

PRESSURE ULCER PREVENTION  
Competency Test

Version 1

Employee Name: \_\_\_\_\_

1. 83yr. Old female admitted to facility from hospital with diagnosis of DM, HTN, CHF, COPD, PVD, and R-Hip fracture. Resident has a history of falls and poor nutritional intake. Upon assessment noted open area to sacral region with yellowish/black nonviable tissue covering 85-90% of wound bed, moderate amount serosanguineous drainage peri-wound boggy and reddened. L-heel with black eschar cap intact. Incontinent of Bowels, has a 16fr/30cc-indwelling catheter intact, anchored to inner thigh with 240cc clear yellow urine. What interventions and/or orders should the admitting nurse get in place for the resident in order to prevent further skin breakdown and promote wound healing

- Pressure Redistribution/Relieving Mattress
- Daily Skin Checks
- Vitamin Therapy
- Offloading Heels
- Nutritional Supplements
- Protein Supplements
- R-Hip immobilize
- Foley Catheter care orders
- Bi-lateral Heel Lifts
- Treatment orders for all individual sites
- Nutritional Evaluation
- All of the above

2. Nursing Skin Admission Assessment must be completed upon admission/readmission with sites identified on sheet and orders implemented for all sites?

- a. True
- b. False

3. How can you assist with preventing pressure ulcers and promoting skin integrity

- Repositioning
- Toileting
- Encourage resident to consume meals
- Offload heels
- Report change in skin condition
- All of the above

4. Staging Pressure Ulcers on Admission and Readmission:

If a nurse has attended the World of Wound 3 day training he/she can stage pressure ulcers on admission and readmission. A Nurse who has not attended the training, should describe, but not stage the wound on admission and readmission.

- a. True
- b. False

5. Noted on bottom of a non-diabetic resident heel a fluid filled darkened black/blue area, Resident has a pair of shoes that fits tightly. How would you classify this area?
  - A. Bruise
  - B. Pressure Ulcer
  - C. Unknown
  
6. What would you do if you noticed an alteration in the resident skin and the treatment nurse was not available to assist?
  - a. Conduct a complete head to toe assessment to ensure resident has no further alteration in skin
  - b. Inform MD of Findings
  - c. Obtain an order for all areas identified if no current order is in place
  - d. Complete an assessment with a description of your findings
  - e. Stage the wound yourself even though you have not attended 3 day training and put an order in place
  - f. Fax nutritional assessment over to RD
  - g. All of the above
  - h. All of the above except E
  
7. How often should you ensure c.n.as apply moisture barrier?
  - a. After every incontinent episode and PRN
  - b. Only when they ask
  - c. Never
  
8. How often should a bed and chair bound resident be positioned?
  - a. Every 2hrs/bed and chair
  - b. At minimum every 2hrs in bed and every hr. in chair
  - c. When ever you have time
  
9. A Pressure ulcer is a wound caused by unrelieved pressure, shear, or friction.
  - a. True
  - b. False
  
10. Match the following terminology
  - a. Blister
  - b. Bruise
  - c. Pressure Ulcer
  - d. Eschar
  - e. Cellulitis
  - f. Abrasion
  - g. Skin Tear
  1. Inflammation of connective tissue, infection in or close to the skin.
  2. Collection of fluid at the junction between the dermis and epidermis due to friction
  3. Black or brown necrotic, devitalized tissue that may be loose or firmly adherent, hard, soft or soggy

4. A wound caused by unrelieved pressure, shear or friction
5. Injury to biological tissue in which the capillaries are damaged, allowing blood to seep into the surrounding tissue.
6. Wound caused by scraping or friction to the skin's surface
7. A separation of the skin layers, often caused by friction and or shearing

Must Score 80% or above

Score\_\_\_\_\_