License Nurse Competency

Objectives One and Two: Risk Factors

1. Explain below an intervention you could use with your CENAs to reduce a resident's risk for pressure wound development in regards to positioning, peri care, nutrition or mobility.

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2. Describe one risk factor for pressure ulcer formation and why the resident is at risk in relation to the physiological changes of aging.

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3. Mr. Johnson has been recently admitted to your facility. You conducted a Braden risk assessment and find that his score in the moderate risk range; however, your nursing judgment tells you he is at high risk. What actions will you take?

   a) Ignore your nursing judgment.
   b) Tell the next shift her Braden score.
   c) Make note of the Braden score but also implement interventions that address the risks you have found while conducting your assessment.

Objectives Three: Accurate Staging

Stage each picture below, and explain why.

a)

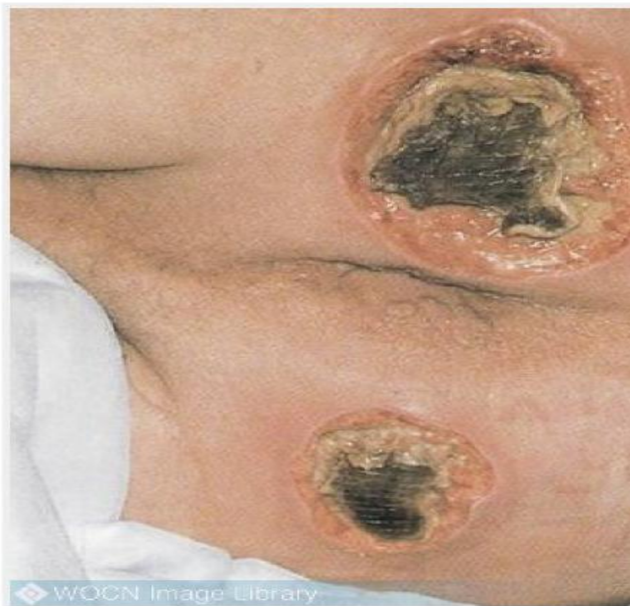
Hint: Skin is closed, red

Hint: Superficial opening.

c)

d)

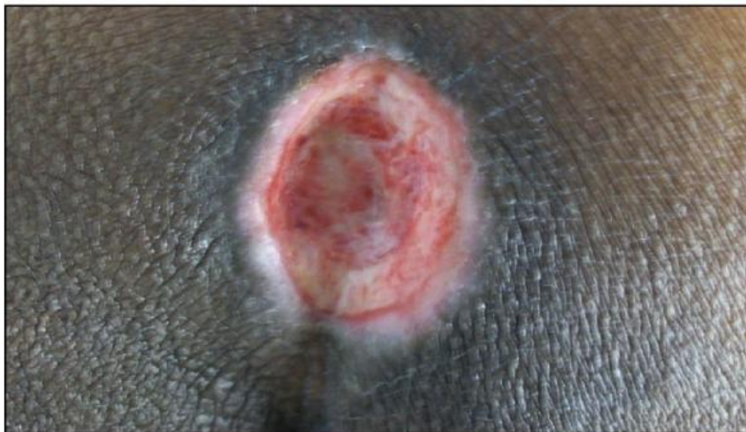
e)



Stage each of the above wounds and provide explanation for choosing that stage and why.

Objective Four: Assess a Wound and Peri Wound

1) You are caring for Mrs. Kay a resident who is 86 year old female; she is needing a re-admit skin check due to a recent hospitalization following a fall with an injury. She fell transferring herself from her w/c to her bed and was found lying on the floor. X-rays taken showed a fractured left trochanter, she was transferred to the hospital and received a left hip pinning. Mrs. Kay's protein levels are within normal limits and she is eating well. Her pain level is well controlled with a routine analgesic as well. She is not able to reposition herself in the bed or her chair. She is non ambulatory but does enjoy getting out for activities. Her cognition is intact and she has a wide range of activities she enjoys. She is able to sit on the toilet with assistance, non-weight bearing on the left. She has been continence of both bowel and urine. As you were conducting the skin check you find the below wound on her coccyx.
Identify the following characteristics listed below.



CMS, (2010). MDS 3.0 Training Materials

a) What Stage you give the above & why.
b) Size- Explain how you would measure and demonstrate with a measuring tool.
c) Location-Describe the location in medical terminology
d) Drainage is present-Describe characteristics of infection
e) Pain-what interventions would you ensure to implement
f) Wound bed-Describe the wound bed
g) Wound margins-Describe edges of this wound
h) Peri wound area-Describe the peri wound
i) Interventions (List three nursing interventions to manage her risks and support the healing of this pressure wound).

Objective Five: Products and Treatment

1) Explain what facility protocols you would follow and what category of product you would expect the physician will order for Mrs. Kaye.

Objective Six: Dressing Change

1) Demonstrate a clean technique dressing change. Your clinical reviewer will set up a mock site for you.

Clinical Reviewer will document below observations made during review.

Competency Answer Key

Objectives One and Two: Risk Factors

1. Describe one intervention you can work with your CENAs to improve in regards to positioning, peri care, nutrition or mobility for the residents in your care now.

   Accept answers related to interventions appropriate for CENAs to perform.

2. Select one risk factor for pressure ulcer formation and explain why the resident is at risk in relation to the physiological change of aging.

   Example of possible answer: Subcataneous tissue thins increasing risk due to lack of protection on bony prominence.

3. Mr. Johnson is a new admission to your home. You conduct a Braden risk assessment and find his scores in the moderate risk range; however, your nursing judgment tells you she is at high risk. What actions will you take?
   a) Ignore your nursing judgment.
   b) Tell the next shift her Braden score.
   c) Make note of the Braden score but also implement interventions that address the risks you have found while conducting your assessment.

Objectives Three: Accurate Staging

a) Stage 1
b) Stage II
c) Stage III
d) Stage IV
e) Unstageable

Objectives Four: Assess a wound and peri wound area

a) Stage - ***Stage III***
b) Size- You may test this skill measuring length and width on picture or ask the learner to measure the wound you made on the potato. ***Facilitator will check measurements for accuracy.***
c) Location - ***Directly above coccyx***
d) Drainage - ***Light***
e) Pain - ***Controlled with analgesics***
f) Wound bed - ***Granulation tissue present***
g) Wound margins - ***No undermining or tunneling***
h) Peri wound area - ***Intact***
i) Interventions (List three nursing interventions to manage her risks and support the healing of this pressure ulcer). ***Interventions may address pressure relief in w/c during activities, toileting program to maintain continence, assist with position changes, pressure relief surface in bed, etc.***

Objective Five: Products and Treatment

1. Select which category of product you expect the physician will order for the pressure ulcer of Mrs. Kay.

   Product to maintain moist wound bed would include the category of hydrogels and covered with an occlusive dressing such as a poly urethan film to maintain the moist wound bed environment. If the nurse uses an alginate product, review the treatment categories with them and when it is appropriate to use an alginate product.

Objective Six: Dressing Change

Observe the dressing change. Monitor to ensure the nurse does not contaminate the field, applies the dressing appropriately and washes hands.

Glossary

1. Colonization- Presence of bacteria in the pressure ulcer that are not causing damage to the tissue.
2. Debride- Remove non-viable tissue from the wound.
3. Epithelialization- Production of epithelial cells that make up the outer layer of skin.
4. Erythema- redness
5. Eschar- Dead tissue that may be loose or attached to the skin. It can be brown or black in color and is non-viable.
6. Exudate- drainage, fluid, or discharge
7. Granulation- Pink- reddish, moist tissue that fills in the wound.
8. Induration- Hardening of tissue.
9. Infection- Invasion of bacteria or other microorganisms that cause harm to the tissue.
10. Maceration- Softening and eventual breakdown of tissue due to constant moisture in normal skin tissue.
11. Peri wound- Area around the wound.
12. Sinus tract- Tunneling of damaged tissue under the skin with an opening at the wound.
13. Slough- Necrotic or non-viable tissue that is separating from healthy tissue.
14. Undermining- Edges of the wound are rolled under due to damage and do not allow for epithelization to occur.
15. Denuded skin- Loss of epidermis due to irritants such as feces and urine or friction.
16. Excoriation- Skin that has been traumatized and is abraded from rubbing or scratching.