

**Resident of the day Monthly Monitoring Form**

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| **Residents Name:** |  | **ROOM NO:** |  |
| **DATE:** |  |
| **CARER**  |  | **SIGNATURE** |  |
| **SENIOR**  |  | **SIGNATURE** |  |
| **ACTIVITIES**  |  | **SIGNATURE** |  |
| **MAINTENANCE**  |  | **SIGNATURE** |  |
| **HOUSEKEEPING**  |  | **SIGNATURE** |  |
|  **SECTION ONE: WHAT HAVE YOU DONE TODAY TO MAKE ME FEEL SPECIAL?****Carer to complete** |
| **Communication:***Glasses/hearing aids all cleaned/checked.*  | **Yes/No** |
| **Personal Care:***Nails/hair/teeth/dentures all cleaned/checked.* | **Yes/No** |
| **Bedroom:***Is bedroom clean and tidy, is Commode empty and clean (if applicable)*  | **Yes/No** |
| **Toiletries/Brushes/Razors:***Are any needed? Are they clean/tidy?**Don’t forget about toothbrushes/denture cleaner.* | **Yes/No** |
| **Wardrobes & Drawers & Sink Unit:***Are they all tidy? Are clothes on hangers or folded?*  | **Yes/No** |
| **Clothing:***Are new clothes or shoes/slippers required? Do all clothes fit? Are all clothes identifiable/Labelled?* | **Yes/No** |
| **SECTION TWO: HEALTH ETC.****Senior to complete** |
| **Have Day/Night needs changed?***Have care plans/Risk assessments been updated?* | **Yes/No** |
| **Observations** | **B/P mmHG\_\_\_\_\_\_\_\_\_\_****Pulse Bpm\_\_\_\_\_\_\_\_\_\_\_****Temp C\_\_\_\_\_\_\_\_\_\_\_\_\_****Resp Rpm\_\_\_\_\_\_\_\_\_\_\_** |
| **Are there any changes to mobility?****Is all mobility/pressure relieving equipment in good order?** | **Stand Aid- Yes/No****Hoist- Yes/No****Sling Details L/M/S Serial number\_\_\_\_\_\_\_\_\_\_\_****Slide Sheet- Yes/No****Wheelchair- Yes/No****Walk Un-Aided- Yes/No** |
| **Have any Antibiotics been prescribed this month?** *If so what for?* | **Yes/No** |
| **Have there been any GP visits this month?***If so what for?* | **Yes/No** |
| **Have there been any DN visits this month?***If yes, why?* | **Yes/No** |
| **Is there a body map in place?***If so, is it all completed appropriately and images uploaded to CMS?* | **Yes/No** |
| **Waterlow score.** |  |
| **MUST score** |  |
| **Weight** |  |
| **Dependency level** |  |
| **Date of last Medication review**  |  |
| **Have there been any visits from External professionals? CMHT, OT, Dietician etc (not GP or DN)***Has documentation been completed?* | **Yes/No** |
| **Any accidents or falls over the past month? If so, have all incident forms been completed and is a risk assessment in place?** | **Number of Falls\_\_\_\_****Incident form completed Yes/No****Risk assessment in place Yes/NO** |
| ***Is EOL/Respect form care plan in place?*** | **Yes/No** |
|  **Section 3: Activity’s** **Activity Co-Ordinator to complete** |
| ***Does the resident participate/Enjoy/Does not participate in Any Activity’s?******What do they enjoy?******If doesn’t participate, what action has been completed to engage and is this documented?*** |  |
|  **Section 4: Maintenance**  **Maintenance staff to complete** |
| **Maintenance room check**  | **Any damage to Bed Yes/No****If NRS, Serial Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Are Electrical items Pat Tested? Yes/No****Décor, is it clean and in good condition Yes/No****If no, has the Maintenance Plan been updated with dates? Yes/No/Na** |
|  **Section 5: Housekeeping**  **Housekeeping staff to complete**  |
| **Has Deep Cleaning been completed?****Has Floor and chairs furniture been cleaned (All furniture pulled away from walls etc?****Have windows/Curtains been cleaned?****Has Mattress been cleaned** **Has sling been laundered** | **Yes/No****Yes/No****Yes/No****Yes/No****Yes/No/NA** |
| **Managers Comments** |
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| **Signature/Date** |  |

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