Health New Zealand
Te Whatu Ora

STOP PRESSURE INJURIES USING 'SSKIN'

SSKIN	CHECK FOR	WHAT TO DO
Surface	Mattresses and seat cushions are not 'bottomed out' and covers are clean and intact. No additional covers over seat cushions, x1 sheet on air mattresses only. Air-mattresses are on correct resident weight setting and air-cells are working.	At risk residents: use pressure reducing or air alternating mattresses, seat cushions and heel lift devices; or "float" heels using pillows. Ensure resident is comfortable, if not reassess equipment. Clean mattresses and seat cushions regularly. Clothes and sheets wrinkle free.
Skin Inspection	**RED SKIN ALERT =** Stage 1 pressure injury is red intact skin that stays red when pressed. On dark skin feel for heat, cool, hard, or boggy skin. Hips, heels and sacrum are the most common pressure injury sites. Check skin and under devices/clothing for red areas/bruising and report.	Ask residents to report any sore areas and inspect these. Remove all pressure off pressure injuries. Keep skin clean and use your facilities skin care guide. Report **RED SKIN** to supervising nurse and **DO NOT** massage red areas as this will increase damage. Check clothing or footwear do not cause pressure and skin marking.
Keep moving	Residents who cannot reposition or mobilise are at most risk. Individualise repositing regimes according to skin changes. Safe handling techniques: slide sheets, transfer belts and hoists. Watch slings as they can cause skin pressure!	Encourage residents to move and reposition themselves regularly. Reposition immobile residents in bed using the 30° lying position and when sitting. Use a pillow between knees and ankles to prevent pressure.
Incontinence	Check skin for redness from urine and/or faeces. Fit continence pads correctly and change according to the 'wetness indicator'. The correct pads are used for morning, afternoon and night. Night pads are placed from 8.30pm.	Regular toileting regime. Encourage fluids. Fold pads lengthwise before applying to shape and aid absorbency. Loosen leak guards to prevent leakage. AVOID SOAP. Use soap substitutes for skin washing. Apply a **thin** layer of barrier cream to inner thighs and buttocks to protect skin from urine/ faeces.
Nutrition	Declining nutritional intake and recent weight loss increase the risk of developing pressure injuries. Loss of appetite may be due to illness or side effects of medication, swallowing issues, ill-fitting dentures, and gum and mouth infections. Resident's hands are cleaned before eating.	Reduced food or fluid intake, or loss of weight = monitor daily food and fluid intake. Inform nurse and involve dietician per Policy. Nutritional supplements serve chilled and in small volumes during day to ensure they are consumed. Regular mouth inspections. Oral hygiene is performed twice a day.

If you have any questions, please discuss with the registered nurse. Aged Residential Care: Pressure Injury Project Working Group Care Worker Training Module. Published November 2025. HE4330.