Care rounding is a structured approach where Health Care Support Workers and Registered Nurses conduct checks and interventions with patients at set times to assess and manage their fundamental care needs. The Registered Nurse will prescribe how frequent the checks are dependant on the patient’s greatest need. They can be as frequent as hourly and no longer than four hourly. As a Health Care Support Worker you will have key role to play in these care rounds and we will now describe the care rounding process.
The question in the top right box is your first step in beginning a conversation with the patient. Sometimes this question may not be the right fit for you, so we encourage you to make it your own and adapt it. Here are some examples:- What is important to you at the moment,? What can I do to help support you in your care today? What would you like to achieve today?
What is delirium? Delirium is sometimes called acute confusion, but a better description is a change in someone’s alertness and awareness. Patients can appear frustrated or frightened, agitated, disorientated and perhaps trying to leave the ward. Hallucinations, delusions and irritability are also often associated with delirium. Or, it may be a decrease in alertness making patients appear sleepy or unable to follow conversations or instructions. This type of delirium is easily missed as patients are often sleepy, but would be very prone to dehydration and pressure damage due to the lack of mobility.

These changes can develop over a short period of time, and so recognising delirium early is really important to give patients the best possible outcomes. A Single Question in Delirium (often shortened to SQiD) to ask is, **is the person more confused or drowsy than normal?** This question is asked at every care round. If the answer to this is yes, this should always be reported to the nurse in charge of the patient’s care. Screening tools are then used in clinical areas by teams to help recognise patients who are more at risk.

Can we prevent delirium? Yes, in many cases we can. Patients are assessed for risk factors on admission to hospital with appropriate steps being taken at this point. During hospital stays, **care rounding** is really important - as this is the time to ask and assess the impact of known risk factors such as pain, dehydration, constipation and environmental factors and take steps to minimise the impact of these. For example, for the patient in pain, they are given painkillers; for the patient at risk of dehydration, they are encouraged to drink.
Someone else’s pain is impossible to feel. However, in health care we can ask patients if they are in pain, and look for signs of patient experiencing pain. If patients report that they are in pain, this should be documented on the care rounding chart and reported to the nurse responsible for looking after the patient. Health care workers can also look for signs of the patient experiencing pain. Is the patient holding themselves (for example where they have a wound)? Are they wincing, or screwing up their face when trying to move around the bed, or when getting up from bed or a chair? Are they avoiding doing things like going to the toilet, or getting out of bed – why is this, is it due to pain? Patients in pain will be further assessed and painkillers will be given as prescribed by medical staff.
Skin and pressure areas must be checked for any signs of redness, discolouration, skin breaks, excoriation or moisture. This is to reduce this risk of a pressure ulcer developing. The risk of a pressure ulcer is increased with immobility, incontinence and poor nutrition. It is therefore important that the HCSW inspects patients skin as part of care rounding.

A pressure ulcer is an area of skin damaged by pressure. It is usually caused by sitting or lying in one position for too long without moving, by rubbing or dragging your skin across a surface. A pressure ulcer can develop in only a few hours and usually starts with the skin to the affected area changing colour. It may appear slightly redder, warmer or darker than usual. If you do NOT take measures to address the cause(s) it can develop into an open wound. It is better to prevent pressure ulcers as they can take a long time to heal. If left untreated, complications may occur and even life threatening.

If the patient’s mobility is restricted there are simple measures that can be taken to reduce the risk of a pressure ulcer developing. These include:

• Regular skin inspection
• Reposition patient regularly. This can be done by regular positional changes in bed or by assisting patient to mobilise or move in chair. When repositioning a patient it is important that skin is not pulled tight, folded or caught up in clothing, equipment or bedding – after repositioning a check must be made of the skin and skin tension released.
• Pressure relieving equipment: Patients within NHSGGC have access to a wide range of pressure relieving equipment which must be used to reduce the risk of pressure damage occurring. These include a pressure relieving cushion / mattress and foot protection.

Here is a useful video demonstrating effective communication with the patient's family and how they can be involved in person centred care:

https://www.youtube.com/watch?v=1mJW9WeppQ0
Mobility is very important in patient rehabilitation and recovery. Document in this box, with a Y or N, if the patient has mobilised.

If the patient has not mobilised, they may need some assistance (from one or more healthcare workers) to do this. If the patient is in a chair and is able to walk or stand (with or without assistance), encourage them to do this as part of care rounding. If the patient is in bed, positional changes are vital to reduce the risk of a pressure ulcer developing. With the assistance of other healthcare workers, change the patient’s position regularly (right tilt / left tilt or on their back). Additional pillows in bed can be used to support patients to be off the ‘at risk areas’ by turning patients to a 30 degree tilt.

Encourage / assist your patient to keep moving, in any way they can – a good way to do this is by doing some simple movement exercises such as lifting their legs or arms. Try and encourage patient to be as independent as possible in doing this.
It is important that patients are able to be as independent as they possibly can be with using the toilet whilst they are in hospital, many will be able to go to the toilet on their own. If the nursing staff are monitoring how much urine or the type of stool a patient has passed then it is important that the patient knows this and is given either a urinal or a bedpan to collect it in. If these containers are used then let the patient know they must buzz the staff when they have used them so that they can be disposed of quickly and safely. If the patient is on a Fluid Balance Chart or a Bristol Stool Chart, it’s essential that you update these after the patient uses the toilet.

Asking the patient if they need to go to the toilet during care rounds is as important as responding to the patients call for help or assistance with using the toilet.

For patients with a catheter, the area around the catheter should be cleaned at least once daily or whenever it is required. The catheter bag should be checked at each care round to ensure it is still draining and that the collection bag is not full. Catheter collection bags should be kept off the ground and emptied when they are approximately 70% full to reduce the risk of contamination or infection.

For those that are not able to control their bowel or their bladder function and are incontinent of urine or stool then the right incontinence products should be used. When is patient is incontinent it is important that the patient is attended too as soon as possible to remove the urine or stool from the patients skin as it can cause skin damage. The skin is cleansed using warm water and a skin cleanser, dried and a skin barrier cream applied before new incontinence products are placed on the patient.

Document on the care rounding chart if the patient used the toilet and what level of assistance you gave them.
Food and fluid is crucial to our health and wellbeing and the delivery of the right amount of food and fluid to each patient is important during their stay in hospital. By supporting people to eat and drink ‘what’s normal for them’ we can help them recover from their illness or surgery and can support a quicker discharge from hospital.

Not eating or drinking enough can make a patient more likely to come to harm whilst in hospital. For example they may be more likely to develop a pressure ulcer or have a fall or be at increased risk of an infection or delirium. Food, fluid and nutrition are fundamental part of basic nursing care.

The first question is whether the patient is nil by mouth? If the answer is yes, the patient is not able to eat and drink then mouthcare should be performed at every care round.

It is vital that we all play our part to support patients to eat and drink ‘what’s normal for them’ whilst they are in hospital. The more opportunities that a patient is offered food and drink the more likely they are to eat and drink.

We must try to ensure that patients have access to food and drink at all times. Aiming for 8 cups of fluid, snacks and meals each day (unless they have been instructed otherwise by medical/nursing staff) indicate on the chart whether the patient has taken a drink, or eaten food. You may also need to chart how much they have had to eat and drink on a food and drink recording chart or fluid balance chart if they are in use.

Key things to remember
- Knowing what a patient likes can help support them to eat and drink. Food and drink on their locker can be a good indication of what they like, also knowing how they take their hot drinks can make a huge difference in keeping them hydrated
- Food and drink left within reach can make a huge difference, it allows the patient to eat little and often with care rounds being a great opportunity to offer and support patients with this
- The right level of assistance to eat and drink matters not only a mealtimes but each time you offer them food and drink. Some patients will need full assistance to eat and drink, some others might need help with opening packets and cutting up food, other might only need prompting and encouragement. Make sure you know what level of assistance the patient needs.
- Knowing who is not eating ‘whats normal for them’ is just as important. Food and drink recording charts can help staff to work out if a patient is getting enough or whether they have to increase the frequency of offering food and drink to encourage them to eat a little bit more

For patients who are managing to eat and drink, brushing teeth or cleaning dentures morning and night is important to keep the mouth clean and stop any problems occurring. Ensure that mouth care is documented on the care rounding chart when it is performed. If it is offered but the patient refuses then this should be documented on the variance sheet on the back.
The environment check is intended to maintain safety, minimise risk and ensure that the patient has to hand what they need in terms of comfort and interest.

Is the nurse call buzzer within reach? Ensure the patient knows how to use it and remind them that they can press the buzzer and a member of nursing staff will be with them as soon as possible.

Are all surfaces and floor space around the bed free from clutter? Could the table and locker do with a tidy and wipe clean? Make sure there are no spillages on the floor that could lead to a slip.

Can the patient reach everything they need? Glasses, drink, snack – do they want a book, a puzzle or perhaps some music? Can they see and hear the television, and is it on a channel that interests them? Can they see a clock or do they have a watch?

Is the height of the bed at its lowest? If the patient’s in bed and the bedrails should be in use, are they up and secured? If the patient’s sitting out of bed, are they comfortable and warm – do they need a footstool or a blanket?
The information check is to confirm the patient has all the information they need. Do they have any questions that you can help them with or get a colleague to answer?

Before leaving them:

- Ask if there’s anything else you can do for them or get for them
- Tell them how long it’ll be before you’re back to see them again
Finally, the Escalation stage is a reminder for you to consider anything that you’re not sure about, any concerns that you might have, or even suggestions about how the patient’s experience could be further enhanced.

Turn over the Care Rounding chart to the Variance Sheet and write down anything specific relating to that episode of care rounding that you think might be important. It’s also vital that you also escalate whatever you write down to one of the Registered Nurses.

Remember that your interaction with patients during care rounding can make such a difference to their experience in hospital. It’s a privilege to be involved in such vital and important roles as we are.