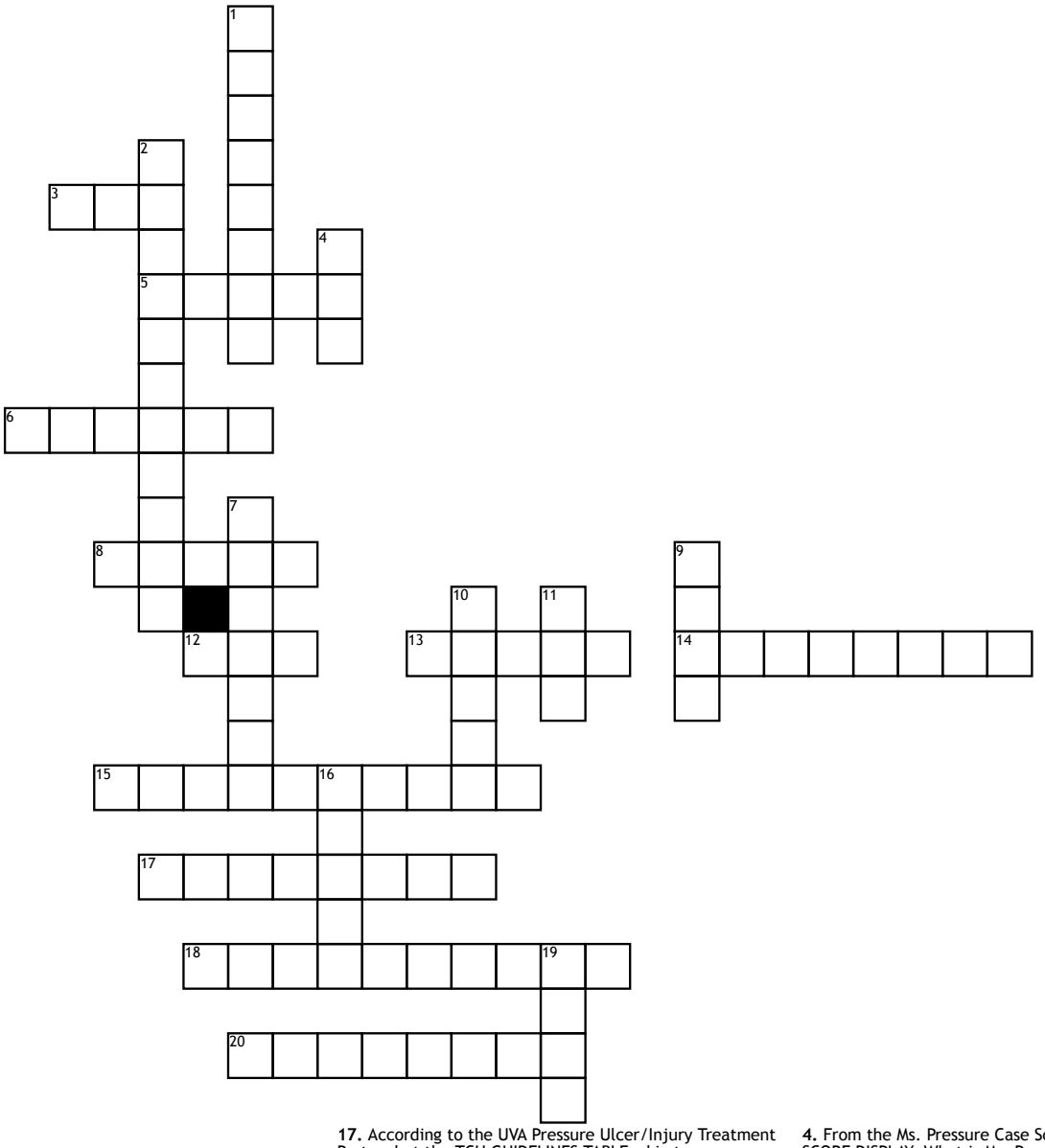
Be A Wound Fair Whiz with Words



Across

3. According to the Standard Work for Two Person Skin Assessment at the TCH GUIDELINES TABLE, after how many hours do you have to reassess a patient after being off the unit?

5. From the Ms. Pressure Case Scenerio at the BRADEN SCORE DISPLAY: This total score shows _____. Fill in your multiple choice answer as a written number. (ex. one, two, three, four)

6. STAGE 4 pressure injuries extend to _____ and bone.

8. Type 3 skin tears have a _____ loss of the flap.

12. SWEEN is used for _____ and/or cracked skin or heels. This is found in the Clean Utilty Supply Room and does not need an order.

13. If a pouching system will not adhere, the first thing to do is to gently cleanse the peristomal skin with warm _____ only. (no bath, barrier, CHG, or Hibacleanse wipes). The next step if the skin is denuded is to apply a light amount of stoma powder and seal it with liquid skin no sting barrier. You can also use a ring barrier or stoma paste to create a good seal.

14. INTERDRY AG is used for patients that have _____ associated skin damage.

15. Aquacel Foams have a _____ for absorption and a gentle silicone border.

17. According to the UVA Pressure Ulcer/Injury Treatment Protocol at the TCH GUIDELINES TABLE, skin tear treatment is : Cleansing with NS, patting dry, if possible re-approximating the skin flap, applying _____gauze and wrapping gently with a kerlix. The dressing is to be changed DAILY and PRN. A wound needs to be entered into the LDA AVATAR and a Be Safe completed for documentation.

18. Duoderm thin or vac drape is used to protect the periwound skin from: 1) the WOUND 2) the DRAINAGE from the wound 3) ZINC paste/zguard 4) periwound MACERATION/injury Fill in blank _____ with the CAPITALIZED word from above.

20. Be sure to use the spray/wipe medical _____ remover for patients with fragile, dry, and bruised skin when removing dressings or foams. Don't forget the Sting Free Barrier after cleaning the wound!

Down

1. The Braden Scale is used as a _____ ulcer/injury PREVENTION tool.

2. Negative Pressure Wound Therapy is primarily used for wounds that: 1) Are MALIGNANT (cancerous) 2) Are surface level and are healing well with red GRANULATION tissue 3) Need CONTRACTION of the wound edges and management of drainage. 4) Are UNSTAGABLE because there is black eschar over the wound. Fill in blank _____ with the CAPITALIZED word from above.

4. From the Ms. Pressure Case Scenerio at the BRADEN SCORE DISPLAY: What is Ms. Pressure's total Braden Score?

7. Sting Free Skin _____ wipes/spray create a protective clear and flexible periwound/peristomal barrier when applying all dressings, tapes, or in some cases ostomy wafers.

9. Apply Triad _____ thick into a wound. Triad can be applied lightly on periwound skin to prevent moisture associated skin damage (MASD).

10. Skin tears NEED a WOC consult according to the UVA Pressure Ulcer/Injury Treatment Protocol at the TCH GUIDELINES TABLE. True or False

11. STAGE 1 pressure injuries remain _____ after 30 minutes.

16. Envision beds MUST have a fitted sheet, draw sheet, taps, and MULTIPLE blue pad to keep the patient padded to prevent pressure and moisture. True/False?

19. When troubleshooting Negative Pressure Wound Therapy with a bottle of Vashe for the Veri Flo instill, check to see if the vent port is _____, remove the bottle from the instill tubing, remove the cap to release the vacuum in the bottle, then reattach the bottle to the instill tubing.