

Pressure Ulcers eCourse: Module 4 – Quiz I

1. Which of the following is probably the most important component in a plan of care to prevent pressure ulcers in high-risk patients and residents?
 - a. Documentation
 - b. Daily skin inspection
 - c. Nutrition
 - d. Managing incontinence

2. Although regular skin assessments should be done on at-risk patients, documentation is only necessary if a pressure ulcer develops.

True False

3. For patients who are bedbound and in a supine position, where should you check for signs of developing pressure ulcers?
 - a. Occiput
 - b. Sacrum
 - c. Heels
 - d. Ischial tuberosities
 - e. Coccyx
 - f. Trochanter

4. It is important to document the wound assessment or potential risk of pressure ulcer development on admission or initial identification of a hospital-acquired pressure ulcer.

True False

5. For patients in side-lying positions, where is the one most important place you need to check for signs of developing pressure ulcers?
 - a. Occiput
 - b. Sacrum
 - c. Heels
 - d. Ischial tuberosities
 - e. Coccyx
 - f. Trochanter

6. Partial pressure ulcer wound assessment should be documented at every shift.
- True False
7. When taking a photograph of a pressure ulcer as visual evidence, which of the following would be useful to include in the picture?
- a. Patient identification
 - b. Date of photograph
 - c. Wound location
 - d. Reference measuring tool
8. Repositioning must take into account any medical conditions such as respiratory or cardiac disorders.
- True False
9. The amount of calories needed by patients under stress with pressure ulcers should be adjusted for:
- a. Weight loss
 - b. Weight gain
 - c. Changes in level of obesity
 - d. Age and gender
10. Hypoproteinemia alters oncotic pressure and causes edema formation.
- True False
11. When a patient or resident develops an inadequate dietary intake, you should first:
- a. Attempt to discover factors compromising intake
 - b. Provide immediate nutritional supplements
 - c. Offer support with eating
 - d. Administer TPN

12. Failure to reposition will result in depleted blood flow that will reduce nutrients required for wound healing.

True False

13. How often should bed and chair-bound patients and residents be repositioned?

- a. Every 30 minutes
- b. Every 1 – 2 hours
- c. Every 2-4 hours
- d. Once a shift

14. At what elevation should the head of the patient's bed be kept to prevent shear?

- a. 10 degree or less
- b. 30 degrees or less
- c. 45 degrees
- d. 90 degrees

15. In addition to repositioning, what other related steps can be taken to reduce risk of pressure ulcer development?

- a. Pressure-redistributing mattresses
- b. Chair cushions
- c. Increased mobility / activity
- d. Weight reduction programs

16. Pressure redistribution can be achieved by:

- a. Nutritional supplements
- b. Increased mobility
- c. Repositioning
- d. Support surfaces

17. Where does moisture come from in patients and residents?

- a. Perspiration
- b. Wound drainage
- c. Condensation
- d. Incontinence

18. Wet skin shows significant increases in temperature and blood flow during pressure load.
- True False
19. Urinary incontinence has a harmful effect on the skin because it:
- a. Causes undesirable alkaline skin conditions
 - b. Encourages destructive enzymatic activity
 - c. Macerates the skin
 - d. Increases friction
20. Perineal skin damage caused by incontinence occurs in what proportion of adults in long term care?
- a. 10 percent or less
 - b. About 25 percent
 - c. About 30 percent
 - d. About 40 percent
 - e. More than 50 percent
21. Which of the following can be used to treat incontinence?
- a. Changing of soiled incontinence aids
 - b. Regular cleansing
 - c. Regular toileting
 - d. Provision of a commode
 - e. Nagging and threatening
22. Regular soaps should be used to clean the patient's or resident's skin.
- True False
23. What other interventions should be considered for incontinent patients?
- a. Toileting schedule
 - b. Bowel and bladder program
 - c. Keeping skin folds clean
 - d. Fecal-collection devices
 - e. External catheters (for males)

Answers to Module 4 – Quiz I

- Q1 b
- Q2 False – Documenting skin assessment is essential for the prevention of pressure ulcers.
- Q3 a,b,c
- Q4 True
- Q5 f
- Q6 False
- Q7 a,b,c,d
- Q8 True – The patient may become very dyspneic or hemodynamically unstable unless cared for in a particular position.
- Q9 a,b,c
- Q10 True
- Q11 a,c
- Q12 True
- Q13 c
- Q14 b – The head of the bed should be lowered to an angle of 30 degrees or less one hour after meals or tube feedings. If this elevation cannot be maintained, the sacral region must be frequently monitored.
- Q15 a,b,c
- Q16 c,d
- Q17 a,b,d
- Q18 False – Wet skin DECREASES temperature and blood flow during pressure.
- Q19 a,b,c,d
- Q20 d
- Q21 a,b,c,d
- Q22 False – Regular soaps can damage the skin; instead specialized, pH-balanced skin cleansers should be used.
- Q23 a,b,c,d,e – ALL of these can be used with incontinent patients and residents to prevent pressure ulcers.