claustrophobia managed with anxiolytics
B. Untreated pneumothorax
C. History of smoking cessation 6 months ago
D. Use of anticoagulant therapy

Answer: B

Explanation: An untreated pneumothorax is an absolute contraindication for HBOT due to the risk of tension pneumothorax under increased atmospheric pressure. Claustrophobia can be managed, smoking cessation reduces risks, and anticoagulation is not a contraindication unless there is active bleeding.

**Question: 1032**

A 60-year-old patient with a venous leg ulcer (6 cm x 4 cm x 0.3 cm) presents with a boggy wound bed, moderate exudate, and periwound maceration. Compression therapy (30–40 mmHg) is applied, and the patient's serum albumin is 3.2 g/dL. Which dressing regimen best supports wound bed preparation and moisture management?

A. Hydrocolloid dressing with weekly changes
B. Alginate dressing with a silicone foam secondary dressing
C. Hydrogel dressing with a transparent film cover
D. Silver sulfadiazine cream with a gauze cover

Answer: B

Explanation: A boggy venous leg ulcer with moderate exudate and periwound maceration requires a dressing that absorbs exudate, maintains moisture balance, and protects the periwound skin. Alginate dressings are highly absorbent and promote autolytic debridement, while a silicone foam secondary dressing manages exudate and prevents maceration. Hydrocolloids risk maceration with moderate exudate. Hydrogels are for dry wounds and inappropriate here. Silver sulfadiazine is antimicrobial but does not address exudate or periwound issues. Compression is appropriate, and albumin (3.2 g/dL) suggests marginal nutritional status.

**Question: 1033**

A 68-year-old patient with a Stage IV sacral pressure ulcer has a hemoglobin A1c of 8.5%, a serum albumin of 2.8 g/dL, and a BMI of 18.5. The wound bed is 70% granulation tissue with moderate exudate. Which intervention should the Wound Ostomy Continence Nurse prioritize to optimize wound healing?

A. Apply a hydrocolloid dressing to manage exudate
B. Initiate a high-protein, high-calorie diet with arginine supplementation
C. Recommend surgical debridement of the wound
D. Start a walking program to improve circulation

Answer: B

Explanation: The patient's lab values indicate poor glycemic control (HbA1c 8.5%), malnutrition (albumin 2.8 g/dL, BMI 18.5), and a complex wound (Stage IV with moderate exudate). Nutritional optimization is critical for wound healing, as low albumin and BMI suggest protein-energy malnutrition, which impairs tissue repair. A high-protein, high-calorie diet with arginine supplementation supports collagen synthesis and granulation tissue formation, addressing the root cause of delayed healing. Hydrocolloid dressings are unsuitable for moderate exudate, surgical debridement is premature without addressing nutrition, and a walking program is inappropriate due to the wound's severity and patient's compromised status.

**Question: 1034**

A 59-year-old patient with a stage 4 pressure injury on the sacrum has a history of paraplegia and recurrent UTIs. The patient's caregiver prioritizes ease of dressing changes due to time constraints. Which dressing supports this goal?

A. Alginate dressing changed daily
B. Foam dressing changed every 3 days
C. Hydrogel dressing changed twice daily
D. Silver-impregnated dressing changed daily

Answer: B

Explanation: Foam dressings, changed every 3 days, are absorbent and suitable for stage 4 pressure injuries, reducing caregiver burden compared to daily or twice-daily changes required by alginate, hydrogel, or silver dressings. This aligns with the caregiver's priority while managing the wound effectively.

**Question: 1035**

A patient with a venous leg ulcer and obesity (BMI 35) is non-compliant with weight management

recommendations. Which educational intervention best addresses obesity as a factor affecting wound management?

A. Develop a gradual weight loss plan with realistic goals and involve a dietitian for support
B. Instruct the patient to follow a low-calorie diet without additional guidance
C. Provide a pamphlet on obesity and wound healing risks
D. Refer the patient to a bariatric surgeon for evaluation

Answer: A

Explanation: A gradual weight loss plan with dietitian support addresses obesity realistically, promoting adherence and improving wound outcomes. A low-calorie diet without guidance, a pamphlet alone, or surgical referral does not provide the tailored support needed for compliance.

**Question: 1036**

A 61-year-old patient with a stage III pressure ulcer (6 cm x 5 cm x 1 cm) has 50% slough and 50% granulation tissue. The patient is on clopidogrel (platelets 200,000/µL). Which debridement modality is most appropriate to minimize bleeding risk?

A. Autolytic debridement with a foam dressing
B. Surgical debridement in the operating room
C. Conservative sharp debridement
D. Chemical debridement with collagenase

Answer: D

Explanation: Clopidogrel increases bleeding risk, making conservative sharp and surgical debridement less safe due to the potential for hemorrhage. Autolytic debridement is safe but slow for a wound with significant slough. Chemical debridement with collagenase is non-invasive, selective, and minimizes bleeding risk, making it the most appropriate choice.

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