

Pressure Injury Pre-Training Knowledge Check - Nurses

This short knowledge check will help us understand your current understanding of pressure injury prevention and management before the upcoming online and face-to-face training. The results will guide us in tailoring the training to focus on areas where support is most needed. The survey will be repeated after the training to measure how well the learning has been retained and to evaluate the effectiveness of the program.

* Required

1. Which of the following defines a Stage 1 Pressure Injury? *

- ☐ Intact skin with non-blanchable redness.
- ☐ Partial-thickness loss of dermis.
- ☐ Purple or maroon localized area of discoloured intact skin.
- ☐ Full-thickness tissue loss with visible fat.

2. A wound bed covered completely by slough or eschar is classified as: *

- ☐ Stage 4
- ☐ Deep Tissue Injury (DTI)
- ☐ Unstageable
- ☐ Stage 3

3. Deep Tissue Injury (DTI) is most likely to progress to which stage once the tissue evolves? *

- ☐ Stage 2
- ☐ Stage 1
- ☐ It remains a DTI forever.
- ☐ Stage 3 or 4

4. In a Stage 2 Pressure Injury, what is the primary characteristic? *

- ☐ Visible bone or tendon.
- ☐ A shallow open ulcer with a red-pink wound bed, without slough.
- ☐ Leathery black tissue.
- ☐ Non-blanchable erythema.

5. Incontinence Associated Dermatitis (IAD) is typically found: *

- ☐ Directly over a bony prominence.
- ☐ Only on the heels.
- ☐ As a deep, circular "punched out" hole.
- ☐ In a diffuse, "blotchy" pattern in skin folds or perianal areas

6. Which characteristic is most indicative of a Pressure Injury rather than IAD? *

- ☐ Burning pain.
- ☐ Irregular edges and satellite lesions.
- ☐ Location over the sacrum or coccyx bony prominence.
- ☐ Redness that blanches easily.

7. What is the recommended angle for a side-lying position to reduce sacral pressure? *

- ☐ 90 degrees
- ☐ 45 degrees
- ☐ 30 degrees
- ☐ 10 degrees

8. A "moist wound healing" environment is preferred because: *

- ☐ It promotes faster epithelialization and cell migration
- ☐ It encourages scab formation
- ☐ It keeps the wound colder.
- ☐ It prevents the need for dressing changes.

9. Which scale is most commonly used in aged care to assess pressure injury risk? *

- ☐ Glasgow Coma Scale
- ☐ Braden Scale
- ☐ FLACC Scale
- ☐ Bristol Scale

10. When using a slide sheet to move a resident, the primary goal is to reduce: *

- ☐ Pressure
- ☐ Moisture
- ☐ Shear and Friction
- ☐ Infection risk

11. Medical Device Related Pressure Injuries (MDRPI) are most commonly caused by: *

- ☐ Poor diet.
- ☐ Oxygen tubing, catheters, or tight splints/braces.
- ☐ Lack of sleep.
- ☐ Old age.

12. Which nutrient is most critical for rebuilding tissue and collagen in a PI? *

- ☐ Vitamin D
- ☐ Carbohydrates
- ☐ Protein
- ☐ Fats

13. Which dressing is most appropriate for a wound with 'Heavy Exudate' and no clinical signs of infection? *
- ☐ Hydrocolloid
 - ☐ Calcium Alginate or Super-absorbent polymer
 - ☐ Transparent Film
 - ☐ Iodine-based ointment
14. Massaging a reddened area over a bony prominence helps improve blood flow and prevent pressure injuries. *
- ☐ True
 - ☐ False
15. "Shear" occurs when the skin stays in place while the underlying bone and muscle slide *
- ☐ True
 - ☐ False
16. You should always use a skin cleanser or pH-neutral wash instead of bar soap for residents with IAD. *
- ☐ True
 - ☐ False
17. A Stage 3 PI involves full-thickness tissue loss where subcutaneous fat may be visible, but bone is not. *
- ☐ True
 - ☐ False
18. A Stage 2 PI can present as an intact or ruptured serum-filled blister. *
- ☐ True
 - ☐ False

19. Moisture from perspiration or incontinence makes the skin more resistant to pressure injury. *

☐ True

☐ False

20. Ring cushions ("donuts") are recommended for offloading the sacrum. *

☐ True

☐ False

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