Daily intentional rounding

Patient name..... .....
Hospital no.....
Ward..... Date.....

RN responsible for care .....
RN Day.....
RN Night.....

Key:
When checked √
Off ward OW

Please enter patient's response to the 4 comfort questions Y = Yes N = No UC = unable to communicate NA = not applicable

Please enter time patient received rounding												
Would you like a drink and/or a snack?												
Do you need to go to the toilet?												
Are we managing any pain you have adequately?												
Is there anything else I can do for you?												
Falls prevention	**At risk of falls? Yes □ No □ Bed rails up □ Bed rails down □**											
Is the bed area safe, clean and free of clutter?												
Check the call bell is within easy reach?												
Is the bed at lowest height?												
SKIN bundle												
Surface Check position of all invasive decives												
Is mattress/seat appropriate/sheets smooth?												
Document skin check key												
Keep Moving Document position key												
Incontinence Clean and dry please check												
Nutrition Malnutrition screening tool completed as per Trust guidelines												
Check heels												
Designation												
Signature												

Position keys
OW Off ward
ST/C Standing from chair
SB Sat in bed
F Front
R Restless
T Therapy
H Patient refused
LR Log rolled
P Position changed for care
M Mobile
LT Left side
RT Right side etc.....

SKIN check keys
A No marking
B Blanching erythema
C Non-blanching erythema
D Broken or blistered (Commence wound care plan)
E Intact dressing etc.
Type of mattress.....
Frequency of positioning.....

Pressure ulcer risk assessment:
High (2 hourly rounding min) □
Medium (4hourly) □
Low (daily) □

Pressure ulcers are generally more localised above bony prominences

Check all these areas on your patient. Please indicate any devices present on the patient by placing the numerical code on the Body Map where appropriate. If any pressure damage identified please place a cross on the relevant area on the body map. If broken or blistered skin, start a wound care plan and complete e-AIMS.

1. O2 mask
2. Cannulae
3. Monitoring devices and cables
4. Epidural/block site
5. Patient extremities not touching foot or head board
6. Drips and drains
7. EVD drain
8. Pressure damage
9. Urinary catheter
10. Remove all VTE devices (stockings, intermittent pneumatic compression e,g Flowtrons) to check heels daily □

Body map 1 & 2 drawn here
(Front and back view)

Document any variance/deviation and any actions resulting from rounding e.g. Pain control medication administered:

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