SERIES 1- MASTER CLASS in WOUND CARE & WOUND DRESSINGS For PHARMACISTS ONLINE COURSE

Medline EDICAL BUSINESS MEDIA

Certified By : GLOBAL DOCTORS

MEDSONS Beyond Quality of Life

SERIES 1- SELF EVALUTION MCQ

NOTE:

- THIS IS A SELF-EVALUATION QUESTION BANK
- NO SCORES ARE REQUIRED
- YOUR ANSWERS OR RESULTS DO NOT NEED TO BE SUBMITTED/MARKED/GRADED

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PACwound
A solution for home dressing

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MULTI CHOICE QUESTION BANK: (ANSWERS ARE HIGHLIGHTED)

Question 1: Basic Wound Assessment

What are the primary components of a basic wound assessment?

A) Size, depth, colour, odour, exudate

B) Pain level, patient's age, wound location

C) Type of dressing, frequency of dressing changes

D) Patient's medical history, allergies

Correct Answer: A)

Explanation: A basic wound assessment involves evaluating physical characteristics of the Wound itself, such as its size (length, width), depth, colour (e.g., red, yellow, black), and odour (if Present), and the presence and type of exudate (drainage). These elements help determine the wound's condition and healing progress. Options B, C, and D include factors that may be relevant to patient care but are not the primary focus of wound assessment.

Question 2: Wound Types and Classification

A pressure ulcer that presents with full-thickness skin loss, visible subcutaneous fat, but no exposed muscle or bone is classified as:

A) Stage 1

B) Stage 2

C) Stage 3

D) Stage 4

Correct Answer: C)

Explanation: Pressure ulcers are classified by stages based on their severity. Stage 3 Involves full-thickness skin loss, meaning both the epidermis and dermis are gone, exposing subcutaneous fat. However, deeper structures like muscle or bone are not visible, which distinguishes it from Stage 4. Stage 1 involves intact skin with redness, and Stage 2 involves partial-thickness loss (epidermis and possibly dermis).

Question 3: Recognizing Signs of Infection

Which of the following may indicate a wound infection?

A) Serous exudate

B) Granulation tissue

C) Foul odour

D) Epithelialization

Correct Answer: C)

Explanation: Foul odour is a common sign of wound infection, often due to bacterial activity producing malodorous by-products. Serous exudate (clear fluid) can be normal, granulation tissue indicates healing, and epithelialization is the process of new skin forming—none of these are typically associated with infection.

Question 4: Wound Types and Classification

What type of wound is intentionally created by a sharp instrument, resulting in a clean cut through the skin?

A) Abrasion

B) Laceration

C) Incision

D) Puncture

Correct Answer: C)

Explanation: An incision is a wound made intentionally with a sharp instrument, such as a scalpel during surgery, resulting in a clean, straight cut. Abrasions are scrapes that remove the outer skin layers, lacerations are irregular tears from trauma, and punctures are deep holes from pointed objects.

Question 5: Recognizing Complications

Which of the following indicates a complication in wound healing?

A) Granulation tissue formation

B) Epithelialization

C) Wound dehiscence

D) Decreased inflammation

Correct Answer: C)

Explanation: Wound dehiscence refers to the reopening of a previously closed wound, which is a complication that disrupts normal healing. Granulation tissue formation and Epithelialization are positive signs of healing, and decreased inflammation can indicate progress toward recovery, not a complication.

Q6. Which of these IS NOT the impact of proper wound management?

A. Prevent infection and complications due to infection
B. Reduce healthcare cost
C. It will disturb patient's quality of life
D. Escalate wound healing progress

Q7. What can you do to correct misconceptions on wound care management, so that patient will receive the correct information?

A. Give advice according to local clinical practice guidelines or from international with regards to the wound
B. Advice patient to buy the dressing items based on words mouth-to-mouth
C. Refused to check information on the dressing materials from the leaflet given or from what being told by the product specialist.
D. Give information based on their own insights and opinion only, without referencing from any evidenced-based information

Q8. Which of these advice is not important to give to the patient when they come and seek help regarding their wound?

A. Prevention of Infection on Wounds
B. Importance to maintain moist wound environment
A. Encourage them to buy the most expensive dressing product
C. If pain is a big concern, suggest for them to consume painkiller before doing dressing.

Q9. Choose the CORRECT wound care counselling that should be given to patient and relative.

A. Deep wound does not need to be cover and can leave it exposed
B. If you notice increase in pain, swelling, strange odour from the wound please go to the nearest clinic or hospital straight away for further management
C. It is normal if your wound has more discharges than before.
D. Wound that is wet need to be expose to air so that evaporation of exudate from wound will make the wound dry faster.

Q10. Which one is NOT a red flag signs on a wound?

A. Signs of wound infection
B. Non-healing wound
C. Changes in skin colour and temperature
D. Beefy red granulation tissues appears.

ANSWERS: 6.C 7.A 8.C 9.B 10.D

Q11. Which of these wound cleansers is not a wound antiseptics?

A. Hypochlorous acid
B. Octenidine hydrochloride
C. Povidone Iodine 10%
D. Sterile Water

Q12. Which of these dressing items is not an antimicrobial dressing?

A. Silver dressing
B. Sucrose Octasulfate
C. Diakly Carbamoyl Chloride
D. Alginate

Q13. A dirty foot will associates with:

A. Increase risk of bacterial and fungal infection
B. Healthy growth of toe-nail
C. A pleasant smell for the nose
D. Lesser risk of developing wound

Q14. Which of these statements is INCORRECT regarding foot care?

A. Wash and inspect your feet daily.
B. Use moisturiser all over the foot without any area of exception.
C. Use lukewarm water when washing the feet.
D. Pat dry after wash the foot.

Q15. Which statement about foot wear and related to it that is correct below this?

A. Opt for a pointed shoe as it exudes elegance, even though it may compromise the comfort of your feet.
B. The optimal time to purchase shoes is during the evening hours.
C. Wearing high heels or stilettos can add inches to your height without causing long-term back pain.
D. Individuals with diabetes experiencing loss of foot sensation can consider wearing open-toe shoes.

ANSWERS: 11.D 12.D 13.A 14.B 15.D

10 MULTIPLE-CHOICE QUESTIONS (MCQS) BASED ON THE PRESENTATION; OVERVIEW OF WOUND DRESSING PRODUCTS;

Q16. What is the primary purpose of a wound dressing?

A) To completely seal the wound from air exposure

B) To provide or maintain a moist environment for healing

C) To dry out the wound for faster healing

D) To prevent all forms of bacterial growth

Q17. What is a primary dressing in wound care?

A) A dressing that absorbs leakage and secures another dressing

B) A dressing that comes in direct contact with the wound bed

C) A dressing used only for deep wounds

D) A dressing applied over a bandage

Q18. Which of the following is NOT a purpose of wound dressings?

A) Promoting angiogenesis and connective tissue synthesis

B) Preventing gas exchange with the external environment

C) Providing protection against bacterial infection

D) Reducing pain

Q19. What is a major issue with traditional and conventional dressings?

A) They are too expensive

B) They cause dehydration of the wound and adhere to the wound

C) They speed up healing too much

D) They are always the best choice for wound care

ANSWERS: 16.B 17.B 18.B 19.B

Q20. Which of the following is an example of a hydrogel dressing?

A) Kaltostat

B) Duoderm Gel

C) Actisorb Plus

D) Primapore

Q21. What is the main disadvantage of hydrogel dressings?

A) They are impermeable to bacteria

B) They cause maceration of the surrounding skin

C) They cannot be used on dry wounds

D) They are always too expensive

Q22. What type of wound is best suited for transparent film dressings?

A) Heavy exudation wounds

B) Infected wounds

C) Wounds with little to no exudate

D) Wounds with exposed bone and tendons

Q23. What is the main component of alginate dressings?

A) Carboxymethylcellulose

B) Hydrocolloid

C) Polyacrylate polymers

D) Brown seaweed or kelp

ANSWERS: 20.B 21.B 22.C 23.D

Q24. Which type of dressing is highly absorbent and used for wounds with heavy Exudate?

A) Film dressings

B) Superabsorbent dressings

C) Hydrogel dressings

D) Tulle dressings

Q25. Which of the following is a contraindication for hydrocolloid dressings?

A) Dry wounds

B) Wounds with minimal exudate

C) Infected wounds

D) Venous leg ulcers

Q26. What is a scar?

A) A permanent skin discoloration

B) A fibrous tissue that replaces normal skin after injury

C) A bacterial infection of the skin

D) A temporary skin irritation

Q27. Which type of scar is raised and extends beyond the original wound boundaries?

A) Atrophic scar

B) Hypertrophic scar

C) Keloid scar

D) Contracture scar

ANSWERS: 24.B 25.C 26.B 27.C

Q28. What is the main difference between hypertrophic and keloid scars?

A) Hypertrophic scars are larger than keloid scars

B) Keloid scars extend beyond the original wound area, while hypertrophic scars stay within the wound boundary

C) Hypertrophic scars are only seen in burns

D) Keloid scars fade over time while hypertrophic scars worsen

Q29. Which treatment is commonly used for reducing hypertrophic and keloid scars?

A) Cryotherapy

B) Silicone gel sheets

C) Antibiotic ointments

D) Moisturizers

Q30. What is the key to scar prevention?

A. rapid wound closure

B. treat inflammation and infection

C. moist wound healing environment

D. All of the above

Q31. Which type of scars are most commonly associated with burns?

A) Atrophic scars

B) Hypertrophic scars

C) Keloid scars

D) Contracture scars

ANSWERS: 28.B 29.B 30.D 31.D

Q32. When to Refer to a Specialist?

A. Scars are painful, itchy, or restrict movement.

B. Keloids or hypertrophic scars are large or worsening.

C. Scars significantly affect the patient's quality of life or self-esteem.

D. All of the above

Q33. Which of the following is NOT a common method for managing scars?

A) Pressure therapy

B) Massage therapy

C) Radiation therapy

D) Hydration and moisturizing

Q34. Which factor can increase the risk of developing thick scars?

A) Proper wound care

B) Genetic predisposition

C) Early use of silicone gel

D) Keeping the wound moist during healing

Q35. Factors that influences scar formation are?

A. Infection or delayed healing

B. Genetic predisposition

C. Poor wound care practices

D. All of the above

ANSWERS: 32.D 33.C 34.B 35.D