Pressure Ulcers eCourse: Module 3 – Quiz II

1. Healthcare organizations should have procedures in place to identify at-risk patients and residents as soon as possible after they enter their facility.

   True False

2. When developing a pressure ulcer treatment plan, you should:

   a. Obtain a complete medical history
   b. Do a full physical examination
   c. Do a nutritional assessment
   d. Assess pain

3. Soft periwound tissue is an indication of infection.

   True False

4. Assessment for pressure ulcers should include:

   a. Validated risk-assessment scale
   b. Head-to-toe skin assessment
   c. Nutritional assessment
   d. Psychosocial assessment

5. An important reason to conduct a skin assessment when a patient is admitted to a health organization is to document any pre-admission damage or conditions.

   True False

6. In long-term care, reassessment for pressure ulcers should occur how often?

   a. Every 24 to 48 hours
   b. Weekly initially, then monthly
   c. Every nurse visit
   d. Yearly

7. A tunneling/sinus tract is a narrow channel of passageway extending into healthy tissue.

   True False

8. How often should you reassess a patient's or resident's skin integrity?

   a. Every shift
   b. When condition changes
   c. Weekly
   d. Monthly

9. Which of the following have been identified as warning signs for pressure ulcer development?

   a. Localized heat
   b. Edema
   c. Induration
   d. Confusion

10. Pressure ulcers that have been subjected to shear are often first seen with undermining.

    True False

11. Under what conditions is it difficult to accurately detect Stage I pressure ulcers?

    a. Darkly pigmented skin
    b. When eschar is present
    c. Under casts and support socks
    d. On bony prominences

12. Contamination of the wound with specific organisms or anaerobes may be detected by their characteristic odors.

    True False

13. The condition of the periwound skin tissue provides useful information for:

    a. Wound-healing diagnosis
    b. Overall health status
    c. Dressing application and removal
    d. Comorbidities

14. Accuracy of pressure ulcer wound measurements may be affected by:

    a. Body positioning
    b. Wound bed is not uniform
    c. Measurements done by different nurses
    d. Measurement units used

15. There is NO relationship between the wound surface area and time to complete pressure ulcer healing.

    True False

16. Which of the following are signs of a pressure ulcer wound infection?

    a. Exudates with persistent inflammation
    b. Delayed healing
    c. Discolored tissue that bleeds easily
    d. Malodor

17. Researchers have concluded that no one scale can accurately predict a patient's risk for developing pressure ulcers.

    True False

18. Deep infection in Stage III and IV pressure ulcers is characterized by an increase in:

    a. Warmth
    b. Tenderness
    c. Pain
    Induration

19. Pressure ulcer pain in absent in Stage III and IV pressure ulcers because the nerve endings have been damaged.

    True False

20. Which of the following factors can cause pain when a patient or resident has a pressure ulcer?

    a. Medications
    b. Damaged nerve endings
    c. Procedures and treatments
    d. Excoriation from incontinence

21. When assessing individuals for risk in developing pressure ulcers, the use of a validated risk-assessment tool is sufficient.

    True False

22. When should pain assessment be done with a pressure ulcer patient?

    a. Before wound procedures
    b. During wound procedures
    c. When dressing is intact
    d. When no procedures are in progress

23. The most reliable indicator of pain is the nurse's clinical observations of the patient.

    True False

24. Management of pressure ulcer-related pain may include:

    a. Repositioning
    b. Covering the wound
    c. Systemic analgesia prior to treatments
    d. Limiting number of dressing changes
    e. Avoiding tape on fragile skin

25. Granulation tissue is pink/red moist tissue comprising new blood vessels that fill an open wound when it starts to heal.

    True False

26. Necrotic tissue is:

    a. Gray
    b. Dry
    c. Brown
    d. Black

27. Eschars are typically gray to black and dry or leathery.

    True False

28. Yellowness in the pressure ulcer wound bed indicates:

    a. Presence of slough or fibrinous tissue
    b. Presence of granulation tissue
    c. Infection
    d. Sign of ischemia

29. A bright red wound bed reflects the presence of necrotic tissue or eschar due to local alteration of tissue perfusion or ischemia.

    True False

30. A dark red wound bed indicates:

    a. Presence of slough or fibrinous tissue
    b. Presence of granulation tissue
    c. Infection
    d. Sign of ischemia

31. The most cost-effective method of implementing a pressure ulcer prevention program is to use risk-assessment scales so that those individuals most at risk can be targeted.

    True False

32. Patients who are predicted by risk-assessment tools to develop pressure ulcers but do not are referred to as false-negatives.

True False

33. Which risk factor is NOT included in the Braden Scale?

a. Tissue perfusion and oxygenation
b. Mobility
c. Sensory perception
d. Exposure to moisture
e. Nutritional status

34. Which of the following scales are specifically designed to assess pressure ulcer risks in pediatric populations?

a. Braden Q Scale
b. Glamorgan Scale
c. Norton Scale
d. Waterlow Scale
e. Braden Scale

35. Which pressure ulcer risk-assessment scale has been criticized for not assessing nutrition and not providing a description of its risk components?

a. Braden Q Scale
b. Glamorgan Scale
c. Norton Scale
d. Waterlow Scale
e. Braden Scale

36. Which pressure ulcer risk-assessment scale is now the most widely used tool in Europe?

a. Braden Q Scale
b. Glamorgan Scale
c. Norton Scale
d. Waterlow Scale
e. Braden Scale

37. The Waterlow Scale often over predicts the number of patients who will develop pressure ulcers.

    True False

38. In which pressure ulcer risk-assessment tool are females scored higher than males, due to anatomical differences?

    a. Braden Q Scale
    b. Glamorgan Scale
    c. Norton Scale
    d. Waterlow Scale
    e. Braden Scale

Answers to Module 3 – Quiz II

Q1 True

Q2 a,b,c,d – ALL of these should be included when developing a pressure ulcer care plan.

Q3 False – Indurated (hard) tissue is an indication of infection.

Q4 a,b – Nutrition and psychosocial status are important for determining at-risk individuals, not for identifying pressures ulcers.

Q5 True – This is to prove that an individual did not acquire the condition during their hospital stay.

Q6 b

Q7 True

Q8 a,b

Q9 a,b,c

Q10 True

Q11 a,b,c

Q12 True

Q13 a,b,c

Q14 a,b,c

Q15 False – Studies have demonstrated a relationship. Large pressure ulcers are less likely to heal within 30 days.

Q16 a,b,c,d

Q17 True – However, researchers acknowledge that the predictive accuracy of a scale is difficult to prove since the scales naturally trigger preventive strategies.

Q18 a,b,c

Q19 False – Individuals with Stage IV pressure ulcers experience MORE pain than individuals with lower-stage ulcers.

Q20 b,c,d

Q21 False – The best assessment includes the use of a risk-assessment tool in combination with a comprehensive skin assessment and clinical judgment.

Q22 a,b,c,d

Q23 False – The most reliable indicator of pain is the individual's report of pain.

Q24 a,b,c,d,e

Q25 True

Q26 a,c,d – Necrotic tissue is moist, not dry.

Q27 True

Q28 a

Q29 False – A black wound bed reflects the presence of necrotic tissue or eschar.

Q30 c

Q31 True

Q32 False – These are false-positives; patients who are predicted to be free of pressure ulcers but get them, are referred to as false-negatives.

Q33 a – Tissue perfusion and oxygenation is a risk factor in the Braden Q Scale.

Q34 a,b

Q35 c

Q36 d

Q37 True – It has the lowest specificity; it is also criticized for its lack of explanatory comments for each of the risk-assessment areas.

Q38 d