## **Wound Management Certification Exam**

**Total Questions:** 30

**Type:** Multiple Choice (One correct answer)

**Passing Score:** 70%

**1.** What is the primary goal of wound care?

a) Keep the wound dry

b) Promote healing and prevent infection

c) Reduce hospital stay

d) Apply as many dressings as possible

**Answer:** b) Promote healing and prevent infection

**2.** Which is the body’s first line of defense against infection?

a) Immune system

b) Skin

c) White blood cells

d) Antibiotics

**Answer:** b) Skin

**3.** When assessing a wound, what should a nurse do first?

a) Apply a new dressing

b) Clean the wound

c) Observe and measure the wound’s size, depth, and appearance

d) Ask about pain only

**Answer:** c) Observe and measure the wound’s size, depth, and appearance

**4.** Which type of wound heals by primary intention?

a) Surgical incision with sutures

b) Large burn

c) Pressure ulcer

d) Infected wound

**Answer:** a) Surgical incision with sutures

**5.** Which factor slows down wound healing?

a) Good nutrition

b) Adequate blood supply

c) Smoking

d) Controlled blood sugar

**Answer:** c) Smoking

**6.** What is the most important infection control step?

a) Using gloves

b) Wearing a mask

c) Hand hygiene

d) Using sterile gauze

**Answer:** c) Hand hygiene

**7.** Which dressing maintains a moist wound environment?

a) Hydrocolloid

b) Dry gauze

c) Transparent film

d) Both a and c

**Answer:** d) Both a and c

**8.** Which nutrient is essential for collagen formation?

a) Vitamin D

b) Vitamin C

c) Iron

d) Calcium

**Answer:** b) Vitamin C

**9.** Which patient is at highest risk for pressure ulcers?

a) Ambulatory patient

b) Bedridden patient with poor nutrition

c) Young adult with broken arm

d) Patient on a high-protein diet

**Answer:** b) Bedridden patient with poor nutrition

**10.** How often should a bedridden patient be repositioned?

a) Every 1 hour

b) Every 2 hours

c) Every 4 hours

d) Once a shift

**Answer:** b) Every 2 hours

**11.** Which scale is used to assess pressure ulcer risk?

a) Morse Scale

b) Braden Scale

c) Glasgow Coma Scale

d) APGAR Score

**Answer:** b) Braden Scale

**12.** Which sign indicates wound infection?

a) Pale wound bed

b) Decreased temperature around wound

c) Purulent discharge

d) Dry wound edges

**Answer:** c) Purulent discharge

**13.** Which wound type is caused by poor circulation in the legs?

a) Arterial ulcer

b) Pressure ulcer

c) Surgical wound

d) Laceration

**Answer:** a) Arterial ulcer

**14.** Which wound type is most painful?

a) Arterial ulcer

b) Venous ulcer

c) Pressure ulcer

d) Surgical incision

**Answer:** a) Arterial ulcer

**15.** Which of these helps prevent wound infection?

a) Reusing old dressings

b) Cleaning with appropriate solution

c) Touching wound with bare hands

d) Skipping dressing changes

**Answer:** b) Cleaning with appropriate solution

**16.** What is the purpose of debridement?

a) Add moisture to wound

b) Remove dead tissue

c) Cover the wound

d) Measure the wound

**Answer:** b) Remove dead tissue

**17.** A patient is on a high-protein diet for wound healing. What should the nurse check regularly?

a) Sleep patterns

b) Water intake and kidney function

c) Clothing size

d) Hair growth

**Answer:** b) Water intake and kidney function

**18.** To prevent aspiration in a patient on tube feeding, the nurse should:

a) Keep the patient lying flat

b) Raise the head of the bed to 30–45 degrees during feeding

c) Feed the patient quickly

d) Feed while the patient is sleeping

**Answer:** b) Raise the head of the bed to 30–45 degrees during feeding

**19.** Which protein level reflects short-term nutrition status?

a) Albumin

b) Prealbumin

c) Hemoglobin

d) Calcium

**Answer:** b) Prealbumin

**20.** What is a sign of chronic malnutrition in lab reports?

a) Albumin < 3.5 g/dL

b) CRP elevated

c) Prealbumin > 15 mg/dL

d) Hemoglobin normal

**Answer:** a) Albumin < 3.5 g/dL

**21.** Which tool is commonly used to check if an older adult is malnourished?

a) Braden Scale

b) Mini Nutritional Assessment (MNA)

c) Morse Fall Scale

d) Pain Scale

**Answer:** b) Mini Nutritional Assessment (MNA)

**22.** Which is the safest wound cleaning solution?

a) Povidone-iodine

b) Hydrogen peroxide

c) Normal saline

d) Bleach solution

**Answer:** c) Normal saline

**23.** What is the main risk with excessive moisture on skin?

a) Faster healing

b) Skin maceration

c) Reduced infection risk

d) Improved circulation

**Answer:** b) Skin maceration

**24.** Which vitamin helps in blood clotting?

a) Vitamin A

b) Vitamin B12

c) Vitamin K

d) Vitamin D

**Answer:** c) Vitamin K

**25.** What is the benefit of using a pressure-relieving mattress?

a) Increases comfort only

b) Prevents and reduces pressure ulcers

c) Helps patient sleep longer

d) Reduces need for repositioning

**Answer:** b) Prevents and reduces pressure ulcers

**26.** A patient’s albumin is low, but C-reactive protein (CRP) is high. What does this suggest?

a) The patient is well-nourished

b) Low albumin may be due to inflammation, not just poor nutrition

c) Albumin is not affected by inflammation

d) No action is needed

**Answer:** b) Low albumin may be due to inflammation, not just poor nutrition

**27.** What type of ulcer is usually painless?

a) Diabetic ulcer

b) Venous ulcer

c) Arterial ulcer

d) Pressure ulcer stage 1

**Answer:** a) Diabetic ulcer

**28.** What is the best advice to give a patient at home for faster wound healing?

a) Eat small meals with protein and vitamins regularly

b) Drink only juices

c) Avoid eating too much protein

d) Reduce water intake

**Answer:** a) Eat small meals with protein and vitamins regularly

**29.** Which nutrient is most important for red blood cell production?

a) Iron

b) Vitamin C

c) Vitamin D

d) Calcium

**Answer:** a) Iron

**30.** Which type of wound dressing is best for absorbing heavy exudate?

a) Foam dressing

b) Transparent film

c) Hydrocolloid

d) Gauze only

**Answer:** a) Foam dressing