Pressure Ulcers eCourse

Knowledge Checkup Module 3

Handout

Knowledge Checkup – Questions

1. When should patients or residents be assessed for pressure ulcers?

2. What places on the body should you check for signs of pressure ulcers for a patient who sits a lot?

3. Where should you check for pressure ulcers on a patient who spends most time in bed?

4. When doing a skin assessment, what should you inspect and palpate for?

5. When should you re-assess skin integrity?

6. What information do you need to document when a pressure ulcer is discovered?

7. When documenting the periwound skin appearance, what type of characteristics should you observe?

8. What are the signs that a pressure ulcer wound may be infected?

9. What are the characteristics of deep infection in Stage III and IV pressure ulcers?

10. What factors cause pain when a patient or resident has a pressure ulcer?

11. When describing a wound appearance, what characteristics should you mention?

12. What are the names of three commonly used pressure ulcer risk-assessment tools for adults?

13. What are the names of two pediatric pressure ulcer risk-assessment scales?

14. What are the six risk factors measured by the Braden pressure ulcer risk-assessment scale?

15. What are the five risk factors measured by the Norton pressure ulcer risk-assessment scale?

16. What are the normal pressure ulcer risk factors measured by the Waterlow Scale?

Knowledge Checkup – Answers

1. At admission, at regular intervals, or when there is a significant change in health condition

2. Shoulder blades, tailbone, buttocks, back of knees, and heels

3. Side of head, shoulder, upper hipbone, upper thighbone, front of knee and sides of feet and ankles

4. Skin integrity, texture, temperature, consistency, moisture and color changes

5. Every shift; whenever the health condition changes; and during regular assessment

6. Site/location, stage/category, odor, periwound skin, dimensions, tunneling/undermining, infection, pain and wound appearance

7. Whether the skin is intact, macerated, dry, indurated or erythemic

8. Exudates with persistent inflammation; delayed healing; discolored tissue that bleeds easily; pocketing

9. Increase in warmth, tenderness and pain

10. Pressure; friction and shear; damaged nerve endings; inflammation, infection, treatments, incontinence, and muscle spasms

11. Color, granulation tissue; amount, color, consistency and adherence of necrotic tissue; and slough, soft or hard eschar

12. Braden, Norton and Waterlow

13. Braden Q and Glamorgan

14. Mobility, activity level, sensory perception, moisture, nutritional status, and friction / shear

15. Physical condition, mental condition, activity, mobility and incontinence

16. Build/weight for height, skin type, gender, age, malnutrition, continence and mobility