Pressure Ulcers eCourse

Knowledge Checkup Module 2

Handout

Knowledge Checkup – Questions

1. Why is it important to prevent pressure ulcers from developing in our patients and residents?

2. What 3 factors contribute to excessive pressure on soft tissue?

3. How does continuous pressure contributes to the development of pressure ulcers?

4. What is a common cause of skin damage due to friction?

5. What are some common causes of damage to the skin due to shear?

6. What pressure-causing effects occur when the bones rub against the skin and underlying deeper tissue?

7. What are some “unusual” causes of circulation loss?

8. What are the four stages/categories used to classify pressure ulcers?

9. What additional two categories of pressure ulcers are recognized by the NPUAP (USA)?

10. What are the main characteristics of a Category / Stage I pressure ulcer?

11. What are the main characteristics of a Category / Stage II pressure ulcer?

12. What are the main characteristics of a Category / Stage III pressure ulcer?

13. What are the main characteristics of a Category / Stage IV pressure ulcer?

14. What types of skin damage should NOT be considered pressure ulcers?

15. What types of individuals are most at risk for developing pressure ulcers?

16. What the 11 common risk factors associated with the development of pressure ulcers?

17. What features of old age contribute to risks for pressure ulcers?

18. How can use of medications contribute to risk of developing pressure ulcers?

19. What are the most common body sites for risk of pressure ulcers in neonates and children?

20. What are the pressure ulcer risk factors in the emergency unit?

Knowledge Checkup – Answers

1. Severe pain and discomfort; fatal complications; burden on pre-existing conditions; robs healthcare resources; increases costs; financial penalties; increased liabilities

2. Intensity, duration and tissue tolerance

3. The skin and underlying tissue do not receive an adequate blood supply

4. Turning and moving patients

5. Sliding down a bed or raising top half of bed too much

6. Blood vessels are compressed; oxygen and nutrients cannot reach the tissue; causes ischemia, hypoxia and necrosis

7. Crumbs in bed; wrinkles in sheets and clothing; slightly titling chair

8. Stages/Categories I, II, III and IV

9. Suspected deep tissue injury; unstageable pressure ulcer

10. Intact skin with non-blanchable redness; painful, firm, soft, warm or cooler

11. Shallow open ulcer with red pink wound bed without slough; intact or open serum-filled blister; shiny or dry shallow ulcer without slough or bruising

12. Full thickness tissue loss; subcutaneous fat visible; slough may be present but does not obscure depth

13. Full thickness tissue loss; exposed bone, tendon or muscle; slough or eschar; often includes undermining and tunneling

14. Skin tears or tape burns; incontinence-related dermatitis, maceration or excoriation

15. Bedridden; in wheelchairs; stroke victims; diabetes or dementia; sedated and those with spinal cord injuries

16. Immobility, advanced age, incontinence, infection, low blood pressure, malnutrition and dehydration, medical devices, friction, medications, mental health, cigarette smoking

17. Skin more fragile; less fat to cushion bony parts; poor nutrition and hydration; impaired respiratory and immune systems

18. Some meds contribute to breakages in skin integrity; tranquillizers decrease sensory perception and mobility; steroids disrupt normal healing process

19. Ear, sacrum, occipital area and scapula

20. Spending hours or days; laying on hard support surfaces; and tissue damage from transport to hospital