

Pressure Injury Prevention Knowledge questionnaire (PIPK)

This questionnaire measures the knowledge about pressure injuries prevention. It can be used for nurses (Registered nurses and Assistant nurses). This 31-items version has good psychometric properties for reliability and validity.

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More information: <https://cuidosalud.com/en/inv/secoacba-project/>

SCORING INSTRUCTIONS

Knowledge score

To calculate the score, each item with correct answer adds 1 point.

- True. Items 1, 2, 4, 5, 7, 9, 10, 15, 16, 19, 20, 23, 24, 25, 26, 27, 29, 30, 31 add 1 point if the answer is True.
- False. Items 3, 6, 8, 11, 12, 13, 14, 17, 18, 21, 22 y 28 add 1 point if the answer is False.

Items with “Don’t know” answer add 0 points to the score. These items can be used for identifying topics with poor knowledge.

The maximum score that can be obtained is 31 points (knowledge index = 100%). From the score, several indices can be calculated:

- Index of knowledge: $\text{Total score} / 31 \times 100$
- Index of ignorance: $\text{Number of “don’t know” answers} / 31 \times 100$

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INSTRUCTIONS

Following, there are a number of statements on the recommendations for the prevention of pressure injuries; some are correct and some are incorrect practices. Please, read each statement carefully and tick the box T (true) or F (false), depending on whether you consider it to be a correct recommendation or not, according with current guidelines. If you really do not know the answer, tick the box "Don't know". Please, try not to leave any items blank.

	T	F	Don't know
1. When repositioning the individual in bed, use some device or fabric to reduce friction and shear forces and avoid dragging on the bed surface.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Offer high-protein, high-calorie nutritional supplements to adults at risk for pressure injuries if dietary intake does not meet nutritional requirements.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When repositioning in bed, patients can be placed over reddened skin areas.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Reassess the risk of pressure injuries when a significant change in patient health status, or clinical situation happens.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Assess and monitor nutrition using some validated assessment tools, in a way appropriate to the population and clinical context.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Skin areas in contact with medical devices (such as masks or tubes) do not have a higher risk for developing pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Describe all pressure injuries using a standardized classification system.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. A cotton and elastic bandage on the heels allows redistributing the pressure and preventing pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. In bedridden patients at risk of pressure injuries, a mattress with pressure-relieving properties should be used instead of a standard mattress.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The skin in contact with medical devices (such as drains or tubes) should be protected by using hyper-oxygenated fatty acids and/or foam dressings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Rubbing the skin with alcohol and massaging over bony prominences is useful to enhance capillary circulation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. It is not necessary to periodically mobilize medical devices (such as masks or tubes) to prevent pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. A comprehensive skin assessment (head to toe) of all patients admitted to a facility (hospital or nursing home) may be done within the first 48 hours after admission.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Repositioning is not necessary in bedridden patients using a pressure-relief mattress.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. The seat tilt should be adequate to reduce pressure and shear forces on the skin in at-risk patients while sitting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	T	F	Don't know
16. In dark-skinned patients, skin assessment should prioritize skin temperature, presence of oedema and change in tissue consistency, instead of the appearance of non-blanchable redness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Protect the skin from moisture by applying hyper-oxygenated fatty acids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. In at-risk bedridden patients, keep semi-incorporated with head elevated between 30° and 45°.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. All risk assessments performed must be registered in the patient's medical record.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Nutritional status should be assessed when the patient is admitted to a health facility or a major change in his/her health status happens.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Length of the surgery is not a risk factor for the development of pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Use a donut-shaped device to relieve the pressure in at-risk patients with reduced mobility.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Use the most appropriate pressure relief mattress based on the patient's characteristics, scheduling repositioning accordingly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. In patients with incontinence, profuse sweating, wound exudation or drainage, consider the use of appropriate management devices (such as urinary catheters, diapers or dressings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. In bedridden patients, do not exceed 30° in the elevation of the head.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Perform a comprehensive assessment in every patient to identify risk factors for pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Examine the skin for signs of redness, areas of non-blanchable erythema, localized heat, induration, or skin breakdown in individuals at risk for pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. The amount of time an individual spends sitting still does not influence the development of pressure injuries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. In patients in bed in the prone position, the face, nose, chin, forehead, cheekbones, chest, knees, fingers, genitals, clavicles, iliac crest, symphysis and back of both feet should be assessed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Systematically use a validated risk assessment scale (Braden, Norton or EMINA).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. In bedridden patients, monitor the skin in high-risk areas for pressure injuries (such as the heels, sacrum, occipital, nose, and hips).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>