TO: All who have requested to use the Pressure Ulcer Knowledge Test

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The Pressure Ulcer Knowledge Test can be administered to all levels of nursing personnel. My reported results are with RN's only. I hand sorted items into 3 subscales. The scales and items are:

Ulcer = 1, 6, 9, 20, 32, 37, 45

Wound = 26, 27, 30, 31, 35, 36, 44

Prevention/Risk = 2, 3,4, 5, 7, 8, 10, 11, 12 13, 14, 15
16, 17, 18, 19, 21, 22, 23, 24, 25, 28
29, 33, 34, 38, 39, 40, 41, 42, 43, 46, 47

Reliability is presented in the manuscript.

You may need to change items to fit your institution, For example, a heel protector in my agency is a heel bow; other heel devices are stated by name i.e. vascular boot, PRAFO. The demographic information may also need to be words to fit your institution.

In many report, manuscript, presentations, etc. where the Pressure Ulcer Knowledge Test is mentioned, you must acknowledge me as the developer.

The following are answered as true: 1, 2, 3, 4, 7, 9, 10,12,15, 16,19, 21, 22, 23, 24, 25, 32, 33, 34, 28, 29, 30, 26,36, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47

False:5, 6, 8, 11, 13, 14, 17, 18, 20, 27, 31,35, 37,

PRESSURE ULCER PREVENTIN SURVEY

I. Background Information

1. Gender (Check One)
   _____ Male
   _____ Female

2. Race/Ethnic Background (Check One)
   _____ African-American/Black
   _____ Asian/Pacific Islander
   _____ Caucasian (Non-Hispanic)
   _____ Mexican/American Hispanic)
   _____ Native American
   _____ Puerto Rican Hispanic
   _____ Other Hispanic
   _____ Other (specify)_____

3. Age in years: _____

4. Check highest level of education achieved:
   _____ High School
   _____ LPN
   _____ Nursing Diploma
   _____ Associate Degree
   _____ Bachelor's Degree
   _____ Other (Specify)_____

5. Check your nursing category:
   _____ Nurse Aide/Assistant
   _____ Nursing Student/Nurse Extern
   _____ LPN/LVN
   _____ RN

6. How many <u>years</u> have you been employed as a <u>nurse</u>?_____

7. What type of patient care units do you <u>usually</u> work on?

   _____ Medicine unit (general or specialty)
   _____ Surgical Unit (general or specialty)
   _____ Medical ICU/Stepdown
   _____ Surgical ICU/Stepdown
   _____ Cardiac ICU/Stepdown
   _____ Emergency
   _____ Rehabilitation Unit
   _____ Operating Room/Recovery
   _____ Other (please state)_____

8. When was the last time you listened to a lecture on pressure ulcers? (Check One)
   _____ 1 year or less
   _____ 2-3 years
   _____ 4 years or greater

9. When was the last time you read an article about pressure ulcers? (Check One)
   _____ 1 year or less
   _____ 2-3 years
   _____ 4 years or greater

10. Have you read the AHCPR Pressure Ulcers in Adults: Prediction and Prevention?
   _____ yes
   _____ no

II. Please answer each of the following by lacing a check mark for each question.

		True	False	Don't Know
1.	Stage I pressure ulcers are defined as nonblanchable erythema.	_____	_____	_____
2.	Risk factors for development of pressure ulcers are immobility, incontinence, impaired nutrition, and altered level of consciousness.	_____	_____	_____
3.	All individuals at risk for pressure ulcer should have a systematic skin inspection at least once a week.	_____	_____	_____
4.	Hot water and soap may dry the skin and increase the risk for pressure ulcers.	_____	_____	_____
5.	It is important to massage bony prominences.	_____	_____	_____
6.	A stage III pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis.	_____	_____	_____
7.	All individuals should be assessed on admission to a hospital for risk of pressure ulcer development.	_____	_____	_____
8.	Corn starch, creams, transparent dressings (i.e., Tegaderm, Opsite), and hydrocolloid dressings (i.e., DuoDerm, Restore) do not protect against the effects of friction.	_____	_____	_____
9.	Stage IV pressure ulcers are a full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structure	_____	_____	_____
10.	An adequate dietary intake of protein and calories should be maintained during illness.	____	_____	_____
11.	Persons confined to bed should be repositioned every 3 hours.	_____	_____	_____
12.	A turning schedule should be written and placed at the bedside.	_____	_____	_____
13.	Heel protectors relieve pressure on the heels.	_____	_____	_____

		True	False	Don't Know
14.	Donut devices/ring cushions help to prevent pressure ulcers.	_____	_____	_____
15.	In a side lying position, a person should be at a 30 degree angle with the bed.	_____	_____	_____
16.	The head of the bed should be maintained at the lowest degree of elevation (hopefully, so higher than a 30 degree angle) consistent with medical condition.	_____	_____	_____
17.	A person who cannot move self should be repositioned while sitting in a chair every two hours.	_____	_____	_____
18.	Persons, who can be taught, should shift their weight every 30 minutes while sitting a chair.	_____	_____	_____
19.	Chair-bound persons should be fitted for a chair cushion.	_____	_____	_____
20.	Stage II pressure ulcers are a full thickness skin loss.	_____	_____	_____
21.	The epidermis should remain clean and dry.	_____	_____	_____
22.	The incidence of pressure ulcers is so high that the government has appointed a panel to study risk, prevention, and treatment.	_____	_____	_____
23.	A low humidity environment may predispose a person to pressure ulcers.	_____	_____	_____
24.	To minimize the skin's exposure to moisture of incontinence, underpads should be used to absorb moisture.	_____	_____	_____
25.	Rehabilitation should be instituted if consistent with the patient's overall goals of therapy.	_____	_____	_____
26.	Slough is yellow or creamy necrotic tissue on a wound bed.	_____	_____	_____

		True	False	Don't Know
27.	Eschar is good for wound healing.	_____	_____	_____
28.	Bony prominences should not have contact with one another.	_____	_____	_____
29.	Every person assessed to be at risk for developing pressure ulcers should be placed on a pressure-reducing bed surface.	_____	_____	_____
30.	Undermining is the destruction that occurs under the skin.	_____	_____	_____
31.	Eschar is healthy tissue.	_____	_____	_____
32.	Blanching refers to whiteness when pressure is applied to a reddened area.	_____	_____	_____
33.	A pressure relieving surface reduces tissue interface pressure below capillary closing pressure.	_____	_____	_____
34.	Skin, macerated from moisture, tears more easily.	_____	_____	_____
35.	Pressure ulcers are sterile wounds.	_____	_____	_____
36.	A pressure ulcer scar will break down faster than unwounded skin.	_____	_____	_____
37.	A blister on the heel is nothing to worry about.	_____	_____	_____
38.	A good way to decrease pressure on the heels is to elevate them off the bed.	_____	_____	_____
39.	All care given to prevent or treat pressure ulcers must be documented.	_____	_____	_____
40.	Vascular boots protect the heels from pressure.	_____	_____	_____
41.	Shear is the force which occurs when the skin sticks to a surface and the body slides.	_____	_____	_____
42.	Friction may occur when moving a person up in bed.	_____	_____	_____

		True	False	Don't Know
43.	A low Braden score is associated with increased pressure ulcer risk.	_____	_____	_____
44.	The skin is the largest organ of the body.	_____	_____	_____
45.	Stage II pressure ulcers may be extremely painful due to exposure of nerve endings.	_____	_____	_____
46.	For persons who have incontinence, skin cleaning should occur at the time of soiling and routine intervals.	_____	_____	_____
47.	Educational programs may reduce the incidence of pressure ulcers.	_____	_____	_____