# Pressure Ulcer Prevention Toolkit

## Module 4 ToolsPicture of puzzle with Tools piece highlighted

2G: Pieper Pressure Ulcer Knowledge Test

4A: Assigning Responsibilities for Using Best Practice Bundle with the left column completed (by the Implementation Team Leader/co-leaders and best practices decided upon earlier by the team

4B: Staff Roles

4C: Assessing Staff Education and Training

Action Plan for Staff Education and Training Tool

### 2G: Pieper Pressure Ulcer Knowledge Test

**Background:** This tool can be used to assess staff knowledge on pressure ulcer prevention. The 47-item test was developed by Pieper and Mott in 1995 to examine the knowledge of nurses on pressure ulcer prevention, staging, and wound description. Questions 1, 3, 15, 29, 33, and 40 have been modified from the original to make it more specific to hospital care.

**Reference:** Pieper B, Mott M. Nurses’ knowledge of pressure ulcer prevention, staging, and description. Adv Wound Care 1995;8:34-48.

**Instructions:**

1. Administer the test to nursing and other clinical staff members.
2. It is generally recommended that responses be anonymous, but some staff might appreciate the opportunity to receive individual feedback. Find out what people on your unit want to do.
3. Use the answer key to evaluate the responses. Note that some questions may need to be modified for your hospital.

**Use:** Mean scores on this test are usually analyzed. Analyze the test results. If you find gaps of knowledge, work with your education department to develop and tailor educational programs that address these items.

#### Pieper Pressure Ulcer Knowledge Test

**For each question, mark the box for True, False, or Don’t Know.**

|  | **True** | **False** | **Don’t Know** |
| --- | --- | --- | --- |
| 1. Stage I pressure ulcers are defined as intact skin with nonblanchable erythema in lightly pigmented persons.
 |  |  |  |
| 1. Risk factors for development of pressure ulcers are immobility, incontinence, impaired nutrition, and altered level of consciousness.
 |  |  |  |
| 1. All hospitalized individuals at risk for pressure ulcers should have a systematic skin inspection at least daily and those in long-term care at least once a week.
 |  |  |  |
| 1. Hot water and soap may dry the skin and increase the risk for pressure ulcers.
 |  |  |  |
| 1. It is important to massage bony prominences.
 |  |  |  |
| 1. A Stage III pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis.
 |  |  |  |
| 1. All individuals should be assessed on admission to a hospital for risk of pressure ulcer development.
 |  |  |  |
| 1. Cornstarch, creams, transparent dressings (e.g., Tegaderm, Opsite), and hydrocolloid dressings (e.g., DuoDerm, Restore) do not protect against the effects of friction.
 |  |  |  |
| 1. A Stage IV pressure ulcer is a full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure.
 |  |  |  |
| 1. An adequate dietary intake of protein and calories should be maintained during illness.
 |  |  |  |
| 1. Persons confined to bed should be repositioned every 3 hours.
 |  |  |  |
| 1. A turning schedule should be written and placed at the bedside.
 |  |  |  |
| 1. Heel protectors relieve pressure on the heels.
 |  |  |  |
| 1. Donut devices/ring cushions help to prevent pressure ulcers.
 |  |  |  |
| 1. In a side lying position, a person should be at a 30 degree angle with the bed unless inconsistent with the patient’s condition and other care needs that take priority.
 |  |  |  |
| 1. The head of the bed should be maintained at the lowest degree of elevation (hopefully, no higher than a 30 degree angle) consistent with medical conditions.
 |  |  |  |
| 1. A person who cannot move him or herself should be repositioned every 2 hours while sitting in a chair.
 |  |  |  |
| 1. Persons who can be taught should shift their weight every 30 minutes while sitting in a chair.
 |  |  |  |
| 1. Chair-bound persons should be fitted for a chair cushion.
 |  |  |  |
| 1. Stage II pressure ulcers are a full thickness skin loss.
 |  |  |  |
| 1. The epidermis should remain clean and dry.
 |  |  |  |
| 1. The incidence of pressure ulcers is so high that the government has appointed a panel to study risk, prevention, and treatment.
 |  |  |  |
| 1. A low-humidity environment may predispose a person to pressure ulcers.
 |  |  |  |
| 1. To minimize the skin’s exposure to moisture on incontinence, underpads should be used to absorb moisture.
 |  |  |  |
| 1. Rehabilitation should be instituted if consistent with the patient’s overall goals of therapy.
 |  |  |  |
| 1. Slough is yellow or creamy necrotic tissue on a wound bed.
 |  |  |  |
| 1. Eschar is good for wound healing.
 |  |  |  |
| 1. Bony prominences should not have direct contact with one another.
 |  |  |  |
| 1. Every person assessed to be at risk for developing pressure ulcers should be placed on a pressure-redistribution bed surface.
 |  |  |  |
| 1. Undermining is the destruction that occurs under the skin.
 |  |  |  |
| 1. Eschar is healthy tissue.
 |  |  |  |
| 1. Blanching refers to whiteness when pressure is applied to a reddened area.
 |  |  |  |
| 1. A pressure redistribution surface reduces tissue interface pressure below capillary closing pressure.
 |  |  |  |
| 1. Skin macerated from moisture tears more easily.
 |  |  |  |
| 1. Pressure ulcers are sterile wounds.
 |  |  |  |
| 1. A pressure ulcer scar will break down faster than unwounded skin.
 |  |  |  |
| 1. A blister on the heel is nothing to worry about.
 |  |  |  |
| 1. A good way to decrease pressure on the heels is to elevate them off the bed.
 |  |  |  |
| 1. All care given to prevent or treat pressure ulcers must be documented.
 |  |  |  |
| 1. Devices that suspend the heels protect the heels from pressure.
 |  |  |  |
| 1. Shear is the force that occurs when the skin sticks to a surface and the body slides.
 |  |  |  |
| 1. Friction may occur when moving a person up in bed.
 |  |  |  |
| 1. A low Braden score is associated with increased pressure ulcer risk.
 |  |  |  |
| 1. The skin is the largest organ of the body.
 |  |  |  |
| 1. Stage II pressure ulcers may be extremely painful due to exposure of nerve endings.
 |  |  |  |
| 1. For persons who have incontinence, skin cleaning should occur at the time of soiling and at routine intervals.
 |  |  |  |
| 1. Educational programs may reduce the incidence of pressure ulcers.
 |  |  |  |

#### Pieper Pressure Ulcer Knowledge Test: Answer Key

| **Question** |  |  |
| --- | --- | --- |
| 1. Stage I pressure ulcers are defined as intact skin with nonblanchable erythema in lightly pigmented persons.
 | **True** |  |
| 1. Risk factors for development of pressure ulcers are immobility, incontinence, impaired nutrition, and altered level of consciousness.
 | **True** |  |
| 1. All hospitalized individuals at risk for pressure ulcers should have a systematic skin inspection at least daily and those in long-term care at least once a week.
 | **True** |  |
| 1. Hot water and soap may dry the skin and increase the risk for pressure ulcers.
 | **True** |  |
| 1. It is important to massage bony prominences.
 |  | **False** |
| 1. A Stage III pressure ulcer is a partial thickness skin loss involving the epidermis and/or dermis.
 |  | **False** |
| 1. All individuals should be assessed on admission to a hospital for risk of pressure ulcer development.
 | **True** |  |
| 1. Cornstarch, creams, transparent dressings (e.g., Tegaderm, Opsite), and hydrocolloid dressings (e.g., DuoDerm, Restore) do not protect against the effects of friction.
 |  | **False** |
| 1. A Stage IV pressure ulcer is a full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure.
 | **True**  |  |
| 1. An adequate dietary intake of protein and calories should be maintained during illness.
 | **True**  |  |
| 1. Persons confined to bed should be repositioned every 3 hours.
 |  | **False**  |
| 1. A turning schedule should be written and placed at the bedside.
 | **True**  |  |
| 1. Heel protectors relieve pressure on the heels.
 |  | **False**  |
| 1. Donut devices/ring cushions help to prevent pressure ulcers.
 |  | **False**  |
| 1. In a side lying position, a person should be at a 30 degree angle with the bed unless inconsistent with the patient’s condition and other care needs that take priority.
 | **True**  |  |
| 1. The head of the bed should be maintained at the lowest degree of elevation (hopefully, no higher than a 30 degree angle) consistent with medical conditions.
 | **True**  |  |
| 1. A person who cannot move him or herself should be repositioned every 2 hours while sitting in a chair.
 |  | **False**  |
| 1. Persons who can be taught should shift their weight every 30 minutes while sitting in a chair.
 |  | **False**  |
| 1. Chair-bound persons should be fitted for a chair cushion.
 | **True**  |  |
| 1. Stage II pressure ulcers are a full thickness skin loss.
 |  | **False**  |
| 1. The epidermis should remain clean and dry.
 | **True**  |  |
| 1. The incidence of pressure ulcers is so high that the government has appointed a panel to study risk, prevention, and treatment.
 | **True**  |  |
| 1. A low-humidity environment may predispose a person to pressure ulcers.
 | **True**  |  |
| 1. To minimize the skin’s exposure to moisture on incontinence, underpads should be used to absorb moisture.
 | **True**  |  |
| 1. Rehabilitation should be instituted if consistent with the patient’s overall goals of therapy.
 | **True**  |  |
| 1. Slough is yellow or creamy necrotic tissue on a wound bed.
 | **True**  |  |
| 1. Eschar is good for wound healing.
 |  | **False**  |
| 1. Bony prominences should not have direct contact with one another.
 | **True**  |  |
| 1. Every person assessed to be at risk for developing pressure ulcers should be placed on a pressure-redistribution bed surface.
 | **True**  |  |
| 1. Undermining is the destruction that occurs under the skin.
 | **True**  |  |
| 1. Eschar is healthy tissue.
 |  | **False**  |
| 1. Blanching refers to whiteness when pressure is applied to a reddened area.
 | **True**  |  |
| 1. A pressure redistribution surface reduces tissue interface pressure below capillary closing pressure.
 | **True**  |  |
| 1. Skin macerated from moisture tears more easily.
 | **True**  |  |
| 1. Pressure ulcers are sterile wounds.
 |  | **False**  |
| 1. A pressure ulcer scar will break down faster than unwounded skin.
 | **True**  |  |
| 1. A blister on the heel is nothing to worry about.
 |  | **False**  |
| 1. A good way to decrease pressure on the heels is to elevate them off the bed.
 | **True**  |  |
| 1. All care given to prevent or treat pressure ulcers must be documented.
 | **True**  |  |
| 1. Devices that suspend the heels protect the heels from pressure.
 | **True**  |  |
| 1. Shear is the force that occurs when the skin sticks to a surface and the body slides.
 | **True**  |  |
| 1. Friction may occur when moving a person up in bed.
 | **True**  |  |
| 1. A low Braden score is associated with increased pressure ulcer risk.
 | **True**  |  |
| 1. The skin is the largest organ of the body.
 | **True**  |  |
| 1. Stage II pressure ulcers may be extremely painful due to exposure of nerve endings.
 | **True**  |  |
| 1. For persons who have incontinence, skin cleaning should occur at the time of soiling and at routine intervals.
 | **True**  |  |
| 1. Educational programs may reduce the incidence of pressure ulcers.
 | **True**  |  |

### 4A: Assigning Responsibilities for Using Best Practice Bundle

**Background:** This tool can be used to determine who will be responsible for each of the tasks identified in your bundle of best practices for preventing pressure ulcers. One way to generate interest and buy-in from the staff is to ask them to self-assign their responsibilities from a prioritized list of tasks that need to be accomplished.

**Reference:** Developed by Boston University Research Team.

**Instructions:** Complete the table by entering the different best practices and the specific individuals who will be responsible for completing each task.

**Use:** Use this tool to assign and clarify the roles and responsibilities of each staff member.

| **What practices will we use?** | **Who will be responsible?** |
| --- | --- |
| *Example:**Perform comprehensive skin assessment on admission, daily or if condition deteriorates.* | *Example:**RN*  |
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### 4B: Staff Roles

**Background:** This table gives an example of how responsibilities may be assigned among different staff members.

**Reference:** Developed by Boston University Research Team.

| **Wound care team[[1]](#footnote-1)**  |
| --- |
| Wound Care Physician  | * Directs patient care, orders tests and treatments, and reviews results
* Collaborates on treatment with wound nurse
* Helps facilitate communication between medical staff, wound team, and unit staff for pressure ulcer practice
 |
| Certified Wound Care Nurse  | * Assesses wounds, does complex treatments, collaborates with physician for care orders
* Works with staff on pressure ulcer education and daily treatments
* Works with all members to educate patient/family about care
* Coordinates prevalence and incidence audits
 |
| **Unit based team** |
| RN | * Conducts or supervises accurate assessment and documentation of head-to-toe skin assessment and pressure ulcer risk (Braden Scale or Braden Risk Assessment) on admission, daily, and if condition deteriorates (or according to facility policy)
* Documents care plan tied to identified risk
	+ Sensory perception
	+ Moisture
	+ Activity
	+ Mobility
	+ Nutrition
	+ Friction/Shear
* Performs or supervises performance of care plan procedures or treatments
* Collaborates with other staff to ensure timely and accurate reporting of any skin issues
* Notifies wound nurse of any skin conditions or high-risk patients
* Notifies physician of any skin problems
* Educates patient/family about risk factors
 |
| LPN | * Conducts accurate assessment and documentation of head-to-toe skin assessment and pressure ulcer risk (Braden Scale) on admission, daily, and if condition deteriorates (or according to facility policy)
* Documents care plan tied to identified risk
	+ Sensory perception
	+ Moisture
	+ Activity
	+ Mobility
	+ Nutrition
	+ Friction/Shear
* Performs care for risk as needed
* Informs RN of any skin issues
 |
| CNA | * Checks skin each time person is turned or cleaned or bed is changed
* Reports any skin issues to nurse
* Turns/repositions patient as ordered
* Offers liquids each time in room
* Keeps skin clean and reapplies protective skin barrier
* Applies products (lotion, cream, skin sealant, etc.) as needed
 |
| Hospitalist | * Reviews needs for specific types of rehabilitation therapy
* Writes orders for specific interventions
 |
| Other staff, such as dietitian, physical therapist, pharmacist, assigned to specific unit | * Act as resource for unit staff
* Educate family if problem is identified
* Modify treatment as needed
* Provide specialized care for patients
 |

### 4C: Assessing Staff Education and Training

**Background:** The purpose of this tool is to assess current staff education practices and to facilitate the integration of new knowledge on pressure ulcer prevention into existing or new practices.

**Reference:** Adapted from Facility Assessment Checklist developed by Quality Partners of Rhode Island. Available in the Nursing Home section of the MedQIC Web site: <https://www.qualitynet.org/dcs/ContentServer?cid=1098482996140&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>.

**Instructions:** Complete the form by checking the response that best describes your facility.

**Use:** Identify areas for improvement and develop educational programs where they are missing.

#### Facility Assessment

Date:

A. Does your facility have initial and ongoing education on pressure ulcer prevention and management for both nursing and nonnursing staff?

**\_\_ No**. If no, this is an area for improvement.

\_\_ **This is an area we are working on.**

\_\_ **Yes**.

B. Does your facility’s education program for pressure ulcer prevention and management include the following components?

|  | **Yes** | **No** | **Person Responsible:** | **Comments:** |
| --- | --- | --- | --- | --- |
| 1. Are new staff assessed for their need for education on pressure ulcer prevention and management?
 |  |  |  |  |
| 1. Are current staff provided with ongoing education on the principles of pressure ulcer prevention and management?
 |  |  |  |  |
| 1. Does education of staff provide discipline-specific education for pressure ulcer prevention and management?
 |  |  |  |  |
| 1. Is there a designated clinical expert available at the facility to answer questions from all staff about pressure ulcer prevention and management?
 |  |  |  |  |
| 1. Is the education provided at the appropriate level for the learner (e.g., CNA vs. RN?)
 |  |  |  |  |
| 1. Does the education provided address risk assessment tools and procedures?
 |  |  |  |  |
| 1. Does the education include staff training on documentation methods related to pressure ulcers (e.g., location, stage, size, depth, appearance, exudates, current treatment, effect on activities of daily living, pressure redistributing devices used, nutritional support)?
 |  |  |  |  |

C. What areas of knowledge does the assessment of staff suggest need more attention in education?

### Action Plan for Pressure Ulcer Staff Education and Training

| **Best Practices to be Used** | **Staff Education Needs** | **Who will be responsible?** |
| --- | --- | --- |
| **For Training Development** | **For Training Implementation** |
| Example: Perform comprehensive pressure ulcer risk assessment on admission, daily, or if condition deteriorates. | Example:Didactic training on using the Braden or Norton Pressure Ulcer Risk Factor Assessment Scale | Example:Education Department | Example:Nursing Department |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. May be large or small group that includes nurses and/or physicians in an outpatient or inpatient setting. [↑](#footnote-ref-1)