Lindsey Lodge Hospice

Standard Operational Procedure for the Care Round Chart on the In-patient Unit

1.0 Introduction

1.1 The care round document is a form for staff to complete hourly for all patients or as a minimum of 3 times per every 7 hours. The care round form provides In-patient Unit staff with continuous information which is timely and focussed to patient and their family's needs.

1.2 The care round form gives the Senior Nurse and the Director of Nursing and Patient Services the ability to review the timely care being delivered in the In-patient Unit.

2.0 Aims and Objectives

The aim of this standard operating procedure is to ensure that all staff undertaking the hourly care rounds are consistent in their approach, ensuring equality and accuracy of the information collected

- Hourly recording of the information collected ensures that reviews and assessments of patients are completed each shift to give an overview and method of communication to all staff for continuous care of the patient.
- The care round form must be completed for the patient and any blanks/gaps in the information recorded must be reported to the nurse in charge.
- Should the In-patient Unit need to deviate from the hourly care round i.e. the rounds are unmanageable, a risk assessment should be undertaken with Senior Nurse or Director of Nursing and Patient Services to determine which patients remain at high risk. As a minimum every patient should be assessed 3 times per 7 hours.

3.0 Area

The standard operating procedure must be followed by all RGN and HCA inpatient staff employed by Lindsey Lodge Hospice and information received made available to all Health Care Professionals involved in the individual patients' care.

4.0 Duties, Accountability and Responsibilities

4.1 **Director of Nursing** and Patient Services **-** is accountable for professional standards within their designated clinical areas.

4.2 **Senior Nurse and Deputy Senior Nurse** – have a 24hour operational responsibility for ensuring that the forms are completed consistently for each patient deemed at risk within their areas of responsibility in line with this standard operating procedure. Also to inform the Director of Nursing and Patient Services /Chief Executive of any care concerns identified.

5.0 The Purpose of the Care Round and the Care Round Form

5.1 Ensures the nurses attend to the patient to find out if the patient needs anything.

5.2 To highlight the dependency of patients.

5.3 To assess the patients' symptom management to ensure timely interventions can be actioned.

6.0 Text Headings on the Form

6.1 Call bell

To ensure the patient is capable of using the call bell and to see if the actually know how to use this. Nursing staff need to ensure the call bell is working and within easy reach.

6.2 Are Bed Rails / Sensor pads needed

This is to ensure the nursing staff receives a prompt to assess the need for bed rails, use of red 'gripper' socks or sensor pad if the patient has been deemed at risk of falling whilst in the In-patient Unit at Lindsey Lodge Hospice

6.3 Reduce bed to the lowest height

This is to ensure the nursing staff has assessed the height of the bed and need to reduce the height if the patient has been deemed at risk of falling. It is expected that those patient's how have been assessed as 'at risk' of falls will receive hourly care rounds.

6.4 Ensure items are close to the patient

To acknowledge that the patient has all their personal items close by and their table is within their reach.

6.5 Pain and Symptom Management

The patient is to be asked during the care round if they are experiencing any pain, nausea and vomiting or other symptoms such as breathlessness, delirium or agitation. If the patient reports any symptoms then the appropriate medication should be prescribed/administered and then the patient is reassessed within 30 minutes of administration, care rounds should continue hourly until the patients symptoms have stabilised.

6.6 Repositioning

Patients are to be asked every hour if they are uncomfortable and would like to stand, move around or walk to reduce the risk of developing pressure ulcers and to make themselves more comfortable. Patients who are unable to move themselves should be asked if they would like their position changing in line with their individual pressure area management plan.

6.7 Nutrition

This is to offer/encourage the patients to take oral fluids +/- snacks and to document this appropriately and also to ensure that the patient's drinks are within easy reach and that they have adequate amounts of them.

6.8 Elimination

The patient is to be offered the toilet every hour and supported to do this.

6.9 Other

General good communication with the patient/families is essential to allying any fears. This needs to include asking the patient if they are clean, dry and comfortable and would they like anything. There is also the opportunity, during the care round to provide emotional and psychological support to the patients and their families to engender a team approach to care.

Actions arising from the hourly care rounds should be recorded in the patient records.

7.0 Monitoring Compliance and Effectiveness

The Senior Nurse will monitor compliance with this document during their daily handover and when reviewing documentation.

8.0 Associated Documents

8.1 Lindsey Lodge Hospice Falls Prevention Policy

8.2 Lindsey Lodge Hospice Pressure Area Management Policy~

8.3 Lindsey Lodge Hospice Nutrition Policy

8.4 Lindsey Lodge Hospice Delirium Guidance

9.0 References

Northern Lincolnshire and Goole Hospitals Standard Operating Procedure for the Care Round Chart

10.0 Definitions

SOP -Standard Operating Procedure

11.0 Consultation

11.1 Clinical Leaders

12.0 Dissemination

Via Lindsey Lodge 'L' drive policies/guidelines

13.0 Implementation

The SOP will be discussed at In-patient Unit team meetings and minutes of the meeting made available to all staff. It will be the responsibility of the Senior Nurse and Deputy Senior Nurse to explain rationale of the form and to ensure awareness and compliance of this form.

14.0 Equality Act

14.1 In accordance with the Equality Act (2010), the Hospice will make reasonable adjustments in the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Hospice will endeavour to develop an environment within which individuals feel able to disclose any disability or concern which may have a long term ad substantial effect on their ability to carry out their normal day to day activities.

14.2 The Hospice will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Hospice's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010)

REFERENCES: See Section 9				
Lead Author of Policy: SN Karen Wright **Responsible Sub-group Quality Assurance** **RATIFICATION DATE BY TRUSTEES 13th July 2017** **Review interval 3 year**				
TO BE REVIEWED	REVIEW COMPLETED	BY	APPROVED BY	CIRCULATION

Appendix 1

Patients Name:	**DOB:**	**NHS No:**

Abbreviations: A= Achieved **N/A** = Not Applicable **S**= Asleep **R**= Reported to nurse in charge **D**=Action documented in Nursing Kardex	**Care Round** This chart must be completed as per Standard Operating Procedure for the use of the care round chart																						
Time (24 hour clock)	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**
Patient is self – caring- requires no intervention at this time, Call bell is at hand and patient knows how to use it. Patient aware to ask for help if needed.																								
Are Bed rails/sensor pads needed (Identify BR= bed rails /S=sensor pads)																								
ENSURE tables and personal items are close to the patient including food, fluids and call bell																								
ASSESS if patient is	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**	**SF**

symptom free i.e. no pain, no nausea or vomiting, agitation or delirium (if **NO** has medication been administered and documented in nursing Kardex) **SF=** symptom free																								
	NO	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**
ENSURE patient is comfortable – change position / bed linen as required																								
OFFER the patient the opportunity to go to the toilet/use a commode																								
ARE relatives present? Y/N																								
Have their needs or queries been addressed? Y/N																								
Sign																								