Ward:	Site: Date:				Addressograph, or								
This care rounding document should be used in non-acute			Э									NF	IS
areas and should be supported by an additional person-cent				d Name Lothia									ian
care plan. Registered Nurses should use clinical judger based on risk assessment, clinical condition and essen													
needs to plan frequency.			DC	DOB									
1hrly 2 hrly 3 hrly hrly (please circle/com			lete) Unit no. / CHI										
Print nam	ne and sign												
Codes	(Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) As	leep (I)	Indeper	ndent, (NW) no	ot on wa	ard, (TH) Theat	re,				
Time of	f Care Rounding												
Documen	t the exact time care rounding took place e.g. 0830	08	00 am			_ 24	hour	nerior	4)7.00 a	m
	Waterlow score less than 10 low risk r				laily s				<u> </u>			1100 0	
စ	Use codes for outcome of skin review		1			1		1		1			
Cal	Waterlow 10+ - Visual Skin Check (tick)											<u> </u>	
a (Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister												
Are	Vulnerable areas? (circle areas of damage)	Heel ((L) (R)	, Hips	(L) (R), Sac	rum, S	Spine,	Other.				<u> </u>
e	If changes in outcome of skin check, consider co	ontine	nce sta	atus, r	eview	freque	ency o	f CR a	nd up	date c	are pla	an	
Pressure Area Care	Have you changed position since												
es:	last CR?												
L L	Positioning (R) or (L) side (B) Back (C) Chair												
	Mattress type / Cushion type	piez	ise sta	ale ly	pe.			1		1		T	1
	Do you need the toilet?												
uo	Is the patient continent of urine? (at time of Care Rounding)												
ati	Continence product changed/offered?												
ui u	Catheter care performed?												
Elimination	Catheter bundle updated daily position cather Is patient continent of faeces?	eter be	low the	e blad	der / n	o mor	e than	2/3 fu	II with	conne	ections	s intact	(
ш	(at time of Care Rounding)												
	Bowel function monitored	Obse	rve bo	wel fu	nction	and u	Ipdate	daily	1		1		
Fluid rition	Would you like a drink? Ensure fluids are within easy reach												
Fluid rition	Fluid Balance Chart (if clinically indicated)												
Food, & Nuti	When did you last eat?												
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack	(NBM)	Nilby	v Mou	th (A)	Assis	tance	Un	date Fo	ood Ch	art if re	quired	
ш ~	Oral Hygiene Performed (ref to risk assessment)			,									
	Appropriate Footwear?												
	Walking aid available(and within reach)												
	Area de-cluttered?												
Falls	Chair and bed height assessed?												
Га	Falls alarm in use and attached?												
	Glasses available for use? (if worn)												
	Hearing aid available for use? (if worn)	4	- :l - t	la a 4 la						NI	<u> </u>	<u> </u>	
	Requires close observation for commo	Jae, i	ollet,	bath	ing o	rsno	wenn	ig	ΥD	Ν			1
Pain	Are you in pain?											<u> </u>	
	Analgesia Given?												
ral	Peripheral Venous Cannula observed?											1	
	Observe for signs of inflammation/swelling	g at ev	ery C	R se	ssion.	Bun	dle/V	IP sco	ore to	be u	pdate	ed da	ily
General	Are you comfortable? Y/N												
Ge	Anything else I can do for you?											1	
	Buzzer within easy reach												
Personal Care Type (specify) Time Given													
Initia	S – document at time of care delivery												
intitu													

Ward:	Site: Date:				Addressograph, or									
This care rounding document should be used in non-acute												IH	5	
areas ar	nd should be supported by an additional pers	son-c	entred	Na	me									
care plan. Registered Nurses should use clinical judgement												Lothia	n	
based on risk assessment, clinical condition and essential care														
needs to plan frequency.				DOB										
1hrly 2 hrly 3 hrlyhrly (please circle/complete)														
				Unit no. / CHI										
	ne and sign													
	(Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) As	leep (I)	Independ	lent, (NW) no	ot on wa	ird, (TH) Theat	re,					
	f Care Rounding t the exact time care rounding took place e.g. 0830													
Document			.00 am	•				period	. – k		- 0	7.00 a	m	
	Waterlow score less than 10 low risk r	equir	es only	y a d	laily s	skin r	eviev	V:						
e	Use codes for outcome of skin review Waterlow 10+ - Visual Skin Check (tick)				I									
Ca													<u> </u>	
a	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister													
Are	Vulnerable areas? (circle areas of damage)	Heel	(L) (R),	Hips	(L) (R), Sac	rum, S	Spine,	Other.					
e	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan													
Ins	Have you changed position since													
Pressure Area Care	last CR?													
Ĕ	Positioning (R) or (L) side (B) Back (C) Chair	<u> </u>												
	Mattress type / Cushion type	piea	ase sta	te ty	be:	1		1			1			
	Do you need the toilet?													
u	Is the patient continent of urine? (at time of Care Rounding)													
Elimination	Continence product changed/offered?													
in	Catheter care performed?													
<u>.</u>	Catheter bundle updated daily position cathe	eter be	low the	blad	der / n	io mor	e than	2/3 fu	II with	conne	ections	intact		
Ξ	Is patient continent of faeces?													
	(at time of Care Rounding) Bowel function monitored	Ohse	rve bow	el fu	nction	and	Indate	daily						
ъс	Would you like a drink?			orra			-puulo							
Fluid	Ensure fluids are within easy reach													
Ē	Fluid Balance Chart (if clinically indicated)													
Food, & Nut	When did you last eat?													
Ъ щ	(B) Breakfast (L) Lunch (D) Dinner (S) Snack	(NBM)	Nil by	Mou	th (A)	Assis	tance	Up	date Fo	ood Ch	art if re	quired		
	Oral Hygiene Performed (ref to risk assessment)													
	Appropriate Footwear?													
	Walking aid available(and within reach)													
()	Area de-cluttered?													
Falls	Chair and bed height assessed?													
ш	Falls alarm in use and attached?													
	Glasses available for use? (if worn)													
	Hearing aid available for use? (if worn)		ailat k	ath						NI			L	
	Requires close observation for commo	Jue, i	onet, t	ain	ing o	I SHO	wern	ig	ΥD	Ν				
Pain	Are you in pain?													
	Analgesia Given?													
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	Observe for signs of inflammation/swelling	at ev	verv CF	R se	ssion	Bun	dle/V	IP sco	ore to	be u	pdate	ed dai	ily	
	Are you comfortable? Y/N										-			
195	Anything else I can do for you?													
0	Buzzer within easy reach													
Person	al Care Type (specify)	Time	e Give	n	I	L	I	1	I	1	I	1		
Initia	S — document at time of care delivery													