

DATA COLLECTION INSTRUMENT

Please fill in your personal information:

Age: _____

Gender: _____

Number of years qualified as a registered nurse: _____

Level of education: _____

Nursing grade (specialised, non-specialised for e.g.): _____

Below are 25 multiple choice questions. Each question consists of 5 answers, only one being correct. PLEASE CIRCLE THE CORRECT ANSWER.

THEME: AETIOLOGY

- 1. There are several causal factors in the development of pressure injuries. Which of the following factors is one of them?**
 - a. Diabetes.
 - b. Incontinence.
 - c. Fever.
 - d. Reduced level of activity.
 - e. I do not know.
- 2. A patient sits with the head of the bed elevated to 60 degrees. What happens when his skin sticks to the underlying surface when he slides down in bed?**
 - a. The pressure increases.
 - b. Problems with the microclimate occur (temperature and relative humidity).
 - c. Shear increases.
 - d. Friction/rubbing increases.
 - e. I do not know.
- 3. What is the average percentage of patients with pressure injuries in ICUs generally?**
 - a. Between 1% and 5%.
 - b. Between 5% and 10%.
 - c. Between 10% and 15%.
 - d. Between 15% and 20%.
 - e. I do not know.
- 4. Excessively moist skin (due to e.g. incontinence or wound exudate) combined with increased body temperature are associated with pressure injury development. Is this statement correct?**
 - a. Yes, excessive skin moisture and raised temperature cause pressure injuries.
 - b. Yes, excessive skin moisture and raised temperature are risk factors for the development of pressure injuries.
 - c. No, wounds that occur in a moist and warm environment are always defined as incontinence-associated dermatitis (IAD).
 - d. No, an increase temperature results in better blood flow and thus decreases the risk of pressure injuries.
 - e. I do not know.

5. **CASE: A patient is sitting in a chair in the morning and in the afternoon, each time 2 hours. The rest of the day he spends in bed. He cannot mobilise himself. When does this patient have the highest risk to develop a pressure injury (if no prevention is applied)?**
- There is no higher risk to develop a pressure injury if a seated position in a chair is combined with a lying position in bed.
 - The risk to develop a pressure injury is highest when he is seated in a chair because high pressure is applied during a short period of time.
 - The risk to develop a pressure injury is highest when he is lying in bed because lower pressure is applied during a longer period of time.
 - The risk to develop a pressure injury is high in this specific case, both when seated in a chair and lying in bed. A short-term high pressure can have the same effect as a long-term low pressure.
 - I do not know.
6. **Which statement is correct?**
- The use of moisture-absorbing pads decreases the risk of pressure injuries.
 - The use of water and soap can erode skin barrier, thereby increasing the risk of superficial skin damage.
 - Massaging the skin (during washing and drying) is effective to prevent pressure injuries.
 - Dressing the heels (with a bandage) will decrease the risk of heel pressure injury development.
 - I do not know.

THEME: CLASSIFICATION AND OBSERVATION

7. **CASE: You observe a new blister on the heel of a patient who can reposition himself in bed. You take a look at his file, but your colleagues never reported a non-blanchable erythema or a wound. Which statement is correct?**
- The blister is not a pressure injury.
 - The blister is a Stage II pressure injury.
 - The blister is a Stage I pressure injury as long as it remains intact.
 - There is insufficient information to know if this is a pressure injury or not.
 - I do not know.
8. **Which of these pictures is a pressure injury Stage I?**

a. Blanchable erythema

b. Non-blanchable erythema



c. Intact blister



d. Open blister



e. I do not know.



9. In which of these stages can necrotic tissue be present?

- a. Stage I, II, III and IV.
- b. Stage II, III and IV.
- c. Stage III and IV.
- d. Stage IV only.
- e. I do not know.

10. CASE: The nurse observes a bony structure in a wound. In which stage can you classify this pressure injury?

- a. Stage IV.
- b. Stage IV if there are signs of undermining of the adjacent tissue.
- c. Stage IV if there is necrosis.
- d. Stage IV if there are signs of a reduction of the supply of blood to the tissue.
- e. I do not know.

THEME: RISK ASSESSMENT

11. CASE: A patient is recently admitted to your nursing unit. The patient has no signs of skin redness (blanchable/ non-blanchable) but is bedridden. When completing the Braden risk assessment tool, the scores indicates that there is no risk for pressure injury development. No prevention is needed. However, you are very surprised because your clinical experience tells you that this patient is at risk. What are you going to do now?

- a. You do not implement a prevention plan because both the skin assessment and the scoring tool indicated that there is no increased risk.
- b. You do not implement a prevention plan because risk assessment instruments are developed to replace clinical judgement.
- c. You take preventive measures because your clinical judgement is as important as the result of the risk screening using the tool.
- d. You decide to reassess the patient on a daily basis (using the instrument) and to start prevention if the Braden risk assessment instrument indicates an increased risk to develop a pressure injury.
- e. I do not know.

12. Which of these statements about the frequency of skin assessment on pressure points in hospital is correct?

- a. The frequency of skin assessment is a medical decision (made by a medical doctor).
- b. Skin areas with an increased risk for pressure injury development should be inspected at least once a week.
- c. The skin of patients at risk should be inspected at least twice a week.
- d. The skin of all patients should be inspected at least daily.
- e. I do not know

THEME: NUTRITION

13. CASE: A 23-year-old previously healthy male was recently admitted to the hospital with a spinal cord injury (car accident). He is immobile and has no problems eating or drinking. Is nutritional supplementation needed to reduce the risk of pressure injuries?

- a. Yes, I provide nutritional supplementations (vitamin tablets) to prevent pressure injuries.
- b. Yes, I provide nutritional supplementation (drinks enriched with the amino acid arginine) to prevent pressure injuries.
- c. No, I will not change the nutrition of this patient as long as no signs of pressure injuries are observed (redness or skin breakdown).
- d. No, I will not change the nutrition of this patient as long as nutritional intake is adequate.
- e. I do not know.

14. Which nutritional elements are the most essential to prevent pressure injuries?

- a. Carbohydrates, fats and proteins.
- b. Proteins and fluids.
- c. Carbohydrates and proteins.
- d. Fats, fluids and proteins.
- e. I do not know.

15. What type of patients (in term of body weight) have an increased risk to develop pressure injuries?

- a. Extremely thin patients.
- b. Obese patients.
- c. Both extremely thin and obese patients.
- d. Body weight and BMI are not associated with pressure injury risk.
- e. I do not know.

THEME: PREVENTION OF PRESSURE INJURIES

16. What is the percentage of patients with an increased risk to develop pressure injuries that receive adequate prevention in a chair and in bed in hospitals?

- a. <20%.
- b. Between 20% and 50%.
- c. Between 50% and 70%.
- d. >70%.
- e. I do not know.

17. CASE: Your colleague informs you that she positioned a patient in bed in a semi fowler position. What does this mean?

- a. The patient lies on his side in an angle of 30 degrees.
- b. The patient lies on his side in an angle of 45 degrees.
- c. The patient lies in a supine position, with both head of bed and upper legs elevated up to an angle of 30 degrees.
- d. The patient lies in a supine position, with the head of bed elevated up to an angle of 45 degrees.
- e. I do not know.

**18. Which repositioning protocol is most effective to prevent pressure injuries?
Starting with supine, then...**

- a. Lateral 30 degrees left- supine- lateral 30 degrees right- supine- lateral 30 degrees left-...
- b. Lateral 90 degrees left- supine- lateral 90 degrees right- supine- lateral 90 degrees left-....
- c. Lateral 30 degrees left- supine- lateral 30 degrees right- supine-lateral 90 degrees left- supine- lateral 90 degrees right-...
- d. Lateral 30 degrees left- lateral 90 degrees left- supine- lateral 30 degrees right-lateral 90 degrees right- supine-...
- e. I do not know.

19. The use of a ring cushion (donuts) is effective to prevent pressure injuries when patients are seated in a chair or wheelchair. Is this statement correct?

- a. Yes, because the pressure near the bony prominence is reduced.
- b. Yes, because it redistributes pressure and shear effectively around the area at risk.
- c. No, because the contact surface between the patient's skin and the surface is smaller.
- d. No, as it is only effective if a patient had a pressure injury in the past.
- e. I do not know.

20. How should bed linen be used to prevent pressure injuries?

- a. Do not secure the sheets under the mattress, so they can move along with the patient.
- b. Do not secure the blanket under the mattress, so it can move along with the patient.
- c. Make sure the sheets are stretched tight.
- d. Put moisture-absorbing pads under the patient.
- e. I do not know.

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22. Which is the most effective technique to position a patient when seated?

- a. In an upright position with the knees in a 90-degree angle and the feet not touching the ground.
- b. In an upright position with the legs being supported so that an angle of more than 90 degrees is created at the knees.
- c. In a semi-reclined position with the knees in a 90-degree angle with the feet not touching the ground.
- d. In a semi-reclined position with the legs being supported so that an angle of more than 90 degrees is created at the knees.
- e. I do not know.

23. CASE: Your patient is lying on a pressure redistributing foam mattress. Do you take other measures to prevent pressure injuries on the heels?

- a. No, a pressure redistributing foam mattress is sufficient.
- b. No, a pressure redistributing foam mattress combined with repositioning is sufficient.
- c. Yes, I will place a pillow from the knee to the Achilles tendon to off-load the heels.
- d. Yes, I will place a pillow under the Achilles tendon to off-load the heels.
- e. I do not know.

24. How does repositioning prevent pressure injuries?

- a. The amount of pressure and shear will be reduced.
- b. The amount and duration of pressure and shear will be reduced.
- c. The duration of pressure and shear will be reduced.
- d. It reduces friction at the bony prominences.
- e. I do not know.

THEME: SPECIFIC PATIENT GROUPS

24. Which of these statements is correct about the development of pressure injuries in the operating room?

- a. Pressure injuries are not likely occur during surgery. If redness is observed after surgery, it is most likely to be a burn wound.
- b. Immobilisation after surgery causes pressure injuries to develop, not the immobilisation during the surgery itself.
- c. When pressure injuries develop during surgery, the first visible signs appear a few days later; making people think they developed after surgery.
- d. A pressure injury appearing postoperatively is always the result of immobilisation during surgery.
- e. I do not know.

25. Which is the location on the body where babies have the highest risk to develop pressure injury?

- a. Occiput.
- b. Heels.
- c. Shoulders.
- d. Sacrum.
- e. I do not know.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.