SSKIN Care Bundle
Pressure Injury Prevention Strategies

Skin Assessment & Skin Care

Check Skin
- During routine care
- Once a shift or more
- Under and around all devices (tubing, casts, braces, catheters)
- After turns and repositioning

Look for
- Changes in skin tone / redness
- Open areas

Communicate / Document
- Results of skin assessment and interventions

Assess Skin
- Using risk assessment (Braden / PURS)

Support Surfaces & Offloading

Remove Layers
- Remove extra clothing, bed linen, and lift slings

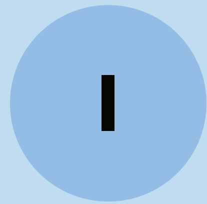
Offload
- Float/offload heels with pillows or heel boots
- Consider upgrading mattress/support surfaces

Consult
- An OT / PT / Advanced Wound Care Clinician

Keep Moving - Redistribute Pressure

Turn and Reposition
- During routine care
- When interacting with patient; make small changes of position to reduce pressure
- Using pillows and wedges to help maintain position

Encourage Mobility
- Promote mobility and self-repositioning



Incontinence & Moisture Management

Manage incontinence
- Establish toileting routine
- Avoid briefs if possible

Manage Moisture
- Use barrier cream to protect skin from incontinence
- Keep skin folds dry

Nutrition - Optimize Nutrition & Hydration

Encourage Food and Fluid Intake
- Offer meals, drinks and snacks

Consult
- A registered dietitian

What is SSKIN?

It's an acronym for 5 groups of actions to identify risk and prevent pressure injuries

For additional information refer to Wound Care intranet site:
https://home.wrha.mb.ca/clinical-initiatives/wound-care/

Winnipeg Regional Health Authority

Office régional de la santé de Winnipeg