HARM FREE game

1001 Approximately how many preventable deaths occur each year in UK hospitals as a result of Venous Thromboembolism (VTE)?

A. 2,500 patients
B. One in three surgical patients
C. 25,000 patients
D. 250,000 patients

C.

1002 When should you carry out a Venous Thromboembolism (VTE) risk assessment on a patient in hospital?
You may choose more than 1 answer.

A. Daily
B. As part of the admission process
C. When a patient's condition or mobility changes
D. Weekly
E. Prior to discharge

B, C, D.

1003 How regularly should patients be assessed for their risk of developing Venous Thromboembolism (VTE)?

In-patients – Low risk who do not require Thromboprophylaxis/ no action required, this should be recorded – Status should be reviewed weekly
Full VTE assessment should be reassessed weekly or as mobility changes.
All day surgery patients and podiatry patients are to be screened at pre-operative assessment or on admission using the assessment tool by the pre-assessment/admitting nurse
Patients who have had a screening at pre-operative assessment do no need to be reassessed unless their clinical condition has changed.
All patients who have at least one risk factor for developing VTE will have the full assessment to be completed by admitting DR and appropriate prophylaxis prescribed on the treatment chart.
Admitting health professional will fit and explain the correct use of stockings to the patient if required.
Theatre team to ensure correct use of calf compression boots if required.
On discharge – The nurse will ensure that patient has a copy of the VTE information leaflet. Verbally remind the patient of the signs and symptoms of VTE and how to reduce risk. If prescribed, discuss the correct use of VTE prophylaxis at home.

1004 Which of these is a form of mechanical prophylaxis?
A. Seamed stockings
B. Hold-up stockings
C. 10-denier stockings
D. Anti-embolism stockings

D.

1005 Which of these preventative measures should be offered to a surgical patient with haemophilia, on admission to hospital, to prevent Venous Thromboembolism (VTE)?
A. Anti-embolism stockings, plenty of drinking water and advice on taking gentle exercise
B. 75mg Aspirin straight away
C. Anti-coagulant drugs, such as heparin, for the first week
D. Strict bed rest for their entire hospital stay

A.

1006 Venous Thromboembolism (VTE) is the collective term for what?

Deep vein thrombosis (DVT) and pulmonary embolism (PE)

1007 What percentage of Urinary Tract Infections can be traced directly to the catheter?
A. 60%
B. 70%
C. 80%

C.

1008 What percentage of Urinary Tract Infections make up all hospital acquired infections?
A. 10%
B. 20%
C. 30%

B.

1009 Most patients with an indwelling catheter will have developed bacteriuria within:
A. 1 day
B. 1 week
C. 1 month

A.

1010 The most common symptoms of a systemic Catheter Acquired Urinary Tract Infection, or CAUTI, are:
A. Pyrexia
B. Offensive urine
C. Cloudy urine

A.

1011 A standard length catheter can be used:
A. For a man only
B. For a woman only
C. For either

C.

1012 When should a catheter be removed?
A. When the doctor says to remove it
B. When the family ask for it to be removed
C. When it is no longer clinically indicated

C.

1013 Which of the following is a complication of an indwelling urinary catheter?
A. Bladder spasm and bypassing
B. Constipation
C. Headaches

A.

1014 Gloves should be worn when manipulating the catheter:
A. All of the time
B. Only a Catheter Acquired Urinary Tract Infection (CAUTI) is suspected
C. If you might get splashed by urine when emptying the bag

A.

1015 A catheter specimen of urine should be taken from:
A. The catheter bag via the tap
B. Directly from the catheter when disconnecting the bag
C. From the sample port

C.

1016 What is ANTT?

Aseptic Non-Touch Technique is used to prevent micro-organism contamination of the site to be
manipulated by not touching key parts during a procedure for example a sterile urinary catheter tip prior to insertion.

1017 Name four drugs that are associated with increased falls?

See medication and risk of falls chart

1018 What environmental issues could contribute to an increased risk of falls?

Position of patient or service user – close to facilities
Nurse call buzzer
Distance to facilities
Consider cogitative impairment to remembering key messages

1019 What public health messages would you discuss with the patient or service user in relation to falls?

Correctly fitting footwear
Vision
Clutter
Medications
Correct use of aids
Carpets/rugs
Hydration/nutrition.

1020 What observations should be carried out if a patient or service user falls?

If unknown injury to the head, neurological observations should be performed – GCS, alongside the remaining observation.
Environmental observations should be considered and noted due to potential reasons of fall.
If known injury to the head neurological observations should be carried out.
In situations referral to GP, ANP or DHU should be considered and undertaken if required.

1021 What information would you give your patient or service user about their dietary and fluid intake in relation to falls?

Important to remain hydrated, difficult when patient/service user could be suffering from urgency, frequency.
Good balanced diet, low dietary intake could lead to lowered Hb levels, anaemia, dizzy spells etc.

1022 Give four physical factors which could contribute to a patient or service user falling.

Eye sight – are glasses fit for purpose
Footwear - does it fit or is it ill-fitting
Inappropriate walking aids
Minimal clutter in the environment

1023 A skin tolerance test can be carried out to assess the duration of time a client can potentially remain in one position before the need for repositioning?
True or False

TRUE

1024 If a client has a Waterlow of 10 or above:
A. They will develop pressure damage
B. They are assessed as at risk and need a pressure area prevention plan
C. They need pressure relief equipment
D. A Datix/Incident needs to be completed

B.

1025 SSKIN stands for
A. Stand, Sit, Keep moving, In the Night
B. Skin, Kare Is Necessary
C. Sit Still Keeps Incidents Happening
D. Surface, Skin Inspection, Keep your patients moving, Incontinence/Moisture, Nutrition/Hydration

D.

1026 What pressure ulcer risk assessment tool has been adopted by DCHS?
A. MUST
B. The Norton Score
C. The Waterlow Score
D. Basic clinical judgement

C.

1027 Choose a definition of what is an avoidable pressure ulcer?
A. When the provider of care did not do one of the following: Evaluate the persons clinical condition and risk factors; plan and implement interventions; monitor and evaluate the impact of interventions
B. When a client is not concordant with the plan of care
C. When all risk is assessed, care is planned, implemented and evaluated, with evidence demonstrated within documentation is in place
D. An inevitability when a client is unwell

A.