Chesterfield Royal Hospital NHS
NHS Foundation Trust

Name:	Attach addressograph
Hospital Number:	Date of Birth:
Patients prefferred name	

Date	
Consultant	
Ward	

Staff caring for patient	
Am	
Pm	
Night	

Comfort/Saftey Checks	
Purpose T pathway	Red/Amber/Green
Frequency of repositioning	

	Essential Care									Symptom Management								Nutrition/hydration			
Time	**Privacy/ Dignity Check**	**position (see codes overleaf)**	**Bed Rail position up/down/na**	**Heels off load** Y/N/NA	**Equipment in working order** Y/N/NA	**Personal hygiene**	**Urine Output (estimate with + 's)**	**Bowel function**	**Initials**	**Pain**	**Agitation**	**Respiratory tract secretions**	**Nausea and Vomiting**	**Breathlessness**	**Check Syringe Driver Chart**	**PRN medications**	**Initials**	**Food taken**	**Drink taken**	**IV/SC fluids**	**Initials**
	Document care given **Use Repositioning codes to indicate position** **Refer to Bristol stool chart for bowel function**									**Document score for each symptom** **0-None 1-mild 2- moderate 3- severe** **If symptomatic give prn & document use/effectiveness.** **If multiple doses in 24hours consider Syringe driver**								**Offer diet and fluids to all able patients and record any intake**			
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Communication

AT each check:
Ask if patient and carer have any questions or concerns
If any changes to condition are noticed liaise with medical team
ENSURE ALL COMMUNICATIONS ARE DOCUMENTED IN THE PATIENTS NOTES

Record any additional communication needs:

Mouth Care

Dentures: Upper ☐ **Lower** ☐ **None** ☐

Own teeth: Yes ☐ **No** ☐

Patients who are likely in last day of life will likely require full support to clean teeth and attend to mouthcare
Record support provided (tick when completed)

Time	**Teeth Brushed**	**Denture care**	**Dry mouth care**	**MCB tool change** white=day yellow=night	**Referred to Doctor**	**Patient declined**	**Initial**

Chesterfield Royal Hospital Foundation Trust
LaDoL Daily chart

Positional Changes		**Profiling bed:**
RT= Right 30 degree tilt **B**= Back **SO**= Sat out **PD** = Patient/family declined	**LT**= Left 30 degree tilt **BU**= Back Sitting up (should be no more than 30 degrees	**C**=Chair position **HT**= Head Tilt **KB**= Knee Break

Skin Checks must be completed 3 times a day IF NOT REQUIRED CLEARLY DOCUMENT REASON				Skin Assessment codes
Date	**Morning**	**Afternoon check**	**Night**	0= normal skin/no damage P= Painful area S= Swelling R= Redness -blanching ML= Moisture lesion LC= localised skin temperature change: hot or cold R= Redness -blanching U= Unstageable D= DTI **Document any pressure damage using EPUAP categories 1,2,3 &4,**
Time				
Completed by:				
Sacrum				
Right hip				
Left hip				
Right buttock				
Left buttock				
Right heel				
Left heel				
Right Ear				
Left Ear				
Spine				
Left Elbow				
Right Elbow				
TEDS/Removed				
Other……				

Daily Falls Checklist				
What level of supervision is currently recommended for this patient?	No specific supervision	Bay watch supervised Bay	1:1 2:1 etc.	
Has this patient fallen during this addmission?	Yes	No	If Yes how many times?	Ammount …….
Is the enviroment as clutter/hazard free as possible?	Yes	No	If no why not?	Specify:
What footwear is the patient using?	Own well fitting slippers	Hospital slipper socks	Other	Specify:
Does the patient understand the use of the call bell	**Yes**	No	If no what is alternative?	e.g Bed rails/hourly rounding
Does the patient wear glasses? **If yes are the clean and in reach?**	**Yes**	No		Specify:
	Yes	No	If No Why?	
Does the patient wear hearing aid?	**Yes**	No		
If yes is it working and is the patient wearing it	**Yes**	No	If No Why?	Specify:
Is a night light required ? **Is it used at appropriate times?**	**Yes**	No		Specify:
	Yes	No	If No Why?	

Actions required from daily falls checklist e.g call family to ask for own footwear, source batteried for hearing aid

Infection Control MRSA WASH DUE TODAY

Day 1 ☐ Day 2 ☐ Day 3 ☐ Day 4 ☐ Day 5 ☐ Continous ☐ N/A ☐

Mattress	**Cushion**	**Specialised Equipment**
☐ High Density Foam ☐ Dynamic replacement ☐ Active Hybrid with pump ☐ Other ……	☐ Integrated cushion ☐ Dynamic cushion ☐ Recliner chair ☐ Bariatric chair	☐ Toto Lateral Tilt **Heel offloading device:** ☐ Pillow ☐ Heel up boots ☐ Repose wedge ☐ Slide sheet (placement under heels for protection from friction/shear)
Ensure pumps are switched on and in good working order with no alarms. Any concerns report to clinical engineering	Check cushion has not bottomed out i.e the foam springs back when the patient stands up (condemn if does)	

Staff to check at each essential rounding

Is there an identified **named nurse** for each shift recorded on the patient daily chart?
Does patient have a range of PRN medication prescribed that will manage likely symptoms?Are the patient/family are fully aware of prognosis and understand current plan of management?
Do family have any concerns questions or worries?Have specific patient wishes, spiritual and cultural needs been reviewed and recorded?
Are all significant events or conversations documented?
Does the patient appear settled and comfortable?
Have patient, carers and family been told of any changes to care or condition?
Have you reported any uncontrolled symptoms or concerns/issue to the medical team?

Things to think about:

If your patient is symptomatic have you treated the symptoms?
Have you informed the family members they can visit as often and for as long as they wish
Have you offered family/carers a comfort pack- comb tooth brush wipes etc.
Have you given the family /Carers a discount voucher for food and drinks at Café at the Royal
Have you offered overnight accommodation or a camp bed to families/carers who are staying

Date/time	Record Keeping	Signature/Designation