1. You are caring for a client who has just had a squamous cell carcinoma removed from the face. Which of these tasks can you delegate to an experienced nursing LPN/LVN?
   a. Teach the client about risk factors for squamous cell carcinoma.
   b. Show the client how to care for the surgical site at home.
   c. Checking for swelling, bleeding, or pain associated with the surgery.
   d. Discuss the reasons for avoiding aspirin use for a week after surgery.

2. As charge nurse in a long-term-care (LTC) facility, you are developing a care plan for a client with a stage 3 pressure ulcer located over the sacrum. Which nursing intervention is most appropriate to delegate to an LPN who works as a team leader in the facility?
   a. Choose the type of dressing to be used on the ulcer.
   b. Use the Norton scale to assess for pressure ulcer risk factors.
   c. Assist the client to change position at frequent intervals.
   d. Inspect and document the appearance of the ulcer daily.

3. You have just received change-of-shift report for the burn unit. Which client should you assess first?
   a. A client with deep partial-thickness burns on both legs who is complaining of severe and continuous leg pain
   b. A client who has just arrived from the emergency department with facial burns associated with a house fire
   c. A client who has just been transferred from the post-anesthesia care unit (PACU) after having skin grafts applied to the anterior chest
   d. A client admitted 3 weeks ago with full-thickness leg and buttock burns who has been waiting for 3 hours to receive discharge teaching

4. You are doing a sterile dressing change for a client with infected deep partial-thickness burns of the chest and abdomen. List the steps of the care plan in the order each should be accomplished.
   a. Apply silver sulfadiazine (Silvadene) ointment.
   b. Obtain aerobic and anaerobic wound cultures.
   c. Administer morphine sulfate 10 mg IV.
   d. Debride wound of eschar using gauze sponges.

5. You are the nurse-manager in the burn unit. Which client is best assigned to an RN who has floated from the oncology unit?
   a. A 23-year-old who has just been admitted with burns over 30% of the body after a warehouse fire
   b. A 36-year-old who requires discharge teaching about nutrition and wound care after having skin grafts
   c. A 45-year-old with infected partial-thickness back and chest burns who has a dressing change scheduled
   d. A 57-year-old with full-thickness burns on both arms who needs assistance in positioning hand splints
6. You perform a skin assessment on a new resident in an LTC facility. Which of the following is of most concern?
   a. Numerous striae are noted across the abdomen and buttocks.
   b. All the toenails are thickened and yellow in color.
   c. Silver-colored is seen on a black mole on the scalp.
   d. An irregular border is seen on a black mole on the scalp.

7. Which of the following assessment data requires the most immediate further assessment or intervention?
   a. Bluish color around the lips and earlobes
   b. Yellow color of the skin and sclera
   c. Bilateral erythema of the face and neck
   d. Dark brown spotting on the chest and back

8. A 22-year-old female client who has been taking isotretinoin (Accutane) to treat severe cystic acne makes all the following statements while being seen for a routine physical examination. Which statement is of most concern?
   a. "My husband and I are thinking of starting a family soon."
   b. "I don’t think there has been much improvement in my skin."
   c. "Sometimes I get nauseated after taking the medication."
   d. "I have been having problems driving when it gets dark."

9. A client is scheduled for patch testing to determine allergies to several substances. Which nursing activities associated with this test are best delegated to a medical assistant working in the allergy clinic?
   a. Explain the purpose of the testing to the client.
   b. Examine the patch area for evidence of a reaction.
   c. Schedule the client to return to the clinic in 2 days for follow-up.
   d. Monitor for anaphylactic reactions after administration of the test.

10. All of these clients are being discharged from the hospital. In planning discharge teaching, for which are you most concerned about the need to use sunscreen?
    a. A 32-year-old with a urinary tract infection who is being discharged with a prescription for tetracycline 250 mg every 6 hours
    b. A fair-skinned 55-year-old who has just had neck surgery and who plans to walk in the yard for 15 minutes 2 times each day
    c. A dark-skinned 62-year-old who has had keloids injected with hydrocortisone
    d. A 78-year-old with a pruritic rash due to an allergic reaction to penicillin

11. As a home health nurse, you are developing the care plan for an elderly client who has just been referred to your agency. One of the nursing diagnoses is Impaired Skin Integrity related to poor nutrition, bladder incontinence, and immobility. Which of the following nursing actions is best to delegate to an experienced nursing assistant who works at the agency?
    a. Tell the client and family to apply the skin barrier cream in a smooth, even layer.
    b. Complete a diet assessment and suggest changes in diet to improve the client’s nutrition.
c. Remind the family to help the client to the commode every 2 hours during the day.
d. Evaluate the client for improvement in documented areas of skin breakdown or damage.

12. You have prepared a care plan for an elderly client living in an LTC facility who has candidiasis in the skin folds of the abdomen and groin. Which intervention is best for you, as the nurse manager, to delegate to an LPN working in the facility?
   a. Apply nystatin (Mycostatin) powder to the area 3 times daily.
   b. Clean skin folds every 8 hours with mils soap and dry thoroughly.
   c. Evaluate the need for further antifungal treatment at least weekly.
   d. Assess for ongoing risk factors for skin breakdown and infection

13. A client who is receiving chemotherapy is admitted with widespread herpes simplex lesions of the oral mucosa and lips. The admission assessment data includes a marked recent decrease in oral intake, level 9 – 10 burning oral pain (0 – 10 scale), and statements by the client indicating emotional distress about the appearance of the lesions. Based on this information, which of these nursing diagnoses is of highest priority?
   a. Risk for infection related to not knowing how to avoid contacting herpes simplex
   b. Acute Pain related to presence of extensive herpes simplex lesions
   c. Imbalanced Nutrition: Less Than Body Requirements related to decreased oral intake
   d. Disturbed Body Image related to the appearance of the oral lesions

14. A client admitted to the ED complains of itching of the trunk and groin. You note the presence of multiple reddened wheals on the chest, back, and groin. Which question is most appropriate to ask next?
   a. Do you have a family history of eczema?
   b. Have you been using sunscreen regularly?
   c. How do you usually manage stress?
   d. Are you taking any new medications?

15. A 62-year-old client has extensive blister injuries to the back and both legs caused by exposure to toxic chemicals at work and is admitted to the ED. Which of these ordered interventions will you perform first?
   a. Infuse lactated Ringer’s solution at 250 mL per hour.
   b. Irrigate the back and legs with 4 L of sterile normal saline.
   c. Obtain blood for a complete blood count and electrolyte.
   d. Document the percentage of total body surface area burned.

16. You have just received the change-of-shift report in the burn unit. Which client requires the most immediate assessment or intervention?
   a. A 22-year-old admitted 4 days previously with facial burns due to a house fire who has been crying since recent visitors left
   b. A 34-year-old who returned from skin-graft 3 hours ago and is complaining of level 8 pain (0 – 10 pain scale)
c. A 45-year-old with deep partial-thickness leg burns who has a temperature of 102.6°F and a blood pressure of 98/46

d. A 57-year-old who was admitted with electrical burns 24 hours ago and has a blood potassium level of 5.6 mEq/L

17. You take the health history for a 60-year-old client who has been admitted to same-day surgery for elective facial dermabrasion. Which information is most important to convey to the plastic surgeon?
   a. The client does not routinely use sunscreen.
   b. The client has a family history of melanoma.
   c. The client has not eaten anything for 8 hours.
   d. The client takes 325 mg of aspirin daily.

18. A newly graduated RN is in the third week of orientation to the medical-surgical unit. Which client is best for you, as charge nurse, to assign to the new graduate?
   a. A 34-year-old who was just admitted to the unit with periorbital cellulitis
   b. A 40-year-old who needs discharge instructions after having skin grafts to the right thigh
   c. A 67-year-old who has a dressing change scheduled after hydrotherapy for a stage 3 pressure ulcer
   d. A 78-year-old who needs teaching before a punch biopsy of a facial lesion

19. An outpatient seen in the clinic for follow-up after being diagnosed with contact dermatitis caused by poison ivy has been taking prednisone (Deltasone) 30 mg daily. You evaluate the client for adverse medication effects. Which information is of most concern?
   a. The client’s blood glucose is 136 mg/dL
   b. The client states, “I am eating all the time.”
   c. The client complains of epigastric pain.
   d. The client’s blood pressure is 148/84

20. As charge nurse, you are observing a newly hired RN. Which action by the new RN requires your most immediate action?
   a. Obtaining an anaerobic culture of a superficial partial-thickness arm burn
   b. Administration of tetracycline with a glass of milk to a client with cellulitis
   c. Debridement of a deep partial-thickness burn wound using wet-to-dry dressings
   d. Teaching a newly admitted burn client about the use of pressure garments
RATIONALE
INTEGUMENTARY PROBLEMS

1. **ANSWER A** – An LPN/LVN who was experienced in working with post-operative clients would know how to reinforce a dressing. In addition, the LPN/LVN would know to notify the supervising RN about the bleeding. Client teaching and assessments are skills that require more education and a greater scope of practice and are appropriate for registered nurses. **Focus: Delegation**

2. **ANSWER D** – LPN/LVN education and scope of practice include assessment and documentation of common health problems. Choice of the type of dressing to use and assessment for risk factors are more complex skills that are more appropriate to the RN level of practice. LPN/LVNs do function as wound care nurses in some long-term-care facilities but the choice of dressing type would fall within the RN’s role. For a stage 3 ulcer, a nurse with an RN-level education would be most appropriate to select the dressing. Assisting the client to change position is a task included in the nursing assistant’s education and would be more appropriate to assign to NA-level staff members. **Focus: Delegation**

3. **ANSWER B** – Facial burns are frequently associated with airway inflammation and swelling, so this client requires the most immediate assessment. The other clients also require rapid assessment or interventions, but not as urgently as the client with facial burns. **Focus: Prioritization**

4. **ANSWER C, D, B, A** – Pain medication should be administered prior to dressing changes since dressing changes for partial-thickness burns are painful, especially if the dressing change involves removal of eschar. The wound should be debrided prior to obtaining wound cultures to avoid obtaining bacteria that are skin contaminants rather than causes of the wound infection. The antibacterial cream should be applied to the area after debridement to gain the maximum effect. **Focus: Prioritization**

5. **ANSWER C** – A nurse from the oncology unit would be familiar with dressing changes and sterile technique. The charge RN from the burn unit would work closely with the float RN to provide partners to assist in providing care and to answer any questions. Admission assessment and development of the initial care plan, discharge teaching, and splint positioning in burn clients all require expertise in caring for clients with burns. These clients should be assigned to RNs who regularly work on the burn unit. **Focus: Assignment**

6. **ANSWER D** – Irregular borders and a black or variegated color are characteristics associated with malignancy. Striae and toenail thickening or yellowing are common in elderly individuals. Silver-colored scaling is associated with psoriasis, which may need treatment, but is not as urgent a concern as the appearance of the mole. **Focus: Prioritization**

7. **ANSWER A** – A blue color or cyanosis may indicate that the client has significant problems with circulation or ventilation. More detailed assessments are needed immediately. The other data may also indicate health problems in major body systems, but potential respiratory or circulatory abnormalities are the priority. **Focus: Prioritization**
8. **ANSWER A –** Because isotretinoin is associated with a high incidence of birth defects, it is important that the client stop using the medication at least a month before attempting to become pregnant. Nausea and poor night vision are possible adverse effects of isotretinoin, which would require further assessment, but are not as urgent as discussing the fetal risks associated with this medication. The client’s concern about whether treatment is effective should be addressed, but this is a lower priority intervention. **Focus:** Prioritization

9. **ANSWER C –** Scheduling the client for an appointment is within the legal scope of practice and training for the medical assistant role. Client teaching, assessment for positive skin reactions to the test, and monitoring for serious allergic reactions are appropriate to the education and practice role of licensed nursing staff. **Focus:** Delegation

10. **ANSWER A –** Systemic use of tetracycline is associated with severe photosensitivity reactions to ultraviolet light. All individuals should be taught about the potential risks associated with overexposure to sunlight or other ultraviolet light, but the client taking tetracycline is at the most immediate risk for severe adverse effects. **Focus:** Prioritization

11. **ANSWER C –** While it is not appropriate for the nursing assistant to plan or implement initial client or family teaching, reinforcement of previous teaching is an important function of the nursing assistant (who is likely to be in the home on a daily basis). Client/family teaching, nutritional assessment and planning, and evaluation for improvement are included in the RN scope of practice. **Focus:** Delegation

12. **ANSWER A –** Medication administration is included in LPN education and scope of practice. Bathing and cleaning clients requires minimal education and would be better delegated to a nursing assistant. Assessment and evaluation of outcomes of care are more complex skills best performed by registered nurses. **Focus:** Delegation

13. **ANSWER B –** The highest priority diagnoses for this client are Acute Pain and Impaired Nutrition. The Acute Pain diagnosis takes precedence because the client’s acute oral pain will need to be controlled to improve the ability to eat and to improve nutrition. The assessment data do not indicate that the client’s lack of understanding about how the virus is contracted contributed to the infection. (The most frequent cause of oral herpes infection in immunocompromised clients is reactivation of previously acquired herpes simplex.) Disturbed body image is a major concern for the client, but is not as high a priority as a need for pain control and improved nutrition. **Focus:** Prioritization

14. **ANSWER D –** Wheals are frequently associated with allergic reactions, so asking about exposure to new medications is the most appropriate question for this client. The other questions would be useful in assessing the skin health history, but do not directly relate to the client’s symptoms. **Focus:** Prioritization

15. **ANSWER B –** With chemical injuries, it is important to remove the chemical from contact with the skin to prevent ongoing damage. The other actions also should be accomplished rapidly; however, rinsing the chemical off is the priority for this client. **Focus:** Prioritization
16. **ANSWER C** – This client’s vital signs indicate that the life-threatening complications of sepsis and septic shock may be developing. The other clients also need rapid assessments and/or nursing interventions, but their symptoms do not indicate that they need care as urgently as the febrile and hypotensive client. 
**Focus:** Prioritization

17. **ANSWER D** – Because aspirin affects platelet aggregation, the client is at increased risk for post-procedure bleeding, and the surgeon will likely reschedule the procedure. The other information is also pertinent, but will not affect the scheduling of the procedure. 
**Focus:** Prioritization

18. **ANSWER C** – A new graduate would be familiar with the procedure for a sterile dressing change, especially after working for 3 weeks on the unit. Clients who require more complex skills such as admission assessments, pre-procedure teaching, and discharge teaching should be assigned to more experienced RN staff members. 
**Focus:** Assignment

19. **ANSWER C** – Epigastric pain may indicate that the client is developing peptic ulcers, which require collaborative interventions such as the use of antacids, H₂ receptor blockers (e.g., famotidine [Pepcid]), or proton pump inhibitors (e.g., esomeprazole [Nexium]). The elevation in blood glucose, increased appetite, and slight elevation in blood pressure may be related to prednisone use, but are not clinically significant when steroids are used for limited periods and do not require treatment. 
**Focus:** Prioritization

20. **ANSWER B** – Dairy products inhibit the absorption of tetracycline, so this action would decrease the effectiveness of the antibiotic. The other activities are not appropriate, but would not cause as much potential harm as the administration of tetracycline with milk. Aerobic bacteria would not be likely to grow in a superficial wound. Debridement of burns should be performed by more experienced nursing staff. Pressure garments may be used after graft wounds heal and during the rehabilitation, not when the client is admitted. 
**Focus:** Prioritization