

CARE HOMES · CARE HOMES

Pressure ulcer prevention checklist

A daily prompt built around the SSKIN approach: Surface, Skin inspection, Keep moving, Incontinence and moisture, Nutrition and hydration.

SSKIN at a glance

	What to check
Surface	Is the person on the right mattress and cushion for their assessed risk? Is it working and set correctly?
Skin inspection	Check pressure areas (heels, sacrum, hips, elbows, shoulders, back of head, ears) at each care visit and record any changes.
Keep moving	Is the person repositioned as often as their care plan says? Are they encouraged to move?
Incontinence and moisture	Keep skin clean and dry, use barrier products as directed and change pads promptly.
Nutrition and hydration	Is the person eating and drinking enough? Are intake and weight monitored?

Top tip

Many teams now add "a" for assessment and "g" for giving information, making aSSKINg. Use whichever framework your organisation has adopted.

Daily resident record

Resident _____ Room _____

Risk level _____ Week commencing _____

Day	Surface OK	Skin checked	Repositioning	Continence care	Food and fluids	Concerns / action	Initials
Mon							
Tue							
Wed							
Thu							

Day	Surface OK	Skin checked	Repositioning	Continence care	Food and fluids	Concerns / action	Initials
Fri							
Sat							
Sun							

Act early

If you see redness that does not fade when pressed, broken skin or a blister over a pressure area, report it straight away to the nurse in charge or the community nursing team, in line with your policy.

Stock up in one order

Order by 4pm for next-day delivery. One account, one invoice.

[Care home equipment →](#)

[Care home supplies →](#)

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