NHS Lothian

Care Homes/Tissue Viability ASSKING Bundle Checklist	Resident's Name: Unit:

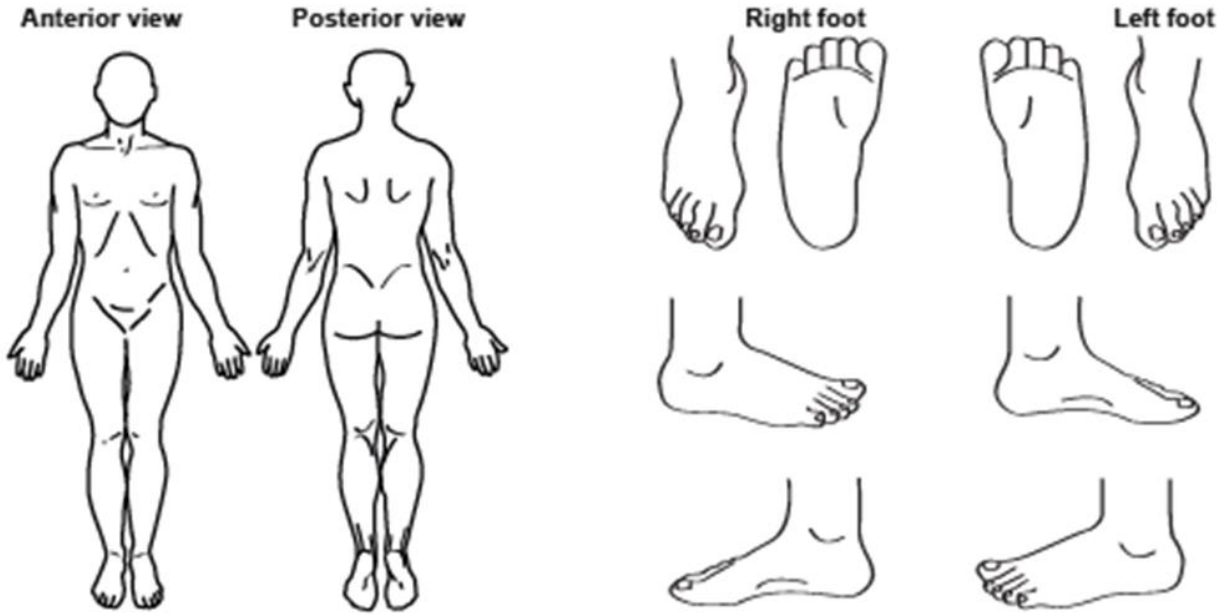
The ASSKING bundle is a bedside tool to help staff and residents monitor skin concerns and proactively reduce the risks of developing a pressure ulcer. Documenting each aspect of the ASSKING checklist can help to achieve this. Residents should be encouraged to change position regularly.
Please refer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

A: Assessment Frequency: ☐ 1 hourly ☐ 2 hrly ☐ 3 hrly ☐ 4 hrly ☐ 6 hrly ☐ 12 hrly									
Date:	15.04.26								
Time:	16:10								
Waterlow score:		Weight (most recent): kg							
S: Skin Assessment YES (Y) or NO (N)									
Skin checked including all pressure areas and under devices e.g., catheters, O_2 tubing and glasses?	Y								
Any skin changes found? If yes, please record on Body Map overleaf	Y								
S: Surface									
Mattress type: ☐ Air ☐ Foam ☐ Mixed/Hybrid									
Cushion type: ☐Air ☐ Foam ☐ Mixed/Gel									
Appropriate mattress?	Y								
Appropriate seating?	Y								
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?	Y								
Air mattress checked and setting correct for resident current weight?	Y								
K: Keep Moving Left (L), Right (R), Back (B), Sitting (S), Mobilising (M)									
Position changed in bed?	R								
Position changed out of bed?	N/A								
I: Incontinence YES (Y) NO (N)									
Is the skin wet?	N								
Is peri-anal skin healthy?	Y								
Offered the use of toilet?	Y								
Passed urine?	Y								
Bowels moved?	N								
Water based barrier cream applied? e.g., Cavilon™, Sorbaderm™	Y								
N: Nutrition YES (Y), NO (N)									
Is food or fluid chart in use?	Y								
Meal, snack or drink offered?	N								
Supplement or fortified food offered?	N								
Staff member initials/Role:	LW/RN								

G: Giving Information: 'Prevent Pressure Ulcers' patient information leaflet (version __)
given to ☐ person ☐ relatives DATE: __/__/__

Wound/Skin damage Reporting

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



Date	15.04.26								
Time	10:00								
Reported to senior staff e.g. nurse, senior carer YES (Y) or NO (N)	Y								
Reported to care home support team or district nurses Y or N. Add referral date if required	N								
Issues found (see Key below)	G2								
Key: **A** – blanching; **B**- non blanching/discoloured; **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	15.04.26								
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	Check in 2 hours								
Staff Initials	LW								