RESIDENT OF THE DAY CHECKLIST

ROOM NO. :
SURNAME :
GIVEN NAME :
DATE OF BIRTH :
Review Date: ____/____/____

Part A - To be completed by CCC / TL / RN / Supervisor

1. **Review Resident Weight** – are there any concerns regarding weight variance YES / NO
   NB. All Residents are to be weighed monthly
2. **Read all entries in the Progress Notes since the date of the last review**
   Are there any entries in the progress notes (since last review) relating to changes in the following?

Behaviours	YES / NO	Mobility & Transfers	YES / NO
Pain Management	YES / NO	Medication Management	YES / NO
Hygiene & Grooming	YES / NO	Nutrition & Hydration	YES / NO
Clinical Care	YES / NO	Skin	YES / NO
Continence Management	YES / NO	Sleep	YES / NO
Communication & Comprehension	YES / NO		

3. Has there been an increase or change in the administration of **PRN medications**? YES / NO

Name of medication	No. since last review	Name of medication	No. since last review

4. **Check Special Considerations on Medication Chart** – still current (if NO revise and amend) YES / NO
5. **Check bowel charts**: Bowel management is effective? YES / NO
6. **Self Medication Assessment:** Resident remains safe to self medicate & the assessment has been signed by GP within the last 12 months. If NO arrange review by GP. YES / NO / NA
7. **Restraint:** 3mthly review by GP required? YES / NO / NA
8. Is there a concern regarding?
   - Incidents: _____ YES / NO
   - Infections: _____ YES / NO
   - Wounds: _____ YES / NO
   - Other (Weight, BP, BGL) : _____ YES / NO

Completed by: _____ Signed & Designation :_____ Date:___/___/___

Part B - To be completed by Care Staff

9. 1. **How have you** 'Made the Resident's Day' _____
   _____
   _____
   2. Check: Resident's Fingernails, Toenails, Toiletries, Denture container clean, Clothing Needs: YES / NO
      List Clothing/Toiletry Requirements: _____
      _____
   3. Tidy resident's room, wardrobe, bedside table etc. YES / NO
   4. If resident has a fridge, it is clean and food is labelled and not past 'used by dates' YES / NO
      (If no inform Manager)
   5. Check General room maintenance
   6. Call bell, Bed, Carpet, Damage to walls, etc.
   7. Maintenance Form completed as required YES / NO

Completed by: _____ Signed & Designation :_____ Date:___/___/___

RESIDENT OF THE DAY CHECKLIST

ROOM NO. :
SURNAME :
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Part C –Completed by Lifestyle Staff

10. **Quality of Life Enhancements Review and Evaluation**. Overview of activities attended since the last review**:**

11. Are there any changes to be made to the Lifestyle Plan? YES / NO
Changes required:

Completed by: _____ Signed & Designation :_____ Date:___/___/___

Part D – Completed by CCC / TL / RN / Supervisor

12. **Evaluation of Care**. An overview of care changes, including outcome from the Clinical Review Meeting
Include incidents, infections, hospitalisation, any significant care changes, or investigations, etc

13. The following amendments have been made to the Care Plan.

14. **Review has resulted in**
Doctor being notified of: _____
Other Actions / Referral to Allied Health Professionals etc. _____

15. ☐ **Changes in care have been communicated to the Resident/Representative as appropriate:** Discuss any toiletry/clothing requirements as indicated above
Name of person spoken to_____ Date:___/___/___

Completed by: _____ Signed & Designation :_____ Date:___/___/___

On completion file in Resident Folder