



HARTFORD INSTITUTE FOR GERIATRIC NURSING
NEW YORK UNIVERSITY COLLEGE OF NURSING

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**TOPIC: PRESSURE ULCER PREVENTION AND
SKIN TEAR PREVENTION
TEST YOUR KNOWLEDGE !**

**Please note: There are currently no contact hours associated to these post-tests.
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1. Print out the Post-Test.
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4. Mail your post-test to:

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Results & Resubmission

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Pressure Ulcer Prevention and Skin Tear Prevention:
Learning Objectives

1. Describe the prevalence of pressure ulcers in older adults in different clinical settings.
2. Define stages of pressure ulcers and classification of skin tears.
3. Identify risk factors for developing pressure ulcers.
4. Screen for pressure ulcers using the Braden Scale.
5. Differentiate between pressure ulcers and skin tears.
6. Implement proactive assessment and nursing care strategies for prevention of pressure ulcers and skin tears.
7. Describe treatment strategies for skin tears.
8. Describe expected outcomes from implementation of preventive strategies for pressure ulcers.

Post-Test Questions

1. The prevalence of pressure ulcers in acute care settings is:
 - a. 15%
 - b. 30%
 - c. 50%
 - d. 75%
2. Which of the following is an intrinsic risk factor for developing pressure ulcers?
 - a. Friction
 - b. Peripheral vascular disease
 - c. Pressure on the heels while lying in bed
 - d. Shear
3. Which of the following increases the risk of developing pressure ulcers?
 - a. Cellulitis
 - b. Diabetes
 - c. Hypertension
 - d. Malnutrition

4. Which of the following is a commonly used valid, reliable tool for predicting pressure ulcer risk?
 - a. Barthel Index
 - b. Braden Scale
 - c. Katz Scale
 - d. Lawton Scale

5. Nursing assessment for pressure ulcers in older adults on acute medical units should be conducted:
 - a. On admission only
 - b. On admission and at least every 48 hours
 - c. Only if risk factors are present
 - d. Weekly

6. Which of the following statements is accurate about the Braden Scale?
 - a. The higher the score the higher the risk of developing pressure ulcers.
 - b. The lower the score the higher the risk of developing pressure ulcers.
 - c. The lower the score the lower the risk of developing pressure ulcers.
 - d. There is no difference in scoring for people with light or dark pigmented skin.

7. A nursing intervention for patients of all pressure ulcer risk levels includes:
 - a. Applying Duoderm to the affected skin area(s)
 - b. Frequent turning and positioning
 - c. Use of a pressure relieving surface
 - d. Use of foam wedges to maintain patients at 30 degree lateral position

8. You would request a pressure relieving surface for a patient with which Braden score?
 - a. Above 15
 - b. Between 13 and 14
 - c. Between 10 and 12
 - d. Below 9

9. "Mechanical forces exerted when skin is dragged across a coarse surface" is the definition of:
 - a. Friction
 - b. Pressure ulcer
 - c. Shear
 - d. Skin tear

10. One method for identifying a stage 1 pressure ulcer in patients with darkly pigmented skin is:
- Assume skin over bony prominences is in the same condition as surrounding skin
 - Compress reddened area to see if it blanches
 - Use a halogen light to look for purple hues in skin
 - Use the same methods as in patients with lightly pigmented skin
11. One domain assessed by the Braden Scale is mobility.
- True
 - False
12. A 94 year old woman has a 4 x 6 cm ulcer over the right ischial tuberosity with subcutaneous fat present in the base and 5 cm of undermining. Identify the most likely stage.
- Stage 1
 - Stage 2
 - Stage 3
 - Stage 4
13. A positive outcome that health care providers should strive for in the assessment and management of pressure ulcers includes:
- Implementation of prevention protocols in patients at risk for developing pressure ulcers
 - Maintenance of incidence and prevalence of pressure ulcers
 - Use of donut-shaped devices for all older patients
 - Use of pressure relieving beds for all older patients
14. Which of the following would best foster wound healing of a skin tear?
- Applying a clear op-site dressing and changing daily
 - Applying a dry, sterile dressing
 - Removing the skin flap
 - Retaining the skin flap and use water-resistant products to protect the surrounding skin

15. According to the Payne-Martin classification system, a skin tear with partial tissue loss is considered stage:
- a. I
 - b. II
 - c. III
 - d. IV

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