Wound Care Certification Review #10
Analyze Skin Integrity Across the Lifespan

1. Which factor most increases a neonate's risk for skin breakdown?
A. Thick epidermal layer
B. Frequent repositioning
C. Immature stratum corneum
D. Low humidity in incubator

2. When assessing a pediatric patient's skin, which finding requires immediate attention?
A. Minor diaper rash
B. Blanchable erythema on the heel
C. Petechiae on the torso and extremities
D. Slight dryness on the elbows

3. Compared to adults, neonates are more prone to epidermal stripping primarily because:
A. Their skin pH is more alkaline
B. The dermal-epidermal junction is weaker
C. They have increased sebaceous activity
D. Their skin has higher collagen density

4. Which pediatric skin assessment finding most suggests possible abuse rather than accidental injury?
A. Bruising over shins and knees
B. Small linear bruises on forearms
C. Circular burns on the buttocks
D. Scratch marks on the forearms

5. In older adults, which physiological skin change most contributes to delayed wound healing?
A. Increased fibroblast activity
B. Thicker epidermis
C. Decreased collagen synthesis
D. Increased sebum production

6. A newborn with an adhesive dressing removal develops superficial skin loss. What is the best preventive measure for future applications?
A. Apply dressings with firm pressure
B. Use silicone-based adhesive dressings
C. Use alcohol wipes before dressing removal
D. Warm the adhesive to improve adherence

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7. In adults, which comorbidity most significantly increases risk for impaired skin integrity?
A. Seasonal allergies
B. Type 2 diabetes mellitus
C. Mild anxiety
D. Controlled hypertension

8. When evaluating skin integrity in geriatrics, the clinician should pay special attention to:
A. Nail thickness and texture
B. Sun-exposed areas only
C. Areas over bony prominences
D. Hair distribution on scalp

9. A pediatric patient with a spina bifida history is at higher risk for pressure injuries primarily because of:
A. Increased activity level
B. Sensory deficits and immobility
C. Rapid skin turnover
D. Excessive sweating

10. In neonates, transepidermal water loss is greatest in:
A. Preterm infants
B. Full-term infants
C. Infants over 3 months
D. Infants fed formula

11. Which environmental factor most contributes to skin breakdown in older adults living at home?
A. Central air conditioning
B. Low humidity and inadequate hydration
C. Sunlight exposure
D. Sleeping on firm mattresses

12. The skin of geriatric patients is more prone to bruising primarily due to:
A. Thicker subcutaneous fat
B. Increased vascular elasticity
C. Capillary fragility and decreased dermal support
D. Elevated vitamin K levels

13. Which intervention is most appropriate for maintaining skin integrity in a bedridden adult?
A. Reposition every 2 hours and use pressure redistribution surfaces
B. Encourage minimal movement to conserve energy
C. Apply alcohol-based cleansers after each incontinence episode
D. Limit protein intake to reduce metabolic demand

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14. A pediatric burn patient presents with partial-thickness injury. The wound nurse should prioritize:
A. Strict fluid restriction
B. Preventing hypothermia and infection
C. Applying heat lamps for comfort
D. Using adhesive gauze dressings

15. When comparing skin assessment findings across the lifespan, which observation is most consistent with normal aging rather than pathology?
A. Loss of subcutaneous fat and decreased elasticity
B. Cyanotic discoloration of extremities
C. Yellowish hue of the sclera
D. Nonblanchable erythema on sacrum

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Answer Key & Explanations

1. C – Neonatal skin is thin with an immature stratum corneum, making it highly vulnerable to injury and fluid loss.
2. C – Petechiae are abnormal findings that may indicate systemic illness, clotting disorders, or abuse.
3. B – The dermal-epidermal junction in neonates is weak, predisposing them to epidermal stripping from adhesives or friction.
4. C – Circular burns on the buttocks are classic signs of intentional injury; location and pattern indicate possible abuse.
5. C – Aging skin exhibits reduced fibroblast and collagen activity, slowing granulation and re-epithelialization.
6. B – Silicone-based adhesives minimize skin trauma in neonates and are the standard for fragile skin.
7. B – Diabetes leads to neuropathy and poor perfusion, significantly impairing wound healing and skin integrity.
8. C – Bony prominences are the most common sites for pressure injury in geriatric patients due to decreased tissue padding.
9. B – Neurological impairment and immobility from spina bifida increase risk of unrecognized pressure injuries.
10. A – Preterm infants have immature skin barrier function, resulting in higher transepidermal water loss.
11. B – Low ambient humidity and poor hydration exacerbate xerosis and skin breakdown in older adults.
12. C – Fragile capillaries and thinning dermis cause ecchymosis with minimal trauma in geriatric patients.
13. A – Repositioning and pressure redistribution surfaces are evidence-based strategies for preventing pressure injuries.
14. B – Pediatric patients have high surface area-to-mass ratio; preventing hypothermia and infection is critical.
15. A – Skin thinning, elasticity loss, and decreased subcutaneous fat are normal age-related changes, not disease.

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