HIGHVIEW

Care Day Date: / /

Affix Resident Label Here

Checklist:

Cut fingernails ☐ Yes ☐ No	Hearing aid batteries changed ☐ Yes ☐ No
Toe nails ok Podiatrist list –see D.T. ☐ Yes ☐ No	Condition of tooth brush ok & change seasonally ☐ Yes ☐ No
Skin Integrity ok ☐ Yes ☐ No	Tidy drawers/wardrobes ☐ Yes ☐ No
Denture ok ☐ Yes ☐ No	Clean and tidy- Mobility Aides/Lifters/Chairs ☐ Yes ☐ No
Clean hair brush / comb ☐ Yes ☐ No	All lights working ☐ Yes ☐ No
Clean glasses ☐ Yes ☐ No	Buzzers & emergency buzzers checked ☐ Yes ☐ No

Observations:

1. T _____
2. P _____
3. R _____
4. B/P: _____
5. SpO2 _____
6. Weight _____
7. Pain score _____
8. Falls _____

RN to complete

Care plan up to date	☐ Yes
Family contacted if any concerns	☐ Yes
Medication audit completed/Scripts	☐ Yes
Sign:	

Other Services

Sort any old clothing mark clothing, check toiletries are in good supply and condition, order or supply any toiletries required.

Questions	Yes	No	Comments
Are you happy with the Activity Program?			
Is there anything you would like to add to the program?			
Has the DT been notified in the communication book?			

Questions	Yes	No	Comments
Are you happy with the meals provided?			
Is there anything you would like to suggest?			
Has the Catering Supervisor been informed?			

Comments: _____

_____

_____

Completed by : _____ Sign: _____