Wound Care Certification Review #5
Assess Patient's History, Current Medical Condition and Co-Morbidities

1. Which of the following medical conditions most commonly impairs oxygen delivery to wound tissue?
A. Chronic obstructive pulmonary disease (COPD)
B. Gastroesophageal reflux disease (GERD)
C. Osteoarthritis
D. Hypothyroidism

2. A 78-year-old patient presents with dry, fragile skin and a stage II pressure injury on the sacrum. Which age-related factor contributes most to this presentation?
A. Increased subcutaneous fat and collagen
B. Decreased skin elasticity and vascularity
C. Increased sebaceous gland activity
D. Enhanced fibroblast proliferation

3. A patient with diabetes and peripheral arterial disease has a non-healing ulcer. Which comorbidity most directly impairs wound perfusion?
A. Chronic kidney disease
B. Peripheral arterial disease
C. Hyperlipidemia
D. Depression

4. Which medication is most likely to delay wound healing by interfering with collagen synthesis?
A. Prednisone
B. Metformin
C. Lisinopril
D. Levothyroxine

5. A patient with urinary incontinence develops a perineal wound with macerated edges. The nurse should first:
A. Increase frequency of dressing changes
B. Apply a hydrocolloid dressing
C. Address incontinence-associated moisture management
D. Consult dietary services

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6. A 72-year-old stroke survivor with limited mobility and cognitive decline is at high risk for which wound complication?
A. Shear-related pressure injury
B. Diabetic foot ulcer
C. Arterial ulcer
D. Venous ulcer

7. A patient with healed venous ulcers presents for follow-up. Which intervention is most appropriate to prevent recurrence?
A. Encourage leg elevation and compression therapy
B. Prescribe topical steroids
C. Initiate antibiotic prophylaxis
D. Apply dry sterile dressings

8. Which hydration status finding is most concerning for wound healing potential?
A. Moist mucous membranes
B. Urine output > 1 mL/kg/hr
C. Serum albumin 4.0 g/dL
D. Dry tongue and poor skin turgor

9. A patient's medication list includes corticosteroids and immunosuppressants. Which nursing intervention is most appropriate?
A. Increase protein intake and monitor for infection
B. Apply compression wraps daily
C. Discontinue dressings every 12 hours
D. Initiate hydrotherapy

10. A 65-year-old man with poorly controlled diabetes and neuropathy presents with a plantar ulcer. Which factor most contributes to ulcer formation?
A. Decreased tissue oxygenation
B. Decreased pain sensation and pressure awareness
C. Elevated hemoglobin
D. Excessive vitamin supplementation

11. Which factor most increases the risk of wound dehiscence following abdominal surgery?
A. Adequate hydration and nutrition
B. Long-term corticosteroid therapy
C. Strict glycemic control
D. Age under 40

12. A patient with chronic venous insufficiency reports itching and dark discoloration of the lower legs. These findings most likely indicate:
A. Arterial occlusion
B. Hemosiderin staining and stasis dermatitis
C. Diabetic neuropathy
D. Fungal infection

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13. Which of the following best describes the impact of mental status on wound care outcomes?
A. Patients with cognitive impairment often demonstrate higher adherence to self-care routines.
B. Anxiety and depression have no measurable impact on wound healing.
C. Cognitive deficits and poor motivation can lead to noncompliance and delayed healing.
D. Mental status only affects wound etiology, not recovery.

14. A patient recovering from a healed pressure injury continues to have limited mobility and mild incontinence. Which preventive measure is most appropriate?
A. Continue pressure redistribution and skin protection regimen
B. Discontinue repositioning since the wound has healed
C. Restrict fluid intake
D. Use adhesive dressings daily

15. A wound care nurse is reviewing a patient's medical record and notes multiple healed ulcers and frequent missed appointments. What should be the clinician's first step?
A. Document the pattern and refer to a psychologist for evaluation
B. Educate on the importance of compliance and identify barriers
C. Schedule weekly wound debridement sessions
D. Increase the strength of dressings

Answer Key & Explanations
1. A – COPD decreases oxygen availability and delivery to tissues, slowing granulation and epithelialization.
2. B – Aging leads to decreased dermal thickness, collagen, and vascularity, increasing skin fragility and risk of pressure injury.
3. B – Peripheral arterial disease restricts blood flow, impairing oxygen and nutrient delivery essential for wound healing.
4. A – Corticosteroids (e.g., prednisone) suppress fibroblast activity and collagen synthesis, delaying wound repair.
5. C – Addressing moisture and incontinence is the priority to prevent further maceration and bacterial growth.
6. A – Immobility and impaired cognition increase shear and pressure exposure, leading to pressure injuries.
7. A – Compression therapy and leg elevation are essential in preventing recurrence of venous ulcers.
8. D – Poor turgor and dry tongue indicate dehydration, which reduces perfusion and impairs cellular repair.
9. A – Immunosuppressive drugs slow healing; protein supplementation supports immune and tissue repair function.
10. B – Peripheral neuropathy reduces pain sensation, allowing repetitive trauma and ulcer formation.
11. B – Corticosteroids delay collagen synthesis and wound strength, increasing dehiscence risk.
12. B – Chronic venous stasis leads to hemosiderin deposits and dermatitis, often precursors to ulceration.
13. C – Mental health affects adherence, nutrition, and motivation—all critical to healing.

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14. A – Continued preventive strategies are vital to avoid recurrence in high-risk individuals.
15. B – Noncompliance should be addressed empathetically through education and identification of barriers to adherence.

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