Name: _____

Date: _____

Pressure Injury Baseline Assessment (answer key – 80% or greater required for passing)

1. Which of these patients have vulnerabilities of developing a pressure injury?
   A. 70 y.o. with fractured femur, been on ED gurney for 5 hours awaiting ortho consult
   B. 41 y.o. diabetic with neuropathy, admitted for blood sugar control
   C. A, B and D
   D. 56 y.o. patient in ICU with ET tube, Arterial line, compression device, restraints
2. Minimally, a patient in the acute care setting should be assessed for pressure injury risk (Braden) at least every:
   A. 48 hours
   B. Q shift
   C. 24 hours
   D. 4 hours
3. When and how should the first comprehensive skin assessment be completed?
   A. When you can get to it
   B. By the end of your shift
   C. Utilize 4 eyes in 4 hours methodology (2 RN's or 2 appropriately trained clinicians)
   D. Before discharge
4. What can you, the RN, do when one of your patients has discoloration of the skin (red, purple, blue) indicating pressure?
   A. See what happens over the next 24 hours.
   B. Let the next nurses know about it. Start a skin care plan.
   C. Place the patient on a pressure-reducing surface and explain to the patient and family that the patient needs to limit pressure to the area.
   D. B&C from above
5. Who is the primary person accountable for patient skin assessment, pressure injury prevention, and documentation?
   A. WOC Nurse (ET nurse)
   B. RN
   C. Nursing assistant
   D. All the above
6. When documenting your comprehensive skin assessment, you do not need to worry about documenting normal findings?
   A. True
   B. False

7. What are the five parameters of a comprehensive skin assessment?
   A. Temperature, Turgor, Moisture, Color, Integrity
   B. Turgor, Texture, Integrity, Moisture, Intactness
   C. Color, Integrity, Moisture, Softness, Temperature
   D. Turgor, Integrity, Temperature, Clamminess, Color
8. According to recent studies, what percentage of healthcare associated pressure injuries can be attributed to medical devices?
   A. 18%
   B. 25%
   C. 30%
   D. 50%
9. Intrinsic risk factors are outside factors increasing the probability for HAPI for the patient?
   A. True
   B. False
10. Risk factors seen in the bariatric population may be:
   A. Lymphedema/vascular changes in extremities
   B. Skin folds with maceration or infection (Candidiasis)
   C. Candidiasis or Dermatitis on the perineum
   D. All the above