

WOUND, OSTOMY, AND CONTINENCE NURSING (WOCN) WOUND TREATMENT ASSOCIATE PRACTICE TEST (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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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. Which assessment tool is commonly used to evaluate pressure ulcer risk?**
 - A. The Norton Scale
 - B. The Waterlow Scale
 - C. The Braden Scale
 - D. The Glasgow Coma Scale

- 2. Which of the following actions is recommended to prevent pressure injuries?**
 - A. Massage red skin over bony prominence
 - B. Turn every 2 hours if bedbound
 - C. Keep head of bed at 90 degrees
 - D. Use unpadded surfaces for comfort

- 3. What is a common complication that can occur with a stoma?**
 - A. Infection at the site
 - B. Stenosis or narrowing of the stoma
 - C. Excessive drainage
 - D. Permanent loss of blood flow

- 4. Which type of tissue is more susceptible to pressure injury due to higher metabolism?**
 - A. Skin
 - B. Fat
 - C. Muscle
 - D. Bone

- 5. Which characteristic is typically seen in a stage II pressure ulcer?**
 - A. Intact skin with redness
 - B. Open ulcer with exposed muscle
 - C. Partial-thickness loss of skin with a blister
 - D. Non-blanchable redness over a bony prominence

- 6. What type of wound healing involves the granulation tissue filling the wound?**
- A. Primary intention healing
 - B. Secondary intention healing
 - C. Tertiary intention healing
 - D. Trauma healing
- 7. What is the expected outcome of using negative pressure wound therapy?**
- A. Decreased blood flow to the wound
 - B. Reduction in pain during healing
 - C. Promotion of wound healing through increased blood flow
 - D. Completely closes the wound without scarring
- 8. What is required for a patient with a coccyx ulcer, low mobility, and moderate moisture levels?**
- A. Only moisture control
 - B. Only pressure redistribution
 - C. Neither
 - D. Both pressure redistribution and moisture control
- 9. What does a score of 15-18 indicate regarding the need for prevention measures?**
- A. Requires no preventive measures
 - B. Requires assessment but no action necessary
 - C. Requires preventive measures
 - D. Requires immediate intervention
- 10. What type of dressing is commonly used for wounds with heavy exudate?**
- A. Hydrocolloid dressings
 - B. Foam dressings
 - C. Transparent film dressings
 - D. Gauze dressings

Answers

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

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Explanations

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1. Which assessment tool is commonly used to evaluate pressure ulcer risk?

- A. The Norton Scale
- B. The Waterlow Scale
- C. The Braden Scale**
- D. The Glasgow Coma Scale

The Braden Scale is widely recognized in clinical practice for evaluating the risk of pressure ulcers. It assesses several factors, including sensory perception, moisture, activity, mobility, nutrition, and friction/shear, assigning a score that helps healthcare professionals determine a patient's susceptibility to pressure injuries. A lower total score indicates a higher risk, guiding preventative measures and interventions for individuals at risk. In contrast, the Norton Scale, while also assessing risk for pressure ulcers, is less frequently used today due to its simplicity and variability compared to the Braden Scale. The Waterlow Scale is another assessment tool but varies in its criteria and is not as broadly accepted as the Braden Scale in various healthcare settings. The Glasgow Coma Scale, however, is specifically designed for assessing consciousness and neurological status, not pressure ulcer risk, making it irrelevant in this context. Thus, the Braden Scale remains the gold standard due to its comprehensive approach and extensive validation in research.

2. Which of the following actions is recommended to prevent pressure injuries?

- A. Massage red skin over bony prominence
- B. Turn every 2 hours if bedbound**
- C. Keep head of bed at 90 degrees
- D. Use unpadded surfaces for comfort

Turning every 2 hours for individuals who are bedbound is a widely recognized and effective strategy for preventing pressure injuries. This action helps to mitigate prolonged pressure on any one area of the body, particularly over bony prominences, which are at a higher risk for skin breakdown. Regular repositioning redistributes weight and improves blood circulation, thereby reducing the likelihood of tissue ischemia and subsequent injury. In addition to this fundamental practice, it's important to consider other preventive measures in conjunction, such as utilizing proper support surfaces, maintaining skin hygiene, and ensuring adequate nutrition. Each of these elements plays a vital role in skin integrity and overall patient care, enhancing the effectiveness of the repositioning schedule.

3. What is a common complication that can occur with a stoma?

- A. Infection at the site
- B. Stenosis or narrowing of the stoma**
- C. Excessive drainage
- D. Permanent loss of blood flow

Stenosis or narrowing of the stoma is a recognized complication that can occur following stoma creation due to various factors, including inflammation, scar tissue formation, or improper surgical technique. This narrowing can lead to complications such as obstructed bowel movements, discomfort, and difficulty managing the stoma. The process can be influenced by the underlying condition necessitating the stoma, the type of stoma created, as well as post-operative healing responses. Addressing stenosis often requires careful assessment and, in some cases, interventions such as dilation or surgical revision to restore proper function and alleviate symptoms. While infection at the site can occur, it is not as specific to stomas as stenosis is. Similarly, excessive drainage and permanent loss of blood flow may complicate stoma management but are less common than stenosis itself. The understanding of these potential complications is crucial for ongoing care and monitoring of individuals with stomas.

4. Which type of tissue is more susceptible to pressure injury due to higher metabolism?

- A. Skin
- B. Fat
- C. Muscle**
- D. Bone

Muscle tissue is more susceptible to pressure injury due to its higher metabolic activity compared to other types of tissues. This increased metabolism means that muscle requires a steady supply of oxygen and nutrients to function properly and heal. When pressure is applied, blood flow to areas of muscle can be compromised more quickly than in tissues with lower metabolic needs. As a result, muscle cells can deteriorate faster under pressure, leading to potential pressure injuries. In contrast, skin acts as a barrier and is the first line of defense against injury, though it too can be damaged under prolonged pressure. Fat tissue, while it can cushion underlying structures, does not have the same metabolic demands as muscle and is generally less prone to injury. Bone is more rigid and does not have the metabolic requirements that make muscle more vulnerable to pressure injuries. Therefore, the metabolic characteristics of muscle contribute significantly to its risk for developing pressure injuries when subjected to sustained pressure.

5. Which characteristic is typically seen in a stage II pressure ulcer?

- A. Intact skin with redness
- B. Open ulcer with exposed muscle
- C. Partial-thickness loss of skin with a blister**
- D. Non-blanchable redness over a bony prominence

A stage II pressure ulcer is defined by partial-thickness loss of skin. This can manifest as an open ulcer, often characterized by a blister, which may be intact or ruptured. The key aspect of a stage II ulcer is that it does not extend into deeper tissues, such as muscle or bone, which differentiates it from more severe stages of pressure ulcers. This definition aligns closely with the characteristics noted in the correct choice, emphasizing the significance of partial-thickness skin loss. The presence of a blister is a typical manifestation of this stage and highlights the impact of pressure on the skin. Therefore, identifying a stage II pressure ulcer involves recognizing these visible signs that indicate damage to the outer layers of skin while sparing deeper structures.

6. What type of wound healing involves the granulation tissue filling the wound?

- A. Primary intention healing
- B. Secondary intention healing**
- C. Tertiary intention healing
- D. Trauma healing

The type of wound healing that involves granulation tissue filling the wound is secondary intention healing. This method occurs when a wound is left open to heal from the bottom up, allowing granulation tissue to form. Granulation tissue is vital in this process; it contains new connective tissue and microscopic blood vessels that help in the healing process by providing the necessary nutrients and support for the development of a more stable scar tissue. In secondary intention healing, the wound edges cannot be approximated, so the body needs to generate new tissue to fill in the defect over time. This healing process is usually seen in larger, deeper wounds or when the risk of infection is high. The granulation tissue ultimately matures and is replaced by more organized collagen, resulting in scar formation. Other forms of wound healing, such as primary intention, typically involve suturing or closing the wound edges together, minimizing the granulation tissue formation. Tertiary intention healing, also known as delayed primary closure, involves cleaning and observing the wound before closure, and while it may allow for granulation, it does not primarily depend on it filling the wound. Trauma healing, while related to wound treatment, does not specifically categorize the healing process, making secondary intention the most accurate choice here.

7. What is the expected outcome of using negative pressure wound therapy?

- A. Decreased blood flow to the wound
- B. Reduction in pain during healing
- C. Promotion of wound healing through increased blood flow**
- D. Completely closes the wound without scarring

The expected outcome of using negative pressure wound therapy (NPWT) is centered around its ability to promote wound healing, primarily through increased blood flow to the affected area. NPWT works by creating a controlled negative pressure environment at the wound site, which helps to draw out excess fluid and exudate while also facilitating a complex set of biological responses that enhance blood circulation. This increased blood flow is vital because it brings essential nutrients and oxygen to the wound tissue, which are crucial for the healing process. Moreover, NPWT can help to stimulate the formation of granulation tissue, further promoting closure of the wound. While pain reduction may occur for some patients due to less movement of the surrounding tissue and a reduction in edema, it is not the primary mechanism of action for NPWT. Similarly, while NPWT can contribute to better outcomes regarding scarring, it may not always result in completely closed wounds without any scarring, as this can depend on various factors, including the wound's nature and patient characteristics. Thus, the focus on promoting healing through enhanced blood flow accurately captures the primary expected outcome of using negative pressure wound therapy.

8. What is required for a patient with a coccyx ulcer, low mobility, and moderate moisture levels?

- A. Only moisture control
- B. Only pressure redistribution
- C. Neither
- D. Both pressure redistribution and moisture control**

In managing a coccyx ulcer, particularly in a patient with low mobility and moderate moisture levels, it is essential to implement both pressure redistribution and moisture control. Low mobility increases the risk of pressure ulcers due to prolonged pressure on bony prominences like the coccyx, therefore pressure redistribution strategies are crucial. This may include the use of specialized cushions or mattresses that help distribute weight more evenly and reduce pressure on the affected area. At the same time, moderate moisture levels can lead to skin maceration and worsen the ulcer. Maintaining skin integrity by controlling moisture through appropriate dressings or barrier products is important to prevent additional skin damage that could hinder healing. Thus, the combination of both pressure redistribution and moisture control is necessary to effectively manage the ulcer and promote healing in this patient population.

9. What does a score of 15-18 indicate regarding the need for prevention measures?

- A. Requires no preventive measures
- B. Requires assessment but no action necessary
- C. Requires preventive measures**
- D. Requires immediate intervention

A score of 15-18 indicates a heightened risk that necessitates the implementation of preventive measures. This score often reflects underlying health conditions or factors that increase vulnerability to further complications or deterioration. By identifying individuals within this score range, healthcare providers can prioritize preventive strategies to avert adverse outcomes, such as pressure ulcers or infections. Hence, it is crucial to take proactive steps rather than waiting for symptoms to manifest, ensuring that patient care is both effective and comprehensive.

10. What type of dressing is commonly used for wounds with heavy exudate?

- A. Hydrocolloid dressings
- B. Foam dressings**
- C. Transparent film dressings
- D. Gauze dressings

Foam dressings are specifically designed to absorb heavy exudate while providing a moist wound environment, which is essential for promoting healing. These dressings are composed of a soft, absorbent polymer material that can hold significant amounts of fluid, which helps manage exudate effectively. The high absorbency reduces the risk of maceration of the surrounding skin, ensuring that the area remains intact and healthy, while also providing cushioning and protection to the wound site. In contrast, hydrocolloid dressings, although they can manage light to moderate exudate, may not be sufficient for wounds with heavy drainage due to the risk of breakdown. Transparent film dressings are best suited for superficial wounds with minimal exudate, as they are designed to maintain a barrier against external contaminants while allowing moisture vapor to escape. Gauze dressings can absorb exudate but often require frequent changes and may not provide the same degree of cushioning and moisture retention that foam dressings offer, making them less ideal for heavily exudative wounds.

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://wocnwoundtreatmentassoc.examzify.com>

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

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