

Nursing

*ABWM-CWS
Certified Wound Specialist Examination*



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Question: 1

As a mandatory reporter of elder abuse, the healthcare provider can fail to report abuse

- A. if advised to do so by a supervisor.
- B. if the healthcare provider does not want to be involved.
- C. under no circumstances.
- D. if advised by a physician to ignore the abuse.

Answer: C

Explanation:

As a mandatory reporter of elder abuse, the healthcare provider can fail to report abuse under no circumstances. Observations must be documented and the report of abuse carried out according to state guidelines. If an employer advises a healthcare provider not to report abuse, the healthcare provider should obtain legal counsel and proceed to report the abuse, as there is a legal duty to report according to both federal and state laws. Laws require mandatory reporting of child abuse and elder abuse. Some states require reporting of domestic violence and may require reporting of certain types of injuries.

Question: 2

When applying the Rule of 9s to determine the percentage of body surface area that has been burned, if an adult patient has burns covering the front of the right arm and anterior trunk (chest and abdomen), the percentage of BSA that is burned is

- A. 9%.
- B. 18%.
- C. 22.5%.
- D. 27%.

Answer: C

Explanation:

When applying the Rule of 9s to determine the percentage of body surface area that has been burned, if an adult patient has burns covering the front of the right arm (4.5%) and anterior trunk (chest and abdomen) (18%), the percentage of BSA that is burned is 22.5%, Rule of 9s:

Head/neck: 9% (4.5% front, 4.5% back)

Anterior trunk: 18%

Posterior trunk: 18%

Leg: front, back)

Arm: 90/0 (4.5% front, 4.5% back)

Genitals: 1%

Question: 3

Which of the following types of debridement is most indicated for a wound with large amounts of unviable tissue and increasing cellulitis?

- A. Sharp debridement
- B. Enzymatic debridement
- C. Wet-to-dry debridement
- D. Autolytic debridement

Answer: A

Explanation:

The type of debridement most indicated for a wound with large amounts of unviable tissue and increasing cellulitis is sharp debridement because this is the fastest method of converting a necrotic wound to a clean wound and allows for better assessment and treatment of the cellulitis. Sharp debridement may be done as a one-time surgical procedure or as a series of sequential debridement. In some cases, laser debridement (considered a form of surgical debridement) may be done if the patient is not a candidate for operative debridement.

Question: 4

The most accurate method of measuring the size and depth of a wound is

- A. ruler.
- B. comparison with known object, such as a coin.
- C. photograph.
- D. stereophotogrammetry.

Answer: D

Explanation:

The most accurate method of measuring the size and depth of a wound is stereophotogrammetry (SPG), which creates images and measurements through the use of a digital camera and computer software. The software calculates the size. If measuring manually, a ruler should be used that measures in mm and cm and the wound size should not be assessed by comparison with known objects, such as a coin.

Question: 5

Undermining most often occurs as the result of

- A. friction.
- B. shear,
- C. blunt trauma.

D. direct pressure.

Answer: B

Explanation:

Undermining most often occurs as the result of shear or when the surface opening of the wound is smaller than the damage under the surface. Undermining is often documented according to a clock face, "Undermining from 1 to 3 O'clock, extending 0.75 cm." A thorough description of the undermining should include how far it extends under the tissue and which areas have the most extensive undermining.

Question: 6

The odor of a wound should be assessed

- A. before the dressing is removed.
- B. before cleaning the wound.
- C. after cleaning the wound.
- D. at all stages of dressing change.

Answer: C

Explanation:

The odor of a wound should be assessed after the dressing is removed and the wound is cleaned because some wound treatments and dressings develop a malodor that may be mistaken for infection. Some infections have a distinctive odor. *Proteus*, for example, has an ammonia-like smell; *Pseudomonas aeruginosa*, a grape-like or sweet odor; and *Escherichia coli*, a floral odor.

Question: 7

If exudate covers less than two-thirds of a dressing after it is removed, the amount of exudates would be classified as

- A. small.
- B. moderate.
- C. large.
- D. excessive,

Answer: B

Explanation:

If exudate covers less than two-thirds of a dressing after it is removed, the amount of exudate would be classified as moderate. If there is a small amount of drainage that covers less than a third of the dressing, it is classified as a small amount. A large amount is drainage that covers more than two-thirds of the dressing. The amount of exudate provides important information about the condition of the wound and the patient's general condition.

Question: 8

Moisture-associated skin damage (MASD) most often results in

- A. maceration of periwound skin.
- B. wound infection.
- C. eschar development.
- D. undermining.

Answer: A

Explanation:

Moisture-associated skin damage (MASD) most often results in maceration of periwound skin. MASD usually results from wound changes that cause excessive exudate or inadequate dressings to absorb the amount of exudate. With maceration, the skin becomes soft and irritated and often takes on a white, water-logged appearance. Skin barriers and more absorptive dressings, such as alginates, are indicated to better manage exudate.

Question: 9

If the edges of a wound are rolled inward, this usually indicates that

- A. the wound is infected.
- B. the wound bed is dehydrated.
- C. the wound bed is too damp.
- D. the wound is healing normally.

Answer: B

Explanation:

If the edges of a wound are rolled inward, this usually indicates that the wound bed is dehydrated and the edges are seeking moisture below the wound surface. The wound edges may be attached to the wound or unattached, such as may occur with undermining. Epithelialization usually goes from the outside edge of the wound toward the center, but this can vary depending on the type and extent of the wound. In some cases, epithelialization may occur in patches or in the middle of the wound bed.

Question: 10

The initial sign of an infection in a chronic wound is often

- A. delayed healing.
- B. serosanguinous drainage.
- C. purulent drainage.
- D. pain.

Answer: A

Explanation:

The initial sign of an infection in a chronic wound is often delayed healing. Typically, an uninfected healing ulcer should show improvement in 2-4 weeks, so if there is no sign of improvement, a wound culture is indicated. The classic signs of infection—erythema, increased temperature, purulent discharge, and edema—may or may not be present, and it can be difficult to distinguish among a deep infection, contamination, and colonization because the response to infection may be altered.

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