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The way to better health

MRD CHECKLIST

MH/ PRINT / 0075 / MRD

PARTICULARS	YES	NO
- IP Number allocated to each Patient	✓	
- Name, Age & Sex of Patient	✓	
- General Admission Consent	✓	
- Initial Assessment of Patient / Diagnosis	✓	
- Nutritional Assessment by Consultant	✓	
- Plan of care counter signed by the Consultant	✓	
- Treatment Orders - Date, Time, Name & Sign.	✓	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	✓	
- Vital Signs Chart (TPR Chart)	✓	
- Intake Output Chart	✓	
- Drug Chart (Duly filled)	✓	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist		
- Anesthesia Assessment Sheet		
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon		
- Surgery Notes - Post Operative Plan		
- Pain Scoring System		
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	✓	

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Patie Mrs.LEEMA ROSE A
Nam 50/Female/MHI202381064
UHII 29/11/2023/IPH202302386
DOB Dr.G. GNANAVELU
DOA
Con

MHI/IPD/2022/002

Medway Heart Institute

...ry heart beat counts

ADMISSION SLIP

Admitting Doctor: DR. GNANAVELU.G **Speciality:** Cardiology

Advised Date & Time: 29/11/2023 @ 10:25 A.M

Provisional Diagnosis: CAD - RECENT Acute

Reason for Admission: ☐ **Medical Management** ☐ **Surgical Management**
☑ **Others** (please specify details) CAG

Admission Type: ☑ **Day Care** ☐ **ER** ☐ **Ward**
☐ **ICU** _____ (Specify details)

Surgery / Procedure Name (if planned):
CAG

Blood Product Requirement: ☐ **No** ☐ **Yes** *(Kindly specify details of components required in space below)*

Expected Duration of Stay: Day care

Expected Cost of Treatment *(as per Financial Counseling Form):*

Payer: ☐ Self ☐ Insurance ☑ Others: ESI

Instructions to Nurse (if any):

prepare & shift to cath lab

Any other Instructions (if any):

—

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr. G. Gnanavelu	91810	29/11/23	10:25

For admission desk staff only:

Room Category:

- ☐ General Ward
- ☐ Single Room
- ☐ Twin Sharing
- ☐ Deluxe Room
- ☐ Suite Room
- ☑ Others RL

Admission intimation Receipt Details		Admission Time in HIS	
Date	**Time**	**Date**	**Time**
29/11/2023	10:25 AM	29/11/2023	10:25 A·M

Source:

- ☑ OPD
- ☐ ER
- ☐ Direct

To be filled only if Blood requirement specified by the Doctor:

Is Blood Reservation and Blood Bank clearance completed as advised: ☐ Yes ☐ No

Front office Staff Signature	Name	Emp. No.	Date	Time
	RESHMA BANU	MH#0264	25/11/23	10:25 AM

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NABH

Patien: Mrs.LEEMA ROSE A
Name: 50/Female/MHI202381064
UHID: 29/11/2023/IPH202302386
DOB:
DOA: Dr.G. GNANAVELU
Cons:

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status: M Occupation: RL	Full Address: No. 40 Rajiv Gandhi Nagar, check Post street, Kamarajapuram chennai. 75	Telephone Number: 8122532721

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
DR. GNANAVELU	29/11/2023 @ 10:25 A.M	29/11/23 19:00	9 hrs 35 mts.

UNIT: FL

MLC ☐ Yes ☑ No If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
CAD - RECENT AWMI	I25.1
MODERATE LV DYSFUNCTION	I50.1
SYSTEMIC HYPERTENSION	I10
TYPE II DIABETES MELLITUS	E11.9

DATE	OPERATION / PROCEDURES	ICPM Code
29/11/23	CORONARY ANGIOGRAM on 29/11/23 SIGNIFICANT LAD DISEASE	88.50

DATE	TYPE OF ANESTHESIA				
29/11/23	☐ GENERAL	☐ SPINAL	☑ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

☐ Cured	☐ Discharge at Request	☐ Expired < 48 hours
☑ Improved	☐ Against Medical Advice	☐ Expired > 48 hours
☐ Unchanged	☐ Absconded	☐ Post-Operative Death
	☐ Transferred to	

Signature of the Consultant 29/11/23

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient...Leema Rose. A who is my .....Mother..... (Relationship).

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.

However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.

I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

I have read out and explained the contents of the above to the Signatory in his vernacular .

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி .....
.....க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date	Signature of the Patient / Relative / Gurdian
	25/11/2023	

உறவுமுறை / Daughter.

Nature of Relationship

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Patient: Mrs.LEEMA ROSE A
Name: 50/Female/MHI202381064
UHID: 29/11/2023/IPH202302386
DOB: Dr.G. GNANAVELU
DOA:
Consultant:

MHI/IP/2022/008

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every heart beat counts

GENERAL CONSENT FOR ADMISSION

I, LEEMA ROSE 'A the ☑ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

☐ Been explained this consent form in English, which I fully understand.

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient	A. Leema rose	Leema Rose. A	29/11/23	10:25 A.M
Surrogate/Guardian (if applicable #)	Ray A	Reena. A *(Write name and relationship with patient)*	29/11/23	10:25 A.M
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		RESHMA BANU.	29/11/23	10:25 A.M
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

DAY CARE DISCHARGE SUMMARY

IP No.	IPH202302386	**D.O.A**	: 29/11/2023
UHID	MHI202381064	**D.O.P**	: 29/11/2023
Name	Mrs. LEEMA ROSE.A	**Room No.**	: RL
Age / Gender	50Years / FEMALE		
Consultant	: **Dr. G. Gnanavelu.** MD., DM., (cardio) FACC Chief Cardiologist	**D.O.D**	: 29/11/2023

DIAGNOSIS:

CAD - RECENT AWMI
MODERATE LV DYSFUNCTION
SYSTEMIC HYPERTENSION
TYPE II DIABETES MELLITUS

PROCEDURE: CORONARY ANGIOGRAM DONE ON 29.11.2023 – SIGNIFICANT LAD DISEASE

BRIEF HISTORY:

Mrs. Leema Rose.A, 50 years old Female, Presented with complaints of chest pain on & off. She was evaluated at ESIC hospital and treated conservatively. She was advised Coronary angiogram and referred to Medway Heart Institute on 29.11.2023 for which he has been admitted.

ON EXAMINATION:

HR: 78bpm ; BP: 130/70mmHg ; SPO_2 : 97% in room air
CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD(28.11.23): Hb- 12.8gm/dl, Urea – 9.00 mg/dl, Creatinine – 0.41mg/dl, Na+- 130mmol/l, K+- 3.31mmol/l, PLT – 347000 cells/cumm, TWBC – 11010cells/cumm, Trop I – 0.19 ng/ml, INR – 1.0.

ECG: Sinus rhythm, HR – 87 bpm, evolved AWMI.

ECHO: Dilated LA, LV, RWMA present - Mid septal, mid anteroseptal hypokinesia. Distal sepal, distal lateral, apical hypokinesia. Moderate LV dysfunction EF – 40%. No PE/ clot / PHT.

CORONARY ANGIOGRAM FINDINGS:

Right-dominant system; **SIGNIFICANT LAD DISEASE.** (reports enclosed)

ADVICE : PCI TO LAD.

ADVICE MEDICATIONS:

SI. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	**TAB. ECOSPRIN**	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	**TAB. AXCER**	90MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	**TAB. ATORVAS**	20MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	**TAB, NITROCONTIN**	2.6MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	**TAB, METOCARD XL**	25MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT, SALT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH **DR. G. GNANAVELU FOR PCI ON 04-12-2023 AFTER APPROVAL FROM ESIC HOSPITAL.**

To report: If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations.
In case of emergency Contact: Medway Hospitals @ 4310 8959.

Dr. G. Gnanavelu. MD., DM., (cardio) FACC
Chief Cardiologist

Typed by: Ezhilarasi.

"I understood the Content of the discharge summary."

Dr. G. Gnanavelu MD, DM(cardio), FACC

MHI/NUR/2022/203

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

Medway Heart Institute
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DAY CARE INITIAL ASSESSMENT FORM

Date: 29/11/23 **Time of arrival:** 10:35

Part A *(to be filled by Nurses)*

Vital Signs: Temp: 98.4 °F) | Pulse / HR: 78 (beats/min) | BP: 130/70 (mmHg)
Respiration: 22 (breaths/min) | SpO_2: 97 (%) | Height: 144 (cms) | Weight: 42.1 (kgs) | BMI: 20.3 kg/m²

Any Language Barrier: ☐ Yes ☑ No If yes, please call Language Coordinator / Translator

Allergies : ☐ Yes ☑ No *If Yes, specify :* —

Psychosocial Assessment:

Alcohol Intake: ☐ Yes ☑ No **Substance Abuse:** ☐ Yes ☑ No **Smoking:** ☐ Yes ☑ No

Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☑ No

If Yes, specify details: —

Pain Screening

Pain: ☐ Yes ☑ No. If Yes, Score: 0/10

Pain Scale used: ☐ PIPPS (28 weeks to < 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (Age more than 12 years)

Duration: — Location: —

Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:
Last 3 months Appetite ☐ Increased ☐ Decreased ☑ No Change
Last 3 months Weight ☐ Increased ☐ Decreased ☑ No Change

Fall Risk Screening for adults: ☑ No Risk
☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem
In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

Fall Risk Screening *(for pediatrics)* —
☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ☑ No Risk
In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

	Signature	Name	Emp. No.	Date	Time
Nurse	[signature]	Mabarla[illegible]	802	29/11/23	10:45

Part B *(to be filled by Physicians)*

Chief Complaints

H/O recurrent chest pain
diagnosed STEMI / ACS / ASMI

Past Medical History

HTN.

Personal History

Significant Family History

Current Medication

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Clinical Examination / Investigation

CVS : S1 S2 (+)

RS : BAE (+)

Echo

Mid septal mild Anteroseptal hypokinesia

EF 40%

Moderate LV.

HIV
HBsAg } negative
HCV

INR : 0.1

urea : 9.0

Creat : 0.4

Na : 130

K : 3.3

Provisional Diagnosis

CAD / ABS / STEMI / NSTEMI

HTN

Plan of Care (including Investigations Ordered)

CABG

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr Muthuvel	85831	29/11/23	10.50

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NABH

Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
29/11/23 12.45 Pm	CAG: (R) Radial 6F sheath, 5F TIG.
	D: SVD of LAD
	Plan: PCI to LAD
	[signature] 93789.
29/11/23 13.00	S/By. Dr Umar.
	Pt received from Cath lab
HR - 84 b/mt	CAG done
SpO2 - 98%	Vitals stable
BP - 128/76 mmHg	
	Pt can be discharged as advised
17.00 pm	[signature]

MHI/DIET/2022/147

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAG / EF-40 / LAD / HTN				
Height: 164 cms	Weight: 42 Kgs	Food allergies: Yes/ No; If yes, specify.....		
Religious Beliefs:	☐ Vegetarian	☑ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1000 Calorie, low fat, low salt, 1000 ml fluid restricted diet				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A)	Patient's related Medical History				
	1)	Weight Change (overall change in past 6 months)				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Oral	No change	Sub - optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric feeds	Starvation
3)	Gastrointestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity (Disease and its relationship to nutrition requirements)					
		☐ 1	☐ 2	☑ 3	☐ 4	☐ 5
		Healthy	Mild co - morbidity	Moderate co - morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
B)	Physical examination					
1)	Decreased fat stores or loss of subcutaneous fat					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
2)	Sign of muscle wasting					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
Total Score = Sum f above 7 components						
Nutritional Status : Based on this patient is						
	Well Nourished	☑ (1 to 14)				
	Moderately Malnourished	☐ (15 to 18)				
	Severely Malnourished	☐ (19 to 35)				
Nutrition Intervention:						
	☑ Oral	☐ Enteral	☐ Parenteral			
Diet counselling provided:	☑ Yes	☐ No				
Frequency of re-assessment:	☑ Weekly		☐ Fort - night	☐ Monthly		
Enteral / Parenteral	☐ Daily		Calorie count:	☑ Yes	☐	

Dietitian Signature / Name / Date / Time: 29/11, 15:00

Maria Catherine (Dietitian)
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
29/Mar, 16:00	A 50 year old female came c/o chest pain was assessed to be well nourished as evident by SGA. K/c/o - HTN / CAD. Patient shifted to Cathlab for procedure (CAG) and kept on NBM. Patient wired to Radial Loop. NBM over. Patient tolerated liquids well. Can initiate on soft solid diet.	[signature] ... Catherine John Senior Dietitian
	Oral intake is good. Educated the patient and family on 1600 calories, low fat, low salt, 2000 ml fluid restricted diet on discharge. Emphasized on small frequent meals c̄ Diet modification and clarification done. Diet chart given on discharge.	[signature] Marie Catherine John Senior Dietitian

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NABH

Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

MHI/NUR/2022/111

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PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CPD / BCS / STEMI / HTN **Allergies if any:** NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
RL	Cath Lab	29/11/23	12:00	CAG

Method of Transfer: ☐ On Bed ☑ On Wheelchair ☐ On Stretcher

ASSESSMENT OF PATIENT:
General condition of Patient: ☑ Conscious ☐ Semi-conscious ☐ Un-conscious

Language Barrier: ☐ Yes ☑ No ☐ If Yes, specify: —

Fall Risk Category: ☐ Low Risk ☐ Medium Risk ☑ High Risk

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.4°C	22 b/mt	[illegible] b/mts	98%	130/70	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: —

Any critical information: —

Any specific recommendation: —

	Signature	Name	Emp. No.	Date	Time
Handover by	[signature]	Mahalakshmi.K	[illegible]	29/11/23	12:00
Handed over to	[signature]	S. Panneerselvam	0026	29/11/23	12:00

After Procedure:
Procedure completed: ☑ Yes ☐ Yes | Any critical information: —

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.1F	20 b/m	84 b/m	97%	130/80 mmHg	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

	Signature	Name	Emp. No.	Date	Time
Handover by	[signature]	S. Panneerselvam	0026	29/11/23	12:50
Handed over to	[signature]	Ramya.J	0252	29/11/23	12:50pm

Medway Hospitals
Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

NABH

Medway Heart institute
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CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr ..GNANAVEL..... has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with bleed. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i)The nature of coronary artery disease (ii)The pumping status of the heart (iii) Your age and general health

These are some of the more serious risks that can happen, but are not the only risks:

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	(I)the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin punture site
Most People	(n) Minor bruising

PATIENT CONSENT:

P acknowledge that Dr ....GNANAVEL..... has explained my medical condition and the proposed procedure. I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment . He has explained my prognosis and the risks of not having the procedure. I have been explained that some reprocessed items might be used once its sterility and integrity is confirmed. I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and converns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	A. Leema Rose	MRS LEEMA ROSE	29/11/23	10.45 AM
witness	Roy A	REENA. A (Daughter)	29/11/23	10.45 AM
Doctor	[signature]	DR. SUPHAN	29/11/23	10.45 AM
Interpreter				

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Patient Details *(Affix Label here)*
Name:
UHID:
DOB: Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் ..... அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளள காண்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த காண்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிட்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிட்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (பலூன் வடிவம் கொண்டதொரு சிறிய சாதனம் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம்

ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I)இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) காண்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
வெகுசொற்ப மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் ..... அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. சாதாரணமான சூழலில், எனக்கு இரத்தமேற்றுதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார், இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்திரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				

JCI ACCREDITED NABH ACCREDITED

MRD

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TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	**Mrs. LEEMA ROSE A**	**ID:**	**MHI202381064**
Age/Gender :	**71 M**	**IPH:**	**IPH202302386**
Cath No. :	**3314**	**DOP:**	**29.11.2023**
Done by	Assisted by	Technician	
Dr.Gnanavelu/Dr.Karthik	Ms. Bavatharini	Mr. Prathap	

DIAGNOSIS: CAD-RECENT AWMI; MODERATE LV DYSFUNCTION, T2DM; HBP

Access: Right Radial artery — Total exposure time: 1'46"

Hardware used: 5F sheath, 5F TIG — DAP : 3.93 Gy.cm2

Contrast used: CONTRAPAQUE 40 ml — Total RAK: 41.1mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Ao Pressure – 105/60(75) mmHg, HR – 76/min, Spo2 -- 99%

Selective coronary angiogram done in multiple angulated views :

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCX
LAD	Type 3 vessel. Proximal LAD astride first septal has 80-90% discrete eccentric stenosis, Mid & Distal LAD have luminal irregularities. Gives 2 major diagonals. First major diagonal has minimal ostial disease; minor septals appear normal.
LCx	Non Dominant. Gives 2 major OMs. LCX & OMs appear normal.
RCA	Dominant. Proximal RCA shows luminal irregularities and Mid & Distal RCA appear normal. Gives PDA & PLB which appear normal.

FINDINGS: RIGHT DOMINANT; SIGNIFICANT LAD DISEASE

ADVICE: PCI TO LAD

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu MD, DM (cardio), FACC
Cl... Cardiologist
Reg. No: 39469

Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

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MHI/NUR/2022/048

DATE & TIME	Observation / Action	Signature with Emp.No
29/11/23	Patient Admission Notes	
10.35	Patient received from RL	[signature]
	Pt conscious and oriented	
	Pt NPO from 7.30 AM	
	Pt RV [illegible] done today	
	Pt preparation done today	
	Pt CBG - 84 mg/dl checked	
	and recorded	
	Pt shifted to Cath Lab @	[signature]
	Cath lab.	
12.10 pm	Pt received from RL to	
	Cath lab. Pt stable.	[signature]
12.20 pm	Procedure started.	
	Rt Radial Approach	[signature] 002
12.25 pm	Inj. Heparin 2,500 U IA given	
12.40 pm	CAG done. Rt Radial sheath	[signature]
	removed. Tight pressure	002
	bandage applied. No	
	oozing, hematoma @ Cath	
	site. Pt stable. Pt shifted	[signature]
12.50 pm	to RL and handed over to	002
	RL s/n with all report	[signature] 002

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Jayadevi	002	29/11/23	1930

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MHI/NUR/2022/048

DATE & TIME	Observation / Action Renal duty notes	Signature with Emp.No
12:00	patient received from cath lab in stable condition	
	vital parameters is normal.	
	procedure site no oozing & no haematoma.	
13:00	patient had oral intake.	
14:00	pt passed urine.	
15:00	pt had (N) diet	
17:00	no special complaints.	
18:00	Vital parameters is normal.	
19:00	D/S handed over to renal duty attendant & D/S, CAG (R) (F), CD, old file (T) IV line & ID band removed pt left @ 19:00	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jayl	JAYAPRIJ	0002	29/11/23	1930

MHI/OT/2022/086

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SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Medway Heart Institute

Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

Name of the Procedure : CAG Location : Cath Lab Date & Time : 29.11.23

Does the Procedure involve Procedural Sedation : ☐ Yes ☐ No

SIGN IN 12.20pm Before Induction of Procedural Sedation		TIME OUT 12.25pm After procedural Sedation and before procedure		SIGN OUT 12.40pm When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)		
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	☑ Yes	Identity by two identifiers	☑ Yes	Name of the Procedure done written down ☑ Yes
Procedure	☑ Yes	Procedures CAG	☑ Yes	Name and site of all specimens / investigations confirms labeling and sent to lab ☐ Yes ☑ NA
Side	☑ Rt ☐ Lt ☐ NA	Side Expected Blood loss ____	☑ Rt ☐ Lt ☐ NA	
Consent	☑ Yes	Position Supine	☑ Yes	Any recovery concerns : ☑ Yes ☐ None If Yes, Pls. specify : Observation
Known Allergy	☐ Yes ☑ No If yes, plaese specify	Consent	☐ Yes	
		Required equipment and implants available	☑ Yes ☐ NA	
Difficult airway / aspiration risk / dentures	☑ No ☐ Yes, equipment and assistance available	Essential Imaging displayed	☑ Yes ☐ NA	
		Antibiotic prophylaxis within last 60 minutes	☐ Yes ☑ NA	
Possibility of hypothermia	☑ No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☑ None If Yes, Pls. specify :
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☑ NA	
All concerned anesthesia equipment and medication check complete ☐ Spo2 ☐ NIBP ☑ Others pls. specify ECG		Anticipated duration briefed	☑ Yes	
		Anticipated blood loss briefed	☑ Yes ☐ NA	
Pre OP medication taken	☐ Yes ☑ No	Adequate fluids and blood available	☑ Yes ☐ NA	
		Team briefed on any critical or unexpected steps	☑ Yes	Corrective action : [signature]
Required equipment for procedure available	☑ Yes ☐ NA	For procedural sedation cases		
		Any patient specific concerns :	☐ Yes ☑ None	
		Intra procedure glycemic control	☐ Yes ☑ NA	
		Any concerns about sterility	☐ Yes ☑ None	

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : S/N Bhavadharani & 0176	Technician : Prathap 0118	Others Please Specify :
[signature] Date : Time :	[signature] 93280 Date : 29.11.23 Time : 12.40pm	Date : 29.11.23 Time : 12.40pm	Date : 29.11.23 Time : 12.40p	[signature] Date : Time :

MHI/CATH/2022/085

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Procedure Monitoring Sheet (Cath Lab)

Patient Name: Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

Age / Sex :

UHID / IP :

Ward Unit :

Consultant :

Diagnosis :

Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse)

PARAMETERS	YES	NO	NA
Vital signs : BP: 130/84 Temp: 98.4 Pulse: 84 RR: 22 SPO2: 97	✓		
Urine voided	✓		
Bowel preparation	✓		
Pre-procedure medication administered		✓	
Procedure site marked		✓	
Skin preparation done	✓		
NPO 7.30 AM	✓		
Loose Tooth removed	-	✓	
Contact lenses / Eye glasses removed		✓	
Prosthesis present		✓	
Jewellery/Nail polish removed	✗	✓	
Checked for Allergies (Drug / food)		✓	
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse :	Date & Time : 29/11/23 @ 9.45		

Intra – Procedural Record (To be filled by the Cath Lab Nurse)

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
29/11/23 12.25pm	101	22	108/67(86)	99%	—	
12.40pm	100	22	108/66(80)	99%	—	
	✓	Procedure	over			

Post Procedure Follow Up Data (to be filled by the doctor)

Time : 12.40 Pm Route : Rt Radial

Complication : Nil

BP : 108/67 mmHg, HR : 100, RR : 22, SpO2 : 99%

Distal Pulse: felt, Puncture Site: No oozing, Haematoma

Advise:

- Shift To: Ward / ICU
- Bed rest up to 8 hours
- Observe puncture site for bleeding
- Watch for Pulse in Rt Radial artery.
- Diet Normal
- Inform Duty Medical Officer SOS
  - a) If patient complains of any Discomfort
  - b) If dressing is Loose or Socked with Blood
  - c) If limbs are Cold / Absent Pulse
- Remove Rt Radial dressing on 30.11.23 at 11 AM /PM after informing to the consultant.
- Special instruction if any:

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes : CAG done. Sheaths removed. Tight pressure bandage Applied. No oozing, Haematoma @ CAG site.

Condition at the end of procedure : ☑ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☐ CCU ☐ Other

Name & Signature of the Nurse : Date & Time : 29.11.23, 12.40 Pm

S. Parah. A. Raaghavan / [illegible].

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Mrs.LEEMA ROSE A
50/Female/MH120238106
29/11/2023/IPH202302386
Dr.G. GNANAVELU

MHI/NUR/2022/045

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 29/11/23		
					Time: M	E	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	3	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	3	3	
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
				TOTAL SCORE	20	20	
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

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Dr.G. GNANAVELU

MHI/NUR/2022/047

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DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

	Date	29/11/23						
	Time	10.35						
S. No.	**PARAMETERS**							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0						
5	Entire leg swollen (Assess for both legs)	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0						
9	Previously documented DVT (Assess for both legs)	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0						
	FINAL SCORE	0						
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low						
	DVT prophylaxis started	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	[signature]						
	Signature & Emp. No. of Sr. RN	[signature]						

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
29/11/2023/IPH202302386
Dr.G. GNANAVELU

MHI/NUR/2022/046

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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	29/11/23	29/11/23							
	Time	10.35	13pm							
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	50							
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓							
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

0 - 24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

INTERVENTIONS *Tick as per the Risk Score*	Date	29/11/13	29/11/13							
	Time	10:25	BPM							
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓							
Remind the patient to use call bell before getting out of bed		✓	✓							
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓							
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓							
Remove excess equipment or furniture to make a clear path		✓	✓							
Keep the patient's bed in the low position at all times except during procedure		✓	✓							
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓							
Bed wheels should be locked		✓	✓							
Encourage family participation in the patient's care		✓	✓							
Ensure that floor of the bathroom is dry and not slippery		✓	✓							
Review medications for potential side effects that can promote falls		✓	✓							
Use safety belts during movement in wheelchair		✓								
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓							
Medium risk interventions (25 - 44)			✓							
Apply all the low risk interventions		✓	✓							
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓							
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓							
Use restraints and bed monitors as ordered by the doctor		✓	✓							
Allow the patient to ambulate only with assistance		✓								
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓							
Do not leave patients unattended in diagnostic or treatment areas		✓	✓							
Accompany the patient while going to bathroom		✓								
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓							
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓							
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓							
Tie red fall risk tag in the bed, wheel chair and stretcher		✓								
Locate the high-risk patients in a room close to the nurses' station		✓	✓							
Answer these patients call bells as quickly as possible		✓	✓							
Provide a commode at bedside (if appropriate)		✓	✓							
Urinal/bedpan should be within easy reach (if appropriate)		✓								
Encourage family members or other visitors to stay with them		✓	NA							
If appropriate, consider using protection devices: safety belts		✓	✓							
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

', 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, In

044-2473 4455

care@medwayhospitals.com

Registration No	: MHI202381064	**Patient Name**	: LEEMA ROSE A
Age	: 50	**Gender**	: Female
IP Number	: MMH/HM/IPH202302386	**Discharge Date**	: 29/11/2023 3:45:00PM
Bill No	: MMH/HM/IPH00399	**Bill Date**	: 29/11/2023 3:39:44PM
Ward Name	: RADIAL LOUNGE	**Bed Name**	: RL-3

NO DUE

Prepared By

Approved By

Checked By

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MH/ PRINT / 0075 / MRD

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	✓	
- Name, Age & Sex of Patient	✓	
- General Admission Consent	✓	
- Initial Assessment of Patient / Diagnosis	✓	
- Nutritional Assessment by Consultant	✓	
- Plan of care counter signed by the Consultant	✓	
- Treatment Orders - Date, Time, Name & Sign.	✓	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	✓	
- Vital Signs Chart (TPR Chart)	✓	
- Intake Output Chart	✓	
- Drug Chart (Duly filled)	✓	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist		
- Anesthesia Assessment Sheet		
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon		
- Surgery Notes - Post Operative Plan		
- Pain Scoring System	✓	
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	✓	

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Mrs.LEEMA ROSE A
50/Female/MHI20238106
09/12/2023/IPH20230246
Dr.G. GNANAVELU

MHI/IPD/2022/002

Medway Heart Institute
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ADMISSION SLIP

Admitting Doctor: Dr. Gnanavelu. G **Speciality:** Cardiology

Advised Date & Time: 9-12-23 9:01

Provisional Diagnosis:

Recent AWMI

Reason for Admission: ☒ Medical Management ☐ Surgical Management
☐ Others (please specify details) _____

Admission Type: ☐ Day Care ☐ ER ☒ Ward
☐ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):

PTCA

Blood Product Requirement: ☒ No ☐ Yes *(Kindly specify details of components required in space below)*

Expected Duration of Stay: 3 Days

Expected Cost of Treatment *(as per Financial Counseling Form):*

Payer: ☐ Self ☒ Insurance ☐ Others: ESI

ESI

Instructions to Nurse (if any):

- Investigations
- vitals monitoring

Any other Instructions (if any):

—

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr. G. Anbu	91810	10/12/23	9:01

For admission desk staff only:

Room Category:
- [x] General Ward
- [ ] Single Room
- [ ] Twin Sharing
- [ ] Deluxe Room
- [ ] Suite Room
- [x] Others G

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
9-12-23	9:01	9-12-23	9:01

Source:
- [ ] OPD
- [ ] ER
- [x] Direct

To be filled only if Blood requirement specified by the Doctor:

Is Blood Reservation and Blood Bank clearance completed as advised: [ ] Yes [x] No

Front office Staff Signature	Name	Emp. No.	Date	Time
	Prathibafo	0192	9/12/23	9:01

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Mrs.LEEMA ROSE A
50/Female/MHI20238106-
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/HOSP/2022/129

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ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	No. 40 Rajiv Gandhi Nagar.	8122532721
Occupation: G/W	Check Post street, Kamaraj apuram, chennai 70	

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
Dr. G.G	9/12/23 9:01	12/12/23 @ 4:30	4 Days

UNIT: Cardiology

MLC ☐ Yes ☑ No If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
CAD - RECENT AWMI CAG - Significant LAD Disease. (29.11.2023) moderate LV Dysfunction systemic hypertension Type II diabetes mellitus.	I25.1
	I50.1
	I10
	E11.9

DATE	OPERATION / PROCEDURES	ICPM Code
09.12.23	Successful PTCA & Stent TO LAD using ONYX Trucor 2.5 X 18 MM done on 09.12.2023	00.66

DATE	TYPE OF ANESTHESIA				
09.12.23	☐ GENERAL	☐ SPINAL	☑ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

☐ Cured	☐ Discharge at Request	☐ Expired < 48 hours
☑ Improved	☐ Against Medical Advice	☐ Expired > 48 hours
☐ Unchanged	☐ Absconded	☐ Post-Operative Death
	☐ Transferred to	

39469

Signature of the Consultant

1149

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient... Leema Rose. A who is my .... Daughter ..... (Relationship).

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.

However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.

I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

I have read out and explained the contents of the above to the Signatory in his vernacular .

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி ./.....
.....க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்	தேதி 09/12/2023	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date	Signature of the Patient / Relative / Gurdian

உறவுமுறை Daughter

Nature of Relationship

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Mrs.LEEMA ROSE A
50/Female/MHI20238106
09/12/2023/IPH20230246
Dr.G. GNANAVELU
Consultant.

MHI/IP/2022/008

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GENERAL CONSENT FOR ADMISSION

I, Leema Rose. A the ☐ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

☐ Been explained this consent form in English, which I fully understand.

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to be administered necessary drugs, medications, intravenous fluids, as advised by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities as a patient as outlined in the patient handbook.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I also consent and agree to the use and/or publication of my treatment details / medical record for medical, scientific or educational purposes (Teaching, research and academics) provided the pictures or the descriptive texts accompanying them do not reveal my identity.

- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.

- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

- I also consent to receive communication on treatment related information via text messages and e-mail as per the details provided at the time of registration.

- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient	A. Leema Rose	Leema Rose. A	9/12/23	9:01
Surrogate/Guardian (if applicable #)	Reena. A	Ray. A *(Write name and relationship with patient)*	9/12/23	9:01
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	Reena. A	Ray. A	9/12/23	9:01
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

MRD

DISCHARGE SUMMARY

IP No.	IPH202302465	**D.O.A**	: 09/12/2023
UHID	MHI202381064	**D.O.P**	: 09/12/2023
Name	Mrs.LEEMA ROSE.A	**Room No.**	: GN
Age / Gender	50Years / FEMALE		
Consultant	: **Dr. G. Gnanavelu.** MD., DM., (cardio) FACC Chief Cardiologist	**D.O.D**	: 12/12/2023

DIAGNOSIS:

CAD - RECENT AWMI
CAG – SIGNIFICANT LAD DISEASE (29.11.2023)
MODERATE LV DYSFUNCTION
SYSTEMIC HYPERTENSION
TYPE II DIABETES MELLITUS

PROCEDURE:

SUCCESSFUL PTCA + STENT TO LAD USING ONYX TRUCOR 2.5 X 18MM DONE ON 09.12.2023.

BRIEF HISTORY:

Mrs. Leema Rose.A, 50 years old Female, Presented with complaints of chest pain on & off. She was evaluated at ESIC hospital and treated conservatively. She underwent Coronary angiogram on 29.11.2023 which revealed CAD – **SIGNIFICANT LAD DISEASE**. Hence she was advised for PTCA to LAD for which she has been admitted.

No H/O fever, cough, pedal edema, vomiting, diarrhea.
Known case of Type II diabetes mellitus, systemic hypertension on medication.
N/K/C/O CVA, hypothyroidism and dyslipidemia.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

P I C C L E	-	NIL
HR	-	96bpm
BP	-	110/80 mmHg
SPO_2	-	96% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft, NT
CNS	-	NFND

INVESTIGATIONS:

BLOOD(03.12.23): Hb- 12.9gm/dl, Urea – 15.70 mg/dl, Creatinine – 0.51mg/dl, Na+- 1332mmol/l, K+- 4.70mmol/l, PLT – 388000 cells/cumm, TWBC – 6670 cells/cumm.

ECG: Sinus rhythm, HR – 87 bpm, evolved AWMI.

ECHO: Dilated LA, LV, RWMA present - Mid septal, mid anteroseptal hypokinesia. Distal sepal, distal lateral, apical hypokinesia. Moderate LV dysfunction EF – 40%. No PE/ clot / PHT.

POST PROCEDURE INVESTIGATIONS:

BLOOD(10.12.23): Urea – 09 mg/dl, Creatinine – 0.44mg/dl.

ECG: Sinus rhythm, HR – 84 bpm, ST depression in I,aVL,V1-V5 leads

ECHO: S/P PTCA. Chambers normal sized. RWMA(+) mid & apical septum, apex, mid & apical anterior hypokinetic. Mild LV systolic dysfunction EF-44%. Normal RV systolic function. Diastolic function normal. All valves normal. IAS / IVS intact. Trivial MR. Trivial TR. No PAH. No pericardial / pleural effusion. No clot / vegetation.

COURSE IN THE HOSPITAL:

Mrs. Leema Rose.A, 50 years old Female, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, She underwent **SUCCESSFUL PTCA + STENT TO LAD USING MEDTRONIC ONYX TRUCOR 2.5 X 18MM DONE ON 09.12.2023** by Right radial approach. Post procedure period was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. She was treated with DAPT, statin, nitrates, beta blockers and other supportive measures. Her general condition improved & Right radial site normal, no hematoma/ bleeding. She got shifted to ward, RFT within normal limits, maintained adequate fluid balance. Her medications are optimized and she is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile
General condition Stable

GCS	-	15/15			
Temp	-	98.6°F	BP	-	130/70mmHg
PR	-	80/min	SPO2	-	97% in room air

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. AXCER (TICAGRELOR)	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. ATORVA (ATORVASTATIN)	4 0 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. NIKORAN (NICORANDIL)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. INAPURE (IVABRADINE)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. TRIMETAZIDINE	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. ENALAPRIL	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. METOPROLOL	25 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
9.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
10.	TAB. ALPRAX (ALPRAZOLAM)	0.25 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
11.	TAB. DOLO (PARACETAMOL)	650 MG	1	0	0	ORAL	AFTER FOOD	SOS

+ DIABETES MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. FORXIGA (DAPAGLIFLOZIN)	5 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

JCI ACCREDITED NABH ACCREDITED

NAME: Mrs.LEEMA ROSE.A UHID: MHI202381064 IP.NO: IPH202302465

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DISCHARGE ADVICE	
DIET	LOW FAT, SALT & DIABETIC DIET.
PHYSICAL ACTIVITY	AS TOLERATED.
REVIEW	REVIEW WITH **DR.GNANAVELU AFTER 1WEEK WITH RFT,ECG REPORTS.**

To report: If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations. Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 4310 8959.

for **CONSULTANT SIGNATURE**

Dr. G. Gnanavelu. MD., DM., (cardio) FACC
Chief Cardiologist

Typed by: Ezhilarasi.

Dr. G. Gnanavelu MD, DM (cardio), FACC
Chief Cardiologist
Reg. No: 39469

Roy. A

"I understood the Content of the discharge summary."

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NABH ACCREDITED

Patier Name: Mrs.LEEMA ROSE A
50/Female/MHI20238106
UHID: 9/12/2023/IPH20230246
DOB: G.G. GNANAVELU
DOA:
Const.

MHI/IP/2022/107

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INPATIENT INITIAL ASSESSMENT

Date: 9/12/23 **Time of arrival in ward:** 9:10

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 96 (beats/min) | BP: 110/60 (mmHg)
Respiration: 20 (breaths/min) | SpO_2: 96 (%) | Height: 145 (cms) | Weight: 40.4 (kgs) | BMI: 19.2 kg/m²

Pain: ☑ Yes ☑ No. If Yes, Score: 0/10
Pain Scale Used: ☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)
Duration: — Location: —
Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

Pt. came for PTCA. She is a K/C/O CAD and undergone coronary Angiogram at 29/11/23 in our hospital. Presently, Pt has no chest pain, no breathlessness no palpitation

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☑ Yes ☐ No. If Yes, duration: Newly diagnosed Hypertension: ☑ Yes ☐ No. If Yes, duration: 1 year

Others:

N/K/C/O TB, Epilepsy, BA

Past Surgical History:

Nil

Present Medication *(for Medication Reconciliation)*:

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. AXCER	90mg	P/O	1-0-1	9/12/23	☑ Yes ☐ No
2	T ASPIRIN	75mg	P/O	0-1-0	8/12/23	☑ Yes ☐ No
3	T. PAN	40mg	P/O	1-0-1	9/12/23	☑ Yes ☐ No
4	T. TRIMEZIDINE	20mg	P/O	1-0-1	9/12/03	☑ Yes ☐ No
5	T. ENALAPRIL MALEATE	2.5mg	P/O	1-0-1	9/12/23	☑ Yes ☐ No
6	T. METOPROLOL	25	P/O	1-0-1	9/12/23	☑ Yes ☐ No
7	T. GLYCERYL TRINITRATE	2.6mg	P/O	1-0-1	9/12/23	☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

Not significant

Personal / Social History *(Tick whichever is applicable)*

Lifestyle: ☐ **Sedentary** ☐ **Active** **Occupation:** _____

Smoking: ☐ **Yes** ☑ **No** **Alcohol:** ☐ **Yes** ☑ **No** **Recreational Drug Use:** ☐ **Yes** ☑ **No**

Others: _____

Menstrual and Obstetric History *(to be filled up for female patients)*:

28 days cycle - regular

General Physical Examination:

Pallor: ☐ **Yes** ☑ **No** **Icterus:** ☐ **Yes** ☑ **No** **Clubbing:** ☐ **Yes** ☑ **No**

Edema: ☐ **Yes** ☑ **No** **Lymphadenopathy:** ☐ **Yes** ☑ **No**

SYSTEMIC EXAMINATION

CVS:

S1S2 (+)

Respiratory System:

BILAE (+)

Gastrointestinal System:

Soft, NT

Central Nervous System:

NFND

Urinary / Reproductive / Locomotor System:

(N)

Skin / Opthalmic / ENT

(N)

Suspected of contagious disease: ☐ Yes ☑ No Immuno compromised status: ☐ Yes ☑ No

Isolation required: ☐ Yes ☑ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☑ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

Nutritional Screening *(ESPEN Guidelines for Nutritional Screening - NRS 2002)*:

Weight loss within the last 3 months? ☐ Yes ☑ No Is the patient severely ill? *(e.g. in Intensive Therapy)* ☐ Yes ☑ No

Reduced dietary intake in the last week? ☐ Yes ☑ No Is the BMI < 20.5? ☐ Yes ☑ No

Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk

No: If the answer is "NO" to all questions, the patient is at Normal and not at risk

Provisional Diagnosis:

Recent AWMI / mild LV Dysfunction / Type II DM / SHTN

Plan of Care:

↓ Admit undr Dr. Anwaar

Plan: PTCA

NPO from 8AM

Investigations Advised:

I Attached

Diet Advice:

☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet

☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet

☐ Neutropenic liquid diet ☐ Others: Diabetic Diet, Low fat, Low Salt Diet

Early Discharge Planning *(fill in those which are appropriate at this stage)*: *PFE: Patient Family Education*

Special support needed at home	☑ Yes ☐ No	If Yes, PFE done
Home equipment anticipated	☑ Yes ☐ No	If Yes, PFE done and equipment advised
Physiotherapy at home anticipated	☑ Yes ☐ No	If Yes, educated on physical limitations, if any
Wound care needs anticipated at home	☑ Yes ☐ No	If Yes, educated on signs on infection
Pain Management	☑ Yes ☐ No	If Yes, PFE done and medication advised
Special Dietary needs	☑ Yes ☐ No	If Yes, educated on dietary restrictions, food drug interactions and allergies
Continuous / ongoing care anticipated	☑ Yes ☐ No	If Yes, educated on various aspects of ongoing care required
Other special education need, i.e.:	☑ Yes ☐ No	If Yes, PFE done
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed	☑ Yes ☐ No	If Yes, specific education given

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. Hari Vignesh	191160	9/12/23	9 AM
Consultant		DR. G. GNANAVEL	39469	9/12/23	9.00
Patient Attendant	Ray.A	Relationship daughter	—	9/12/23	9.00

Mrs. EEMA ROSE A
50/Female/MHI20238106
09/12/2023/IPH20230246
Dr.G. GNANAVELU

022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
	PCI to LAD
9/12/23	
12.45	App - (R) Radial artery — Inj Heparin 5000 IU
	By using 6F 3.0 EBU, LCA engaged — Ct Radial cocktail
	By using 0.014" BMW tip guidewire, lesion crossed
	parked distally. Predilated with Apollo 2x10mm
	balloon at 10 atm, 10s. Onyx Trucor 2.5 x 18mm
	DES deployed at 12 atm 15s. Post stent dilation
	(POT) done with 2.75 x 8 Mozec NC at 12 atm 10s
	Check cart revealed no flap, dissection, thrombus
	Medtronic Onyx TruCor™ RX DES 2.5 mm x 18 mm REF TRCR25018X LOT 0011908436 2026-08-13
	Rx
	— IVF - 30cc/hr
	— Drugs as per chart
ACT - 272	
	Sd/- Gnanavelu

DATE	NOTES
11-12-2023	Screening Echo
10:50 am	S/P PTCA
	· No pericardial / pleural effusion
	· Chambers normal sized
	· RVMA – Mid & apical septum, apex, Mid & apical anterior hypokinesia
	- Mild LV systolic dysfunction
	· Normal RV systolic function
	· Diastolic function – Normal
	· All values – Normal
	- IAS / IVS intact
	- Trivial MR
	· Trivial TR NO PAH
	- No clot / vegetation
	LVIDD: 42 EDV: 59 ml
	LVIDS: 33 ESV: 33 ml
	EF: 46 % EF: 44 %
	RV TDI: 15 cm/s
	· TAPSE: 23 mm
	E/A: 1.32
	Med E/E': 11.39
	Lat E/E': 12.67
	TRPG: 23 mmHg
	RVSP: 33 mmHg
	Done by: Zibiah (PA, RCS)
	MHI/0053/AP.

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/ICU/2022/036

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CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mrs. Leema Rose. the ☑ Patient or ☐ Representative of patient have *(please tick the correct option above and below):*

☑ Read

☑ I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my patient's illness and I am aware of the all the possible outcomes.

☑ Been explained this consent form in English / Tamil, which I fully understand and understood the information provided about **ICU Treatment**

I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

A Central venous catheter or central line is a long, soft, thin, hollow tube placed into a large vein (blood vessel). Compared to a peripheral line, central line is larger, longer and is placed into a large vein in the neck, upper chest or groin.

Intended benefits:

Common reasons for having a central line include:

- To give IV medications over a long period of time because a large vein can tolerate an IV catheter for a longer time than a small vein. Examples of such medications are antibiotics and chemotherapy.
- To rapidly deliver large amounts of fluid or blood, for example when a person is in shock.
- To give multiple drug infusions in critically ill patients
- To directly measure blood pressure in a large or central vein. This can help determine how much fluid a person needs.
- For patients who require frequent blood draws to be sent to the laboratory, the central line allows for blood to be drawn without repeatedly pricking the patient.
- To deliver nutrition directly into the blood when food or liquids cannot be given through the mouth, stomach, or intestine.
- To give vasopressors (Blood pressure increasing drugs) for a patient in shock, as giving vasopressors through peripheral line can cause injury to the small blood vessels.
- In some cases, two of the lumens on the central line can be used to perform dialysis, with one lumen used to take blood out of the vascular system and another lumen used to return the dialyzed blood to the body.

Possible risks and complications:

- Discomfort during placement: Discomfort can result from the needle stick and placement of the catheter at the time it is inserted.
- Bleeding: Bleeding can occur at the time the catheter is inserted. The bleeding is usually mild and stops by itself
- Infection: Any tube (catheter) entering the body can make it easier for bacteria from the skin to get into the bloodstream. Special care in cleaning and bandaging the skin at the catheter site can decrease the risk of infection.
- Thrombosis
- Arrythmia
- Pneumothorax (Collapsed lung): When a central venous catheter is placed in the chest area, if the needle passes through or misses the vein, the needle could pierce the lung causing the lung to collapse. If this happens, lung will be reflated by placing a tube between the ribs to remove the air that has leaked from the lung.

I have been explained the implications of not undergoing this procedure like:

- Worsening of clinical condition of the patient.
- Repeated pricking for blood samples.
- Difficulty in getting peripheral venous access.
- When high dose vasopressors are needed, ischemia to the distal part of the limb.

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:
Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.
The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:
The procedure might be needed for you / your patient for any of the following reasons:
- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
- when patient needs help to breathe
- when patient has a head injury and cannot breathe on his / her own
- when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:
- Injury to teeth or dental work
- Injury to the throat or trachea
- Bleeding
- Lung complications or injury
- Aspiration (stomach contents and acids that end up in the lungs)
- Other Risks (if any): ______

Possible alternatives:
Non invasive ventilation can be helpful in a few situations. But when Endotracheal Intubation is required, there can be no alternative treatment offered.

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	[signature] (Husband)	Mr. Alagesan (Write name and relationship with patient)	9/12/23	14.35
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	A. [signature] (Son in law)	Mr. Palraj	9/12/23	14.35
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned procedure, to the patient / patient representative. I am confident that he / she has understood the information fully as described in this document.

	Signature	Name	Reg. No.	Date	Time
Doctor	[signature]	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	9/12/23	14.35

Medway Hospitals®
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

Patient Details *(Affix Label here)*
Name:
UHID:
DOB: Sex:
DOA:
Consultant:

MHI/ICU/2022/036

Medway Heart Institute
Every heart beat counts

உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

_____என்ற பெயர் கொண்ட □ நோயாளியான அல்லது □ நோயாளியின் பிரதிநிதியான
_____ நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உள்ளவற்றில் சரியான விருப்பத்தேர்வை தயவுசெய்து டிக் செய்க)

□ வாசித்திருக்கிறேன்
□ சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.
□ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சுவாச வழிமுறை, மத்திய சிரை அணுகுவசதி இதய தமனி தமனிக்குழல்கள் உட்பட மூச்சுப் பெருங்குழலுக்குள் குழாய் செருகுதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:
ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:
மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

- ஒரு சிறிய நாளத்தைவிட, ஒரு பெரிய நாளமானது நீண்ட காலஅளவிற்கு ஒரு IV கதீட்டரை தாங்கும் என்பதால், நீண்ட காலஅளவிற்கு IV மருந்துகளை வழங்குவதற்காக. ஆண்ட்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு ஆபத்தான நிலையிலுள்ள நோயாளிகளுக்கு ஒன்றுக்கு மேற்பட்ட பல மருந்து உட்செலுத்தல்களை வழங்குவதற்கு.
- ஒரு பெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனைஅகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிகுத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வகை செய்கிறது.
- வாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- புறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பொருத்தப்படும்போது அசௌகரியம்: ஊசியால் குத்தும்போது மற்றும் கதீட்டரைப் பொருத்தும் நேரத்தில் அதனை உட்செலுத்துகின்ற நேரத்தில் அசௌகரியம் ஏற்படக்கூடும்.
- இரத்தக்கசிவு: கதீட்டர் உட்செலுத்தப்படும் நேரத்தில் இரத்தக்கசிவு நிகழக்கூடும். இந்த இரத்தக்கசிவு வழக்கமாக மிகச்சிறிய அளவில் லேசாக இருக்கும் மற்றும் அது தானாகவே நின்றுவிடும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதீட்டர்), சருமத்திலிருந்து பாக்டீரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதீட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉறைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுரையீரல் உறைக்காற்று நோய் (நுரையீரல் துவண்டு மடிதல்): மார்பு பகுதியில் ஒரு மைய சிரைகதீட்டர் பொருத்தப்படும்போது ஊசி சிரை / நாளத்தின் வழியாக கடந்து செல்லுமானால் அல்லது அதை தவறவிடுமானால் அந்த ஊசி நுரையீரலுக்குள் ஊடுருவி, நுரையீரல் துவண்டு மடிவதை விளைவிக்கும். இது நிகழுமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காற்றை அகற்றுவதற்கு விலாக்களுக்கு இடையே ஒரு குழாயை வைப்பதன் மூலம் நுரையீரல் மீண்டும் மீட்பு வீக்கம் பெறுமாறு செய்யப்படும்.

இந்த மருத்துவ செயல்முறையை மேற்கொள்ளவில்லை எனில், கீழ்க்கண்டவை போன்ற விளைவுகள் நிகழலாம் என்று எனக்கு விளக்கிக் கூறப்பட்டிருக்கின்றன:

- நோயாளியின் மருத்துவ / உடல்நிலை மோசமடைதல்.
- இரத்த மாதிரிகளுக்காக திரும்பத்திரும்ப ஊசி குத்துவது.
- புறவெளி இரத்தநாள அணுகுவசதியை பெறுவதில் சிரமம்.
- அதிக அளவிலான வாசோபிரெசர்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தஓட்டத்தடை

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:
மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை மூச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் மூச்சுத்திணறல் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவ, உங்களது / உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழல், ஆக்சிஜனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும்.
சுவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய், குரல்வலைக்கு சற்றுகீழே தொடங்குகிறது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு மூச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான மூச்சு சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த மூச்சு சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. மூச்சுக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திசு ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. மூச்சுப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது மூச்சு / காற்றுப்பாதையை அடைப்பின்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிஜன் தடையின்றி, தாராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:
கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கூடும்:

- உணர்விழப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக மூச்சுப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது / உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது
  சுவாசிக்க உதவ:
- சுவாசிப்பதை நோயாளி நிறுத்திவிட்டபோது அல்லது சுவாசிப்பதில் சிரமம் இருக்கும்போது
- சுவாசிப்பதற்கு நோயாளிக்கு உதவி தேவைப்படும்போது
- நோயாளிக்கு தலைக்காயம் ஏற்பட்டிருக்கும்போது மற்றும் தானாகவே அவரால் சுவாசிக்க இயலாதபோது
- ஒரு கடுமையான காயம் அல்லது நோயிலிருந்து மீண்டு வருவதற்காக நீண்ட காலஅளவிற்கு ஒரு நோயாளி உணர்விழப்பு மருந்தின் கீழ் அல்லது மயக்க நிலையின் கீழ் வைக்கப்படுவது அவசியமாக இருக்கும்போது.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியிழுத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:
உடலுக்குள் ஊடுருவாத சுவாச ஏதுவாக்கல் முறையானது, சில குழ்நிலைகளில் உதவிகரமாக இருக்கக்கூடும். ஆனால், மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியப்படும்போது, வேறு மாற்று சிகிச்சை முறைகள் வழங்கப்படுவதற்கு வழியில்லை.

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எவக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிபட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.
இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள *மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட* மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.

	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
நோயாளி				
பதிலாள் / பாதுகாவலர் (பொருந்துமானால் #)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)		
பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்லை; ஏனெனில்:			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருந்துமானால்)				

***ஆண்களுக்கு வலது பெருவிரல் மற்றும் பெண்களுக்கு இடது பெருவிரல் ரேகை பதிவு | # உரிய வயது வராதவராக அல்லது ஒப்புதல் கொடுக்க இயலாதவராக நோயாளி இருந்தால் மட்டுமே.**

கீழே, கையொப்பமிட்டுள்ள மருத்துவராகிய நான், திட்டமிடப்பட்ட ஆபரேஷன் / நடைமுறை குறித்த தன்மை, ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள், கிடைக்கும்என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பின் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அவர், இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

MHI/ICU/2022/040

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Medway Heart Institute
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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

ICU PROGRESS NOTES

Date : 9/12/23
Time : 14 · 30
Doctor's Name : Dr. Anish

ICU SCORES *(as Appropriate)*	**CLIF ACLF / AD score:** **SOFA score:**	**MELD score:** **SAPS II score:**	**AARC score:** **APACHE II score:**

ICU Day Background
RECEIVED FROM CATH LAB
S/P PCI TO LAD
RECENT AWMI / MILD LVSD / [illegible]

Issues last 24 hours

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M Pupils
Pain score Drains

Cardiovascular system NSR
HR - 70 Rhythm - STS Cardiac Output -
BP - 100/70 CVP - S1S2
Cardiac Medications:

Respiratory system
Oxygen supplementation – NIL 98% RA
Saturation / PaO2-
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

GIT
P/A Soft
Bowels – Y / N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1.
2.
3.

Labs
Hb TC Platelets
Urea Creatinine
Na K
Bilirubin AST ALT
INR
Others

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

- IVF @ 30ml/hr
- MOBILIZE TOMORROW
- Na/K/UREA CREAT/ECG TOMORROW
- MONITOR UOP/BP.
- W/F BLEEDING/HEMATOMA/SWELLING AT PUNCTURE SITES

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	9/10/23	14:30

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date : 10/12/23
Time : 8:30am
Doctor's Name : Dr. G. Abilan

ICU SCORES (as Appropriate)	CLIF ACLF / AD score:	MELD score:	AARC score:
	SOFA score:	SAPS II score:	APACHE II score:

ICU Day Background
Recent AWMI.
Mild LVSD.
T2DM / SHT.

Issues last 24 hours
s/p PCI to LAD done yesterday
pt stable.

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E4 V5 M6 15/15 Pupils B/L PERL
Pain score Drains Nil

Cardiovascular system
HR - 92 Rhythm - NSR Cardiac Output -
BP - 128/82 CVP -
Cardiac Medications: S1S2 ⊕

Respiratory system
Oxygen supplementation –
Saturation / PaO2- 96% - RA
Ventilator : Spontaneous / Controlled

Last C x R -
Drains -
BS B/E ⊕
RR = 22/min

GIT
P/A soft
Bowels – Y / N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

I / 1140ml.
O / 1800ml.
-660ml

Microbiology
Invasive lines
1. peripheral line. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1. –
2.
3.

Labs

Hb		TC		Platelets	
Urea	9	Creatinine	0.44		
Na		K			
Bilirubin		AST		ALT	
INR					
Others					

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

- Drugs as per chart
- I/O chart
- Sitch Monitoring
- Room shift after rounds

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. [illegible]	9810	10/12/23	8:40am

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
	S/B Dr. [illegible]
10/12/23 @9:50	[illegible] of chest pain
	Swelling in forearm
	[illegible]
	BP - 124/70 mmHg
	PR - 97/min
	[illegible]
	[illegible]
	T 1140 / 0 1800
	E 60 mg
Echo screening	plan
[illegible] of CAD	compression bandage (R) forearm
[illegible]	S. Cr - 0.47 / U - 09
Mod w [illegible]	Tc [illegible] / [illegible]
No [illegible]	ECG / T. [illegible]
	[illegible]
	procedure note — [illegible] / Forearm swelling (R)
	— compression bandage applied in forearm proximally

DATE	NOTES
11/12/23 9:30	Dr ... Team
	Iteration ...
	...
	...
	P 80/m
	BP 130/80
	...
	plan
	- D/s today
	- ...
	- T-...
12/12/23 ...	... Dr. ... (CMO)
	Pt reviewed - no complaints
	O/E - pt conscious oriented, afebrile.
	... - ... RS - ... PA - ...
	Adv
	- ...
	- follow ...
	- ...
	- ... today

R... 183085

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Medway Heart Institute
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Pati Mrs.LEEMA ROSE A
Nan 50/Female/MHI20238106
UHI 09/12/2023/IPH20230246
DOI Dr.G. GNANAVELU

URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

DATE	3/12/23		
COLOUR			
REACTION			
SPECIFIC GRAVITY	1.015		
APPEARANCE			
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN	NORMAL		
PUS CELLS			
EPITHELIAL CELLS			
RBC	NIL		
CASTS			
CRYSTALS			
OTHERS			

MICROBIOLOGY-CULTURE REPORTS

DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY

MHI/IP/2022/065

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DIABETIC CHART

Patient Name: Mrs.LEEMA ROSE A
UHID: 50/Female/MHI20238106
DOB: 09/12/2023/IPH20230246
Dr.G. GNANAVELU

ACTUAL WEIGHT 40.4 kg HbA1c 5.5

PREVIOUS DIABETIC MEDICATIONS T. FORXIGA 5mg 1-0-0

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
9/12/23	9.00	138 mg/dL	–		DR. ANISH
9/12/23	14.30	100 mg/dl.	–		Dr. Anish Nelson Reg. No: 88434
9/12/23	19.00	115 mg/dl	–		Dr. Anish Nelson Reg. No: 88434
10/12/23	7.30	94 mg/dL	–		Dr. Anish.
11	13.00	112 mg/dl	–		DR. ANISH
	18.30	107 mg/dl	–		
11/12/23	6.30	109 mg/dl	T. Forxiga 5mg		K. 13/12/23
	12.30	104 mg/dl	–		Dr. Salai

INSTRUCTIONS FOR INSULIN INFUSIONS

* Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.
* Target Blood Sugar 150-200 mgs.
* To monitor K+ separately.

Urine Acetone

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

MHI/IP/2022/069

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BLOOD GROUP

—

INVESTIGATION SHEET

Patient Name: Mrs.LEEMA ROSE A
50/Female/MHI20238106
UHID: 09/12/2023/IPH20230246
DOB: Dr.G. GNANAVELU

Date	3/12/23	10/12/23				
HAEMATOLOGY						
Hb	12.9					
P.C.V	38.4					
Platelets	388000					
TLC	6670					
Polymorphs	59.2					
Lymphocytes	27.0					
Eosinophils	0.8					
Mono / Basophils	12.7/0.3					
E.S.R						
BIO-CHEMISTRY						
Urea	15.70	09				
Creatinine	0.51	0.44				
Sodium	132					
Potassium	4.70					
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.470					
D.Bilirubin						
I.Bilirubin						
S.G.O.T	30					
S.G.P.T	24					
ALP	104					
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Date	24/11/23	3/12/23				
COAGULATION						
PT / INR						
Fibrinogen						
D Dimer						
LIPID PROFILE	178					
Total Cholesterol	198					
Triglyceride	90					
H.D.L	70					
L.D.L	99					
VLDV	18.0					
THYROID FUNCTION						
T.S.H	0.432					
T.3						
T.4	1.01					
SEROLORY						
HIV						
HBsAg	Negative					
V.D.R.L						
COVID 19						
RT- PCR						
IgM						
Ig						
HBA1C	5.5					
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						

MHI/IP/2022/074

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

DM, HTN

Patient Name: Mrs.LEEMA ROSE A
UHID: 50/Female/MH120238106
DOB: 09/12/2023/IPH20230246
Dr.G. GNANAVELU

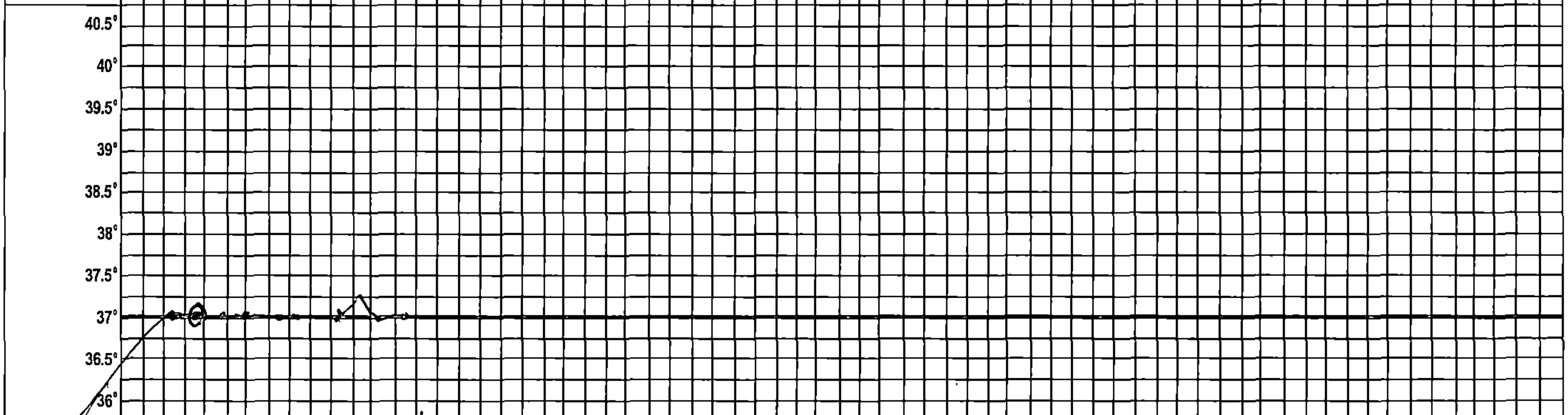
VITAL INFORMATION SHEET

BLOOD GROUP	
ON ADMISSION	
Height in CM	**Weight in Kg.**
145 cm	40.4 kg

Diagnosis: AWMI, SHTN, DM

Procedure: PTCA to LAD

NO. OF DAYS	DOA	D1	D2
DATE	9/12/23	10/12/23	11/12/23
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10



	DOA		D1		D2
PULSE	96	80	96	79	80b/m
RESP	20	24	19	20	22b/m
B.P.	110/60	108/73	113/78	105/71	130/70
SPO2	96%	98%	98%	97%	97%
DAILY WEIGHT	40.4	40.4			
24 HRS INTAKE	1140 ml		600 ml		
24HRS OUTPUT	1800 ml		1450 ml		
BALANCE	-660 ml		-850 ml		
MOTION	✓		✓		

MHI/IP/2022/103

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Mrs.LEEMA ROSE A
50/Female/MHI20238106
09/12/2023/IPH20230246
Dr.G. GNANAVELU

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EARLY WARNING SCORE MONITORING CHART

Name: _____ **Age/Sex:** _____ **Patient Id No:** _____

NEWS key 0 1 2 3	DATE / TIME	9/12/23 9:00	10/12/23 11:00	10/12/23 18:00	11/12/23 6:00	11/12/23 10:00	DATE / TIME
A+B Respirations Breath/ min	>25						>25
	21-24				2		21-24
	18-20						18-20
	15-17						15-17
	12-14						12-14
	9-11				1		9-11
	<8						<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96						>96
	94-95				1		94-95
	92-93				2		92-93
	<91						<91
o2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % eg: In hypercapnic respiratory failure only use scale 2 under the direction of qualified clinician	>96 on oxygen						>96 on oxygen
	95-96 on o2				2		95-96 on o2
	93-94 on O2				1		93-94 on O2
	>93 on air						>93 on air
	88-92						88-92
	86-87				1		86-87
	84-85				2		84-85
	<83%				3		<83%
Air or Oxygen ?	A= Air						A= Air
	O2litre/ min				2		O2litre/ min
	Device						Device
C Blood Pressure	>220						>220
	201-219						201-219
	181-200				2		181-200
	161-180						161-180
	141-160						141-160
	121-140						121-140
	111-120						111-120
	91-100				1		91-100
	81-90				2		81-90
	71-80						71-80
	61-70						61-70
	51-60						51-60
	<50						<50
Diastolic BP	mmHg				90	70	mmHg
C Pulse ats / min	>131						>131
	121-130				2		121-130
	111-120				2		111-120
	101-110				1		101-110
	91-100				1		91-100
	81-90						81-90
	71-80						71-80
	61-70						61-70
	51-60						51-60
	41-50				1		41-50
	31-40						31-40
	<30						<30
D Consciousness Score for New onset of confusion (no score if chronic)	Alert						Alert
	Confusion						Confusion
	V						V
	P						P
	U						U
E Temperature Degree Celsius	>39.1 degree Celsius				2		>39.1 degree Celsius
	38.1-39.0				1		38.1-39.0
	37.1-38.0						37.1-38.0
	36.1-37.0						36.1-37.0
	35.1-36.0				1		35.1-36.0
	< 35.0						< 35.0
NEWS Total		4	0	6	0	0	
Monitoring Frequency		1hr	4hrly	1hrly	4hrly	1hrly	
Escalation of Care Y/N		NO	NO	NO	NO	NO	
Initials by RN		SM	[illegible]	[illegible]	[illegible]	[illegible]	
Initials by Sr. RN		Nea 24	Nea 24	Nea 24	Nea 24	Nea 24	

Note: Nurses are trained to Call Code 99 (100) when they get score of 3 in any single parameter or aggregate score of > 5

Score and monitoring frequency	4	Every Hourly
	3	Every 2nd Hourly
	2	Every 4th Hourly

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Mrs.LEEMA ROSE A
50/Female/MHI20238106
09/12/2023/IPH2023024
Dr.G. GNANAVELU

MHI/IP/2022/066

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INTAKE & OUTPUT CHART

Date	From: 9/12/23	To: 10/12/23	Bed No: Gw c 1
24 Hrs : Started Time : 7.00		Ended Time : 7.00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	100ML.	350 ML		
OUTPUT	200ML	550ML.		

Total Intake: Total Output: Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
8.00						
	Total	Intake	Cefth	Cab.	100ml.	100ml
11.30	150.					
16.00	100					
18.00	100.					

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
	urine output			9.00	to. 12.	200ML		
	300					500		
	250					750		
			Total Intake -			450ml		
			Total output -			750ml		
								Nurse
								024

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MHI/IP/2022/066

Medway Heart Institute
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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

INTAKE & OUTPUT CHART

Date From: 10/12/23 To: 11/12/23			Bed No: CW(1)	
24 Hrs : Start 7:00			Ended Time : 7:00	
NPO Started :			NPO Over at :	
SHIFT		Afternoon	Night	Restricted Fluid (RF)
INTAKE		2	480 ml	
OUTPUT			650 ml	

Total Intake: 600ml | Total Output: 1450 | Difference: -850ml

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
10/12/23 @			TOTAL	INTAKE	150 ml	
21.00	150ml					300
2.30	150ml					150
6.00	150ml					600

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			TOTAL OUTPUT		800ml			
20.00	250ml					1050		
2.00	200ml					1250		
6.00	200ml					1450		
		TOTAL	INTAKE	-	600ml			
		TOTAL	OUTPUT	-	1450ml			
								Doc 024

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Mrs.LEEMA ROSE A
5(ıalı I202381064
0(20.. H202302465
Dr.G. GNANAVELU

MHI/IP/2022/066
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Date	From: 11/12/23	To: 12/12/23	Bed No: Gw-1	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 7:00		Ended Time : 7:00		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	625 ml			
OUTPUT	500 ml			

Total Intake: Total Output: Difference:

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
8.00	125					125	9.45	200					200		
8.20	125					250	10.50	200					400		
8.4	125					375	12.00	100					500		
9.0	125					500									
11.30	125					625									

Total Intake - 625 ml
Total output - 500 ml

Naa
0224

MHI/DIET/2022/147

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: Recent AWMI / DM / HTN / PTCA / EF-40%				
Height: 144 cms	Weight: 42.4 Kgs	Food allergies: Yes/ No; if yes, specify......		
Religious Beliefs:	☐ Vegetarian	☑ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1000 calories, low fat, low salt, 2000 ml fluid restricted, diabetic diet.				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A)	Patient's related Medical History				
	1)	Weight Change (overall change in past 6 months)				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Oral	No change	Sub - optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric feeds	Starvation
3)	Gastrointestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity (Disease and its relationship to nutrition requirements)					
		☐ 1	☐ 2	☑ 3	☐ 4	☐ 5
		Healthy	Mild co - morbidity	Moderate co - morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
8)	Physical examination					
1)	Decreased fat stores or loss of subcutaneous fat					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
2)	Sign of muscle wasting					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
Total Score = Sum f above 7 components						

Nutritional Status : Based on this patient is			
	Well Nourished	☑ (7 to 14)	
	Moderately Malnourished	☐ (15 to 18)	9
	Severely Malnourished	☐ (19 to 35)	

Nutrition Intervention:			
☑ Oral		☐ Enteral	☐ Parenteral
Diet counselling provided:	☑ Yes	☐ No	
Frequency of re-assessment:	☑ Weekly	☐ Fort - night	☐ Monthly
Enteral / Parenteral	☐ Daily	Calorie count: ☐ Yes	☑ No

Dietitian Signature / Name / Date / Time: [signature] 9/12/23, 17:00

Maria Catherine John (401)
Senior Dietitian

MHI/DIET/2022/147

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
9/12/22, 13:00	A 70 year old female came c No specific complaint was assessed to be well nourished as evident by SGA. K/c/o - DM/HTN Patient shifted to Cathlab for procedure (PCI) and kept on NBM. Patient visited to c/o. NBM over. Patient tolerated diabetic liquid diet. Can initiate on diabetic soft solid diet.	Maria Catherine John (Signature) Senior Dietitian
12/12/22, 10:00	Patient visited to ward. Oral intake is good. Educated the patient and family on 1500 calories, low fat, low salt, 2000 ml fluid restricted, diabetic diet on discharge. Emphasized on small frequent meals & low glycemic control. Diet modification and clarification done. Diet chart given on discharge.	Maria Catherine John (Signature) Senior Dietitian

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

PSYCHOLOGICAL WELLBEING REPORT

Date: 11/12/23 Time: 12.15pm.

Unit: ICW1

Clinical diagnosis:

Surgery/ Procedure: PTCA - LAD.

Impression: Visual Hallucinations / flashes of images?

- fear of death / death anxiety
- intrusive thoughts ⊕
- sleep ↓, appetite Ⓝ, calm affect, oriented
- flashes of dead people images (once this IPV)

Breathing technique (mindfulness) was recommended & practiced while check up. Suggested to consult psychiatrist.

Employee ID: MH0274PSY

Signature of the Psychologist:

MHI/NUR/2022/111

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Patient Details (Affix Label here)
Name: Mrs.LEEMA ROSE A
UHID: 50/Female/MHI20238106
DOB: 09/12/2023/IPH20230246
DOA: Dr.G. GNANAVELU
Consul

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PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: AWMI, SHTN, DM Allergies if any: NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
IInd FLOOR	Cath Lab	9/12/23	12.16	PTCA

Method of Transfer: ☐ On Bed ☑ On Wheelchair ☐ On Stretcher

ASSESSMENT OF PATIENT:

General condition of Patient: ☑ Conscious ☐ Semi-conscious ☐ Un-conscious

Language Barrier: ☑ Yes ☐ No ☐ If Yes, specify:

Fall Risk Category: ☐ Low Risk ☑ Medium Risk ☐ High Risk

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.1°F	20b/m	96%	96%	110/80	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: –

Any critical information: –

Any specific recommendation: –

	Signature	Name	Emp. No.	Date	Time
Handover by	A	A. Anitha	0222	9/12/23	12.16
Handed over to	[signature]	Bharathamani	0176	9/12/23	12.15

After Procedure:
Procedure completed: ☑ Yes ☐ Yes | Any critical information: Nil

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98°F	22 b/min	104 bt/min	99%	102/62(76)	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

	Signature	Name	Emp. No.	Date	Time
Handover by	[signature]	Bharathamani	0176	9/12/23	13.55
Handed over to	[signature]	Anithi	0282	9/12/23	13.55

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CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

Patient Name	Mrs.LEEMA ROSE A 50/Female/MH120238106- 09/12/2023/IPH20230246	Sex: M/F	
Consultant:	Dr.G. GNANAVELU	UHID	

CONDITION A

Dr .GNANAVELU has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with bleed. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i)The nature of coronary artery disease (ii)The pumping status of the heart (iii) Your age and general health

These are some of the more serious risks that can happen, but are not the only risks:

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	(I)the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin punture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I acknowledge that Dr ...GNANAVELU...... has explained my medical condition and the proposed procedure. I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment . He has explained my prognosis and the risks of not having the procedure . I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and converns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be *treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition*

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	A Leemarose	A Leema Rose	9/12/23	9.10
witness	Ray.A	Reena.A	9/12/23	9.10
Doctor	(signature)	Dr Siva	9/12/23	9.10
Interpreter				

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இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்ஐடி (UHID) :

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் ..... அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின். ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும், இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளள கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிட்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிட்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (பலூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம்

ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை.) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I)இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் ..... அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும். செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில். எனக்கு இரத்தமேற்றுதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்டும் என்பதை எனக்கு விளக்கினார். இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்திரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				

JCI ACCREDITED NABH ACCREDITED

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MRD

TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

Patient name	**MRS. LEEMA ROSE**	**ID:**	**MHI202381064**
Age/Gender	**50 F**	**IPH:**	**IPH 202302465**
Cath No.	**3369**	**D.O.P.**	**9.12.2023**

Done by DR. G.GNANAVELU/DR.SIVA

Technician : Mr. Pandian
Scrub nurse : Ms. Sathya

DIAGNOSIS: AWMI – LYSED WITH SK; MODERATE LV DYSFUNCTION; T2DM; HBP
CAG: SVD – SIGNIFICANT MID LAD DISEASE

APPROACH : Right radial artery

HARDWARE : 6F sheath, 6F EBU 3 guide catheter

CONTRAST : CONTRAPAQUE 150 ml

Total exposure time:1280"
Total RAK: 279 mGy
Total DAP: 61 Gy.cm2

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 5000 IU; Inj Fentanyl 25 mcg IV

HEMODYNAMIC DATA: ABP 106/66 (79); HR 92 bpm; SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
MID LAD	TUBULAR 70% STENOSIS	BMW	2 X 10 SC Balloon 8 atms	2.5 x18 ONYX TRUCOR 12 atms 10 s	2.75 X 8 NC BALLOON 12 atms	TIMI III FLOW

REMARKS: Uneventful procedure. ACT at the end of the procedure was 285s.

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu MD, DM (cardio), FACC
Chief Cardiologist
Reg. No: 39409

MRS. Leema Rose. A
50yrs /F
MHI2023 81064
Dr. Gnanavelu.

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/12/23	cath lab.	
12.15	=> Pt Received from IInd floor to cath Lab. conscious and oriented.	
12.20	=> vitals stable. IV line left side patent. VIP score 0/5	0176
12.35	=> Sterile drapping done. PTCA Procedure started.	
12.45	=> Rt Radial arterial approach under local anaesthesia	0176
	=> IVF: NS 30ml/hr IV started.	
12.50	=> Inj: NTG 200mcg + Inj: Heparin 5000IU IA given o/b Dr. GGr (ctc)	0176
13.30	=> BP: 114/70 (84) mmHg, HR: 86 b/mt SpO2: 99% vitals stable.	
13.35	=> ACT - 272 secs checked. O/B Dr. GGr (CTC)	0176
13.40	=> Procedure PTCA done. Rt Radial arterial sheath removed. Tight plaster bandage applied. no oozing & hematoma over the site.	0176
13.55	=> Pt shifted to CCU all reports hand over to S/N. Uma mageswari.	0176

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	S. Panch	S. Panchavarnam	0020	9/12/23	13.5

Mrs. Leema Rose. MHI/OT/2022/086
50yrs/F
MHI202381064
Dr-Gnanavelu

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SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Medway Heart Institute

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

Name of the Procedure : PTCA Location : Cath lab. Date & Time : 9/12/23

Does the Procedure involve Procedural Sedation : ☐ Yes ☑ No

SIGN IN 12.35 Before Induction of Procedural Sedation	TIME OUT 12.45 After procedural Sedation and before procedure	SIGN OUT 13.40 When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)	(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure	
Patient Confirmation	All team members introduce themselves by Name and Role	To be done for each procedure in case of multiple procedures
Identity by two identifiers ☑ Yes	Identity by two identifiers ☑ Yes	Name of the Procedure done written down ☑ Yes (PTCA)
Procedure ☑ Yes	Procedures PTCA ☑ Yes	Name and site of all specimens / investigations ☐ Yes ☑ NA confirms labeling and sent to lab
Side ☑ Rt ☐ Lt ☐ NA	Side Rt Radial arterial approach ☑ Rt ☐ Lt ☐ NA Expected Blood loss NA.	
Consent ☑ Yes	Position Supine. ☑ Yes	Any recovery concerns : ☐ Yes ☑ None If Yes, Pls. specify :
Known Allergy ☐ Yes ☑ No If yes, plaese specify	Consent ☑ Yes Required equipment and implants available ☑ Yes ☐ NA	
Difficult airway / aspiration risk / dentures ☑ No ☐ Yes, equipment and assistance available	Essential Imaging displayed ☑ Yes ☐ NA	
Possibility of hypothermia ☑ No ☐ Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes ☐ Yes ☐ NA Name of the Antibiotic given	Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☐ None If Yes, Pls. specify :
All concerned anesthesia equipment and medication check complete ☑ Spo2 ☑ NIBP ☑ Others pls. specify G-Clp	Venous Thromboembolism Prophylaxis Provided ☐ Yes ☑ NA Anticipated duration briefed ☑ Yes Anticipated blood loss briefed ☑ Yes ☐ NA	
Pre OP medication taken ☐ Yes ☑ No	Adequate fluids and blood available ☑ Yes ☐ NA Team briefed on any critical or unexpected steps ☑ Yes	Corrective action :
Required equipment for procedure available ☑ Yes ☐ NA	For procedural sedation cases Any patient specific concerns : ☐ Yes ☑ None Intra procedure glycernic control ☐ Yes ☑ NA Any concerns about sterility ☐ Yes ☑ None	

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : R/N. Sandhiya 0004	Technician : Mr Paraliyen 2501	Others Please Specify :
Date :	Date : 9/12/23	Date : 9/12/23	Date : 9/12/23	Date :
Time :	Time : 13.50	Time : 13.50	Time : 13.50	Time :

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Procedure Monitoring Sheet (Cath Lab)

Patient Name	Mrs.LEEMA ROSE A 50/Female/MHI20238106 09/12/2023/IPH20230246	Age / Sex :	
UHID / IP :		Ward Unit :	
Consultant :	Dr.G. GNANAVELU	Diagnosis :	

Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse)

PARAMETERS	YES	NO	NA
Vital signs : BP: 110/60 Temp: 98.1 Pulse: 96 RR: 20 SPO2: 96%	✓		
Urine voided	✓		
Bowel preparation			
Pre-procedure medication administered		✓	
Procedure site marked			
Skin preparation done	✓		
NPO 8.00	✓		
Loose Tooth removed			
Contact lenses / Eye glasses removed			
Prosthesis present			
Jewellery/Nail polish removed			
Checked for Allergies (Drug / food)			✓
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse :	Date & Time : 9/12/23 @ 12.16		

Intra – Procedural Record (To be filled by the Cath Lab Nurse)

Time	HR / min	RR / min	BP mmHg	SpO_2%	Medication / Remarks	Sign. of Nurse
9/12/23 12.35	103 bt/mt	22 br/mt	120/73 (88)	99%	–	
12.50	98 bt/mt	22 br/mt	114/70 (84)	99%	–	
13.00	100 bt/mt	22 br/mt	106/77 (87)	99%	–	
13.15	98 bt/mt	22 br/mt	104/70 (80)	99%	–	
13.30	100 bt/mt	22 br/mt	99/60 (74)	99%	–	
13.45	98 bt/mt	22 br/mt	108/62 (74)	99%	–	
	——	Procedure got over			——	

Post Procedure Follow Up Data (to be filled by the doctor)

Time : 13.50 Route : Rt Radial arterial approach

Complication : Nil

BP : 100/62 (76) mmHg, HR : 104 b/t/mt, RR : 20 b/r/mt, SpO2 : 99%.

~~Distal~~ Brachial Pulse: felt, Puncture Site: no oozing & hematoma

Advise:

- Shift To: Ward / ICU ✓
- Bed rest up to 12 hours
- Observe puncture site for bleeding
- Watch for Pulse in Rt Radial artery.
- Diet DM diet.

- Inform Duty Medical Officer SOS
  a) If patient complains of any Discomfort
  b) If dressing is Loose or Socked with Blood
  c) If limbs are Cold / Absent Pulse
- Remove Rt Radial arterial dressing on 10/12/23 at 19.00 AM /PM after informing to the consultant.
- Special instruction if any: Nil

Dr Logha
Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes :

Procedure PTCA. done. Rt Radial arterial sheath removed. Tight plaster bandage applied. no oozing & hematoma

Condition at the end of procedure : ☑ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☑ CCU ☐ Other _____

Name & Signature of the Nurse :

Date & Time : 9/12/23 @ 13.55

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Pa Mrs.LEEMA ROSE A
Ne 50/Female/MHI20238106
UH 09/12/2023/IPH202302465
DO Dr.G. GNANAVELU
DO
Co

MHI/NUR/2022/053

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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 9/12/23 Time of Arrival: 9.10 Mode of Admission: ☑ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☑ Yes ☐ No If Yes, Name of the Relative: _____

Relationship with Patient: daughter Contact Person's Name: Miss. Reena Relationship: daughter

Contact No.: 8122532721 Primary language spoken: ☑ Tamil ☐ English ☑ Indian ☐ International

Interpreter needed: ☑ Yes ☐ No

Patient status: ☑ Conscious ☐ Unconscious ☐ Disoriented | Patient Vulnerable: ☐ Yes ☑ No

Menstrual History : LMP : _____ Menopause: _____

Medical History : DM / HTN / Co - Morbility : 1 years Yes If yes specify

Drugs History : Antiplatelet _____ (Specify)

Psychological Status: ☑ Calm ☐ Anxious ☐ Withdrawn ☐ Agitated ☐ Depressed ☐ Sleeping Difficulty

Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☑ No

If Yes, specify details: _____

Socio Economic Status: ☐ Employed ☐ Retired ☐ Own Business ☑ Home-Maker ☐ Others: _____

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 95 (beats/min) | BP: 110/80 (mmHg)

Respiration: 20 (breaths/min) | SpO_2: 96 (%) | CBG: 138 (mg/dl) | Height: 145 (cms) | Weight: 40.4 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☑ No ☐ Medication ☐ Blood Transfusion ☐ Food ☑ Not known

If Yes, specify: _____

Pain: ☐ Yes ☑ No. If Yes, Score: 0/10 **Pain Scale Used:** ☐ Wong-Baker FACES Pain Rating Scale (7-12 years)

☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: _____ Location: _____

Pain Character: ☑ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:

Last 3 months Appetite: ☐ Increased ☐ Decreased ☑ No Change

Last 3 months Weight: ☐ Increased ☐ Decreased ☑ No Change

Type of Patient: ☐ Diabetic ☑ Non Diabetic Type of Diet: normal diet

Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: Miss. catherine Time: 10.00

Orient Patient if: ☑ Conscious **Orient Patient Attendant if:** ☐ Unconscious ☐ Disoriented

☑ Room ☑ Side Rails ☑ Toilet Bell ☑ Patient Information Board ☑ Bathroom ☑ Bed Controls

☑ Use of Footstool ☑ Grab Bars ☑ Nurses Call Bell ☑ Television ☑ Light Controls ☑ Telephone

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	☐ Yes ☑ No		
Hearing Impairment	☐ Yes ☑ No		
Chewing Difficulty	☐ Yes ☑ No		
Walking Difficulty	☐ Yes ☑ No		

Daily Activity Of Living:

Activity	Independent	Assisted	Dependent
Bathing	☑	☐	☐
Dressing	☑	☐	☐
Eating	☑	☐	☐
Walking	☑	☐	☐
Toilet Use	☑	☐	☐

Pressure Injury Risk Assessment: Braden Scale

Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	(4)	Rarely Moist	(4)	Walks Frequently	(4)
Slightly Limited	3	Occasionally Moist	3	Walks Occasionally	3
Very Limited	2	Very Moist	2	Chair Fast	2
Completely Limited	1	Constantly Moist	1	Bed Fast	1
Mobility	**Score**	**Nutrition**	**Score**	**Friction & Shear**	**Score**
No Limitation	(4)	Excellent	(4)	No apparent problem	(3)
Slightly Limited	3	Adequate	3	Potential Problem	2
Very Limited	2	Probably In-Adequate	2	Problem Present	1
Completely immobile	1	Very Poor	1		

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

Total Score: 23 Action needed: ☒ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☒ No

If yes, Location: _____ Grade: _____ Size: _____

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

Variables		Numeric Value
History of falling (immediate or within 6 months)	No	(0)
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	(15)
Ambulatory Aid None / Bed Rest / Nurse Assist		(0)
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	(0)
	Yes	20
Gait Normal / Bed Rest / Wheel Chair		(0)
Weak		10
Impaired		20
Mental Status Oriented to own stability		(0)
Overestimated or forgets limitations		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics	No	0
	Yes	(15)
Score Interpretation: *0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk* **Total Score**		30

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

- ☑ Familiarize the patient with the immediate surroundings
- ☑ Remind the patient to use call bell before getting out of bed
- ☑ Keep the two side rails in the raised position at all times for all patients regardless of age
- ☑ Keep the call bell, bedside table, water, glasses within the patient's easy reach
- ☑ Remove excess equipment or furniture to make a clear path
- ☑ Keep the patient's bed in the low position at all times except during procedure
- ☑ Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed
- ☑ Bed wheels should be locked
- ☑ Encourage family participation in the patient's care
- ☑ Ensure that floor of the bathroom is dry and not slippery
- ☑ Review medications for potential side effects that can promote falls
- ☑ Use safety belts during movement in wheelchair
- ☑ The patients are not ambulated by themselves. They are to be ambulated only with assistance

Medium risk interventions (25 - 44)

- ☑ Apply all the low risk interventions
- ☑ Tie yellow fall risk tag in the bed and Wheel chair / Stretcher
- ☑ Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat
- ☑ Use restraints and bed monitors as ordered by the doctor
- ☑ Allow the patient to ambulate only with assistance
- ☑ Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care
- ☑ Do not leave patients unattended in diagnostic or treatment areas
- ☑ Accompany the patient while going to bathroom
- ☑ Advice the patient to use grab bars near the toilet, bathtub, and shower
- ☑ Make sure the family and other visitors understand the restrictions mentioned above

High-risk interventions (above 45)

- ☐ Apply all the low and medium risk interventions
- ☐ Tie red fall risk tag in the bed, wheel chair and stretcher
- ☐ Locate the high-risk patients in a room close to the nurses' station
- ☐ Answer these patients call bells as quickly as possible
- ☐ Provide a commode at bedside (if appropriate)
- ☐ Urinal / bedpan should be within easy reach (if appropriate)
- ☐ Encourage family members or other visitors to stay with them
- ☐ If appropriate, consider using protection devices: safety belts

Initial Assessment to Special Needs and Vulnerability of Patient:

	Yes	No	Remarks *(please specify)*
Terminally ill patients		✓	
Patients with intense chronic pain		✓	
Woman in labor or experiencing termination of pregnancy		✓	
Patients with emotional or psychological distress		✓	
Patient suspected of drug or alcohol dependency		✓	
Victims of abuse and neglect		✓	
Patients whose immune system is compromised		✓	
Patient with infections and communicable diseases		✓	
Does the patient have implants		✓	
Has tracheotomy been done		✓	
Has colostomy been done		✓	
Any other potential needs of the patient		✓	

DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

S. No.	Parameters	Yes / No	Score
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	☐ Yes ☑ No	
2	Bedridden recently >3 days or major surgery within four weeks	☐ Yes ☑ No	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	☐ Yes ☑ No	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	☐ Yes ☑ No	
5	Entire leg swollen (Assess for both legs)	☐ Yes ☑ No	
6	Localized tenderness along the deep venous system (Assess for both legs)	☐ Yes ☑ No	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	☐ Yes ☑ No	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	☐ Yes ☑ No	
9	Previously documented DVT (Assess for both legs)	☐ Yes ☑ No	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	☐ Yes ☑ No	

Risk Score Interpretation (Probability of DVT): **Final Score**

Tick the score obtained (✓)

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**		Low	9/12/22	9.10
Moderate Risk	**1 to 2**				
High Risk	**3 to 8**				

Personal Belongings / Valuables:

Valuables	Description	With Patient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant	Remarks
Dentures	☐ Upper ☐ Lower ☐ Both ☑ Nil				
Hearing Aid	☐ Right ☐ Left ☑ Nil				
Eye glasses / Contact lens	☐ Yes ☑ No				
Jewellery	☐ Yes ☑ No				
Other valuables *(specify)*					

Report (List of X-ray, ECG, lab reports retained with the nurse): _____

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	Roy.A	Reena.A	*Relationship* daughter	9/12/22	9.10
Nurse	A. Smith	A. Smithe	0222	9/12/22	9.10
Unit In-Charge	Nair	L. Nalini	0024	9/12/22	9:30

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NABH ACCREDITED

Pat Mrs.LEEMA ROSE A
Na 50/Female/MHI20238106
UH 09/12/2023/IPH20230246
DO Dr.G. GNANAVELU
DO
Co

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: AWMI, SHTN, DM
GCS: 15/15
NEWS / PEWS Score: 0
POD: —
Ventilator day: —
Central line days: —
Peripheral line day: Right: Left: —
Ryle's Tube: ☐ Yes ☑ No Day: —
VIP Score: —
Urinary Catheter: ☐ Yes ☑ No Day: —
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —

B

BACKGROUND

Type of surgery: —
Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: Room Air
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 96 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/80 (mmHg) | SpO_2: 96 (%) | Height: 145 (cms) | Weight: 40.4 (kgs) | BMI: 19.2 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 30 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Normal diet
Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: } Nil
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No If Yes, modified care plan date: —
Pending follow-up orders: —
Special instructions if any: Today Plan PTCA

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Anitha	0022	9/12/23	12.15
Handover taken by		Ramachandran	0156	9/12/23	12.15
Document endorsed		R. Nalini	0084	9/12/23	13.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Morning duty notes	
9/12/23		
⇒ 9.00	⇒ patient Admitted in IInd FLOOR	
	⇒ Patient conscious and oriented	Ai 0224
10.00	⇒ Medication given as per drug chart	
	⇒ Pt vital signs checked & recorded	
11.00		Ai 0224
	⇒ Pt NPO: 8.00 Clock	
	⇒ Today Plan PTCA	
11.30	⇒ I/o chart monitoring	
	⇒ preparation done	
	⇒ constent done	
12.00	⇒ Pt hand over given to cath Lab staffs	Ai 0224

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nur	S. Nalini	0084	9/12/23	13:00

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9-12-23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: AWMI/T2DM/SHTN/MILD LVD GCS: 15/15

NEWS / PEWS Score: — POD:

Ventilator day: — Central line days: 0/15

Peripheral line day: Right: Left: cephalic

Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: —

Urinary Catheter: ☐ Yes ☑ No Day:

Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —

B

BACKGROUND

Type of surgery: PTCA — LAD Date of surgery: 9/12/23

Allergies if any: NKAD

On room air / oxygen: RA IV fluids on flow: IVF NS 30ml/hr.

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp 98.4 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 24 (breaths/min)

BP: 108/73 (mmHg) | SpO_2: 94 (%) | Height: 145 (cms) | Weight: 40.4 (kgs) | BMI: 19.2 kg/m²

Others : —

Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 39 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High

Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA

Current diet: Diabetic diet Drains: —

R

RECOMMENDATION

Referral doctors: —

Pending medications: —

Pending medication indent: —

Pending lab reports / Investigations: -

Critical value alert and its corrections: —

Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: —

Pending follow-up orders: —

Special instructions if any: urea, creatine tomorrow, wound dressing tomorrow plan, screening Echo.

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Aarthi	0282	9/12/23	19:30
Handover taken by	[signature]	Madhumitha	0244	9/12/23	19:45
Document endorsed	[signature]	S. Nalini	0084	9/12/23	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/12/23 14.30	EVENING DUTY REPORT Patient Received from cathlab. Patient is conscious & oriented pt vitals are monitoring. Rt Radial approach.	
15.00	pt tree oral liquid there is no any issues.	
16.00	pt on continuous cardiac monitoring.	
17.30	pt had complaint of pain & hematoma. So Rt puncture side inform to Dr. Anish. Advised to applied Ice bag application. Inform to cathlab staff.	
18.00	loose the dressing, mild reduce the hematoma.	
19.30	pt vitals are monitoring pt Report hyo to night duty SIN.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0024	9/12/23	20:30

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/12/23. Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

Diagnosis: AWMI | T2DM | SHTN
GCS: 15/15
NEWS / PEWS Score: —
POD: —
Ventilator day: —
Central line days: —
Peripheral line day: Right: — Left: brachial metacarpal
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/1
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B — BACKGROUND

Type of surgery: PTCA to LAD
Date of surgery: 9/12/23
Allergies if any: NKAP
On room air / oxygen: on Room air
IV fluids on flow: RVF - NS - 30cc/hr
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp 97.7°F | Pulse / HR: 80 (beats/min) | Respiration: 24 (breaths/min)
BP: 117/64 (mmHg) | SpO_2: 94 (%) | Height: 145 (cms) | Weight: 40.4 (kgs) | BMI: 19.2 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: NIL
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: _____
Pending follow-up orders: —
Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by		Madhumitha	0884	10/12/23	8.00
Handover taken by		Ranja. R	0159	10/12/23	8.00
Document endorsed	Nalini	S. Nalini	0084	10/12/23	8.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/12/23 @19.45	Pt hand over taken from evening duty staff. Pt was hemodynmically stable. Pt on room air. Pt PTCA to LAD was done. (R) Radial approach Pressure bandage Present. Procedure site no oozing and hematoma. IVF-NS-30cc/hr on flow.	D2HH.
20.10	Pt Oral dinner taken.	
20.40	Pt medication given as per drug chart.	D2HH
21.30	GIB Dr. Anish.	
23.00	Pt was sleeping	
2.00	Pt V/S are checked and recorded.	D2HH
4.00	Morning sample taken.	
5.00	Morning care given.	
6.00	ECG and CBG taken.	
4.00	Pt I/O was maintained	
4.30	Pt hand over to Morning duty staff	D2HH.

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Na	S. Nalini	0084	10/12/23	8:00

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: AWMI | MILD LV DYSFUNCTION | T2 DMD / SHTN
GCS: 15/15
NEWS / PEWS Score:
POD: —
Ventilator day:
Central line days: —
Peripheral line day: Right: — Left: Metacarpal
Ryle's Tube: ☐ Yes ☑ No Day: —
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day: —
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: PTCA + TO LAD
Date of surgery: 9/12/23
Allergies if any: NKDA
On room air / oxygen: R.A - 99%
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.4 °F) | Pulse / HR: 95 (beats/min) | Respiration: 16 (breaths/min)
BP: 129/89 (mmHg) | SpO_2: 99 (%) | Height: 165 (cms) | Weight: 60.9 kgs) | BMI: 19.9 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: ⇒ DM diet
Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: NIL
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☐ No. If Yes, modified care plan date: —
Pending follow-up orders: —
Special instructions if any: Pt Shifted to ward @ 13.00

	Signature	Name	Emp. No.	Date	Time
Handover given by		Dayalan R	0187	10/12/23	13.00
Handover taken by		A. Nandhini	0170	10/12/23	13.00
Document endorsed		E. Nalini	0084	10/12/23	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/12/23 @ 8.00	MORNING DUTY NOTES	
	→ pt taken over from night duty staff, pt on conscious & oriented, VIS checked & recorded IV line patent PCI+LAD (R) radial approach pressure bandage (P) no oozing & hematoma no complaints	[signature]
8.30	→ pt had breakfast done medication given as per drug chart	
9.00	→ pressure bandage (R) IV line removed	[signature]
	→ pt today ward shifted plan, urea, creatinine (P) collected	
9.40	→ DR. SHIVA SIR order to icepack done, T. dolo 650 mg T.IVABRED 5mg pt on oral given → pt no complaints	[signature]
13.00	→ pt handing over to ward staff	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	6024	10/12/23	13:00

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50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: DWMI | MILD LV DYSFUNCTION GCS: 15/15
NEWS / PEWS Score: – POD: –
Ventilator day: Central line days: –
Peripheral line day: Right: – Left: Metacarpal
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score 0/5.
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: PRO PTCA - LAD Date of surgery: PRO 9/12/23
Allergies if any: NKDA
On room air / oxygen: on Room Air IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 79 (beats/min) | Respiration: 20 (breaths/min)
BP: 105/77 mmHg) | SpO_2: 97 (%) | Height: 115 (cms) | Weight: 10.8 (kgs) | BMI: 19.2 kg/m²
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: Diabetic diet Drains: –

R — RECOMMENDATION

Referral doctors: Nil
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: –
Pending follow-up orders: –
Special instructions if any: To do Screening FCho tomorrow

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Nanthini	0170	10/12/23	19.30
Handover taken by		A. ALBINA	0088	10/12/23	9.30
Document endorsed	Nurse	S. Nalini	0024	10/12/23	20.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/12/23 @ 13.00	Evening duty Notes → Patient taken over from on Staff Nurse → Patient Conscious & oriented → Patient vital Signs Checked & Recorded	
14.00	→ Medication given as per drug Chart → Patient Mobilized well → Patient I/o Chart Monitored	
18.30	→ Patient vital Signs Checked & Recorded	
19.30	→ Patient handing over to Night duty Staff Nurse.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nag	E. Nalini	0024	10/12/23	20.00

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/12/23 Shift: ☐ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: AWMI / MILD LV DYSFUNCTION GCS: 15/15
NEWS / PEWS Score: 00 POD: —
Ventilator day: — Central line days: —
Peripheral line day: Right: — Left: METACARPAL
Ryle's Tube: ☐ Yes ☑ No Day: — VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day: —
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: — Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: ON ROOM AIR IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 22 (breaths/min)
BP: 130/90 (mmHg) | SpO_2: 97 (%) | Height: 145 (cms) | Weight: 44 (kgs) | BMI: 23.2 kg/m²
Others : NIL

Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ No ☐ NA Wound Dressing done: ☐ Yes ☑ No ☐ NA
Current diet: NORMAL DIET Drains: —

R

RECOMMENDATION

Referral doctors: —
Pending medications: —
Pending medication indent: —
Pending lab reports / Investigations: —
Critical value alert and its corrections: —
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: _____
Pending follow-up orders: —
Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0082	10/12/23	7.00
Handover taken by		S. Dawathachini	021	10/12/23	7.30
Document endorsed		S. Nalini	0084	10/12/23	8.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/12/23	NIGHT DUTY NOTES	
19:00	Patient handovers taken from the evening duty staff. Patient is stable	0084.
20:00	Due medications are given to the patient	0084
22:00	vitalsigns are checked & recorded	0084
2:00	I/o chart is maintained	0084
7:00	Patient handovers given to the morning duty staff	0084

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	L. Nalin	0084	11/12/23	8:00

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09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: AWMI / mild LD GCS: 15/15

NEWS / PEWS Score: — POD: —

Ventilator day: Central line days: —

Peripheral line day: Right: Left: D3

Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/—

Urinary Catheter: ☐ Yes ☑ No Day:

Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: — Date of surgery: —

Allergies if any: NKDA

On room air / oxygen: RA IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/80 (mmHg) | SpO_2: 98 (%) | Height: 145 (cms) | Weight: 40.4 (kgs) | BMI: 23.2 kg/m²

Others :

Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High

Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA

Current diet: DM Diet Drains: —

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations: } nil

Critical value alert and its corrections:

Changes in nursing care plan: ☐ Yes ☐ No. If Yes, modified care plan date: ______

Pending follow-up orders: —

Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by	S. [signature]	S. Devadharshini	0212	11/12/23	12-2?
Handover taken by	—	Discharged —			
Document endorsed	[signature]	S. Nalini	0024	11/12/23	18:50

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12/12/23	Morning Duty Notes	
7.30	⇒ Pt handing over taken from night duty staff.	
	⇒ Pt conscious oriented.	S. D.
	⇒ Pt V/s & I/O chart checked & recorded.	
8.00	⇒ Pt Due medication given.	
	⇒ Pt 5. Echo today Done.	
12.00	⇒ Pt V/s & I/O Chart Checked & recorded.	S. D. 12/12
12.30	⇒ Pt handing over given to evening duty staff	
	Discharge Summary	
11/12/23 @ 18.30	⇒ patient today plan discharge.	
	⇒ patient conscious & oriented.	
	⇒ patient vital Signs Checked & Recorded	
	⇒ patient IV line & IJD Removed	
	⇒ patient all reports handing over to patient & patient attender	

Document endorsed by:	Signature	Name	Emp. No.	Date	Time
	Nalini	S. Nalini	0024	11/12/23	20:00

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ADULT NURSING CARE PLAN

Patient Name	Mrs.LEEMA ROSE A
	50/Female/MHI20238106
UHID	09/12/2023/IPH202302465
DOA	Dr.G. GNANAVELU

MHI/NUR/2022/044

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Initial Date: 9/12/23 Time: 8:00	Modified Date: Time:
Reason for Modification:	Diagnosis: AWMI / T2DM / SHTN

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had Ⓡ diet	[signature] 0212
			E pt had diet	[signature] 0282
			N pt had Ⓡ diet	[signature]
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt is on Room Air	[signature] 0212
			E pt maintain on RA	[signature] 0282
			N Pt on Room Air. Spo2 96%.	[signature]
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O chart monitored	[signature] 0212
			E pt I/O chart maintain	[signature] 0282
			N Pt I/O Chart. Maintain	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☑ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt mobilized well E pt mobilized to bed N Pt mobilized to bed	08/22 08/22 08/22
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☑ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt self voided E Pt self voided N Pt self voided.	08/22 08/22 08/22
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M maintain normal skin integrity E pt Maintain skin integrity N Pt maintain skin Integrity	08/22 08/22 08/22

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☑ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☑ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☑ Encourage patient to do daily bathing and oral hygiene ☑ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt well groomed E Pt well groomed N Pt well groomed	[signature] [signature] [signature]
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☑ Patient will have no life-threatening situations	☑ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M ID band present E Pt ID band (+) N Pt ID band (+)	[signature] [signature] [signature]
COMFORT AND SLEEP ☑ Pain Control ☑ Sleep Patterns ☐ Others:	☑ Patient will have comfortable sleep ☑ Patient will verbalize / or through behavior about pain relief and adequate sleep	☑ Provide clean calm and restful environment ☑ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M Provided comfortable position E Pt comfortably N Pt comfortable position	[signature] [signature] [signature]
OBSERVATION ☑ Vital Signs ☑ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M V/s checked & recorded E Pt vitals are checked & monitor. N	[signature] [signature]
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☑ Spiritual Needs ☑ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☑ Patient will achieve spiritual needs ☑ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☑ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E — N —	—

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☑ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt good communicated E Pt maintain well communication N Pt good communication	
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Medication given as per drug chart E Pt Medication as per drug chart N Pt Medication as per drug Chart.	

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nal	S. Nalini	0024	9/12/23	20:00

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ADULT NURSING CARE PLAN

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 10/12/23 **Time:** 8.00. **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** AWMI / MILD LVD / T2DM / SHTN

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M → Pt on DM diet E Pt on DM Diet N Pt On Dm diet	
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M → Pt on room air - 99 E Pt on Room air N Pt on Room Air.	
FLUID & ELECTROLYTES ☐ Oral ☑ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M → Pt on I/O chart maintained E I/o chart maintained N I/O Chart maintained.	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt on bed rest E Pt slowly mobilized N Pt mobilise safely.	
ELIMINATION ☐ Catheter, bedpan, urinal ☑ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M → pt on (N) elimination pattern E pt self voided N Pt Self Voided.	
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M → pt on (N) skin Integrity E Pt (Rt) hand hematoma (Fe) N Pt (Rt) hand Healed (Fe).	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt on stay clean well groomed E Pt well groomed N Pt on will Stay	
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M Pt on check ID band (+) E ID band (+) N ID band (+)	
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E — N —	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Pt on VS checked recorded E Vitals are checked N Vital Sign Chart.	
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E — N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt can have good communication E Pt well communicated N Pt have Communi	
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Medication given as prescribed E Due medication was given N	

	Signature	Name	Emp. ID	Date	Time
Endorsed by		S. Nalini	0084	10/12/23	18:00

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ADULT NURSING CARE PLAN

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 11/12/23 **Time:** 4:00 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** PTCA - LAD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt had DM Diet E N	5
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on Room air E N	5
FLUID & ELECTROLYTES ☐ Oral ☑ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt I/O chart maintained E N	5

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt mobilized well E N	5.
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☑ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt Self Voided E N	5
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M — E N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☑ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt good hygiene maintained E N	S.D.
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☑ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M Pt ID Band checked E N	S.D.
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E N	
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Pt VIs checked & Recorded E N	S.D.
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt Communication well E N	S.D
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Pt Due Medication given E N	S.D

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nale	R. Nalini	0024	11/12/23	14:00

MHI/NUR/2022/045

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NABH ACCREDITED

Patient Name: Mrs.LEEMA ROSE A
50/Female/MHI20238106
09/12/2023/IP:H20230246
Dr.G. GNANAVELU

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 9 | 12 | 23
Time: M | E | N

					M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	1
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	3	3
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	23	19	15
				Initial & Emp. No. of Staff Nurse:	[illegible] 622	[illegible] 0282	[illegible]
Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**	[illegible] 24	[illegible] 24	[illegible] 24

S.No. : 22

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NABH ACCREDITED

Mrs. LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 10	12	23
					Time: M	E	N.
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	3	3	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	3	3
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	3	3	3
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	3
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	19	19	18
				Initial & Emp. No. of Staff Nurse:	[illegible]	[illegible]	[illegible]
				Initial & Emp. No. of Sr. Staff Nurse:	[illegible]	[illegible]	[illegible]

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

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NABH ACCREDITED

Patient Name: [redacted]
L..D:
DOB:
DOA:
Consultant:

Mrs. Leema rose
50y IP 2023816 64
20230 2465

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

				Date:	11	12	23
				Time:	4	12	21

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4		
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4		
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4		
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3		
				TOTAL SCORE	23		
				Initial & Emp. No. of Staff Nurse:	[illegible]		
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6				**Initial & Emp. No. of Sr. Staff Nurse:**	[illegible] 24		

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MHI/NUR/2022/052

Patient Name: Mrs. LEEMA ROSE A
50/Female/MHI20238106
UHID: 09/12/2023/IPH20230246
DOB:
DOA: Dr G. GNANAVELU
Cons

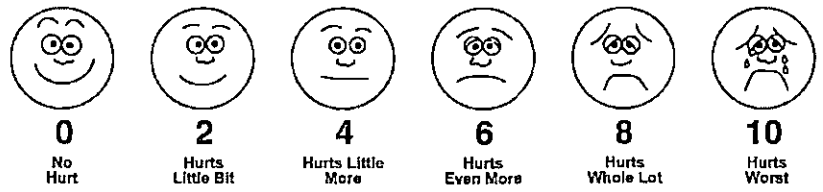
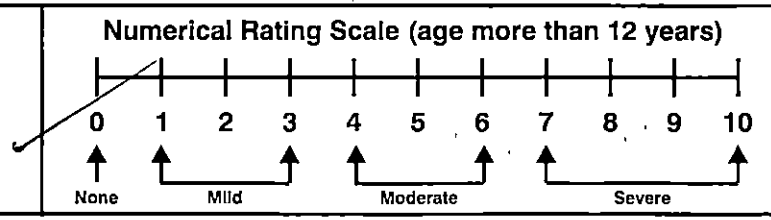
Medway Heart Institute
very heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9.00	0/10	no pain	—	—	—	0224	Nas 0024
		Patient Received from cathlab @ 14.30					
14.30	0/10	No pain	—	—	—	0282	Nas 0024
15.30	0/10	No pain	—	—	—	0282	Nas 0024
16.30	0/10	No pain	—	—	—	0282	Nas 0024
17.30	0/10	No pain	—	—	—	0282	Nas 0024
18.30	0/10	No pain	—	—	—	0282	Nas 0024
19.30	0/10	No pain	—	—	—	0282	Nas 0024
20.30	0/10	No Pain	—	—	—	0224	Nas 0024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9/12/23 21:30	0/10	NO Pain	-	-	-	02HH	024
22.30	0/10	NO Pain	-	-	-	02HH	024
23:30	0/10	NO Pain	-	-	-	02HH	024
10/12/23 00.30	0/10	NO Pain	-	-	-	02HH	024

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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NABH ACCREDITED

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/052

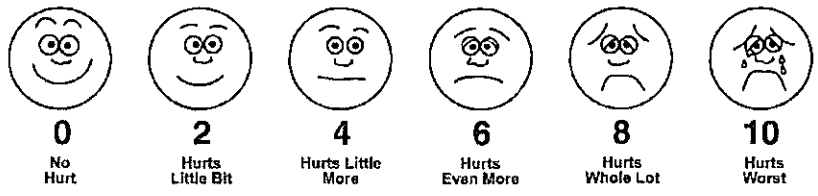
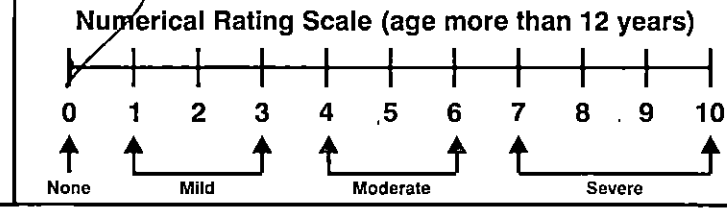
Medway Heart Institute
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10 12/23 1.30	0/10	NO Pain	—	—	—	02HH	Nurse 024
2.30	0/10	no Pain	—	—	—	02HH	Nurse 024
3.30	0/10	no Pain	—	—	—	02HH	Nurse 024
4.30	0/10	no Pain	—	—	—	02HH	Nurse 024
5.30	0/10	no Pain	—	—	—	02H H	Nurse 024
6.30	0/10	no Pain	—	—	—	02HH	Nurse 024
7.30	0/10	no Pain	—	—	—	02HH	Nurse 024
8.30	0/10	NO pain	—	—	—		Nurse 024
9.30	0/10	NO pain	—	—	—		Nurse 024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10.30	0/10	no pain	—	—	—		Nad 024
11.30	0/10	no pain	—	—	—		Nad 024
12.30	0/10	no pain	—	—	—		Nad 024
16.30	0/10	no pain	—	—	—		Nad 024

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (Intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/NUR/2022/052

Medway Heart Institute
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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
20.30	0/10	No pain	—	—	—	0088	Nag 0024
0030	0/10	No pain	—	—	—	0088	Nag 0024
4.30	0/10	No pain	—	—	—	0088	Nag 0024
8.30	0/10	No pain	—	—	—	0088	Nag 0024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
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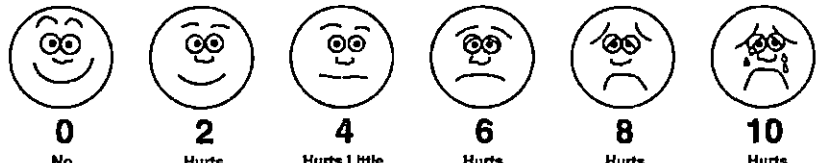
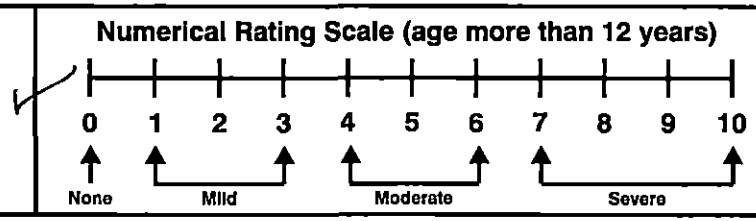
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (Intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-Intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
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Pharmacological Interventions as per doctor's prescription	

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Patient Details
Name: Mrs.LEEMA ROSE A
UHID: 50/Female/MHI20238106
DOB: 09/12/2023/IPH202302465
DOA: Dr.G. GNANAVELU
Consult:

MHI/NUR/2022/047

Medway Heart Institute
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DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

	Date	9/12/23	10/12/23	11/12/23				
	Time	9.00	8.00	6.00				
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0				
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0				
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0				
5	Entire leg swollen (Assess for both legs)	0	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0				
9	Previously documented DVT (Assess for both legs)	0		0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (*commonly mistaken as DVT*), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0 6	0				
	FINAL SCORE	0	0	0				
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low	Low	Low				
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

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(A Unit of United Alliance Healthcare Pvt Ltd)

NABH ACCREDITED

Patient Name: Mrs.LEEMA ROSE A
Patient ID: 50/Female/MHI20238106
Date: 09/12/2023 / IPH20230246
UHID: Dr.G. GNANAVELU
DOB:

Medway Heart Institute
em heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	9/12/23	9/12/23	9/12/23	10/12/23	10/12/23	10/12/23	11/12/23		
		Time	8.00	14.30	20.00	8.00	14.00	20.00	8.00		
History of falling (immediate or within 6 months)	No		0	0	0	0	0	0	0	0	0
	Yes		25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No		0	0	0	0	0	0	0	0	0
	Yes		20	20	20	20	20	20	20	20	20
AMBULATORY AID											
None / Bed Rest / Nurse Assist			0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker			15	15	15	15	15	15	15	15	15
Furniture			30	30	30	30	30	30	30	30	30
GAIT											
Normal / Bed Rest / Wheel Chair			0	0	0	0	0	0	0	0	0
Weak			10	10	10	10	10	10	10	10	10
Impaired			20	20	20	20	20	20	20	20	20
MENTAL STATUS											
Oriented to own stability			0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations			15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Total Score			30	45	50	50	50	50	30		
Low Risk (0 - 24)											
Medium Risk (25 - 44)			✓								
High Risk (45 or above)				✓	✓		✓	✓			
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN			Nur 24	Nur 24	Nur 24	Nur 24	Nur 24	Nur 24	Nur 24		

0 - 24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

INTERVENTIONS *Tick as per the Risk Score*	Date	9/12/12	9/12/12	9/12/12	10/12/12	10/12	10/12	11/12		
	Time	9.00	14.30	8.00	8.00	14.00	20.00	8.00		
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	—	✓		✓	—	✓		
Remind the patient to use call bell before getting out of bed		✓	✓	✓		✓	✓	✓		
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓		—	✓	✓		
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓		✓	✓	✓		
Remove excess equipment or furniture to make a clear path		✓	✓	✓		✓	✓	✓		
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓		✓	—	✓		
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓		✓	✓	✓		
Bed wheels should be locked		✓	✓	✓		✓	✓	✓		
Encourage family participation in the patient's care		✓	✓	✓		✓	✓	✓		
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓		✓		✓		
Review medications for potential side effects that can promote falls		✓	✓	✓		✓	✓	✓		
Use safety belts during movement in wheelchair		✓	✓	✓		✓	✓	✓		
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓		✓		✓		
Medium risk interventions (25 - 44)										
Apply all the low risk interventions			✓	✓		✓	✓	✓		
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher			✓			✓		✓		
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat			✓			✓		✓		
Use restraints and bed monitors as ordered by the doctor			✓			✓	✓	✓		
Allow the patient to ambulate only with assistance			✓			✓		✓		
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care			✓			✓	✓	✓		
Do not leave patients unattended in diagnostic or treatment areas			✓			✓	✓	✓		
Accompany the patient while going to bathroom			✓			✓	✓	✓		
Advice the patient to use grab bars near the toilet, bathtub, and shower			✓			✓		✓		
Make sure the family and other visitors understand the restrictions mentioned above			✓			✓	✓	✓		
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions			✓			✓	✓	✓		
Tie red fall risk tag in the bed, wheel chair and stretcher			✓			✓	✓	✓		
Locate the high-risk patients in a room close to the nurses' station			✓			✓		✓		
Answer these patients call bells as quickly as possible			✓			✓	✓	✓		
Provide a commode at bedside (if appropriate)			✓			✓	✓	✓		
Urinal/bedpan should be within easy reach (if appropriate)			✓			✓		✓		
Encourage family members or other visitors to stay with them			✓				✓	✓		
If appropriate, consider using protection devices: safety belts			✓			✓	✓	✓		
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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Patie: Mrs.LEEMA ROSE A
Nami: 50/Female/MHI20238106
UHID: 09/12/2023/IPH202302469
DOB: Dr.G. GNANAVELU
DOA:
Consl.....

MHI/IP/2022/055

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PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☐ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☑ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to	☐ Low motivation / desire to learn	☐ Written Instuctions
understand and follow directions		

Completed By : Date 9/12/23 Time 9:00 Nurse Signature :

Learning Record

Need	Date 9/12/23	Visit 1 L	P	O	Date 10/12/23	Visit 2 L	P	O	Date 11/12/23	Visit 3 L	P	O	Signature
Disease													Doctor
☐ Information on Disease / Diagnostics		P	D	V		P	D	V		P	D	J	18/1100
☑ Treatment		P	D	V		P	D	V					
Medications		P	D	V						P	D	J	Doctor / Nurse
☑ Information on Safe and Effective use of medicines		P	D	V									
☐ Information on drug / drug and drug / food interactions										P	D	J	
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)										P	D	J	
Pain Management													Nurse
☑ Reporting of pain		P	D	V									
☑ Pain Management		P	D	V									
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Post-A

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☑ Diet Instruction for patients at Nutritional risk		plan	V			–	–	–		plan	V		Maria Catherine John Senior Dietitian
☑ Diet advice for home		–	–	–		–	–	–		plan	V		Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other_____(State Relationship)

PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material

OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written Material given and explained (if any)

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	✓			Diet Advice	✓		
ECG Report	✓			CT Scan Report			
Doppler Report				CT Scan Film		✓	
X-Ray Report		✓		ECHO Report	✓		
X-Ray Film	✓			Ultrasound Report			
Compact Disk				Any Other Report			

Name of Attendant / Patient : Ray A Signature :_____

Name of Discharge Nurse A. Nandhini Signature :

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Patient Name: Mrs.LEEMA ROSE A
50/Female/MHI20238106
UHID: 09/12/2023/IPH20230246
DOB: Dr.G. GNANAVELU
DOA:
Consult

MHI/ICU/2022/056

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Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 9/12/23 Time: 9.00

Checklist	Yes	No	NA	Action / Remarks
MEDICAL				
Daily Consultant Visit	✓			
Plan of care discussed	✓			
Discharge Planning				
Others if any				
NURSING				
Safety Precautions Ensured	✓			
Care of Lines and Tubes	✓			
Infection Control Measures	✓			
Skin Care	✓			
Response to assistance				
Others if any				
DIETICIAN				
Diet Adequate	✓			
Special Request	✓			
PHYSIOTHERAPIST				
Available for Assistance for Activities of Daily Living				
Others if any				
PATIENT CARE SERVICES				
Room Cleaning satisfactory				
Room Amenities Adequate				
Billing Update available				
Non-Availability of any service				
Spiritual Needs (if yes specify)				
Others if any				

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor	N. J A S	Dr. Hari Vignesh	181100	9/12/23	9AM
Nursing Staff	A	A. Anitha	0122	9/12/23	9.00
Dietician		Maria Catherine John Senior Dietitian	2401	9/12/23	12.00
Physiotherapist					
Patient Care Service Staff					

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/IP/2022

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FAMILY COUNSELLING FORM

CONSULTANT- DR. Gnanavelu | DIAGNOSIS- AWMI/MLD IVD/TDM/SHTN

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
9/12/23	DOCTOR	Husband	family updated as no emergent condition			
10/12/23	DOCTOR	HUSBAND	pt condition explained to family			9/12/23

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

MHI/IP/2022/054

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IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 10/12/23 Time: 13:00 Transferred from: CCU To: Gen-2

Diagnosis: Recent AWMI / Mild LV D / T2DM / SHT.

Vital Signs: Temp: 98.4(°F) | Pulse / HR: 91 (beats/min) | BP: 130/79 (mmHg) | Respiration: 19 (breaths/min)

Part B *(to be filled by Physicians)*

Any Critical Investigations:

Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	☑ Clear ☐ Crepitation ☐ Rhonchi ☐ Others:	☑ Yes ☐ No
Abdomen	☑ Soft ☐ Tender ☐ Distended ☐ Others:	☑ Yes ☐ No
Heart Sound	☑ Normal ☐ Feeble ☐ Loud ☐ Others:	☑ Yes ☐ No
CNS	☑ Conscious ☑ Oriented GCS Score: 15/15	☑ Yes ☐ No
For Surgical Patients (if applicable)	*Surgical Site:* ☐ Healthy ☐ Soakage ☐ Others:	☑ Yes ☐ No

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. ATACAR	90mg	PO	1-0-1	10/12/23@8:00	☐ Yes ☐ No
2	T. ASPIRIN	75mg	PO	0-1-0	"	☑ Yes ☐ No
3	T. PAN	40mg	PO	1-0-1	"	☐ Yes ☐ No
4	T. TRIMETAZIDINE	20mg	PO	1-0-1	"	☐ Yes ☐ No
5	T. ENALAPRIL	2.5mg	PO	1-0-1	"	☐ Yes ☐ No
6	T. METOPROLOL	25mg	PO	1-0-1	"	☐ Yes ☐ No
7	T. Glyceryl trinitrate	2.6mg	PO	1-0-1	"	☐ Yes ☐ No
8	T. Atorvas	20mg	PO	0-0-1	"	☐ Yes ☐ No
9	T. NICORAN	5mg	PO	1-0-1	"	☐ Yes ☐ No
10	T. ALPRAX	0.25mg	PO	0-0-1	"	☑ Yes ☐ No
11	T. DOLO	650mg	PO	1-1-1	"	☐ Yes ☐ No
12	T. INSPIRE	5mg	PO	1-0-1	"	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

—

Patient Condition: ☑ Stable ☐ Sick-need urgent care ☐ Others: _____

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		Dr. K. Anusuya	91810	10/12/23	13:00
Receiving Doctor		Dr. K. Anusuya	134559		13:00

Part C ***(to be filled by Nurses)***

Check for	Transferring Nurse	Receiving Nurse
Drains	☐ Chest ☐ Abdominal ☑ Others: _____	☑ Yes ☐ No
Respiratory	Air Way Type: ☐ Patent ☐ Tracheostomy ☐ Others: _____ Oxygen Therapy: ☑ No ☐ Yes via: _____ Rate: _____ li/min	☑ Yes ☐ No
NG Tube / Oral	☐ Yes ☑ No ☐ For Feeding ☐ Gastric Suction ☐ Fluid Restriction	☑ Yes ☐ No
Foley's Catheter	☐ Yes ☑ No	☑ Yes ☐ No
Intravenous Access	☑ Peripheral Line ☐ Central Venous Line ☐ Others: _____	☑ Yes ☐ No
Pressure Injury	☐ Yes ☑ No If Yes, give details: _____	☑ Yes ☐ No
Score	Fall Risk: WELLS: NEWS / PEWS:	☑ Yes ☐ No
Patient Belongings	☐ Yes ☑ No If Yes, give details: _____	☑ Yes ☐ No
Handover Details	Medication Administration Record explained: ☐ Yes ☐ No Lab & Diagnostic Reports handed over: ☑ Yes ☐ No	☐ Yes ☐ No
Patient Attendant Informed	☐ Yes ☐ No If No, give details: _____	☑ Yes ☐ No

Additional Details *(if any)*:

—

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		Sonya R	0151	10/12/23	18
Receiving Nurse		B. Vanisri	0195	10/12/23	13.00

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

HOME MEDICATION USAGE FORM

Allergies: NKDA.

Diagnosis: Recent AWMI / Mild LV dysfunction / T2DM / SHTN

Prescribed drug name	Medication name brought by Patient/ Attender	Dose	Freq.	Qty.	Batch No. & Expiry date
T. Axcer	T. Axcer	90mg	BD	8	GTE1662A 4/26
T. Aspirin	T. Ecosprin	75 mg	OD	13	04609769 4/25
T. Pan	T. Pantoprazole	40mg	BD	10	0024 B/25
T. Trimetazidine	T. Thremidon	20mg	BD	10	TDN23005 6/26
T. Enalapril	T. Enam	5 mg	½-0-½	11	V23009T5 4/25
T. Metoprolol	T. Metloc ER	25mg	BD	10	MER2163D 5/25
T. Atorvas	T. Atorvastatin	20mg	OD	10	HSTA10 4/25
T. Foxiga	T. Foxiga	5mg	OD	12	FF2308 1/26

<25°C

	Signature	Name	Emp. No.	Date & Time
Doctor		Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	9/12/23 @ 15:31
Clinical Pharmacist		Anisha	0151	9/12/23 @ 15:24

This is to certify that, I take full responsibility of the quality and potency of the medications that I have brought to the hospital. Medications that I have got are stored with proper medication storage recommendation given by the manufacturer (Room temperature (below 25°C) or Fridge temperature (2°- 8°C)). Any Adverse effects that is caused or effects that affects my recovery due to improper storage condition of medications that I have got from home, will be under my responsibility. I am aware that several medications that are available in Indian and International market are spurious and bogus which can cause harm to my health. I assure that Medway Hospitals or its employees will not be held responsible for any outcome/ results in the future.

	Signature/ Thumb impression	Name	Date	Time
Patient	A Leema Rose	A. Leema Rose	9/12/23	15:28
Guardian		(Name and Relationship with the Patient)		

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff		Aarthi	9/12/23	15:30

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME: Mrs.LEEMA ROSE A
50/Female/MHI20238106-1
AGE / SEX: 09/12/2023/IPH202302465
Dr.G. GNANAVELU

IP No. / UHID No

Ward / Bed No.

JLD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
9/12/23	8:00	Rt CUBITAL	0/5	Patent	flushed	followed	
	14:30	Cubital	0/5	Patent	flushed	followed	
	20:00	Cubital	0/5	patent	flushed	followed	
10/12/23	8.00	cubital	0/5	patent	flushed	followed	
		← IV	line	Removed		@ 9.30 ←	
9/12/23	8:00	Rt Peripheral	0/5	patent	flushed	followed	
	14:30	Rt Cephalic	0/5	patent	flushed	followed.	
	20:00	Rt Cephalic	0/5	patent	flushed	followed	
10/12/23	8.00	Rt cephalic	0/5	patent	flushed	followed	
	14:30	Lft cephalic	0/5	patent	flushed	followed	
	20:00	Lft Cephalic	0/5	patent	flush	followed	
11/12/23	8.00	Lft cephalic	0/5	Patent	flushed	—	
		—				—	
				IV line Removed			

MHI/PHARM/2022/028

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NABH ACCREDITED

Mrs.LEEMA ROSE A
50/Female/MH120238106
09/12/2023/IPH20230246
Dr.G. GNANAVELU

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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 **of** 1 **Height (cms):** 145cm **Weight (kg):** 40·4

KNOWN MEDICINE ALLERGIES ***(If NONE is confirmed, write NKDA in box 1)***

Drug Details	Description of Allergy	Doctor's Sign:
		Name: Dr. Hari Vignesh Reg. No. 181100

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
9/12/23	12.50	INJ: NTG ✱	200mcg	IA	[signature]	102466	[signature]	01786 / 00814	12.50
9/12/23	12.50	INJ: HEPARIN ✱	5000 IU	IA	[signature]	102466	[signature]	01786 / 0004	12.50

REGULAR PRESCRIPTIONS *To be filled in by Doctors only* ↓			**Date →** / **Time ↓**	To be filled by Nursing Staff only. Sign and time given		
				9/12/23	10/12/23	11/12
DRUG NAME T. AXCER			8.00	→		9.00
Dose 90mg	**Route** P/O	**Frequency** 1-0-1				
Dr. Sign & Reg. No. / Seal 181100		**Start Date & Time** 9/12/23, 9 AM	20.00	2040	2000	
		Stop Date & Time				
Additional Info:						
DRUG NAME T. ASPIRIN						
Dose 75mg	**Route** P/O	**Frequency** 0-1-0	14.00	→	14.00	14.00
Dr. Sign & Reg. No. / Seal 181100		**Start Date & Time** 9/12/23, 9AM				
		Stop Date & Time				
Additional Info:						
DRUG NAME T. PAN			7.00	→	7.10	9.00
Dose 40mg	**Route** P/O	**Frequency** 1-0-1				
Dr. Sign & Reg. No. / Seal 181100		**Start Date & Time** 9/12/23, 9AM	19.00	7 PM		
		Stop Date & Time				
Additional Info:						
DRUG NAME T. TRIMETAZIDINE			8.00	→		9.00
Dose 20mg	**Route** P/O	**Frequency** 1-0-1				
Dr. Sign & Reg. No. / Seal 181100		**Start Date & Time** 9/12/23, 9AM	20.00	2040	2000	
		Stop Date & Time				
Additional Info:						
DRUG NAME T. ENALAPRIL MALEATE (if SBP 7120)			8.00	→		9.00
Dose 2.5mg	**Route** P/O	**Frequency** 1-0-1				
Dr. Sign & Reg. No. / Seal 181100		**Start Date & Time** 9/12/23, 9AM	20.00	2040	2000	
		Stop Date & Time				
Additional Info:						
Area In-charge Nurse Signature:				024	024	024

Clinical Pharmacist Medway Heart Institute

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

DRUG NAME
T. METOPROLOL

Dose	Route	Frequency
25	P/O	1-0-1

Dr. Sign & Reg. No. / Seal
18/100

Start Date & Time: 9/12/23, 9AM
Stop Date & Time:

Additional Info:

DRUG NAME
T. GLYCERYL TRINITRATE

Dose	Route	Frequency
2.6 mg	P/O	1-0-1

Dr. Sign & Reg. No. / Seal
18/100

Start Date & Time: 9/12/23, 9AM
Stop Date & Time: 9/12/23 @ 13.45

Additional Info:

DRUG NAME
T. ATORVAS

Dose	Route	Frequency
20 mg	P/O	0-0-1

Dr. Sign & Reg. No. / Seal
10266

Start Date & Time: 9/12/23 @ 13.45
Stop Date & Time:

Additional Info:

DRUG NAME
T. MIKORAN

Dose	Route	Frequency
5 mg	P/O	1-0-1

Dr. Sign & Reg. No. / Seal
10266

Start Date & Time: 9/12/23 @ 6.45
Stop Date & Time:

Additional Info:

DRUG NAME
T. ALPRAX

Dose	Route	Frequency
0.25	P/O	0-0-1

Dr. Sign & Reg. No. / Seal

Start Date & Time: 9/12/23 @ 21.00
Stop Date & Time:

Additional Info:

Area In-charge Nurse Signature:

Date →	To be filled by Nursing Staff only. Sign and time given						
Time ↓	9/12/23	10/12/23	11/12				
8.00	→	8.00	9.00				
20.00	20.00	20.00					
8.00							
20.00							
20.00	20.00	20.00					
8.00	→		9.00				
20.00	20.00	20.00					
21.00	21.00	21.00					
	Nee 2024	Nee 2024	Nee 0024				

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

	Date → / Time ↓	To be filled by Nursing Staff only. Sign and time given							
		10/12	11/12						
DRUG NAME T-DOLO X3d	8.00	[illegible]	9.00						
Dose 650mg / Route PO / Frequency 1-1-1	14.00	14.00							
Dr. Sign & Reg. No. / Seal [signature] / Start Date & Time 10/12/23 @9.00 / Stop Date & Time	20.00	2000							
Additional Info:									
DRUG NAME T-IMANRE	8.00	[illegible]	9.00						
Dose 5mg / Route PO / Frequency 1-0-1									
Dr. Sign & Reg. No. / Seal [signature] / Start Date & Time 10/12/23 @9.00 / Stop Date & Time	20.00	2000							
Additional Info:									
DRUG NAME									
Dose / Route / Frequency									
Dr. Sign & Reg. No. / Seal / Start Date & Time / Stop Date & Time									
Additional Info:									
DRUG NAME									
Dose / Route / Frequency									
Dr. Sign & Reg. No. / Seal / Start Date & Time / Stop Date & Time									
Additional Info:									
DRUG NAME									
Dose / Route / Frequency									
Dr. Sign & Reg. No. / Seal / Start Date & Time / Stop Date & Time									
Additional Info:									
Area In-charge Nurse Signature:		[signature]	[signature]						

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
9/12/23	12.30	IVF: NS	500ml	20ml/hr	IV	0.9% NS	-	-	[illegible]	103066	12.30	10/12/23 1.30	[illegible]

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
9/12/23	8 AM	NPO	[illegible]	181100					
9/12/23	20:00	DM diet	[illegible]	Dr. Anish Nelson Reg. No: 88434					
10/12/23	8.00	DM diet	[illegible]	[illegible]					
11/12/23	9:00	Diabetic diet	[illegible]	134559					

NURSE IDENTIFICATION RECORD

(to be entered by all the nurses involved in administering medications prescribed in the chart)

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
9/12/23	Evening	Anithi	0282.	M.		Evening			
9/12/23	Night	Madhumitha	0244	[illegible]		Night			
10/12/23	Morning	Ramya. R	0189	[illegible]		Morning			
10/12/23	Evening	A. Devika	018[illegible]	[illegible]		Evening			
10/12/23	Night	A. ALBINUS	0088	[illegible]		Night			
11/12/23	Morning	Darsadharshini	0211	S		Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

MHI/PHARM/2022/060

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REQUISITION

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

Name of Patie
Age / Sex
Consultant Na

IP No. :
DOA :
UHID No. :
Room No. :

S.No.	Date	Medicine Name	Qty.
1)	9/12/23	Syringe 5ml	4
2)		kidney tray	1

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FC

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

Name of Patient
Age / Sex
Consultant Name .

IP No. :
DOA :
UHID No. :
Room No. :

S.No.	Date	Medicine Name	Qty.
1	9/12/23	DS gloves.	6.

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FO

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

Name of Patient
Age / Sex
Consultant Name .

IP No. :
DOA : 9/12/23
UHID No. :
Room No. : ICU

S.No.	Date	Medicine Name	Qty.
1)	9/12/23	T. Nikoran 5mg	10
2)		Easy bath	1
3		Under pad	2
4		posiflush	2
5		Bedpan	1

Nurse Name

Pharm Bill & Name

PHTN.

MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

B

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

NAME

BLOO

UHID NO : 202381064 AGE : 50y SEX : F

HEIGHT : 145cm WEIGHT : 40.4kg B.S.A : 1.4m²

10/12/23 - (3)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8.00	91	Sinus	98.4	128/82	94	warm	++	19	Br/L	96	ON RA ON AIR
9.00	94	Sinus	98.4	140/86	99	warm	++	18	Br/L	99	〃
10.00	96	Sinus	98.4	138/80	99	warm	++	19	Br/L	98	〃
11.00	90	Sinus	98.4	138/90	100	warm	++	18	Br/L	99	〃
12.00	91	Sinus	98.4	118/72	86	warm	++	19	Br/L	98	〃
13.00	86	Sinus	98.4	114/86	87	warm	++	20	Br/L	99	〃
			pt		shifted	to	ward	@	13.00		

PREVIOUS DAY - HOURS

DRAINAGE

URINE => 1800ml.

TOTAL INTAKE => 2140ml

TOTAL OUTPUT => 1800ml

BALANCE => 660ml

T2DM / SHTN.

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INTERMEDIATE CARE FLOWCHART

B

Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

NAME :

UHID NO : 202381064 AGE : 50Y SEX : F

BLOOD (

HEIGHT : 145CM WEIGHT : 40.4Kg B.S.A : 1.4m2

10/12/23 -> (2)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
6.30	92	Sinus	97.2	113/78	90.	warm	++	20	Bld	98%.	On Room air
7.30	90	Sinus	97.2	113/78	90.	warm	++	21	Bld	98%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE I

TOTAL INTAKE

TOTAL OUTPUT I

BALANCE

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

IMEDIATE CARE FLOWCHART

B

NAME : UHID NO : 202381064 AGE : 50Y SEX : F

BLOOD GROUP :

HEIGHT : 145 cm WEIGHT : 40.4 Kg. B.S.A : 1.46 m²

9/12/23 — (V)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
14.30	80	Sinus	98.4F	108/73	85	warm	++	24	Br/cl	94%	Pt on RA
15.30	82	Sinus	98.6F	124/78	93	warm	++	20	Br/cl	98%	"
16.30	84	Sinus	98.2F	134/84	104	warm	++	18	Br/cl	97%	"
17.30	86	Sinus	98.8F	116/79	91	warm	++	14	Br/cl	98%	"
18.30	82	Sinus	98.6F	120/75	90	warm	++	18	Br/cl	98%	"
19.30	80	Sinus	98.4F	114/73	88	warm	++	20	Br/cl	96%	"
20.30	78	Sinus	97.2F	123/75	91	warm	++	20	Br/cl	97%	"
21.30	80	Sinus	97.2F	104/82	94	warm	++	26	Br/cl	97%	"
22.30	78	Sinus	96.2F	114/64	82	warm	++	22	Br/cl	97%	"
23.30	79	Sinus	97.2F	102/68	99	warm	++	14	Br/cl	96%	"
00.30	74	Sinus	97.2F	110/73	85	warm	++	19	Br/cl	96%	"
1.30	78	Sinus	97.3F	96/64	95	warm	++	18	Br/cl	97%	"
2.30	84	Sinus	97.2F	108/72	84	warm	++	18	Br/cl	97%	"
3.30	91	Sinus	97.2F	104/69	81	warm	++	19	Br/cl	98%	"
4.30	84	Sinus	97.2F	110/73	85	warm	++	18	Br/cl	96%	"
5.30	91	Sinus	97.2F	104/69	81	warm	++	19	Br/cl	97%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

14 SIS: AWMI / MILD LV DYSFUNCTION / 120M

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

INTERMEDIATE CARE FLOWCHART

A

NAME

UHID NO : 202381064 AGE : 50Y SEX : F

SURGICAL PROCEDURE : PTCA → LAD

POSTOP DAY : D2

FLUID REQUIREMENT :

10/12/23 → (3)

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
10/12/23 @8.00							—					100	100	100	+ 100
9.00							—					50	150	150	+ 150
10.00							—						150	150	+ 150
11.00							—						150	150	+ 150
12.00	800						800						150	150	− 650
13.00							800						150	150	− 650

SPECIFIC OBSERVATIONS/REMARKS

—

MEDICATION / DRUGS

—

Dx: AWMI / MILD LV DYS FUNCTION

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

RMEDIATE CARE FLOWCHART

A

NAME :

UHID NO : 2023106A AGE : 50Y SEX : F

SURGICAL PROCEDURE : PTCA-LAD

POSTOP DAY : D2

FLUID REQUIREMENT :

10/12/23 - 2

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
10/12/23 6.30		-					1800						500	960	-840
4.30		-					1800					50	550	1140	-660

SPECIFIC OBSERVATIONS/REMARKS

—

MEDICATION / DRUGS

—

. ASPS :- AWMI / MILD LVD / T2DM / SHTN /

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Mrs.LEEMA ROSE A
50/Female/MHI202381064
09/12/2023/IPH202302465
Dr.G. GNANAVELU

NAME :

RMEDIATE CARE FLOWCHART

A

UHID NO : 202381064 AGE : 50Y SEX : FEMALE

SURGICAL PROCEDURE : PTCA → LAD

POSTOP DAY : D0

FLUID REQUIREMENT :

9/12/23 → 1

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT 2000	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE 1600	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.		IVF NS			H.T.	H.T.	G.T.		
14.30	—	—					200	30				—	—	130	-70
15.30	200	200					400	30				100	100	260	-140
16.30	-	200					400	30				200	300	490	+90
17.30	—	200					400	30				—	300	520	+120
18.30	850	1050					1050	30				—	300	550	-500
19.30	—	1050					1050	30				-	300	580	-470
20.30		1050					1050	30				50	350	660	-390
21.30	250	1300					1300	30				100	450	790	-510
22.30		1300					1300	30				50	500	840	-430
23.30		1300					1300	30					500	900	-400
00.30		1300					1300	30					590	930	-370
1.30		1300					1300	30					500	960	-340
2.30		1300					1300	RL					500	960	-340
3.30		1300					1300						500	960	-340
4.30		1300					1300						500	960	-340
5.30	500	1800					1800						500	960	-840

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
—	—