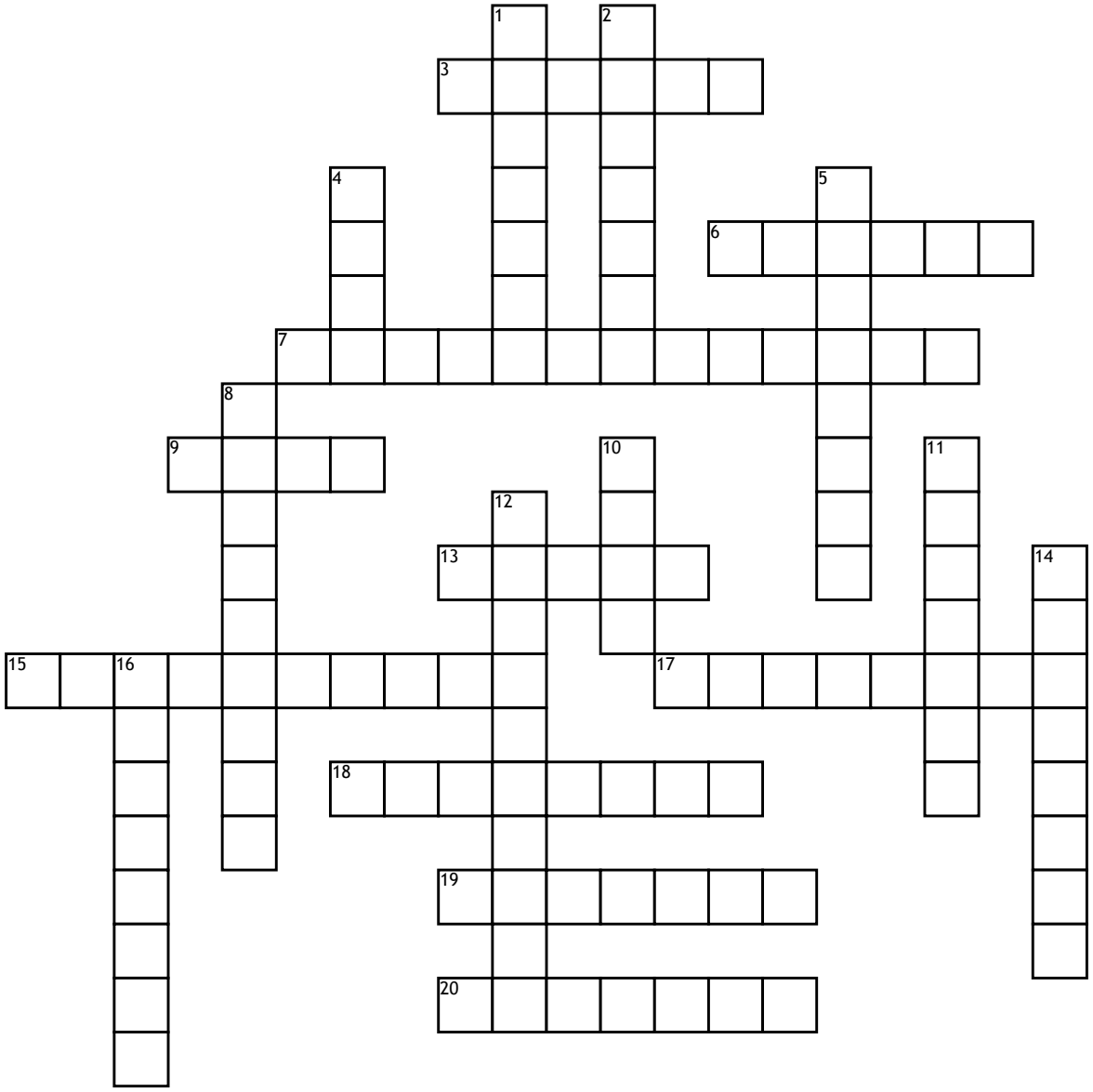
Name: _____ Date: _____

Pressure Injury Prevention Crossword



Across

3. During assessment, _____ all dressings unless ordered not to do so by provider.
6. The RN will assess the patient's pressure injury risk using the _____ scale.
7. Routine _____ is still required when the patient is on a specialty bed.
9. High risk braden score is 18 or ____.
13. The best way to protect skin is to stop skin exposure to _____ and feces.
15. Perform 4-eye skin _____ every shift.
17. For pressure relief, _____ patient early and maximize independence.
18. Use transfer aides to reduce _____ and shear.
19. Avoid the use of Adult _____ in high risk patients.
20. Presence of _____ devices is one of the risk factors for pressure injuries.

Down

1. Assess under all _____ such as splints, braces, and SCD's.
2. Order wound _____ when pressure injury is suspected.
4. Initiate ____ plan for all "skin at risk" or for patients with actual skin breakdown.
5. All high-risk _____ should have education provided about skin care.
8. Poor _____ and oxygenation are some of the risk factors in patients with pressure injuries.
10. Perform ____ hygiene before touching the patients.
11. Use _____ wipes and creams/ ointments to protect skin.
12. Chair cushion, heel protector, and _____ dressings are some of the pressure reduction tools.
14. Use a temporary no-harm _____ until the wound care nurses enter wound care orders.
16. Initiate routine repositioning _____ in bed and chair.