

CERTIFIED WOUND CARE NURSE (CWCN) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://certifiedwoundcarenurse.examzify.com>



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the MOST significant assessment parameter for a patient with a lower extremity ischemic ulcer?**
 - A. Consistent dressing changes
 - B. Daily weight monitoring
 - C. Repositioning
 - D. Blood pressure measurement

- 2. Which condition is most likely indicated by a painful full-thickness ulcer with a violaceous ring in a patient with Crohn's disease?**
 - A. Pressure ulcer
 - B. Venous ulcer
 - C. Pyoderma gangrenosum
 - D. Diabetic ulcer

- 3. What percentage of body weight loss in 30 days is a key indicator of undernutrition?**
 - A. 5%
 - B. 10%
 - C. 15%
 - D. 20%

- 4. How does infant skin compare to adult skin in terms of healing risk?**
 - A. Has a significantly higher metabolic rate and is at a greater risk for breakdown.
 - B. Has a slower rate of epidermal turnover and is slow to heal.
 - C. Is more permeable than adult skin and topical products should be used cautiously.
 - D. Has a slower healing rate and should have frequent dressing changes.

- 5. Where should the needle be inserted when performing a procedure adjacent to the wound bed?**
 - A. Into the wound directly.
 - B. Into the tissue adjacent to the wound bed.
 - C. At the center of the ulcer.
 - D. On the opposite side of the wound.

- 6. What is a key indicator of primary lymphedema during a clinical examination?**
- A. Positive Stemmer's sign
 - B. Negative Stemmer's sign
 - C. High limb temperature
 - D. Skin discoloration
- 7. A patient who rarely eats a complete meal and has only three servings of protein daily will be given what score for Nutrition on the Braden Scale?**
- A. 1
 - B. 2
 - C. 3
 - D. 4
- 8. What does the Stemmer sign indicate?**
- A. Presence of lymphedema
 - B. Severity of arterial insufficiency
 - C. Sign of infection in wounds
 - D. Assessment of venous reflux
- 9. Which signs are typically associated with general systemic illness, including fever and malaise?**
- A. Hydrocolloid signs
 - B. Venous disease signs
 - C. Signs of infection
 - D. Signs of hydrolysis
- 10. Proton pump inhibitors are administered to fistula patients to maintain what daily output goal?**
- A. 100 ml
 - B. 500 ml
 - C. 1 liter
 - D. 2 liters

Answers

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1. C
2. C
3. A
4. A
5. B
6. A
7. B
8. A
9. C
10. C

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Explanations

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1. What is the MOST significant assessment parameter for a patient with a lower extremity ischemic ulcer?

- A. Consistent dressing changes
- B. Daily weight monitoring
- C. Repositioning**
- D. Blood pressure measurement

In the context of managing a lower extremity ischemic ulcer, the most significant assessment parameter is repositioning. This is crucial because patients with ischemic ulcers often experience compromised blood flow to the affected area, which can lead to tissue necrosis if pressure is not alleviated. Repositioning helps to redistribute pressure, improve circulation, and minimize further injury to the ulcer, thereby promoting healing. While consistent dressing changes, daily weight monitoring, and blood pressure measurement may be relevant in general wound care and patient management, they do not directly address the need to relieve pressure on the ischemic area. Regular repositioning is essential in preventing further deterioration of the ulcer and enhancing the healing process by ensuring that adequate blood flow, which carries nutrients and oxygen essential for repair, is maintained.

2. Which condition is most likely indicated by a painful full-thickness ulcer with a violaceous ring in a patient with Crohn's disease?

- A. Pressure ulcer
- B. Venous ulcer
- C. Pyoderma gangrenosum**
- D. Diabetic ulcer

The presentation of a painful full-thickness ulcer with a violaceous ring in a patient with Crohn's disease is indicative of pyoderma gangrenosum. This condition is known to be associated with inflammatory bowel diseases, particularly Crohn's disease, and often manifests as an ulcerative lesion on the skin. The key features supporting this diagnosis include the character of the ulcer being painful and full-thickness, along with the presence of a violaceous (purple) ring, which is characteristic of the borders found in pyoderma gangrenosum. The painful nature and rapid progression of the ulcer can also serve to distinguish it from other ulcerative conditions. In contrast, pressure ulcers are typically associated with prolonged pressure and do not have the specific violaceous border. Venous ulcers are more commonly found in the lower extremities and have shallower characteristics without the prominent borders seen in pyoderma gangrenosum. Diabetic ulcers generally occur in locations that are subject to pressure or shear forces (such as the feet) and also lack the distinctive ring pattern typical of pyoderma gangrenosum. Thus, the combination of the location, appearance, and underlying condition aligns closely with pyoderma gangrenosum as the correct

3. What percentage of body weight loss in 30 days is a key indicator of undernutrition?

- A. 5%**
- B. 10%
- C. 15%
- D. 20%

Losing 5% of body weight within 30 days is considered a significant indicator of undernutrition because it suggests that the body is not receiving adequate nutrients to maintain its normal functions. This level of weight loss triggers a clinical concern that a more profound assessment of nutritional status and support may be necessary. Weight loss at this rate may result from various factors such as illness, inadequate dietary intake, or malabsorption, and it typically signifies that the individual may be at risk of ongoing health complications. Health care professionals recognize that a 5% weight loss is often the threshold at which further evaluation and intervention may be warranted to prevent further deterioration of the patient's nutritional status and overall health. In contrast, while the higher percentages indicate more severe weight loss and should also be taken seriously, the 5% mark is crucial for early intervention strategies in managing undernutrition. Recognizing this early signal helps health care providers implement necessary dietary adjustments or treatment plans promptly, potentially mitigating more substantial health issues down the line.

4. How does infant skin compare to adult skin in terms of healing risk?

- A. Has a significantly higher metabolic rate and is at a greater risk for breakdown.**
- B. Has a slower rate of epidermal turnover and is slow to heal.
- C. Is more permeable than adult skin and topical products should be used cautiously.
- D. Has a slower healing rate and should have frequent dressing changes.

Infant skin is characterized by having a significantly higher metabolic rate compared to adult skin, which influences its healing dynamics and risk factors. With a higher metabolic rate, infants have an increased demand for nutrients and oxygen, making their skin more susceptible to injury and breakdown. This heightened vulnerability is partly due to the developmental stage of their skin, which is thinner and more delicate than that of adults, resulting in a greater likelihood of complications from pressure, friction, and moisture. Understanding this increased risk is vital for wound care in infants, as their skin requires careful monitoring and intervention to prevent breakdown and promote effective healing. Providing appropriate care is crucial, as infants may not respond to injuries and wounds as robustly as adults. Other options present considerations related to skin healing but do not correctly address the primary risk factors inherent in infant skin compared to adult skin.

5. Where should the needle be inserted when performing a procedure adjacent to the wound bed?

- A. Into the wound directly.
- B. Into the tissue adjacent to the wound bed.**
- C. At the center of the ulcer.
- D. On the opposite side of the wound.

Inserting the needle into the tissue adjacent to the wound bed is the correct approach when performing a procedure related to wound care. This method allows for proper access to the affected area while minimizing trauma to the wound itself. By targeting the surrounding tissue, it avoids direct disruption of the wound bed, reducing the risk of introducing more bacteria or causing further injury. This technique also ensures that any medication or substance being administered can effectively reach the targeted area without compromising the healing process of the wound. It is essential to protect the integrity of the wound while still addressing any medical needs nearby. In contrast, inserting the needle directly into the wound could lead to contamination and increased risk of infection. Targeting the center of the ulcer may not provide the necessary therapeutic effect to the surrounding issues, and accessing the opposite side of the wound may not be effective for local treatment. Thus, focusing on the adjacent tissue is the most appropriate and safest method in this context.

6. What is a key indicator of primary lymphedema during a clinical examination?

- A. Positive Stemmer's sign**
- B. Negative Stemmer's sign
- C. High limb temperature
- D. Skin discoloration

A negative Stemmer's sign is a vital indicator when assessing for primary lymphedema during a clinical examination. Stemmer's sign refers to the ability to pick up a fold of skin at the base of the second toe or finger. In cases of primary lymphedema, the sign is negative, indicating that the fold of skin cannot be pinched or lifted. This is due to the accumulation of lymphatic fluid that leads to skin thickening and fibrosis, which are characteristic of lymphedema. In addition to indicating lymphedema, the presence of a negative Stemmer's sign helps differentiate it from other conditions that might mimic its symptoms. Understanding this can aid in early diagnosis and management of lymphedema, which is crucial for preventing complications such as infections and further swelling. While other choices might present symptoms that can occur in various skin and vascular conditions, they do not serve as definitive indicators of primary lymphedema. The negative Stemmer's sign is uniquely associated with the lymphatic condition, making it a key diagnostic criterion in clinical evaluations.

7. A patient who rarely eats a complete meal and has only three servings of protein daily will be given what score for Nutrition on the Braden Scale?

- A. 1
- B. 2**
- C. 3
- D. 4

The Braden Scale for predicting pressure sore risk includes a section on nutrition, which assigns scores based on a patient's dietary intake and nutritional habits. In this context, a score of 2 indicates that the patient is eating inadequate amounts in terms of protein and overall nutrients but is not entirely malnourished. In the scenario provided, the patient rarely eats complete meals and consumes only three servings of protein daily. This suggests that while the patient is getting some protein, it is not sufficient to meet the body's nutritional needs optimally. The score of 2 reflects that the patient likely has some dietary intake but is at risk for poor nutritional status due to inadequate consumption. Higher scores on the Braden Scale denote better nutritional status, while lower scores indicate greater concern for nutritional deficiencies. Thus, a score of 1 would indicate significant malnutrition, which is not the case here, as there is some protein intake present. Conversely, scores of 3 and 4 would imply adequate or good nutritional intake, which does not align with the patient's described eating habits. Therefore, assigning a score of 2 is appropriate based on the specifics of the patient's dietary consumption.

8. What does the Stemmer sign indicate?

- A. Presence of lymphedema**
- B. Severity of arterial insufficiency
- C. Sign of infection in wounds
- D. Assessment of venous reflux

The Stemmer sign is a clinical test used primarily to assess the presence of lymphedema. It is performed by attempting to pinch the skin on the second toe or finger; if the skin can't be lifted easily, this is a positive Stemmer sign, indicating the presence of thickened skin due to the accumulation of lymphatic fluid. The indication of lymphedema is notably important in wound care because managing underlying conditions like lymphedema can help improve healing and outcomes in patients with wounds. Recognizing this condition early is crucial for implementing appropriate treatment and management strategies, therefore aiding in wound care and patient education. In contrast, other conditions reflected in the options relate to different assessments and indications. For example, severity of arterial insufficiency would likely be assessed through other clinical tools, while signs of infection and venous reflux involve different diagnostic criteria and physical examination techniques. Understanding the specific role of the Stemmer sign in diagnosing lymphedema enhances one's ability to manage related complications effectively.

9. Which signs are typically associated with general systemic illness, including fever and malaise?

- A. Hydrocolloid signs
- B. Venous disease signs
- C. Signs of infection**
- D. Signs of hydrolysis

The typical signs associated with general systemic illness, such as fever and malaise, are linked to the body's response to infection. When an infection occurs, the immune system activates, leading to systemic symptoms like increased body temperature (fever) and a general feeling of discomfort or weakness (malaise). These signs indicate that the body is fighting off pathogens, which can include bacteria, viruses, or fungi. In contrast, the other options relate to specific conditions rather than general systemic illness. Hydrocolloid signs pertain to wound care techniques and their effects on the wound environment. Venous disease signs are associated with altered venous circulation and may include issues like swelling or varicosities, which do not encompass systemic responses. Signs of hydrolysis refer to the chemical process that affects wound healing and moisture levels but are not indicative of systemic illness. Thus, understanding the context and implications of systemic signs is crucial for identifying and managing infections effectively.

10. Proton pump inhibitors are administered to fistula patients to maintain what daily output goal?

- A. 100 ml
- B. 500 ml
- C. 1 liter**
- D. 2 liters

Proton pump inhibitors (PPIs) are often used in patients with gastrointestinal conditions, including those with fistulas, to decrease gastric acid production. In the context of managing fistulas, maintaining an output goal of around 1 liter daily is important to help balance the fluid and electrolyte losses that can occur. This target is typically set to prevent dehydration and promote a more favorable healing environment. By reducing gastric acidity, PPIs can also help in minimizing complications such as mucosal damage and promote the effective absorption of nutrients from dietary intake, thereby assisting in the overall management of the patient's condition. Choosing a target output of 1 liter is practical, as it is generally manageable and aligns with typical recommendations in clinical practice for maintaining fluid balance while allowing for proper wound healing and nutritional support.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://certifiedwoundcarenurse.examzify.com>

We wish you the very best on your exam journey. You've got this!

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