OSCE checklist for pressure area care

An OSCE checklist for pressure area care covers assessing risk with your local tool, checking skin over bony points and under devices, relieving pressure by repositioning, keeping skin clean and dry, using the right support surface, recording what you find and reporting any damage.

OSCE checklist for pressure area care: steps to practise

1. Clean your hands, introduce yourself, confirm the patient's name and date of birth (and wristband if an inpatient), explain what you will check and gain consent.
2. Close the curtains, keep the patient covered where you can and offer a chaperone if they want one. Wear gloves and an apron if you may touch body fluids or broken skin.
3. Review the risk score from the validated tool your setting uses, the care plan and the last skin check. Ask about pain or soreness, continence, mobility and eating and drinking.
4. Check the skin over the sacrum, buttocks, heels, hips, elbows, shoulders, ears and the back of the head, and anywhere a device presses on the skin, such as oxygen tubing, masks, catheters or splints.
5. Look for redness that does not fade when pressed, blisters, broken skin, warmth, swelling, hardness or a boggy feel, and ask about pain at each site.
6. Take particular care with darker skin, where redness may be hard to see. Compare with nearby skin and use touch, temperature and firmness as well as colour.
7. Clean soiled skin promptly with a mild, pH-balanced cleanser, pat it dry and never rub or massage reddened areas. Use a barrier product if the care plan says so.
8. Help the patient change position on the schedule in the care plan, using moving and handling equipment to avoid friction and shear. Offload the heels so they do not rest on the bed.
9. Check that the mattress or cushion matches the risk level and works properly, and keep sheets smooth and dry. Encourage food and drink as allowed and report poor intake.
10. Remove gloves and apron and clean your hands. Record the skin findings, the position and the time. Report any new or worsening damage to the nurse in charge at once so it can be reviewed and escalated as your policy says.

What candidates commonly forget

- Rubbing or massaging a red area
- Forgetting heels, ears and the back of the head
- Missing damage under devices
- Not adjusting the check for darker skin
- Not gaining consent or protecting dignity
- Not recording the time of repositioning or reporting new damage

Local policy comes first

This is our own practice checklist. Your college, hospital or country may do some steps differently. Where local policy and this list disagree, follow local policy.

Practise the hands-on steps with a classmate or in a skills lab, because an AI patient cannot watch your technique. You can practise the talking part with an AI patient, and try one station free with no sign-up. Next, try Pressure area assessment after a hip fracture. Back to the nursing foundation OSCE page: nursing foundation OSCE, or see the full OSCE checklist list.

Common questions

What is the OSCE checklist for pressure area care?

Confirm identity and consent, protect privacy, review the risk score, check skin over bony points and under devices, keep skin clean and dry without rubbing, reposition on schedule, use the right support surface, encourage nutrition, record and report damage.

How do I check skin that does not look red?

Compare with nearby skin and look for changes in colour, temperature, firmness and swelling, and ask about pain. Redness is not the only sign, especially in darker skin.

Should I massage a red pressure area?

No. Massaging or rubbing can damage the tissue further. Relieve the pressure, keep the skin clean and dry, and report it.

Which areas are most at risk?

The sacrum, buttocks, heels, hips, elbows, shoulders, ears and the back of the head, plus skin under devices.

Sources

- NICE CG179: pressure ulcers
- NMC: standards of proficiency for registered nurses

Checked 2026-11-13. Fees and rules change, so confirm them with the regulator before you book.