**P11 Power Failure**

(To be completed in the event of a power cut)

Appendix 1

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| --- | --- | --- |
| Name of Person We Support: |  | Date:Time: |
| Unit: |  |
| IAS number: |  |
| Staff Member Name: |  |
| **Daily Diary Notes Please circle: AM PM Nights** |
| **Day Staff**; use the headings (on the left)**. Night Staff**; record time of check |
| **Personal Care**Full detail of personal / oral care provided |  |
| **Creams/Skin** Creams applied, pressure care or skin integrity |  |
| **Health/Concerns**Any health issues or concerns |  |
| **Continence** Include urine and bowel continence |  |
| **Mobility and Equipment**Mobility details and equipment checks |  |
| **Food and Fluid**Record all food and fluid intake |  |
| **How I spend my day**Include all interaction and activities |  |

**Monitoring forms only to be completed if needed**

|  |
| --- |
| **Bowel Monitoring** |
| Date  | Time | Type | Comments | Completed by |
|  |  |  |  |  |
|  |  |  |  |  |
| **Urine Continence Monitoring Form** |
| Date | Time | Condition of Incontinence Pad (circle) | Comments | Completed by |
|  |  | Dry | Damp | Wet | Very Wet |  |  |

|  |
| --- |
| **Catheter Use** |
| Date | Morning Total (mls) | Completed by |
|  |  |  |
| Date | Afternoon Total (mls) | Completed by |
|  |  |  |
| Date | Night Total (mls) | Completed by |
|  |  |  |

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| --- |
| **MUST Tool** |
| Date | Weight | Name of person who carried out weighing |
|  |  |  |

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| --- |
| **Pressure Care** |
| Date | Time | Position moved from | Position moved to  | Comments | Completed by |
|  |  |  |  |  |  |
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| --- |
| **Food Intake** |
| Date | Breakfast | Mid AM | Lunch | Completed by |
|  |  |  |  |  |
| Date | Mid PM | Tea | Supper | Completed by |
|  |  |  |  |  |
| Date | Nights |  |
|  |  |  |

|  |
| --- |
| **Fluid Intake** |
| Date | Morning Shift | Morning Total | Completed by |
|  |  |  |  |
| Date | Afternoon Shift | Afternoon Total | Completed by |
|  |  |  |  |
| Date | Night Shift | Night Total | Completed by |
|  |  |  |  |