

Pressure Ulcer Jeopardy

Divide group into 2 teams, each team needs a spokesperson. Starting with one team allow them to choose a category and point value of question. They can discuss as a team and the spokesperson gives the answer (within 10-15 seconds), if correct they get the points added to their score. If they give an incorrect answer, the other team has a chance to steal the points by giving the correct answer (within 10-15 seconds). Alternate from team to team until all questions answered. The team with the most points wins.

Questions/answers are printed on following pages, cut them and place on an index card. Place the index card in the appropriate category/point value pocket on the board.

100 points A&P

What is the body's first line of defense against infections/microorganisms?

The skin – needs to be intact to keep germs out

200 points A&P

What are the first signs of a pressure ulcer?

Persistent redness, whitish non-blanchable, dark/bruise look in people with darker skin tones

300 points A&P

Name the places on the body pressure ulcers are most likely to occur?

Bony prominence – back of head, ears, shoulders, spine, hips, coccyx/sacrum, inner knees, inner/outer ankles, heels, toes, sides of feet

400 points A&P

What is the difference between a stage II and a stage III pressure ulcer?

Stage II – partial loss, through the skin, superficial, abrasion, blister, shallow crater
Stage III – full thickness involving subcutaneous tissue, may extend down to but not through muscle and underlying fascia

100 points FACTS/TERMS

Another name for pressure ulcer is?

Bed sore, decubitus ulcer

200 points FACTS/TERMS

T or F – A resident has a higher risk of developing a pressure ulcer within the first two weeks of admission?

True, change in status, illness, immobile in hosp, you don't know them yet

300 points FACTS/TERMS

You want your quality measure QM score to be high or low? and how many residents in nursing homes develop pressure ulcers?

Low, shows how many residents have pressure ulcers and up to 25%

400 points FACTS/TERMS

Define friction and shearing

Friction – skin rubbing over surface, on sheets etc

Shearing – when the skin sticks to a surface and muscles/bones move in the direction the body is moving

100 points PREVENTION

T or F – Most pressure ulcers are avoidable?

True, shows problems in basic cares

200 points PREVENTION

How often should an at risk resident be inspected (skin looked at) for skin breakdown?

At least daily, with all cares

300 points PREVENTION

What do you look/feel for with a skin inspection?

Any changes in skin color, feel heels for mushy feeling, areas of pain to resident

400 points PREVENTION

How do you check for bottoming out?

Place hand under cushion and feel, raise fingers up to check for at least 1 in of padding if in chair place hand under buttocks, direct pressure areas if in bed can check under shoulders, hips

100 points POSITIONING/REPOSITIONING

Donut type cushions help relieve/prevent pressure?

False- actually increase pressure and decrease blood flow

200 points POSITIONING/REPOSITIONING

How can you protect the heels when a person is in bed and why do you avoid keeping HOB elevated?

Heel protectors, sheep skin at foot of bed, pillow under lower leg/ankle area (unless problems with blood clots) and HOB elevated places most of body weight on coccyx/sacrum area – if slide down friction and shearing occur

300 points POSITIONING/REPOSITIONING

If a resident has a pressure ulcer how do you position them and when side lying where do you place pillows and why?

Avoid placing them on pressure ulcer behind back, between knees and ankles/feet – it keeps body aligned (shoulders/hips) and keeps bony areas from touching and decreases pressure/stress to hip

400 points POSITIONING/REPOSITIONING

What are the rules for frequency of repositioning, in bed and if unable to shift weight and up in chair?

Every 2 hours, every hour if in chair and if can teach them to shift weight every 15 minutes.

100 points RISK FACTORS

Cognitive impairment and edema are both risk factors for developing pressure ulcers?

True – may not recognize pain or remember to change position, edema makes skin more fragile and may indicate circulatory problems

200 points RISK FACTORS

An obese resident and a very thin resident may both be at risk for developing a pressure ulcer?

True, obese doesn't = nutrition. Mobility a big factor – if very obese probably not as mobile and difficult to place pillows etc to reduce pressure

300 points RISK FACTORS

List 3 things that put a resident at risk for developing a pressure ulcer (other than cognitive impair. and edema)

Restraints, incontinence, immobility, acute illness, diabetes, history of ulcer, poor nutrition, weight loss, certain meds/diseases, new admission

400 points RISK FACTORS

Name 3 sources of moisture that can damage the skin

Incontinence –urine and liquid stool
sweat wound drainage

100 points NUTRITION

It is important to weigh a resident more than monthly if they are at high risk of or have skin breakdown?

True, weekly or every other week –
Nutritional intake and skin health are directly related

200 points NUTRITION

Name 2 food sources of protein

Meat, peanut butter, cheese, eggs

300 points NUTRITION

Which is more important in preventing or treating a pressure ulcer nutrition fluids/hydration or both

Both are important in skin health

400 points NUTRITION

When feeding a resident, which foods or fluids are most important and which ones do you start with or encourage most?

Protein sources, any supplements, fortified foods, high calorie supplements, fluids