



Pressure Ulcers eCourse

Knowledge Checkup All

Handout

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Knowledge Checkup – Questions

1. What other terms are sometimes used to describe a pressure ulcer?
2. What intrinsic factors can cause pressure ulcers?
3. What are the six classifications / stages of pressure ulcers?
4. What at-risk factors can affect pressure ulcer development for individuals undergoing surgery?
5. What are some of the challenges to preventing pressure ulcers in the operating room?
6. Why is a complete skin assessment recommended for each surgical patient?
7. Which unit in the hospital would most likely have the highest risk patients for pressure ulcer development?
8. What are the common body sites for pressure ulcers in the pediatric population?
9. What is the main reason for repositioning infants and children?
10. What are the eight bony areas of the body where pressure ulcers typically occur?

11. Why do pressure ulcers develop on bony sites of the body?
12. How does pressure occur to soft tissue, and when can this happen?
13. How does friction occur, and when can this happen?
14. When does shearing occur?
15. What pressure-causing effects can occur that promote pressure ulcers?
16. What type of patient would experience uninterrupted pressure due to impaired mobility?
17. Why is it important to do a pressure ulcer risk assessment on each patient / resident?
18. How soon should a skin assessment be done at admission? How often should skin reassessment be done?
19. What are some of the causes for pressure ulcer development?
20. What is the most cost-effective tool to use in PU prevention program?

21. When is a good time to do a skin inspection?

22. What role does repositioning play in pressure ulcer prevention?

23. What does debridement do?

24. How can a checklist be used in preventing pressure ulcers?

25. What is the role of the family in preventing pressure ulcers?

Knowledge Checkup – Answers

1. Bedsore, pressure sore and decubitus ulcer
2. Immobility due to a spinal cord injury, brain damage, or coma. Age, malnutrition, dehydration, low blood pressure, and emotional stress are also factors.
3. Categories/stages I through IV, suspected deep tissue injury and unstageable.
4. Anesthesia, duration of pressure, age and type of surgical procedure.
5. Factors include positioning, anesthesia, duration of the surgery, vulnerability of the patient, pressure distribution, length of stay, inability to access patients' skin because sterile drapes, and inability of patients to perceive pain and discomfort.
6. Skin status is a risk factor for pressure ulcer development. A skin assessment establishes a comparative baseline for postoperative status.
7. Intensive care because patients are often immobile for long periods of time.
8. Ear, sacrum, occipital area and scapula.
9. To reduce or eliminate pressure thereby maintaining circulation to areas of the body at risk for pressure ulcers.
10. These are elbows, knees, ankles, heels, scalp, the back, tail bone and hips.
11. A person's body weight is concentrated on these areas when lying on a surface that is unyielding.
12. This occurs when the layers of the skin slide over one another or over deeper tissue such as occurs when one slides down a bed or chair.
13. Friction occurs when the skin is rubbed against an external surface such as turning a patient in bed.
14. This happens when the skin moves one way and the underlying bone moves the opposite direction.
15. Capillaries are compressed and oxygen and nutrients cannot reach the tissues.
16. Patients who are neurologically impaired, heavily sedated or anesthetized, restrained, demented, or recovering from a traumatic injury, such as a pelvic or femur fracture.

17. Knowing which individuals are at-risk can result in taking preventative steps to reduce PU prevalence and incidence.
18. A skin assessment should be done as soon as possible after admission. Reassessment of skin integrity should be done on every shift or when the patient's condition changes.
19. Causes include: pressure, friction shear, impaired mobility, moisture, and the inability to feel pain.
20. Using a risk-assessment scale as it identifies patients who are most in need of preventative care.
21. Good times are when bathing, dressing or assisting a patient or resident.
22. Failure to reposition will result in ongoing ischemia and inevitable tissue damage.
23. Keeps the wound free of damaged, dead and infected tissue.
24. A checklist can help determine the pressure ulcer status of patients or residents. The checklist should include such things as location of the pressure ulcer, stage, drainage, size, type of dressing used, nutritional status, and whether the wound contains viable tissue.
25. The more the patient and their care-givers know of the risk factors, they better they can help to prevent and/or identify the condition.