Ward:	Site:	Date:	Addressograph, or
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency. **1hrly 2 hrly 3 hrly _____hrly** (please circle/complete) **Print name and sign** _____			Name DOB Unit no. / CHI

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830													
	08.00 am ←				**24 hour period**							→	**07.00 am**
Pressure Area Care	**Waterlow score less than 10 low risk requires only a daily skin review**: Use codes for outcome of skin review												
	Waterlow 10+ - Visual Skin Check (tick)												
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister												
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other……..											
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
	Have you changed position since last CR?												
	Positioning (R) or (L) side (B) Back (C) Chair												
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?												
	Is the patient continent of urine? (at time of Care Rounding)												
	Continence product changed/offered?												
	Catheter care performed?												
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
	Is patient continent of faeces? (at time of Care Rounding)												
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach												
	Fluid Balance Chart (if clinically indicated)												
	When did you last eat?												
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance **Update Food Chart if required**												
	Oral Hygiene Performed (ref to risk assessment)												
Falls	Appropriate Footwear?												
	Walking aid available(and within reach)												
	Area de-cluttered?												
	Chair and bed height assessed?												
	Falls alarm in use and attached?												
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)												
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?												
	Analgesia Given?												
General	Peripheral Venous Cannula observed?												
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N												
	Anything else I can do for you?												
	Buzzer within easy reach												
Personal Care *Type* _____ *(specify)* **Time Given** _____													
Initials – document at time of care delivery													

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