SSKIN Bundle

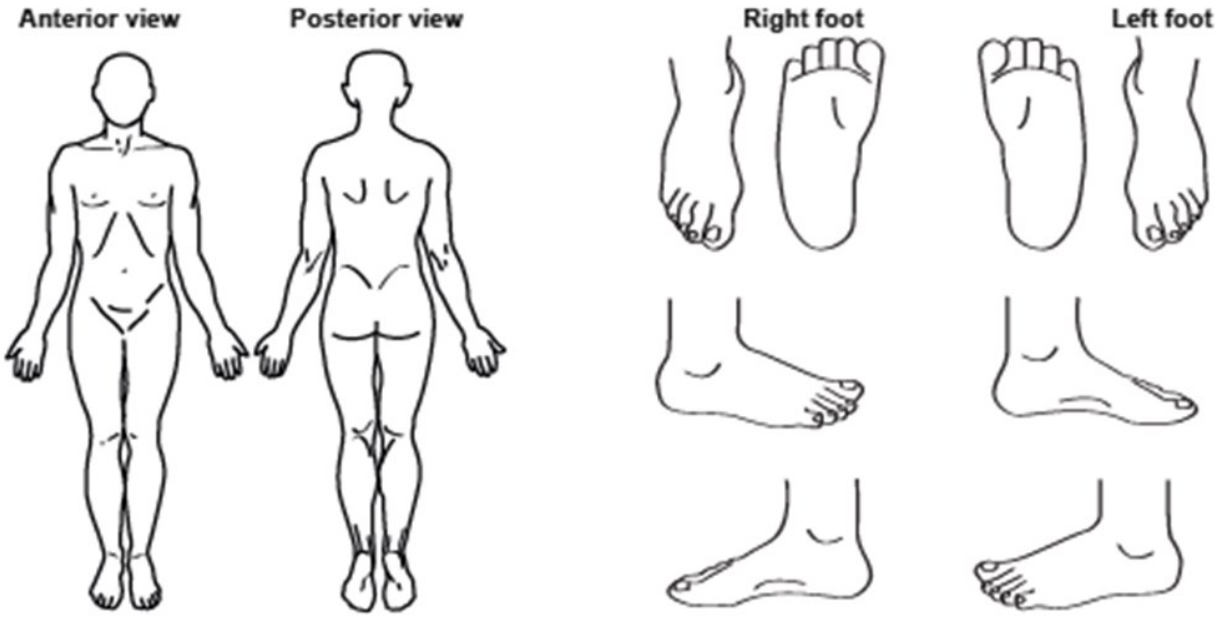
The SSKIN bundle is a bedside tool to help staff and residents to monitor skin concerns and proactively reduce the risks of developing a pressure ulcer. Documenting each aspect of the SSKIN checklist can help to achieve this. Residents should be encouraged to change position regularly. Please refer to the 'Prevent Pressure Ulcers' leaflet for more information.

Resident Name: _____ Unit: _____

Frequency of Assessment (Please circle) : 1 Hourly 2 Hourly 3 Hourly 4 Hourly 6 Hourly 12 Hourly															
Date:	24/03/22														
Time:	16:10														
Waterlow Score (most recent):	21		Weight (most recent):												
Skin Assessment: Yes (✓) or No (X)															
Skin checked, including all pressure areas & under devices e.g., catheters/o2 tubing, glasses etc.	✓														
Any skin changes found? If yes please record on body map overleaf	✓														
Surface: Yes (✓) or No (X)															
Mattress Type (please circle): Air Foam Mixed															
Cushion Type (please circle): Air Foam Mixed/Gel															
Appropriate mattress	✓														
Appropriate seating	✓														
Heel Protection: Boots (B), Pillows (P), Offloading Mat (M), Dermal Pad (D)	B														
Equipment Checked (e.g. No alarms, flashing lights or loss of air)	✓														
Air mattress checked and setting correct for residents current weight	✓														
Keep Moving: Left (L), Right (R), Back (B), Sitting (S), Mobilising (M)															
Position changed in bed	R														
Position changed out of bed	X														
Incontinence: Yes (✓) or No (X)															
Is the skin wet?	X														
Is peri-anal skin healthy?	✓														
Offer use of toilet?	✓														
Passed Urine?	✓														
Bowels Moved?	X														
Water based barrier cream applied? E.g. Cavilon, Sorbiderm, etc.	✓														
Nutrition: Yes (✓) or No (X)															
Is food or fluid chart in use?	✓														
Meal, snack or drink offered?	X														
Supplement or fortified food offered?	X														
Staff member initials:	LW														
Staff member role:	RN														

Wound/Skin Damage Reporting:

Mark wounds or skin damage with an X on the diagram and complete the boxes below:



Date	24/03/22							
Time	10:00							
Reported to senior staff e.g., Nurse, Senior Carer, etc.	✓							
Reported to Care Home Support Team or District Nurses? Yes (✓) or No (X). Please fill in date of referral	✓ 28/03/22							
Issues Found (See key below):	1. C 2. E							
Key: A=Blanching, B= Non-blanching/red/purple, C=Blistered/Broken, D=Black, E=Covered by dressing, F=Heat/Hardness G=Grade of pressure ulcer (e.g. G2)								

Unable to complete the check? Complete the chart below:

Date of check not completed:	24/03/22						
Time:	12:22						
Reason for skin not being checked:	Resident in activity						
Action taken if skin not checked (e.g. check in 4 hours, escalated to next shift etc)	Check in 2 hours						
Staff Initials:	LW						

Resources given:

Pressure Ulcer information given to person/relatives? Please date when given	✓ 28/03/22	