HESI FUNDAMENTALS PROCTORED EXAM

1. The nurse is admitting an older patient from a nursing home. During the assessment, the nurse notes a shallow open reddish, pink ulcer without slough on the right heel of the patient. How will the nurse stage this pressure ulcer?

a. Stage I

b. Stage II

c. Stage III

d. Stage IV

ANS: B

This would be a Stage II pressure ulcer because it presents as partial-thickness skin loss involving epidermis and dermis. The ulcer presents clinically as an abrasion, blister, or shallow crater. Stage I is intact skin with nonblanchable redness over a bony prominence. With a Stage III pressure ulcer, subcutaneous fat may be visible, but bone, tendon, and muscles are not exposed. Stage IV involves full-thickness tissue loss with exposed bone, tendon, or muscle.

2. The nurse is completing a skin assessment on a patient with darkly pigmented skin. Which item should the nurse use **first** to assist in staging an ulcer on this patient?

a. Disposable measuring tape

b. Cotton-tipped applicator

c. Sterile gloves

d. Halogen light

ANS: D

When assessing a patient with darkly pigmented skin, proper lighting is essential to accurately complete the first step in assessment—inspection—and the entire assessment process. Natural light or a halogen light is recommended. Fluorescent light sources can produce blue tones on darkly pigmented skin and can interfere with an accurate assessment. Other items that could possibly be used during the

assessment include gloves for

infection control, a disposable measuring device to measure the size of the wound, and a cotton-tipped applicator to measure the depth of the wound, but these items are not the first items used.

3. The nurse is caring for a patient with a Stage IV pressure ulcer.

Which type of healing will the nurse consider when planning care for this patient?

a. Partial-thickness wound repair

b. Full-thickness wound repair

c. Primary intention

d. Tertiary intention

ANS: B

Stage IV pressure ulcers are full-thickness wounds that extend into the dermis and heal by scar formation because the deeper structures do not regenerate, hence the need for full-thickness repair. The full-thickness repair has four phases: hemostasis, inflammatory, proliferative, and maturation. A wound heals by primary intention when wounds such as surgical wounds have little tissue loss; the skin edges are approximated or closed, and the risk for infection is low. Partial-thickness repairs are done on partial-thickness wounds that are shallow, involving loss of the epidermis and maybe partial loss of the dermis. These wounds heal by regeneration because the epidermis regenerates. Tertiary intention is seen when a wound is left open for several days, and then the wound edges are approximated. Wound closure is delayed until risk of infection is resolved.

4. The nurse is caring for a group of patients. Which patient will the nurse see **first**?

a. A patient with a Stage IV pressure ulcer

b. A patient with a Braden Scale score of 18

c. A patient with appendicitis using a heating pad

d. A patient with an incision that is approximated

ANS: C

The nurse should see the patient with an appendicitis first. Warm applications are contraindicated when the patient has an acute, localized inflammation such as appendicitis because the heat could cause the appendix to rupture. Although a Stage IV pressure ulcer is deep, it is not as critical as the appendicitis patient. The total Braden score ranges from 6 to 23; a lower total score indicates a higher risk for pressure ulcer development. A score of 18 can be assessed later. A healing incision is approximated (closed); this is a normal finding and does not need to be seen first.

5. The nurse is caring for a patient who is experiencing a full-thickness repair. Which type of tissue will the nurse expect to observe when the wound is healing?

a. Eschar

b. Slough

c. Granulation

d. Purulent drainage

ANS: C

Granulation tissue is red, moist tissue composed of new blood vessels, the presence of which indicates progression toward healing. Soft yellow or white tissue is characteristic of slough—a substance that needs to be removed for the wound to heal. Black or brown necrotic tissue is called eschar, which also needs to be removed for a wound to heal. Purulent drainage is indicative of an infection and will need to be resolved for the wound to heal.

6. The nurse is caring for a patient who has experienced a laparoscopic appendectomy. For which type of healing will the nurse focus the care plan?

a. Partial-thickness repair

b. Secondary intention

c. Tertiary intention

d. Primary intention

ANS: D

A clean surgical incision is an example of a wound with little loss of tissue that heals with primary intention. The skin edges are approximated or closed,

and the risk for infection is low. Partial-thickness repairs are done on partial-thickness wounds that are shallow, involving loss of the epidermis and maybe partial loss of the dermis. These wounds heal by regeneration because the epidermis regenerates. Tertiary intention is seen when a wound is left open for several days, and then the wound edges are approximated. Wound closure is delayed until the risk of infection is resolved. A wound involving loss of tissue such as a burn or a pressure ulcer or laceration heals by secondary intention. The wound is left open until it becomes filled with scar tissue. It takes longer for a wound to heal by secondary intention; thus the chance of infection is greater.