WOUND CARE TEST QUESTIONS

1. The three layers of the skin include all except the
   a. epidermis
   b. dermis
   c. subcutaneous
   d. subdermis

2. List three physiological changes of the skin related to aging:
   a. _____
   b. _____
   c. _____

3. Pressure ulcers are usually located over bony prominences and caused by unrelieved pressure resulting in damage of underlying tissue.
   a. True
   b. False

4. Initial assessment of a pressure ulcer must include:
   a. the location, the size (length x width x depth), the stage
   b. sinus tracts, undermining, tunneling, exudate
   c. necrotic tissue, presence of absence of granulation tissue, epithelialization
   d. all of the above

5. List three risk factors for developing a pressure ulcer:
   a. _____
   b. _____
   c. _____

6. Low-air-loss and air-fluidized beds are only indicated for residents with stage III or stage IV pressure ulcers.
   a. True
   b. False

7. A pressure ulcer that is superficial and presents as a blister with partial thickness skin loss involving epidermis and dermis is graded as a
   a. stage I
   b. stage II
   c. stage III
   d. stage IV

8. A stage I pressure ulcer will present with
   a. warmth and edema,
   b. induration or hardness,
   c. nonblanchable erythema
   d. discoloration of the skin

e. all of the above

9. While sitting in a wheelchair, the resident should be encouraged to change position or shift his/her weight at least every
   a. every 30 minutes
   b. every 1 hour
   c. every 45 minutes
   d. every 2 hours

10. When floating heels off of the mattress, the heels should be raised
   a. enough for your hand to fit between the bed and the heels
   b. 2 inches off of the bed
   c. just enough for a piece of paper to pass between the bed and the heels
   d. at least one inch off the bed

11. Donut-type devices are the recommended positioning device for residents at risk for development of pressure ulcers.
   a. True
   b. False

12. This term is used if a support device is found to be inadequate and is determined by placing an outreached hand under the overlay below the pressure ulcer or below the part of the body at risk for a pressure ulcer.
   a. bottoming out
   b. pressure reduction
   c. shear reduction
   d. positioning management

13. List three preventative measures to take when a resident is at risk for developing pressure ulcers:
   a. _____
   b. _____
   c. _____

14. Define sterile technique as related to pressure ulcer care:
   _____
   _____

15. Define clean technique as related to pressure ulcer care :
   _____
   _____

16. Removal of devitalized tissue in pressure ulcers when appropriate for the resident's condition and consistent with resident goals is
   a. irrigation
   b. sterile technique

c. debridement
d. exudates

17. Wounds need to be cleaned initially and at each dressing change.
a. True
b. False

18. The cardinal rule when determining a dressing change for a pressure ulcer is
a. keep the ulcer tissue dry and the surrounding intact skin moist
b. keep the ulcer tissue moist and the surrounding intact skin dry
c. keep the ulcer tissue and surrounding intact skin moist
d. keep the ulcer tissue and surrounding intact skin dry

19. A 2 week trial of topical antibiotic ointment should be considered
a. for pressure ulcers that continue to produce exudates after 2-4 weeks of optimal resident care
b. for clean pressure ulcers that are not healing
c. both a. and b.
d. none of the above

20. List three clinical signs of infection of a pressure ulcer:
a. _____
b. _____
c. _____

21. To prevent cross contamination of wound supplies, individual residents should have their own dressing supplies.
a. True
b. False

22. Pressure ulcer care must be performed with sterile gloves.
a. True
b. False

23. List three physiologic changes associated with aging that can impact nutritional status:
a. _____
b. _____
c. _____

23. To prevent pressure ulcers, which of the following interventions are appropriate?
a. Frequency of skin assessments may need to be increased if the residents status deteriorates.
b. Keep the head of the bed above a 30 degree angle at all times to reduce pressure and shearing force on the sacral area.

c. When positioning or lifting up the resident in bed, health care providers should not drag skin across linens to prevent skin injury cause by friction and shearing
d. Both a. and b.
e. Both a. and c.

25. What is the most severe type of pressure ulcer?
a. stage III
b. stage I
c. stage IV
d. stage II

26. Identify three nutritional interventions that may be taken when someone has a pressure ulcer:
a. _____
b. _____
c. _____

27. Water is the largest component of the body.
a. True
b. False

28. List three functions of water in the body.
a. _____
b. _____
c. _____

29. This nutrient repairs the body from wear and tear, builds new tissue and contributes to numerous essential body functions.
a. protein
b. carbohydrate
c. fat
d. sugar

30. A pressure ulcer that presents as a deep crater with or without undermining adjacent tissue is
a. stage I
b. stage II
c. stage III
d. stage IV
e.

31. Systemic antibiotic therapy should be initiated for residents with all except:
a. bacteremia
b. sepsis
c. osteomyelitis
d. colonization

32. The intact skin surrounding a pressure ulcer is called
    a. wound bed
    b. periulcer
    c. subdermis
    d. abscess

33. Which type(s) of dressing requires the least amount(s) of time
    a. wet to dry dressing
    b. hydrocolloid dressing
    c. film dressing
    d. both b. and c.

34. Dehydration and malnutrition are risk factors for developing pressure ulcers.
    a. True
    b. False

35. The following labs are indicators that place a resident at risk of development for pressure ulcers:
    a. serum albumin level less than 3.5g/dL
    b. weight loss greater than 10 percent in the last month
    c. hemoglobin level less than 12g/dL
    d. all of the above

36. Physiological changes associated with aging that affect nutritional intake do not include
    a. changes in taste and smell
    b. decrease in the ability to concentrate urine and decreased thirst
    c. decrease in GI motility
    d. decrease in hearing and cognition
    e. decrease in lean body mass

37. Adults can live only about 10 days without water as opposed to several weeks without food.
    a. True
    b. False

38. Water
    a. helps maintain body temperature
    b. serves as the building material for growth and repair of the body
    c. plays an important role in cell metabolism
    d. all of the above

39. This vitamin helps the formation of collagen, maintains the intracellular cement substance and helps with iron absorption
    a. Thiamine

b. Vitamin A
c. Vitamin C
d. Zinc

40. Performing non sterile wound care requires less time than sterile wound care.
a. True
b. False

41. The wound healing process does not include:
a. inflammatory phase
b. proliferation phase
c. infection phase
d. maturation phase

42. With aging, the skin (epidermis)
a. does not change
b. becomes thicker and dryer
c. becomes thinner and dryer

43. When documenting on a pressure ulcer, daily assessment should include all but
a. vital signs
b. location of pressure ulcer
c. odor present
d. drainage, if purulent

44. Daily documentation should also include
a. communication to physicians
b. communication to responsible party
c. complaints of pain
d. all of the above

45. Weekly assessments and documentation of pressure ulcers, should include
a. All listed below
b. Stage of ulcer, including size (width, length, depth)
c. Location of ulcer
d. Odor and drainage, including color and amount
e. Description of tissue

46. Downsizing of pressure ulcers is recorded when documenting the healing process of a pressure ulcer.
a. True
b. False

47. The following note would not be appropriate for supportive documentation of a pressure ulcer:
a. No improvement seen in sacral pressure ulcer

b. Pressure ulcer worse.
c. Physician notified of progress in wound and new order received.
d. Open area has increased from 3 cm in diameter x 1 cm deep as of last week to 5 cm diameter x 2 cm deep.

48. The following note would be supportive documentation for dressing changes:
a. Sacral ulcer rinsed and covered with clean dressing.
b. Sacral pressure ulcer rinsed with normal saline and covered with 6 4x4s
c. Sacral ulcer cleansed
d. Sacral ulcer treatment done as ordered

49. List 4 signs and symptoms of dehydration.
a. _____
b. _____
c. _____
d. _____

50. Zinc supplements do not increase rates of wound healing when zinc levels are normal.
a. True
b. False

51. A 30% loss of LBM (lean body mass) will significantly decrease and possibly stop all wound healing until LBM is restored.
a. True
b. False

52. When a pressure ulcer is draining purulent material, consider it infected.
a. True
b. False

53. What type of product protects the skin better and longer from incontinence?
a. Powders
b. Moisturizers
c. Moisture Barriers
d. Lotions
e. Cleansers

54. Using the face of a clock as a reference point
Length is measured from __ o'clock to __ o'clock