Pressure Ulcers eCourse: Module 3 – Quiz I

1. One of the most important ways to prevent pressure ulcers is to:

   a. Do regular skin assessments
   b. Provide support surfaces for all
   c. Identify at-risk individuals
   d. Do regular repositioning

2. If a patient or resident is found to be at low risk for a pressure ulcer, further reassessment is not necessary.

   True False

3. All at-risk patients should be assessed for pressure ulcers:

   a. At time of admission
   b. At regular intervals
   c. At any significant change of health condition
   d. Upon discharge

4. The classic signs of infection apply to pressure ulcer wound infections.

   True False

5. When doing a skin assessment, which of the following should you check for?

   a. Bogginess
   b. Induration
   c. Non-blanchable erythema
   d. Edema

6. In acute care, reassessment for pressure ulcers should occur how often?

   a. Every 24 to 48 hours
   b. Weekly initially, then monthly
   c. Every shift
   d. After the patient dies

7. Pain is relatively minor in most pressure ulcer cases.

True False

8. In home 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. Every fourth nurse visit

9. Periwound skin refers to the tissue inside the pressure ulcer wound.

True False

10. When doing regular patient skin assessments, where is it important to check?

a. Elbows
b. Under special garments and protective wear
c. Areas that lack sensation to pain
d. Areas of past skin breakdown

11. The periwound skin is intimately involved in the circulatory response to wounds and the risks of infection.

True False

12. Why is it important to document the anatomical location of every pressure ulcer?

a. Affects interventions
b. Determines treatment costs
c. Affects liability
d. Healing prognosis

13. Tunneling is tissue destruction that occurs under the intact skin around the wound perimeter.

True False

14. Which of the following may indicate a bacterial contamination of a pressure ulcer wound?

    a. Induration
    b. Maceration
    c. Purulent exudates
    d. Foul odor

15. Stage III and IV pressure ulcers will all have deep wounds.

    True False

16. What are main disadvantages of using sheet tracings to measure the size of a pressure ulcer wound?

    a. Time consuming
    b. Expensive
    c. Size of area is difficult to estimate
    d. Requires special equipment

17. Undermining refers to channeling that extends from any part of the wound and may pass through subcutaneous tissue and muscle.

    True False

18. Deep infection is a frequent complication of Stage I and II pressure ulcers and is characterized by an increase in warmth, tenderness and pain.

    True False

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

    a. Pressure, friction, and shear
    b. Damaged nerve endings
    c. Inflammation
    d. Infection

20. The goal of pain management in the pressure ulcer patient is to eliminate the cause of the pain and to provide analgesia.

    True False

21. It is safe to assume that if a patient does not express or respond to pain, it does not exist.

    True False

22. Patients with pressure ulcers may feel increased pain during procedures such as dressing changes and debridement.

    True False

23. It is important to document the appearance of the pressure ulcer by assessing the color of the wound base as a percentage of:

    a. Black
    b. Yellow
    c. Red
    d. Green

24. Granulation tissue will jump or twitch if pinched.

    True False

25. Slough tissue is red/orange to black in color.

    True False

26. Devitalized tissue manifests itself as dark or black eschar on the wound or as yellow fibrinous material on the wound base.

    True False

27. When documenting the clinical appearance of necrotic tissue, you should include:

    a. Color
    b. Exudate
    c. Consistency
    d. Adherence

28. Nurses should consider all risk factors independent of the scores obtained on any validated pressure ulcer prediction scales.

    True False

29. A red wound bed indicates:

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

30. Risk-assessment tools are also useful to identify specific risk factors in individuals so that appropriate prevention interventions can be undertaken.

    True False

31. A pale red wound bed with spontaneous bleeding indicates:

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

32. Patients who are predicted by risk-assessment tools to be of low risk to develop pressure ulcers, but in fact do, are referred to as false-positives.

    True False

33. The advantages of using the Braden pressure ulcer risk assessment scale are:

a. Good reliability and validity
b. Can be used in a variety of clinical settings
c. Works with diverse groups including ethnic populations
d. Provides details on each risk factor

34. One of the benefits of the Braden Scale is that it can be modified to suit local clinical settings.

True False

35. Which pressure ulcer risk-assessment scale was developed for the elderly population in the United Kingdom?

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

36. Which pressure ulcer risk-assessment scale measures physical and mental condition, activity, mobility and incontinence?

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

37. Which pressure ulcer risk-assessment scale has two risk sections – one for normal risk and one for special risk?

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

38. Which pressure ulcer risk-assessment tool categorizes its scores into “at risk”, “high risk” and “very high risk”?

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

Answers to Module 3 – Quiz I

Q1 c

Q2 False – Reassessment must be done on a regular basis because even the most stable patient or resident can become at-risk for pressure ulcers, particularly in an acute care setting.

Q3 a,b,c

Q4 False – Pressure ulcer wound infections also exhibit exudates with persistent inflammation, delayed healing, granulation tissue that bleeds easily, pocketing and malodor.

Q5 a,b,c,d – All of these, plus changes in skin integrity, texture, turgor, temperature, moisture and color changes, need to be assessed.

Q6 a

Q7 False – Pain is a common complication that is often undertreated; it is often the most distressing symptom patient report.

Q8 c

Q9 False – It refers to the tissue immediately surrounding the pressure ulcer wound.

Q10 a,b,c,d

Q11 True

Q12 a,d

Q13 False – This is undermining; tunneling is a narrow channel extending into healthy tissue.

Q14 c,d

Q15 False – In places with little subcutaneous tissue, such as the occiput, ear and fingers, the ulcers will be shallow.

Q16 a,c

Q17 False – This is tunneling; undermining is tissue destruction that occurs under intact skin around the wound perimeter.

Q18 False – Deep infection is a complication with Stage III and IV pressure ulcers and is characterized by an increase in warmth, tenderness and pain.

Q19 a,b,c,d

Q20 True

Q21 False – Nurses should watch for visual cues of pain.

Q22 True – The nurse should try and prevent such discomfort and takes steps to relieve it.

Q23 a,b,c

Q24 False – Granulation tissue may bleed; healthy muscle tissue will jump or twitch if pinched.

Q25 False – Slough tissue is yellow/white to gray in color.

Q26 True

Q27 a,b,c,d

Q28 True – Because not all risk factors are found in any one scale.

Q29 b

Q30 True

Q31 c,d

Q32 False – These patients are false-negatives; patients who were predicted to develop pressure ulcers, but did not are false-positives.

Q33 a,b,c,d

Q34 False – It is important NOT to alter the scale by adding or deleting items as this will change its accuracy.

Q35 c

Q36 c

Q37 d

Q38 d