Southern Health Santé Sud

Delivery of Care Record

Month:____________________ Year:______________________

ADDRESSOGRAPH/LABEL

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
INTAKE/EATING ABILITY	G – Good (Most) F – Fair (~ ½) P – Poor (~1/4) D – Declined I – Independent PA – Partial assist M – Min assist MX – Max Assist																															
	Br																															
	Lu																															
	Su																															
BLADDER FUNCTION	I – Independent A – Assist P – Product checked/changed PN – Product not checked/changed C – Catheter emptied 0 – Has not voided																															
	N																															
	D																															
	E																															
BOWEL FUNCTION	0 – No BM N – Normal L – Loose H – Hard I – Independent 1 – Small 2 – Moderate 3 – Large																															
Date of last BM from previous month:	N																															
**If no BM in 3 days, report to nurse*	D																															
**Report any unexpected loose BM to nurse*	E																															
BATHING T – Tub	S – Shower P - Partial BB – Bed Bath D – Declined I – Independent																															
	N																															
	D																															
	E																															
HYGIENE Y – Yes	N – No D – Declined P – Partial I – Independent N/A – Not applicable																															
Mouth Care	N																															
**Report if resident declines mouth care, or if it was*	D																															
not provided as per the care plan	E																															
Nail Care (as per care plan)	N																															
F – Fingernails	D																															
T – Toenails	E																															
Shave	N																															
**Report if resident declines a shave, or if it was not*	D																															
provided as per the care plan	E																															
PERI CARE	Y – Yes I – Independent N – No D – Declined																															
**Report if resident declines peri care, or if it was*	N																															
not provided as per the care plan	D																															
	E																															
SKIN OBSERVATION (as per care plan)	Y – Yes N – No H – HCA Skin Observation Form C – Change identified																															
**The HCA Skin Observation Form is completed*	N																															
weekly on bath day plus anytime a problem is	D																															
observed.	E																															

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TRANSFERS (as per care plan/SCHIPP logos) Y – Yes N – No SC – Significant change																																
**Report any situations in which a resident was not transferred according to care plan/SCHIPP logos, or where there is a significant change*	N																															
	D																															
	E																															
BEHAVIOUR OBSERVED C – Cheerful/Content R – Responsive *(observed behaviours expressing unmet needs, response to stimuli or to approaches of care team)* B – Behaviour mapping																																
**Report unexpected responsive behaviours*	N																															
	D																															
	E																															
SLEEP A – AM rest P – PM rest 0 – No sleep W – Slept well PS – Poor sleep																																
	N																															
	D																															
	E																															
RESTRAINT CHECK (Ensure frequency of checks, and timeline for removal is included) Initial to confirm checks were completed																																
Restraint Type & Method Of Application: ___________________________________	N																															
	D																															
Frequency of Restraint Checks:__________	E																															
Restraint Type & Method Of Application: ___________________________________	N																															
Frequency of Restraint Checks: __________	D																															
	E																															
Restraint Type & Method Of Application: ___________________________________	N																															
Frequency of Restraint Checks: __________	D																															
	E																															
A check involves removing a restraint a minimum of 10 minutes every 2 hours with care, ambulation and hydration																																
CARE NEEDS (as per care plan) (e.g. pressure offloading, walks) C – Completed N – No N/A – Not applicable																																
1.	N																															
	D																															
	E																															
2.	N																															
	D																															
	E																															
Initials *(confirm that HCA has given verbal report to nurse responsible for resident on the shift & that care has been provided in accordance with the Integrated Care Plan)*																																
	N																															
	D																															
	E																															