

# Receptionist - Daily Checking Schedule

## Equipment Check List (equipment boxes)

UTC Location: .....

Date ...../...../.....

Name of Receptionist: .....

Time .....

| <b>Box 1: Clinician</b>                                                     |         |                          | <b>Box 2: Clinician</b>       |                                                                             |         | <b>Box 3: Clinician</b>        |                          |                                                                             |  |                          |                          |
|-----------------------------------------------------------------------------|---------|--------------------------|-------------------------------|-----------------------------------------------------------------------------|---------|--------------------------------|--------------------------|-----------------------------------------------------------------------------|--|--------------------------|--------------------------|
| Item                                                                        | Out     | In                       | Item                          | Out                                                                         | In      | Item                           | Out                      | In                                                                          |  |                          |                          |
| Stethoscope                                                                 |         |                          | Stethoscope                   |                                                                             |         | Stethoscope                    |                          |                                                                             |  |                          |                          |
| Thermoscan                                                                  |         |                          | Thermoscan                    |                                                                             |         | Thermoscan                     |                          |                                                                             |  |                          |                          |
| Auroscope/Ophthalmoscope                                                    |         |                          | Auroscope/Ophthalmoscope      |                                                                             |         | Auroscope/Ophthalmoscope       |                          |                                                                             |  |                          |                          |
| Keeler Earpieces (3.5) x1 box                                               |         |                          | Keeler Earpieces (3.5) x1 box |                                                                             |         | Keeler Ear Pieces (3.5) x1 box |                          |                                                                             |  |                          |                          |
| Keeler Earpieces (4.5) x1 box                                               |         |                          | Keeler Earpieces (4.5) x1 box |                                                                             |         | Keeler Ear Pieces (4.5) x1 box |                          |                                                                             |  |                          |                          |
| Pulse Oximeter (held/finger)                                                |         |                          | Pulse Oximeter (held/finger)  |                                                                             |         | Pulse Oximeter (held/finger)   |                          |                                                                             |  |                          |                          |
| BP Monitor                                                                  |         |                          | BP Monitor                    |                                                                             |         | BP Monitor                     |                          |                                                                             |  |                          |                          |
| Large Cuff                                                                  |         |                          | Large Cuff                    |                                                                             |         | Large Cuff                     |                          |                                                                             |  |                          |                          |
| Medium Cuff                                                                 |         |                          | Medium Cuff                   |                                                                             |         | Medium Cuff                    |                          |                                                                             |  |                          |                          |
| Small Cuff                                                                  |         |                          | Small Cuff                    |                                                                             |         | Small Cuff                     |                          |                                                                             |  |                          |                          |
| Patella Hammer                                                              |         |                          | Patella Hammer                |                                                                             |         | Patella Hammer                 |                          |                                                                             |  |                          |                          |
| Confirmed above check list complete & Equipment cleaned at start of session |         | <input type="checkbox"/> | <input type="checkbox"/>      | Confirmed above check list complete & Equipment cleaned at start of session |         | <input type="checkbox"/>       | <input type="checkbox"/> | Confirmed above check list complete & Equipment cleaned at start of session |  | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                             | Initial | Initial                  |                               | Initial                                                                     | Initial |                                | Initial                  | Initial                                                                     |  | Initial                  | Initial                  |

  

| <b>Box 4: HCSW</b>                                                          |         |                          | <b>Box 5: HCSW</b>           |                                                                             |         | <b>Box 6: Spare Equipment</b> |                          |                                                                             |  |                          |                          |
|-----------------------------------------------------------------------------|---------|--------------------------|------------------------------|-----------------------------------------------------------------------------|---------|-------------------------------|--------------------------|-----------------------------------------------------------------------------|--|--------------------------|--------------------------|
| Item                                                                        | Out     | In                       | Item                         | Out                                                                         | In      | Item                          | Out                      | In                                                                          |  |                          |                          |
| Thermoscan                                                                  |         |                          | Thermoscan                   |                                                                             |         | Stethoscope                   |                          |                                                                             |  |                          |                          |
| Pulse Oximeter (held/finger)                                                |         |                          | Pulse Oximeter (held/finger) |                                                                             |         | Thermoscan                    |                          |                                                                             |  |                          |                          |
| Adult Lead                                                                  |         |                          | Adult Lead                   |                                                                             |         | Auroscope/Ophthalmoscope      |                          |                                                                             |  |                          |                          |
| Child Lead                                                                  |         |                          | Child Lead                   |                                                                             |         | Keeler Earpieces (3.5) x1 box |                          |                                                                             |  |                          |                          |
| Paediatric Lead                                                             |         |                          | Paediatric Lead              |                                                                             |         | Keeler Earpieces (4.5) x1 box |                          |                                                                             |  |                          |                          |
| BP Monitor                                                                  |         |                          | BP Monitor                   |                                                                             |         | Pulse Oximeter (held/finger)  |                          |                                                                             |  |                          |                          |
| Large Cuff                                                                  |         |                          | Large Cuff                   |                                                                             |         | BP Monitor                    |                          |                                                                             |  |                          |                          |
| Medium Cuff                                                                 |         |                          | Medium Cuff                  |                                                                             |         | Large Cuff                    |                          |                                                                             |  |                          |                          |
| Small Cuff                                                                  |         |                          | Small Cuff                   |                                                                             |         | Medium Cuff                   |                          |                                                                             |  |                          |                          |
|                                                                             |         |                          |                              |                                                                             |         | Small Cuff                    |                          |                                                                             |  |                          |                          |
|                                                                             |         |                          |                              |                                                                             |         | Patella Hammer                |                          |                                                                             |  |                          |                          |
| Confirmed above check list complete & Equipment cleaned at start of session |         | <input type="checkbox"/> | <input type="checkbox"/>     | Confirmed above check list complete & Equipment cleaned at start of session |         | <input type="checkbox"/>      | <input type="checkbox"/> | Confirmed above check list complete & Equipment cleaned at start of session |  | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                             | Initial | Initial                  |                              | Initial                                                                     | Initial |                               | Initial                  | Initial                                                                     |  | Initial                  | Initial                  |

**Any further comments:**

|               |                   |                   |
|---------------|-------------------|-------------------|
|               | <b>AM</b>         | <b>PM</b>         |
| <b>Signed</b> | .....             | .....             |
| <b>Date</b>   | ...../...../..... | ...../...../..... |

# HCSW / CR - Daily Checking Schedule

## Equipment Check List

Please Initial each box, tick if appropriate in comments box

UTC Location: .....

Date: ...../...../.....

Name of HCSW/CR: .....

Time: .....

| Task                                                      | Morn                                                     | Eve                  | Checks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Comments             |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
|-----------------------------------------------------------|----------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------|----------------------|--------|--------------|----------------------|----------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|-----------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|--|
| AED Complete check carried out                            |                                                          |                      | <input type="checkbox"/> Green Light on<br><input type="checkbox"/> Both Pads in Date<br><input type="checkbox"/> Resus Pack Present<br><br><input type="checkbox"/> Put away at end of shift                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Red Emergency Boxes Checked                               |                                                          |                      | <table border="1"> <tr> <td>Sealed:</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Box No:</td> <td></td> </tr> <tr> <td>Expiry Date:</td> <td></td> </tr> </table><br><input type="checkbox"/> Put away at end of shift                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Sealed:              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Box No:              |        | Expiry Date: |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Sealed:                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Box No:                                                   |                                                          |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Expiry Date:                                              |                                                          |                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| ECG Checked and in working order                          |                                                          |                      | <input type="checkbox"/> Working / Paper insitu<br><input type="checkbox"/> Leads untangled<br><input type="checkbox"/> Plugged in<br><input type="checkbox"/> Essential Equip Present (Electrodes)<br><input type="checkbox"/> Essential Equip Present (Razors)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Blood glucose calibrated<br>Box left clean and stocked up |                                                          |                      | <table border="1"> <thead> <tr> <th colspan="2">Box 1</th> <th colspan="2">Box 2</th> </tr> </thead> <tbody> <tr> <td>Reading:</td> <td><input type="text"/></td> <td>Reading:</td> <td><input type="text"/></td> </tr> <tr> <td>Comments</td> <td></td> <td>Comments</td> <td></td> </tr> </tbody> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Box 1                |                                                          | Box 2                |        | Reading:     | <input type="text"/> | Reading: | <input type="text"/> | Comments             |                      | Comments             |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Box 1                                                     |                                                          | Box 2                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Reading:                                                  | <input type="text"/>                                     | Reading:             | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Comments                                                  |                                                          | Comments             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Temp Thermometer Checked and Record                       |                                                          |                      | <table border="1"> <thead> <tr> <th>Area</th> <th>CUR AM</th> <th>MAX AM</th> <th>MIN AM</th> <th>CUR PM</th> <th>MAX PM</th> <th>MIN PM</th> </tr> </thead> <tbody> <tr> <td>Base</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Cassettes</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Stat dose:</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table> | Area                 | CUR AM                                                   | MAX AM               | MIN AM | CUR PM       | MAX PM               | MIN PM   | Base                 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Cassettes | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Stat dose: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |  |
| Area                                                      | CUR AM                                                   | MAX AM               | MIN AM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CUR PM               | MAX PM                                                   | MIN PM               |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Base                                                      | <input type="text"/>                                     | <input type="text"/> | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="text"/> | <input type="text"/>                                     | <input type="text"/> |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Cassettes                                                 | <input type="text"/>                                     | <input type="text"/> | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="text"/> | <input type="text"/>                                     | <input type="text"/> |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Stat dose:                                                | <input type="text"/>                                     | <input type="text"/> | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="text"/> | <input type="text"/>                                     | <input type="text"/> |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Sharps Box Checked                                        |                                                          |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Medication Expiry Dates Checked                           |                                                          |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |
| Fridge Checked/Cleaned                                    |                                                          |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                          |                      |        |              |                      |          |                      |                      |                      |                      |                      |                      |                      |           |                      |                      |                      |                      |                      |                      |            |                      |                      |                      |                      |                      |                      |  |

**TO BE COMPLETED AND FILED IN HCSW DAILY CHECKING SHEET FOLDER ON A DAILY BASIS**

Any further comments:

|        | AM                | PM                |
|--------|-------------------|-------------------|
| Signed | .....             | .....             |
| Date   | ...../...../..... | ...../...../..... |