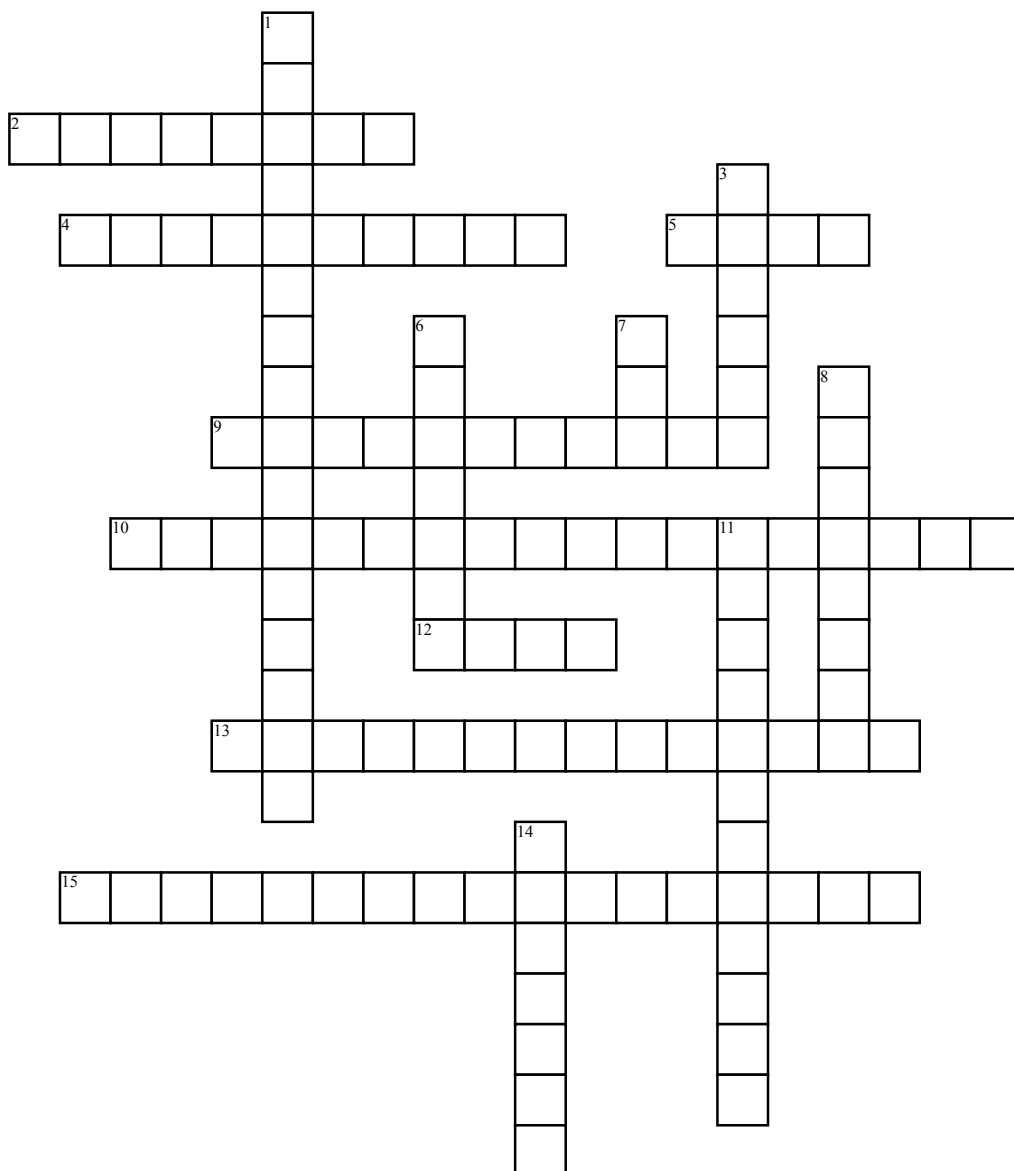


Skin Assessment



Across

2. Use _____ cream to OPEN skin to sacrum, buttocks, or perineum Q8 hours and after every episode of incontinence to prevent skin breakdown.
4. Use _____ cream on INTACT skin to sacrum, buttocks, or perineum Q8 hours and after every episode of incontinence to prevent skin breakdown.
5. Abbreviation for a skin injury acquired during the patient's stay in the hospital.
9. The _____ is a tool used to predict the patient's risk for developing a pressure ulcer.
10. Patients with _____ disease are predisposed to pressure ulcers of the feet, particularly the heels. (two words).

12. It is important to _____ the patient every 2 hours in bed to prevent skin breakdown.

13. It is important to identify and keep _____ elevated and protected in order to prevent or increase skin breakdown. (two words).

15. One of the six subscales of the Braden Scale. (two words).

Down

1. Immobility, incontinence, and impaired sensation may combine to place these patients at exceptionally high risk. (three words).

3. A _____ overlay mattress provides pressure relief and aides in the treatment of pressure ulcers. Holes in the mattress allow the passage of air, which prevents moisture and heat from increasing.

6. Regardless of the total Braden Scale score, it is always better to _____ than to treat.

7. Utilizing _____ nurses for a skin assessment increases the reliability and accuracy of the exam.

8. Always _____ your skin assessment at least every shift even if there are no problems.

11. When using a _____ it is important to limit 2 layers or less under the patient, only using paper pads; not linen or cloth.

14. A _____ can be placed on the sacrum, heels, or elbows to prevent a pressure injury from developing or on an existing pressure injury to prevent further breakdown and promote healing.