Tissue Integrity NSG 100 Exam 3 Practice (Sample)

Study Guide

Everything you need from our exam experts!

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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

1. List key strategies for turning and repositioning to prevent pressure ulcers.

A. Reposition at least every 2 hours; use a structured turning schedule; use pressure-relieving devices; inspect skin at contact points; use log-roll technique; avoid dragging the patient.

B. Reposition once a day; avoid turning.

C. Only reposition when pain occurs.

D. Use only bed elevations.

2. What best describes negative pressure wound therapy (NPWT) and common contraindications?

A. NPWT uses controlled negative pressure to remove exudate and promote granulation; indications include large chronic wounds, burns, and dehisced wounds.

B. NPWT uses positive pressure to dry the wound.

C. NPWT uses heat to sterilize the wound.

D. NPWT is a topical antibiotic cream.

3. The Braden Scale categories and scoring: which option correctly lists the six domains used to assess risk?

A. Each category is scored 1-4, with Friction/Shear also 1-4.

B. The total Braden score ranges from 6 to 23, with lower scores indicating higher risk.

C. Higher Braden scores indicate higher risk.

D. The Braden Scale assesses only nutrition status.

4. Which statement correctly differentiates Stage 3 from Stage 4 pressure injuries?

A. Stage 3 involves full-thickness skin loss with fat visible; Stage 4 involves bone, tendon, or muscle exposure

B. Stage 3 is deeper than Stage 2

C. Stage 3 involves only superficial skin redness

D. Stage 3 involves full-thickness skin loss with fat visible; Stage 4 involves full-thickness tissue loss with bone, tendon, or muscle exposed

5. During wound assessment, how should undermining be documented?

A. Clock position and depth

B. Only wound length

C. Wound color only

D. Tunneling description only

6. Which statement best describes epithelialization in wound healing?

A. Epithelialization is the formation of new thin, pale pink skin covering the wound bed.

B. Epithelialization is red, granular tissue with high vascularity.

C. Epithelialization is necrotic tissue.

D. Epithelialization is a thick crust of dried exudate.

7. Partial-thickness wounds are defined as involving which structures?

A. Involves deeper tissues such as muscle or bone.

B. Involves epidermis and part of the dermis.

C. Involves only epidermis.

D. Involves subcutaneous tissue and fascia.

8. What is the purpose of measuring depth with a sterile probe?

A. Determine pain level

B. Assess infection risk

C. Assess tissue involvement and guide treatment

D. Measure drainage

9. Which healing type occurs when tissue loss and the wound heals by filling with granulation tissue and scar?

A. Primary intention healing

B. Secondary intention healing

C. Tertiary intention healing

D. Regenerative healing

10. Which phase of wound healing is characterized by clot formation to stop bleeding?

A. Hemostasis

B. Inflammation

C. Proliferation

D. Maturation/remodeling

Answers

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

Explanations

1. List key strategies for turning and repositioning to prevent pressure ulcers.

A. Reposition at least every 2 hours; use a structured turning schedule; use pressure-relieving devices; inspect skin at contact points; use log-roll technique; avoid dragging the patient.

B. Reposition once a day; avoid turning.

C. Only reposition when pain occurs.

D. Use only bed elevations.

Preventing pressure ulcers during turning and repositioning hinges on consistently relieving pressure, minimizing shear, and actively monitoring the skin. Repositioning at least every 2 hours, guided by a structured turning schedule, ensures that no area—especially common sites like the sacrum, heels, and elbows—remains under continuous pressure. Using pressure-relieving devices such as specialized mattresses, overlays, and cushions helps distribute weight more evenly and reduces the load on vulnerable spots. Inspecting the skin at contact points each time you turn or reposition catches early signs of breakdown, allowing prompt interventions. The log-roll technique keeps the spine aligned and minimizes shear forces on the skin and underlying tissues, while avoiding dragging the patient prevents friction injuries. Together, these elements create a consistent, tissue-protective approach to repositioning. Other options fall short because they miss essential components—too infrequent turning, no use of devices, or neglecting skin assessment and safe moving techniques—leaving patients at higher risk for developing ulcers.

2. What best describes negative pressure wound therapy (NPWT) and common contraindications?

A. NPWT uses controlled negative pressure to remove exudate and promote granulation; indications include large chronic wounds, burns, and dehisced wounds.

B. NPWT uses positive pressure to dry the wound.

C. NPWT uses heat to sterilize the wound.

D. NPWT is a topical antibiotic cream.

Negative pressure wound therapy uses controlled negative pressure (suction) applied to the wound bed. This draws out excess fluid, reduces edema, and helps draw the wound edges together while promoting blood flow and granulation tissue formation. That combination makes it especially useful for large or chronic wounds, wounds that have dehisced after surgery, and burns where optimizing the wound bed and drainage accelerates healing. Common contraindications include necrotic tissue with eschar that has not been debrided, since sealing over dead tissue can trap infection. It should not be used with untreated osteomyelitis or other uncontrolled deep infections. If there are exposed blood vessels or organs, or an active fistula to a body cavity, suction can cause injury or poor healing. Malignancy within the wound is a precaution. Wounds with significant uncontrolled bleeding or in situations where a proper seal cannot be maintained are also contraindicated.

3. The Braden Scale categories and scoring: which option correctly lists the six domains used to assess risk?

A. Each category is scored 1-4, with Friction/Shear also 1-4.

B. The total Braden score ranges from 6 to 23, with lower scores indicating higher risk.

C. Higher Braden scores indicate higher risk.

D. The Braden Scale assesses only nutrition status.

Understanding how the Braden Scale measures risk starts with its scoring system. It uses six domains to rate a patient's risk factors: Sensory Perception, Moisture, Activity, Mobility, Nutrition, and Friction/Shear. Each domain contributes to a total score. Five domains are scored 1–4, while Friction/Shear is scored 1–3, giving a possible total of 6–23. Lower totals indicate greater risk, higher totals indicate lower risk. This is why the statement that the total score ranges from 6 to 23 with lower scores meaning higher risk is correct. It isn't about nutrition alone, and higher scores do not indicate higher risk.

4. Which statement correctly differentiates Stage 3 from Stage 4 pressure injuries?

A. Stage 3 involves full-thickness skin loss with fat visible; Stage 4 involves bone, tendon, or muscle exposure

B. Stage 3 is deeper than Stage 2

C. Stage 3 involves only superficial skin redness

D. Stage 3 involves full-thickness skin loss with fat visible; Stage 4 involves full-thickness tissue loss with bone, tendon, or muscle exposed

The key idea is how deep the injury goes and what tissues are exposed. Stage 3 is full-thickness skin loss with fat visible, meaning the wound goes through the skin into the subcutaneous tissue but does not expose bone, tendon, or muscle. Stage 4 goes even deeper, with full-thickness tissue loss and exposure of bone, tendon, or muscle, often with undermining or tunneling. This precise wording—Stage 3 as full-thickness skin loss with fat visible and Stage 4 as full-thickness tissue loss with bone, tendon, or muscle exposed—makes the difference clear.

5. During wound assessment, how should undermining be documented?

A. Clock position and depth

B. Only wound length

C. Wound color only

D. Tunneling description only

Undermining is tissue loss that extends under the edge of the wound. To document it clearly, you map where around the wound the undermining is occurring and how deep it goes. Using a clock reference around the wound makes the location easy to communicate, and noting the depth gives the extent of tissue loss. For example, you might record undermining at 6 o'clock extending 1 cm, or 0.5–1 cm at multiple positions (such as 3 and 9 o'clock) with the maximum depth noted. This precise description helps guide treatment decisions, dressing choices, and pressure relief. Documenting only the wound length misses this important under-edge loss; describing color focuses on appearance, not undermining; tunneling describes internal channels within the wound bed, not under the edge.

6. Which statement best describes epithelialization in wound healing?

A. Epithelialization is the formation of new thin, pale pink skin covering the wound bed.

B. Epithelialization is red, granular tissue with high vascularity.

C. Epithelialization is necrotic tissue.

D. Epithelialization is a thick crust of dried exudate.

Epithelialization is the process of re-epithelializing the wound surface during the proliferative phase, as epithelial cells migrate from the wound edges and from deeper structures to cover the wound bed. As this layer forms, the surface appears as a thin, pale pink skin over the wound, indicating restoration of the epidermal barrier. This description best captures what epithelialization looks like clinically. The other descriptions refer to different aspects of healing: red, granular tissue is granulation tissue with high vascularity; necrotic tissue is dead tissue that must be removed for healing to proceed; a thick crust is dried exudate or a scab, not the epithelial layer forming. Proper moisture and clean conditions support epithelialization and help the new epidermis establish a protective barrier.

7. Partial-thickness wounds are defined as involving which structures?

A. Involves deeper tissues such as muscle or bone.

B. Involves epidermis and part of the dermis.

C. Involves only epidermis.

D. Involves subcutaneous tissue and fascia.

Partial-thickness wounds extend through the epidermis and into the superficial part of the dermis, but do not reach deeper structures. This depth allows healing mainly by re-epithelialization from the wound edges and from remaining dermal appendages in the superficial dermis. In contrast, injuries that reach deeper tissues like muscle or bone are full-thickness, and injuries involving only the epidermis are superficial or first-degree. So the description that fits partial-thickness is that it involves epidermis and part of the dermis.

8. What is the purpose of measuring depth with a sterile probe?

A. Determine pain level

B. Assess infection risk

C. Assess tissue involvement and guide treatment

D. Measure drainage

Depth measurement with a sterile probe helps you determine how deep a wound goes and which tissue layers are involved, which is essential for planning care. Knowing the depth tells you whether the wound involves just surface skin, subcutaneous tissue, or deeper structures like fascia or muscle, and this directly guides what you do next. With this information you can decide how aggressively to debride, what kind of dressing or packing to use, whether additional therapies are needed, and if a wound specialist or surgeon should be involved. This measurement is not a direct method for judging pain, infection risk, or drainage; those are assessed through patient symptoms, clinical signs, and observation of wound exudate. Using a sterile probe also protects the wound from introducing additional bacteria while giving an accurate reading of depth.

9. Which healing type occurs when tissue loss and the wound heals by filling with granulation tissue and scar?

A. Primary intention healing

B. Secondary intention healing

C. Tertiary intention healing

D. Regenerative healing

Secondary intention healing occurs when there is tissue loss and the wound is not closed together. In this process, the wound bed fills with granulation tissue—new connective tissue and small blood vessels produced by fibroblasts and capillaries—providing a foundation for repair. As healing proceeds, the wound contracts and a scar forms from collagen deposition, resulting in an extendable, fibrous tissue rather than a perfectly restored original tissue. This contrasts with primary intention healing, where edges are brought together and tissue loss is minimal, leading to little scarring, and with tertiary intention healing, where the wound is kept open to drain or monitor infection before being closed later. The description of tissue loss plus filling with granulation tissue and scar is characteristic of secondary intention healing.

10. Which phase of wound healing is characterized by clot formation to stop bleeding?

A. Hemostasis

B. Inflammation

C. Proliferation

D. Maturation/remodeling

Stopping bleeding through clot formation is the first step in wound healing. When tissue is injured, blood vessels constrict and platelets quickly gather at the site to form a plug. At the same time, the coagulation cascade activates and fibrin stabilizes the plug, creating a clot that seals the wound and prevents further blood loss. This phase is what stops bleeding and provides a temporary barrier that paves the way for the next stages of healing. After hemostasis, inflammation clears debris and microbes, proliferation builds new tissue and blood vessels, and remodeling strengthens the repaired area. The clot-forming phase is specifically about stopping bleeding, not tissue regeneration or scar formation.

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://tissueintegritynsg100exam3.examzify.com

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