

### MRD CHECKLIST

PARTICULARS PARTICULARS	YES	NO
- IP Number allocated to each Patient		
- Name, Age & Sex of Patient	1	
- General Admission Consent		
- Initial Assessment of Patient / Diagnosis	1	
- 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		



P; Mrs.PREMA T ...... N: 52/Female/MHI202381034 U 09/12/2023/IPH202302466 Dr.Anbarasu mohanraj 



\_very heart beat counts

# Medway Hospitals

The way to better health.
(A Unit of United Alliance Healthcare Pvt Ltd)

### ADMISSION SLID

ADMISSION SELF
Admitting Doctor: Dr. And arms o Speciality: OTUS.
Advised Date & Time: 9   2   2   3 ( \omega)   1   2   2   3   ( \omega)   1   2   2   3   ( \omega)   1   2   3   4   4   4   4   4   4   4   4   4
Provisional Diagnosis:
Type I Dabeli Mellins, gysland
Provisional Diagnosis:  Type () On ab eli Mellins, systeme  lype elenn on effort Agrie, CAG-Double.  Procenter Admission: Medical Management Surgical Management
Reason for Admission:
Others (please specify details)
Admission Type: Day Care ER Ward
CU (Specify details)
Surgery / Procedure Name (if planned):
CABY.
Blood Product Requirement: No Yes (Kindly specify details of components required in space below)
Expected Duration of Stay: 6- 7days
Expected Cost of Treatment (as per Financial Counseling Form):
Payer: Self Insurance Others: Chil hon.
Instructions to Nurse (if any):  All with in general ward Ealgory.
Any other Instructions (if any):
·
De Arbora Maria
Doctor's Signature   Moha Name   Reg. No.   Date   Time
Doctor signature VIONATATINE  Reg. No.  Date VIII Time

For admission desk staff of	only:		• , -
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		
Admission intimation	Receipt Details	Admission	Time in HIS
Date	Time	Date	Time
2/12/23	11.295~	09/12/23	11: 49 D.M
To be filled only if Blood	OPD ER Direct requirement specified by the		□ No
Front office Staff Signature	Name RESHMA BAW	Emp. No. 0 MH10264	Date Time - 09/12/23 11:49 4
The state of the s	<del></del>	1	<u> </u>
	· · · · · · · · · · · · · · · · · ·		A TO A SUBTRIBLE OF THE SECOND
		, , an	r Dr. Arlasa Möha Tog Mo: 55476

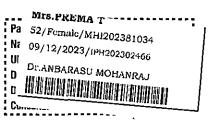
Ľ,

Γ



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







## **ADMISSION FORM**

Marital State	is Full Address	, padouotham	on Koil Shee	Telephone Number				
Non-unation	HAS DE	finaturan	<b>¬</b> .	9952928265				
Occupation		finaphren dvanchey-	P03705	_				
Referred fro		Admission Date & Time		al No. of Days				
De. Y	M 9/12/23	11:4900 16/12/2	30 18.30 8	Days				
UNIT	UNIT MLC Yes No If Yes AR No. :							
	FINAL	. DIAGNOSIS		ICD Code				
DOUBL	E UESSEL CORONAR	Y ARTERY DIE	FASE EFFORT	7251				
ANGII	A NORMAL LU 5YST	DLIC FUNCTION	W-EF-60%.	Too.8				
TYPEII	DIABETES MELLI	TUS SYSTEM	IC HYPERTENSI	DN 150.1				
Dys L	PIDEMIA			E11.9				
				₫1o				
				£78.5				
				2 10:52				
DATE	OPE	RATION / PROCEDURE	<u> </u>	ICPM Code				
	OFF PUMP CORO	NARY ARTER/ E	SYPASS CTRAFTING	 ]				
	MINCHERY INAMA	) X 2GIRAFTS:	SVGI TO LAD	36.12				
1 . 23	SURVIEW COLON	E UN 11.12.	2023	99.00				
11.12.23			·	, ,				
DATE	TY	PE OF ANESTHESIA	·					
11.12.23	GENERAL . SF	PINAL LOCA	L REGIONAL	☐ EPIDURAL				
		DISCHARGE STATI	JS					
☐ Cured	☐ Dischar	ge at Request	□ F	Expired < 48 hours				
Improve	☐ Against Medical Advice ☐ Expired > 48 hours							
—   □ Unchan	Abscon-	ded red to	<u> </u>	ost-Operative Death				
Dr. Anb	rasu Mohair			<del>- )</del>				
·	g No: 55476\		S. Aleu	Lay erso				
√ Signature	of the Consultarit	Signature of the Consultant Signature of Medical Records Officer						

S.No.: 5

# AUTHORISATION FOR TREATMENT I PAYMENT

		medical, Staf f of the Hospital Investigate treat and
		eration under anaesthesia or other wise as may be
·		of my illness / patient
who is my :(Re	·lationship).	
I hereby under take to settle all the bills for	or hospitalisation charges re	elated 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	s due to the hospital as agre	ed above, I hereby authorise the hospital to transfer
		s deemed fit and proper by the hospital authorities.
I also acknowledge having been informed	d if the General Rules and F	egulations of the Hospital and that all cash, jewellery
and valuables belonging to the patient or	theis attendants have beer	removed to a place of safety / handed over to the
next of kin and I absolve the hospital of a	ny responsibility with regard	to any loss.
I have read out and explained the conten	ts of the above to the Signa	tory in his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செ	சய்ய அதிகாரம் வழங்குதல்	
இதன் மூலமாக நான் நிர்வாகம், மருத்துவம்,	தாதியா், ஏனைய மருத்துவ ஊ	ழியர்கள் எனக்கு/நோயாளி
		- ாதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க
•		ரம் வழங்குகிறேன். நான் / இதீல் குறித்துள்ள நோயாளின்
செலவுக்கன தொகை முழுவதும் செலுத்த இ	தன் மூலம் உறுதி அளிக்கிறேன்	π.
மேல் கூறியது போல் வேளை நான் தங்கள்	் மருத்துவத்திற்கான செலவுக	ளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு
_, _	சிகிச்சை செய்ய இடமாற்ற ஒப்ட	துலை எனது உறவினா்கள் மூலமாக பெற நான் அதிகாரம்
அளிக்கீறேன்.		
மருத்துவமனையின் பொது சட்ட தீட்டங்கள் ப	பற்றி தெரிவிக்கிப்பட்டிருக்கிறே	សំរ.
நோயாளிக்கு உரிமையான எல்லா பணம், ந	கை மதிப்பிடக்கூடி பொருட்கள்	யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு
நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ள	ாது. இந்த மருத்துவமனை எஎ	ாது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
என உறுதி செய்கிறேன்.	•	•
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்	கப்பட்ட பிறகுதான் கையொப்ட	் யபிட்டேன்.
Device O.		$V.\Lambda$
8 xx		JNV /
செவிலியர் கைபைர் பம்	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date (05.12.2	Signature of the Patient / Relative / Gurdian

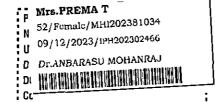
enalumn Husband

Nature of Relationship



relevant information on my part.

handbook.





### **GENERAL CONSENT FOR ADMISSION**

l, _	the Patient or Representative of patient have
	lease tick the correct option above and below)  Read
L	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

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 declare that I have been explained about my rights and responsibilities as a patient as outlined in the patient

 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	T. Prémes	·T. Prema	9/12/23	11:49
Surrogate/Guardian (if applicable #)	, str	(Write name and relationship with patient)	9 12 23	11649
Reason for surrogate consent	Patient is unable to give consent b			
Witness	7/2	, Joel	9/19/23	11:491
Interpreter (if applicable)				

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



Mrs.PREMA T

52/Female/MHl202381034 09/12/2023/IPH202302466





### ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

	ADMISSION CRITERIA FOR INTENSIVE CARE UNIT					
S. No.	PARAMETERS		( ✓ AS PRIATE			
140.			<u> </u>			
	Hemodynamic instability defined as Pulse less than 40 or more than 150 beats/minute		i			
	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure		<del> </del>			
1			<del> </del>			
	Mean arterial pressure less than 60 mm Hg  Diastolic arterial pressure more than 120 mm Hg					
	Respiratory rate more than 35 breaths/minute		<del>                                       </del>			
	Hespiratory rate more than 30 breaths/himute		<b></b>			
	Cardio-vascular System	i i	l			
-	Acute myocardial infarction					
	Cardiogenic shock .					
	Complex arrhythmias requiring close monitoring and intervention					
	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support					
2	Hypertensive emergencies					
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain					
	Post cardiac arrest	ļ				
	Cardiac tamponade or constriction with hemodynamic instability		<b>_ </b>			
	Dissecting aortic aneurysms		_ -			
	Complete heart block	l	1			
-	Miscellaneous Conditions					
			ļ			
3	Septic shock with hemodynamic instability	<del>                                     </del>	- - <u>-</u>			
	Hemodynamic monitoring Clinical conditions requiring ICU level nursing care	<del>-</del>	-∤			
	Clinical conditions requiring 100 lever ruraing care					
	Post procedure elective admission					
4	Post Coronary Angioplasty	<u>~</u>				
,	Post Cardio-vascular Surgery					
	Following anglographic procedure					
	Complication resulting from the angiographic procedure including any significant change in pulse in the	i	1			
	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-		1			
5	procedure					
:	Significant findings on diagnostic angiography warranting further therapy that would necessitate inpatient					
	admission is also a reasonable indication for admission	<u> </u>	<u> </u>			
	Admission at the time of the study is encouraged if problems are suspected or arise					
	Pulmonary System					
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)	İ	1			
	Pulmonary emboli with hemodynamic instability		1			
_	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory					
6	deterioration					
	Need for nursing / respiratory care not available in such intermediate care units		<u> </u>			
	Massive hemoptysis					
	Respiratory failure needing imminent intubation .					
	Demolfailtee		1			
	Renal failure		1			
7	Oliguria or anuria for more than 12 hours  Metabolic acidosis (pH < 7.1)	<del> </del>	+			
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline	<del> </del>	<del>                                     </del>			
	Tationis requiring hemodialysis carrie performed in too when the blood pressure is porcetifie					

S. No.		PARAMETERS					MARK ✓ AS APPROPRIATE	
8	Endocrine System and Metabolism related Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis Thyroid storm or myxedema coma with hemodynamic instability Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl Other endocrine problems such as adrenal crises with hemodynamic instability Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring Hypo or hypernatremia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered mental status Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias Hypo or hyperkalemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or muscular weakness Hypophosphatemia with muscular weakness							
	_	Signature	Name	· · · · · ·	Reg. No.	D	ate	Time
Do	octor	F	Dr. mo	wen	112-2-36	11	11212	l2 .20
	DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT							
S. No.	PARAMETERS MARK ✓ AS APPROPRIATE							
1		nemodynamic parameters					\frac{1}{2}	
2	Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent					3		

3	3 Minimal oxygen requirement (not more than 3 L by nasal prongs)					
4	Intravenous / Inotropic / Vasopressor support and vasodilators are no longer necessary					
5 Cardiac dysrhythmias are controlled		ac dysrhythmias are controlled			-	
6	Presen	ce of distal pulses				<b>1</b>
7 No signs of bleeding and hemator		gns of bleeding and hematoma at puncture site				
8	End of I	ife care pathway chosen				<u>.</u>
		Signature	Name	Reg. No.	Date	Time

.







Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd)

#### DISCHARGE SUMMARY

IP No.

: IPH2022302466

D.O.A

: 09/12/2023

UHID

: MHI202381034

D.O.D

16/12/2023

Name

: MRS. PREMA.T

Room No :

207

Age / Gender : 52Years / FEMALE

Consultant

: Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

D.O.S: 11.12.2023

#### **DIAGNOSIS:**

DOUBLE VESSEL CORONARY ARTERY DISEASE EFFORT ANGINA NORMAL LV SYSTOLIC FUNCTION - EF: 60% TYPE II DIABETES MELLITUS SYSTEMIC HYPERTENSION DYSLIPIDEMIA

#### **SURGERY:**

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2 GRAFTS: SVG TO LAD, SVG TO PDA DONE ON 11.12.2023

#### BRIEF HISTORY:

Mrs. Prema.T 52 years old female, a known case of Type II diabetes mellitus, Systemic hypertension, Dyslipidemia, Effort angina, CAG - Double vessel disease, has come for CABG. Patient was apparently normal till one month ago when she developed chest pain - retrosternal, on exertion associated with palpitation and sweating. Initially, she went to Dr. Moorthy's clinic where she was advised Coronary Angiogram. She went to Sugam Hospitals and underwent Coronary Angiogram on 23.11.2023 which showed Double vessel disease. She then came to Medway Heart Institute on 27.11.2023 where she was advised early CABG. Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, she is getting admitted for the same.

No H/O Breathlessness, Syncope or Swelling of Legs.

No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism

#### 93. #9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel

**f** @MedwayHospitals

(C) @medwayhospitals

medway-hospitals

@medwayhospitals



**Medway Group of Hospitals** 

Medway Centre of Excellence (Chennai)

Kodambakkam 044-2473 4455

Mogappair

Kumbakonam 044-26530011 | 044-2473 4455 |

Chengalpattu 044-27426829

Villupuram 04146-242000

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454

E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665





Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH2022302466

NAME: MRS. PREMA.T

UHID: MHI202381034

#### **ON EXAMINATION:**

Patient Conscious, Oriented and afebrile.

97.4°F TEMP

HR70bpm BP 130/80 mmHg

SPO<sub>2</sub> 96% in room air

CVS S1S2 (+) RS **BAE (+)** 

Abdomen Soft, non - tender

**CNS NFND** 

#### **BLOOD INVESTIGATIONS:**

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	14.0	Male: 13.7 - 17.5	gms%
<u>_</u>		Female: 11.2 - 15.7	
HAEMATOCRIT	42.5	39-52	%
FWBC ·	11590	4000 - 10000	Cells/Cumm
NEUTROPHILS	62.9	40-70	%
YMPHOCYTES	27.2	20 - 40	%
EOSINOPHILS	7.1	0 - 6	%
MONOCYTES	2.5	0-6	%
BASOPHILS	0.3	0 - 2	%
PLATELET	430000	Male: 1.5 - 3.5	Cells/cumm
-		Female: 1.5 - 3.7	
Urea	23	14 - 40	mgs/dl
Creatinine	0.64	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
1		Child: 0.2 - 0.8	
Sodium (Na+)	139	135 - 145	mmol/I
Potassium (K+)	3.53	3.4 - 5.5	mmol/l
T. Bilirubin	0.38	0.2-1.0	mg/dl
D. Bilirubin	0.13	0.00 - 0.4	mg/dl
1. Bilirubin	0.25	0.4-0.6	mg/dl
S.G.O.T	17	<38	U/L
S.G.P.T	18	<41	U/L
ALP	106	Adult: 42 - 141	U/L
GGT ,	22	Male: 10 - 45	U/L
		Female: 5 - 32	
Fotal Protein	7.7	6.0 - 8.0	gm/dl
5. Albumin	4.4	3.5 - 5.0	gm/dl

1	-#O	Tet Main Dood United India Col	ony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

₱ @MedwayHospitals

@medwayhospitals

in @medway-hospitals

@medwayhospitals



**Medway Group of Hospitals** 

Medway Centre of Excellence (Chennai)





Every heart beat counts

PATIENT

NAME: MRS. PREMA.T

UHID: MHI202381034

PROTHROMBIN TIME	0.4	Normal: 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction: 2.0 - 3.0 Deep Vein Thrombosis: 2.0 - 3.0 Pulmonary Embolism: 2.0 - 3.0 Artificial Cardiac Value: 3.0 -4.5 Recur.Systmic Embolism: 3.0 - 4.5 INR	
HBA1C	6.6	Normal: Below 6.0 Good control: 6.1-7.0 Fair Control: 7.1-8.0 Unsatisfactory: 8.1-10.0 Above 10: poor control (GHB is an index of your blood Sugar control for the past (3 months)	%
Г.S.Н	3.00	Adult: 0.25 - 5.0 New born- 4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	ulU/ml
Г3	78	"Adult: 60 - 152 New born - 4 days: 96 - 730 1 - 11 Months: 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	7.44	"Adult: 4.6 - 9.3 New born - 4 days: 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs: 6.3 - 13.16	ug/dl

ECG: HR - 60bpm, Sinus rhythm, left axis deviation, No significant ST - T changes

CXR: PA film, prominence BVM, lung fields clear.

ECHO: EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 96ML, ESV: 31ML, EF: 66%, AORTIC GRADIENT - MAX GRADIENT - 13 MM HG, MEAN GRADIENT - 7 MM HG, ALL CHAMBERS NORMAL SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION - EF: 60%, GRADE I DIASTOLIC DYSFUNCTION, NORMAL RV SYSTOLIC FUNCTION, IAS / IVS INTACT, ALL VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, IVC NORMAL IN SIZE AND COLLAPSING, NO CLOT / VEGETATION / EFFUSION. 4

ı	 		@medwayhospitals	94457 94457 1800 572 3003
	 Maduan Onena af Hank	L-1-	Madwey Castes of To	(Ob

Medway Centre of Excellence (Chennai) Medway Group of Hospitals Kodambakkam Mogappair Kumbakonam Chengalpattu Villupuram **Heart Institute** Institute of Pulmonology 044-26530011 | 044-2473 4455 | 044-27426829 044-2473 4455 04146-242000 044 - 4310 8959 044-2473 4454 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665 MHI/HOSP/2022/118



Heart
Institute
Every heart beat counts

NAME: MRS. PREMA.T

UHID: MHI202381034

(A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH2022302466

#### COURSE IN THE HOSPITAL:

Mrs. Prema.T 52 years old female, was admitted with above mentioned complaints. She underwent **OFF** PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2 GRAFTS: SVG TO LAD, SVG TO PDA ON 11.12.2023. She was shifted to SICU with stable hemodynamics and Inj. Nor Adrenaline 0.02μ/kg/min supports. She was extubated on the same day (11.12.2023) at 15.05 hours. Drains were removed on POD1 (12/12/2023). She was shifted to ward on POD 2 (13/12/2023). Suture removal was done on POD4 (15/12/2023). Patient course in the hospital was uneventful. Her medications are optimized and she is being discharged in a stable clinical status.

#### CONDITION ON DISCHARGE:

!R -

84/min

BP

120/70mmHg

SPO<sub>2</sub>

94% in room air

#### POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	10.9	Male: 13.7 - 17.5 Female: 11.2 - 15.7	gms%
Urea	35	14 - 40	mgs/dl
Creatinine	0.50	Male: 0.7 - 1.2 Female: 0.5 - 1.0 Child: 0.2 - 0.8	mgs/dl
Sodium (Na+)	137	135 - 145	mmol/l
Potassium (K+)	3.39	3.4 - 5.5	mmol/l

ECG: HR – 72bpm, sinus rhythm, left axis deviation, T wave inversions in anterolateral leads.

CXR: PA film, Sternal wires seen, prominence BVM, minimal left, no right pleural effusion.

ECHO: S/P CABG, EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 87ML, ESV: 30ML, EF: 64 %, ALL CHAMBERS ARE NORMAL IN SIZE, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION – EF: 60%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 16CM/S, TAPSE: 14MM, ALL VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 9 MM HG, MEAN GRADIENT – 4 MM HG, GRADE I DIASTOLIC DYSFUNCTION, TRIVIAL MR, TRIVIAL TR, NO PAH, TRACE PERICARDIAL EFFUSION BEHIND RA, MINIMAL BILATERAL PLEURAL EFFUSION, NO CLOT / VEGETATION.

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959

₱ @MedwayHospitals

(O) @medwayhospitals

in @medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam Mc 044-2473 4455 044-

Mogappair 044-26530011

Kumbakonam 044-2473 4455 Chengalpattu 044-27426829

Villupuram 04146-242000 Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454

E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665

MHI/HOSP/2022/118





NAME: MRS. PREMA.T

UHID: MHI202381034

Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH2022302466

#### **ADVICE MEDICATIONS:**

SI	NAME OF THE DRUGS	CTRENCTI	DOS LOT	FRE	QUEN	CY	ROUT	RELATIONSHI	DUD ATION
NO.	WITH GENERIC NAME	STRENGTH	DOSAGE	M	A	N	E	P WITH MEAL	DURATION
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	I	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. ATORVA (ATORVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2WEEKS
5	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	o	I	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
6	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML	·	0	o	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)
7	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	I MONTH
8	SYP ALEX PLUS (DEXTROMETHORPHA N HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
9	TAB.ANXIT (ALPRAZOLAM)	I TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959
--

• @MedwayHospitals

odambakkam

@medwayhospitals

@medway-hospitals

@medwayhospitals



**Medway Group of Hospitals** 

Chengalpattu Villupuram Kumbakonam 044-26530011 | 044-2473 4455 | 044-27426829 04146-242000

Heart Institute 044 - 4310 8959

Medway Centre of Excellence (Chennai)

Institute of Pulmonology 044-2473 4454

14-2473 4455

Mogappair

-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665

MHI/HOSP/2022/118



NAME: MRS. PREMA,T

UHID: MHI202381034

Every heart beat counts

#### **DIABETIC MEDICATIONS:**

Si.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FRE	QUEN	CY	ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME			M	A	N		WITH MEAL	
		_							
1	TAB. GLADOR M2	1 TABLET	2MG/	1/2	0	1/2	ORAL	BEFORE	TO
	(GLIMEPIRIDE +		500MG					FOOD	CONTINUE
	METFORMIN)								
	,								

DISCH	DISCHARGE ADVICE				
DIET	HIGH PROTEIN, LOW SALT				
	LOW FAT / DIABETIC DIET				
PHYSICAL ACTIVITIES	RESTRICTED.				
FLUID RESTRICTION	NIL				
	REVIEW WITH				
REVIEW	DR. ANBARASUMOHANRAJ AFTER				
	22/12/2023 WITH HB, FBS, PPBS UREA,				
	CREATININE, SODIUM, POTASSIUM,				
<u> </u>	CHEST X RAY				

To report: If fever> 101 'F / Difficulty in breathing / Headache / Giddiness/chest pain/ Groin swelling/bleeding / discharge at operated site/ Any other significant symptoms.

In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai

Dr. ANBARASU MOHANRAJ Reg. No: 55476

They. 140, 50470

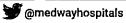
Inc. 140 Continued the Continued the Continued the Summing S erstood the Summ Director and Clinical lead – Cardio Vascular and Thoracic Surgery discharge

95, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

🕇 @MedwayHospitals

(O) @medwayhospitals

@medway-hospitals



94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam Mogappair 044-2473 4455 044-26530011

Kumbakonam 044-2473 4455

Chengalpattu 044-27426829

Villupuram 04146-242000

**Heart Institute** 044 - 4310 8959 Institute of Pulmonology 044-2473 4454

E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665

MHI/HOSP/2022/118



# Mrs.PREMA T 52/Fcmalc/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



# **INPATIENT INITIAL ASSESSMENT**

Date: 9 lb-123 Time of arrival in ward:  2.15
Allergies (if Yes, specify details):
Drugs
Blood Transfusion
Food □ Yes ☑ No
Others
Vital Signs: Temp: 9.4 (°F)   Pulse / HR: 50 (beats/min)   BP: 130 60 (mmHg)  Respiration: 20 (breaths/min)   SpO <sub>2</sub> : 92 (%)   Height: 41.5 (cms)   Weight: 66.2 (kgs)   BMI: 55.49   M <sup>2</sup>
Pain: Yes No. If Yes, Score: 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  The Pt well app @ lufore 20 days after which  the developed that pain and pt undergone Coronaey Angiogram  at Sugam 1+ ospital on 23/11/23. Pt some here for  just here management & treetment. Presently Pt has  no complaints
PAST MEDICAL HISTORY (with duration of illness):  Diabetes Mellitus: ☐ Yes ☐ No. If Yes, duration: 2 yard Hypertension: ☐ Yes ☐ No. If Yes, duration: ☐ Others:  N/K/(10 7B, BA, Spilepry
Past Surgical History:  1 Luemorrhoidectory - 20yeors buck

Pre	esent Medication (for Medication R	econcilia	ition):	<del>-</del> -		
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued durin hospital stay
	T. ANGIPLAT 2.5	2.5m	Plo	1-0-1	9/12/23	☐-Yes ☐ No
	T. METOPROLOL XL	12.5m	PIO	1-0-1	9/12/23	☑ Yes □ No
	SUCCINATE (PROLOMET					☐ Yes ☐ No
	· · · · · · · · · · · · · · · · · · ·					☐ Yes ☐ No
						☐ Yes ☐ No
		L				☐ Yes ☐ No
						☐ Yes ☐ No
		_				☐ Yes ☐ No
						☐ Yes ☐ No
$\neg$						☐ Yes ☐ No
Fam	similar illnen in	tu veletiv	fonu Vi	L 1 Hu		
Pe:	Similer illnum in  1st degru m  rsonal / Social History (Tick which estyle:   Sedentary  Active	ever is a <sub>l</sub>	oplicable) pation:	How wif		
Per Lif Sn	Similer illnen in 1st degree n	ever is a <sub>l</sub>	oplicable) pation:	How wif	Հ ll Drug Use: □.Yes □	
Per Liff Sn Ot	Similer illnum in  It degree as  resonal / Social History (Tick which restyle:   Sedentary   Active  noking:  Yes  No Alcohol:	ever is ap Occup : □ Yes [	oplicable) eation:′	How Wy Recreationa		
Per Lift Sn Ot	Similer illner in  Ist degree re resonal / Social History (Tick which restyle:   Sedentary  Active roking:  Yes  No Alcohol: hers:	ever is ap Occup : □ Yes □	oplicable) pation:  No  ofor fema	How Wile Recreationa — ale patients):	ll Drug Use:_□.Yes [	
Per Lift Sn Ot	Similer Illnum in    Standard Land Land Land Land Land Land Land Lan	ever is ap Occup : □ Yes □	oplicable) pation:  No  ofor fema	How Wile Recreationa — ale patients):	ll Drug Use:_□.Yes [	
Per Lift Sn Ot Mer	Similer Illnum in    Standard August	ever is ap Occup : Tes [ e filled up	oplicable) pation:  No  ofor fema	How Wile Recreationa — ale patients):	ll Drug Use:_□.Yes [	No

<u> </u>	<u>,                                     </u>
SYSTEMIC EXAMINATION	
cvs:	
$S_1S_2\mathcal{D}$	
Respiratory System:	
BIL AED	
Gastrointestinal System:	
Soft, NT	
Central Nervous System:	
NFNO	
Urinary / Reproductive / Locomotor System:	
Skin / Opthalmic / ENT	
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 ☐	3N8
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:	
CAD - DVD	
Plan of Care:  L Admit under Dr. Anborone	
Plon: CABL On 11/12/23	

.

				•	ارچ ہے ا	
Investigations Advised:		_				
L A Atached					• • •	
<b>V</b> ,.						
Diet Advice:						
☐ Nil per Oral ☐ Clear liquid diet	☐ Normal liqui	d diet	☐ Diabetic	liquid diet		
☐ Semisolid diet ☐ Soft solid diet	☐ South Indiar	normal diet	☐ North Inc	dian normal d	iet	
☐ Neutropenic liquid diet ☐ Others:	lalt, Low	fet die	t		_	
Early Discharge Planning (fill in those which are		s stage):	PFE: Pa	atient Family l	ducation	
Special support needed at home	☐ Yes ☐ No	If Yes, PFI	E done	<del>.</del>		
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	<u> </u>	Reg. No.	Date	Time	
Resident Doctor Dr. Anbarasu Mohar	pr. Hari 1	ligner -	181100	9/12/23	12.30 PM	
Consultant Reg No 55476	, A	RASU	25476.	09/12/23	141.15	
Patient Attendant	Relationship	18	~	91,12	12.30	





# MTB.PREMA T 52/Female/MH1202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



**DOCTOR'S PROGRESS NOTES** DATE **NOTES** Hydroos SIB Dr. Mohamed 1 · CAD\_DVD Plan! CABG NGA Patient (VS->S152 A) NYBAEA P/A> Sift, NT MON - Mondo whats

1

	· · · · · · · · · · · · · · · · · · ·
DATE	NOTES
	-
09/12/23	SB DR. ANWAYA
11.30/10	Parient revieused
	clo' chestpain ong obs
Julinelita	to/F: Patient conscious/ oriented,
nopair	S/B. UN - 5,52 (F)
pholobitis-	RS - BAE(P)
FILLEDIAN	cale - NIRVD
<del></del>	· P/A - SOFT non -tender.
-	UITOUS: FIR - 82 DM
	BP-110/800/10/19
<u> </u>	RR-18 men
	Sp02 - 98% RA
	10/V/CQ
<u> </u>	- monitor vitals
The same of the sa	- Continue the days as perchast.
K. 13176	_ plan' CAPG on 11/12/23 _ toget, Angestheric Hitness
10	- toget Analsheric Fithess
<u> </u>	

\_\_\_\_\_



### Mrs.PREMA T 52/Female/MHi202381034 09/12/2023/IPH202302466







		}
	DOCTOR'S PROGRESS NOTES	
DATE	NOTES	
10/12/23	elB. Dr. Cujirk (DNO)	
11:00Am	- pt. reviewed.	
	- No specific composits.	
	2/8- Pt. cocsoson,	
	on ented	
	Baluste.	
	&R: CUS-5182@	1
	28 - BAB (P), NAS.	-
<b></b>	PA-soft. Adu	
Input	1100 mg.	
outful	1950me - cont. drag as per de	tra
, ,	- Plan. CABG on 11/12/23	1
Bp: 120/71		   
HE: 100 PI	J'Aneu.	
CAO5; d2.1	J.RA 183573.	1
		-
		]
	· · · · · · · · · · · · · · · · · · ·	

<del>-</del>	, , , , , , , , , , , , , , , , , , ,
DATE	NOTES
10.12.23	3/18 Dr. Anuslyg
णप्तातः o	Patient sevieued.
	clo; chest-pain on a off
	DIE: patient Concious, briented,
	0/5! CVR-5162(P)
	Rs -BAECO
	CNIS - MEND
	P/A - 607t, non-tender:
·	Utals: HR-82b/M
	BP-110 80 mm Hg
	RR - KIMLO
	SP62-98-1-RA
_	- Phosted for ciner to mossing
	nipofrom 12 mid night
	- consent
	- tants poeparatein
T COLORS	Pre-medication
	- Check pro - Opcies
	- Shitewordingy.
	· · · · · · · · · · · · · · · · · · ·
<del></del>	







DOCTOR'S PROGRESS NOTES		
DATE	NOTES	
11/12/2023	Max proma: Bzy F underwent openBx2	
@1225	she was shift to sew is following hemodynamics.	
	HR-718 BPM	
	BP-116/12/mmtg	
	CVP - B months	
	apo, - 100x, an rentilator	
	Kentilator:	
	mode: vev fin - 50%. peop: 5 monts.	
	supports life non adrendine 0.00 jug leglais.	
	plan:	
-	we on s, entrebate	
	Por hast	
	20 Anharau	
Ĺ	PA·Kanthika (MH10216)	
,		
,		
	·	

DATE	NOTES
12/12/2023.	SIB Dr Anburusu / DR. Rajesh / Dr praviers
	170D-J
	s/p opens x 2 grafts
RBS-142mg 106.	patront coscious, oriented, atebrile
	B/2: 146/70 mm/ty
Hb	5/10: 96% On room air
U+r9	1412: 84 bjim
Excatine.	7/0: 2494:5ml / 2223 ml. balance +2615ml
	Aclequal wrine author On weath
AB9.	remphenes folt woom
p11 - 7·4	Supporte Nill
1100 - 37.9	Dreineige : 430 ml.
100 - 68.9	
1+100 - 270	
B.L- 3.4	
1+b - 14.1	
Na -134	plan.
K -3.61	-12. F. 2.4 liter perday
	-> Mood chest physica
	-> Mobilize, spircomekey
	-) Nehulisatices
	T. Metaprolo/ 25 mg
	/-0-/
	-> Remove drains + Art lone
	Shift to 100 I
	Tiviso .
	<u></u>

í





# Mrs.PREMA T 52/Female/MH1202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
13/12/2023	8/B. Dr Anharasu /DR Rajesh / Dr pravcem
131 8:00	100-11
	SIP OPEABX 2 grafts.
Hb -	patront conscious prionted, atehrico.
vrea -	Bp: 105/68 mm/ty
ercat	HR: 106 ppm
Nat-	Sport on roomair
jet -	I/o: 2502ml/2815 ml balance -318ml.
	Adequato
RBS-117mg/dL.	Tolerating and feeding
0	Tolorating aval feeding  periplines felt werm
	Buliliorts Nill
	<u> </u>
	plan
	-> K.f 2.4 likes perday
	-) Good chest physion  -) Good chest physion  -) sprometery  -) Nebulnuticen  -> Shift to wend.
	graver - iprometery
	-> Nebulnaticen
	-> Shoff to wend.
	· · · · · · · · · · · · · · · · · · ·

DATE	NOTES
13/2/23	SIB-DA. Hari Vignesh (DMO)
2.30 PM POD	PA reviewed
	· · · · · · · · · · · · · · · · · · ·
vitaly stall	Ole - bic foil
Stalle	pt consaious
	O riented
	SIE- (US-S,S 2 F)
	PS-BIL AED
	(NS - NEND
	P19- Soft
	NT
	2d V
	- RF 2, 4/L/D
	-Vitale monitoring
	- Out Physio / Spinometay
	181100 - Netrulinstrion
	Molgiliem tru pt
· · ·	- As pu deurg chart
-	· · · · · · · · · · · · · · · · · · ·
	<del></del>

ş; \_\_\_\_





#### Mrs.PREMA T 52/Female/MH1202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



¿very heart beat counts

Dr.Anbarasu mohanraj

DOCTOR'S PROGRESS NOTES		
DATE	NOTES	
13/12/23	S/B. Dr. Swith (DMD)	
9:30pm		
7	DD+2 - S/P - OPCAB X2 grafts.	
	bl. review ed.	
That shall	le: No Soudie compaints	
Virlau		
	of R- bot considering	
<u>-</u>	, bokagio	
	Alalele.	
	8/R - CUS-S/S, P)	
	PR-BARP	
·	PA-50/4	
	<u>Adr.</u>	
	- vitale mantoning	
	- Pollow dry Clast.	
	- R F 2.4 L / Day.	
	- chart physiof spiromotry  - well-lise fol.  - Mobilise fol.	
	- Nebulilation.	
	- Mobilise fol.	
	61m2	
	18.84.3	
	103.57	

DATE	NOTES
14/12/22.	SB. Dr. Swith Como
8:20 An	
	by reinousof.
8p- 90/60 Bmg)	
BP - 1 mm	ale 10 - and complorate of contribution
HB- 87 Pban	TR = for conscious,
2005 dP-1.74b	Oriented,
	Afaliste.
	1 = ws-1,g,t
	W8 - BUE (3)
	PA-Sold wown
	Adv
	- vitals monstoning
	- Lollo w dry chat w/o distroy desatures
	, ,
	- Zyour 208
	B (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	(83543)
-	
-	<del></del>

Ē





#### Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.anbarasu mohanraj



Every heart beat counts

		DOCTOR'S PROGRESS NOTES
	DATE	NOTES
	H-12-23	5 B Do. Anusuya
	000	S/P-OPCARX 3.900HK
	4.301	patient reviewo
	2	clo mildPain in the susaical site.
	00	0/5' Patient Conscious, oriented, A7ephla
		CAR CARS-6162(P). CARS-NOPAID
		B-BAED · P/n - 607t, non-tend
	-	HE? Docksing intact
		- no kago
		nduiro.
		- monitor vitals
		- Confinue the dauge as
		Perchart :
		- Plan: Suture removal pa 15.12.23
		- mobilise the patient (tomestow)
_	J. J. J.	- Continue chest Physio & spiromo
	100	The state of the s
	1300	
(		
		,

DATE	NOTES	
1,0173		7
14/12/23	SIB-On. Hari Vignuti	1
P	on in	7
10bw /	Pt reviewd	1
	OlE-GL feil	
Vitaly Statu	Pt ionni on	
( talin	ogniented	<i>f-</i>
	:	
	SIE-US-5,526	_  
	LI BLAF D	4
	· · · · · · · · · · · · · · · · · · ·	4
	PIR-SOFT 7	4
	A7	4
	- N /	$\dashv$
	184	$\dashv$
	Vitals manitoring	$\dashv$
	- SR forwarrow	4
	$\sim 10^{-1}$	$\dashv$
	- Mobiling the pt	_ /_
	- Chur Physio / Spi nomi	7
	- Inform 505	7
		$\rfloor$





# Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



Every heart beat counts

DOCTOR'S PROGRESS NOTES		
DATE	NOTES	
15 12 23	S/B DO-ANWAYYO	
10-00AM	- POST OF COSE OF OPCABY 39X07-12	
	patient reviewed	
POD -14	, clo pour voduced now	
دے ــــــــــــــــــــــــــــــــــــ	SE CNS-6162P	
	RI - BAE (P)	
INTONS Stable	L/E: Guture removed	
Mar.	wound healthy Advice	
	A hoating - mo nitox vitals	
ho ho	- Continuo the same	
700	<u></u>	
1341615		
1.1.2	0) 10 10 10 10	
15/12/28	CICIR - 120 in Flago	
10:30pm	19052.012 Care of BIDCAB X B gruper.	
2 pilm	DIF: comoù, prented, afsile	
20 m	sn s/E.	
(Ok 10) 700	my Ws: (1820)	
3p - 101	12x BAECO	
pr-96-1.	YE.	
1	Supra romano	
	ward healty _ months withels	
	Fly - Collow up dry drave	
	January, Joseph.	



CHENNAI: # 2/26, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024.

Tel: 044 - 2473 4455 | Mobile No: 9962 985 985

KUMBAKONAM: No. 142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 61 2103. (Taniore Dist). Ph: 0435 - 2412345 | Mob : 7397720491

E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com

	Mrs.PREMA T	RE-OPERATIVE CHECKLIST			
Name .	, , ,	Age: 72 y Gender: 15 U	Age: 72 4 Gender: 15 UHID No.:20238603		
Ward:	di.anbarasu mohanraj		B.S.	A.S.	
	Clinical Diagnosis:			,	
	Proposed Procedure:  CAB (1)				
CHECKLIST					
1.	Identification Band on Hand Checked?				
2.	Surgical consent Signed? a. Special Consent signed if required.		_		
3.	Anesthetist Consultation (If required?)				
4.	History AND Physical Onchart?  a. Height				
5.	Allergic to drugs? po + (Anow?				
6.	Surgical Preparation done? 423.				
7.	Nill by Mouth From				
8.	Blood Grouping & Rh Typing				
9.	Investigation  X - Ray  LECG  LAB			<u> </u>	
10.	Blood Sugar 125 mg/al Time 6:30				
11.	TPR Chart Pulse 80.5/1/2 Temp 97°2 BP 130/70 RR 225/14				
12.	Time Voided a. Retention ☐ Yes ☐ No				
13.	Enema				

14.	a. Prosthesis Removed	1	
	d. Dentures Removed Yes No / Not Applicable		
15.	Valuables and Jewellery Removed  ☐ Yes ☐ No Secured ☐ Yes ☐ No	\	
16.	Pre-Operative Medication Admistered		
	a. Time b. Nurse		
17.	Blood Transfusion requisition Onchart		
18.	X-Ray No		
	ECG/ECHO	1	
	Ultra Sound	1	
	C.T. Scan	j	
	MRI Scan	J	
	TMT	<b>J</b>	
	Medication		
	10/12/23		
		_	
	7. Alpara 0.25 given	Olhi	
	. 0		
	Others		r,
		robeo	of Staffs
		~ <del>````</del> <del>````</del> <del>```</del> <del>```</del> <del>``</del>	28

Methol



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

#### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

## MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

	Name: Mrs. Prema T	Age 55 F UHID
	Diagnosis Effort Angue. Double vend disease.	Plan CARL
	Serology Serology	Stopped Avan er on 6/12/
	EURO Score / STS Score 0 69 1/2	PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):
	Diabetes Mellitus (HB1AC)	DM, HTW Associated Illness
	Carotid Doppler —	Thyroid Enzymes N 74 - 7-4
	Sr. Creatinine	Any other illness of concern
	Alien's Test	Myocardial viability if needed
	Varicose Veins	
}	Pulmonologist Clearance	•Nephro Clearance:
	Neurology Clearance :	Dental Clearance:
	Mitral Regurgitation Assessment Prival Me	
	Nursing:	Billing Clearance:
	Physiotherapy ~	Spirometry taught
	Concerns from Surgical Team :	SIGNATURE:

Mrs. Prema. T., a known ears of Type I DM, Eysternic hypesternion, Dysupidemia, effort Angina Double vessel disease has come for CABG. patient was apparently romal 1511 one wonth ago when the deseloped that pain a continue - retrosternal, radiating to the back, ansociated with palpitation and sweating. He Angua on Exertion xisdays. In tally the west to Dr. moostry's clinic where he was advised coronary Angügran. He ardinvent care on 2) (11/23 Which showed Double versel disease. Hence She was adviced casa, No the Breathlesses / Sprope / palpi. Iwelling & Legs. Go Bpm Simon shythm.

EIG:

\*. \* . . . . . . . . . . . . .







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

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ

1. Mr./Ms:/Mrs ......PREMA...
tick correct option and below):

need arises.

# **CONSENT FOR SURGERY**

. the Patient or Representative of patient have (Please

Read
[/We have been explained the current clinical condition of me/my patient
Been explained this consent form in English, which I fully understand and understood the information
provided about the disease באאמעםאליןאדנצאי בוצעפער אפעבער אונעפער בארעם אפער and about the
procedureCor እክቶችን ሕጹፕዌዶታ ቤሃየሕድሩ G. የልዚብ አፋ (full name of operation / procedure
given below in this consent form)
I am now aware of the intended benefits, possible risks and complications and available alternatives to the said operation / procedure. I am also aware that results of any operation / procedure can vary from patient to patient and I declare that no guarantees have been made to me regarding success of this operation / procedure. I am aware that while majority of patients have an uneventful operation and recovery few cases may be associated with complications. I am aware of the common risks and complications associated with this operation / procedures and understand that it is not possible to list all possible risks and complications of any operation / procedure.
I have been told about additional procedure that may be come necessary during the surgery which includes
I also understand that sometimes a planned operation / procedure may need to be postponed or cancelled if patient's clinical condition worsens or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequence by submitting the withdrawal in writing.
I am aware that I may require administration of blood and / or blood products during or after the operation / procedure as found necessary by the doctor (for which a separate consent shall be obtained).

I am also aware of the expected course after the operation / procedure and the care to be provided and understand that sometimes admission to an Intensive Care Unit and or extension of duration of hospitalization may be required and or there may be requirement of extra medicines or treatments thereby leading to increase in the treatment expenses depending upon the body's response to the treatment / procedure.

. Dive of

I am now also aware that during the course of this operation /procedure the doctor will be assisted by medical and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the

Possible risks & complications 1. Bleeding 2. Infection 3- Stroke
4. Smythmis 5- Prolonged Icu stay 6. Mild nisk to life
Benefits Symptom free survival
Alternatives Augh risk Proch.
■ The likelihood of success of the surgery (Percentage / Other commands) 969
* Possible results of non-treatment 1. Myocarduct infantion

• I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery 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 sign this form.

2. Heart Failure

DETAILS	PATIENT / RELATIVES	WITNESS		
Name ( in BLOCK LETTER)	MRS. PREMA	. JOBL		
Relationship	3elf	Hwsband		
Signature	T. Prens	· 7m)		
Date & Time	10/12/23@14.00	10/12/22@14.00		
Name & Signature of Doctor with Registration No.:				

112236

Dr. Anbarasu Mohani ... Reg No: 55476

**Doctor Seal** 







நோயாளி விவறங்கள்:(Affix Label here)	:
សវេមាក់ :	į
UKID :	•

பிறந்த தேதீ

## <u>அறுவை சிகிச்சை ஒப்புதல் படிவம்</u>

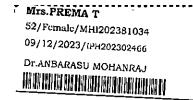
1. நான்	நோயாளி அல்லது நோயாளியின் பிரதிநிதி தயவுசெய்து மேலேயும் கீழேயும் பொருத்தமானன
தேர்வு வ	<del>ர</del> ய்யவும்
	யுக்கள்
or e	னது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.
இந்த ஒ	ப்புதல் படிவம் ஆங்கிலத்தில் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகீச்சையின் செயல்பாட்டின் முழுப்பெய
யல்மு	றை பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.
் நே	rக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன்.  மேலும் அந்த

- நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கிடைக்கச் செய்கிறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும் நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கிறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும் மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் தொடர்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் அடைமுறையுடன் தொடர்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கிறேன்.
- நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில நேரங்களில் தீட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து கொள்கீறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் தீரும்பப் பெறுதலை எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் தீரும்பப் பெற முடியும் மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நீர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).

இந்த அறுவை சிகிச்சை / நடைமுறையின் போது மருத்துவா் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவாா் என்பதையும், தேவை ஏற்பட்டால் தொடா்புடைய நிபுணா்களிடமிருந்து மருத்துவா் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது அறிவேன்.

• சாத்தியமான அபாயங்கள் மற்றும் சி	க்கல்கள்	1 ,
<del>- 4</del>		
நன்மைகள்		
மாற்றுவழிகள்		
• அறுவை சிகீச்சையின் வெற்றி வாய்	ப்பு (சதவீதம் / பிற கட்டளைகள்) 	
• சிகீச்சையின்றி சாத்தியமான முடிவுக	ன்	
நேரங்களில் தீவிரமான பராமரிப்பு	ழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்ப அலகு மற்றும் / அல்லது மருத்துவமனையில் எ ர் அல்லது சிகீச்சைகளின் தேவை இருக்கலாம். இ	அனுமதீக்கப்படும் கால அளவு தேவைப்படலாம்
எந்தவொரு திசு அல்லது உடல் பகுதி தகவல்களை நான் பெற்றேன் மற்ற நடைமுறை தொடர்பான கேள்விகளை நோக்கம் கொண்ட நன்மைகள் மற்ற	யை அகற்ற மருத்துவமனையை நான் அங்கீகரி றும் முழுமையாகப் புரிந்து கொண்டேன் என்று எக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அதவ றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும் னிலையில் செருகல் மற்றும் நிறைவு செய்ய வேவ	ழறையில் எனது உடலில் இருந்து அகற்றக்கூடிய க்கீறேன். இந்த ஒப்புதல் வடிவத்தீல் வழங்கப்பட்ட அறிவிக்கீறேன். எனது வியாதி, செயல்பாடு / ன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும் பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நான் ண்டிய அனைத்து துறைகளும் (இந்த வடிவத்தில்)
விபரங்கள்	நோயாளி / உறவினா்	சாட்சியம்
பெயர்		
உறவுமுறை		
கையொப்பம்		,
நாள் & நேரம்		
மருத்துவரின் பெயர் மற்றும் பதி	ų எண், കെயொப்பம்:	







# **CONSENT FOR ANAESTHESIA SERVICES**

1. NRS PREMA			e patient or 🖽 the	e representative of patient have,			
olease tick the correct option above and below) ☑ Read							
☐ nead ☐ i / We have been explained the current clinical condition of me / my patient							
Been explained this co	Been explained this consent form in English, which I fully understand and understood the information provided about						
Operation / Procedure							
(full name of operation   procedur	(AROMAPM	ARTERY	EYPHIS	GRAFTIMY			
(full name of operation / procedur	e given below in this o	consentform) <sup>[</sup>	•	•			
expected outcome and what needed for this operation, so to the with anaesthesia can occur sensation, loss of limb function. I understand that these risks at they may apply to a specificity for my procedure and that the physical condition, the type of the lithas been explained to me without sedation, may not sensethesia.	could happen if my of hat my doctor can perhat all forms of anaerand include the renorm, paralysis, stroke, be apply to all forms of a period anaesthesia. It is enaesthetic technic procedure, my doctor that sometimes an aucceed completely explained to me that and arterial Line	condition remains erform the operation sthesia involve so note possibility of prain damage, heat naesthesia and thounderstand that the ique to be used it or's preferences, anaesthetic technand therefore ar the following may Lumbar Punctur	e untreated. I also on or procedure. I also on or procedure. I also of infection, bleed art attack or death. I also of anaes of determined by reas well as my own inque which involved the rechnique.  The procedure of the procedure of the procedure of the procedure.	pecific risks have been identified below, as thesia service checked below will be used many factors including my / my relative's desire.  I wes the use of local anaesthesia, with or may have to be used including general rt of anaesthesia during or after surgery omy			
General Anaesthesia	Expected Results	Total unconsciou maintain airway	us state that may inv	volve placement of a tube into the windpipe to			
Alternatives	Technique		the blood stream, b	preathed into the lungs, or given by other routes			
☐ Spinal ☐ Epidural	Risks	Sore throat, injur	y to vocal cords, tee ction / memory los	th, lips, eyes; awareness during the procedure, ss, aspiration pneumonia, permanent organ			
☐ Others	Benefits	- Early Recovery					
	Denems	- Relief of Anxiety					
Spinal or Epidural Analgesia / Anaesthesia	Expected Results	Temporary decre	eased or loss of feel	ing and / or movement in the lower half of the			
☐ With Sedation /GA ☐ Without Sedation	Technique		ough a r eedle / cath utside the spinal can	neter placed either directly into the spinal canal al			
☐ GA ☐ Others							
	Benefits	Post-operative p		ral catheter that can be left in-situ safer under			
Major / Minor Nerve Block	Expected Results	Temporary loss of	offeeling and / or mov	vement of a specific limb or area			
☐ With Sedation / GA☐ Without Sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation					
Alternatives ☐ GA	Risks			tion, bleeding / hematoma, toxicity due to local overt to general anaesthesia, brain damage			
<ul><li>☐ IV Regional Anaesthesia</li><li>☐ Spinal/Epidural Anesathesia</li><li>☐ Others</li></ul>	Benefits	- Pain Free - Safer under cer	tain conditions				

	legional Anaesthesia	Expected Results	Temporary loss of feeling and / o	r movement of a limb	1	1	
<ul><li>☐ With Sedation / GA</li><li>☐ Without Sedation</li></ul>		Technique	Drug injected into veins of arm or leg while using a tourniquet				
Alternatives		Risks	Infection, convulsions, persistent numbness residual pain, injury to blood vessels				
☐ Major/Minor Nerve Block ☐ GA		_ "	- Pain Free		· · · · · ·		
☐ Others		Benefits	- Safer under certain conditions				
Monitorer	aesthesia care	Expected Results	Decreased anxiety and light sedation similar to normal sleep				
(with sed	aestresia carc	Technique	Drug injected into vein of arm				
Alternat □ Ger ana	aesthesia	Risks	Prolonged sedation, need for air	way control			
🔲 Spinai / Epi		Benefits	Anxiety free; Early discharge			_	
Others		— —					
_	aesthesia Care	Expected Results	No changes in the system		<i>;</i>		
(without sedati Alternatives	on)	Technique	None				
☐ General and ☐ Mild Sedation		Risks	Patient may have pain and anxie	ety	·		
Others	Off	Benefits	Early discharge				
	· · · ·		Fig. 1 Ton.			_	
	EARLY CHILDHOOL			•			
			pehaviour and learning with pruring pregnancy and in early cl		ted exposure to g	eneral	
		•	unng pregnancy and meany c sentative, do further hereby de		we 18 years of age	200	
			n giving consent without any fe			2 a S O I I	
		•	,	·	•	,	
		- (-) ( (-) 4	hailba				
	=		hat I have been made aware of elf or 🔲 my above named patie		•		
	•	•	•	ent being luny awar	e or the nature, po	iteritiai	
risks and complications, intended benefits and possible alternatives.							
			tative, do further hereby declar			on the	
			tative, do further hereby declar g consent without any fear, thre			on the	
	g this form, mentally s	sound and am giving	g consent without any fear, thre		eption.		
	g this form, mentally s		consent without any fear, thre	at or false misconc		on the	
	g this form, mentally s	humb Impression	* Name	at or false misconc	eption.		
date of signin	g this form, mentally s	humb Impression	* Name	at or false misconc	Date	Time	
date of signing Patient Surrogate/Guar	g this form, mentally s	humb Impression	* Name  MRS. PREM	at or false misconc	Date	Time	
date of signin	g this form, mentally s Signature / T	humb Impression	* Name  * MQ2 PREM /  (Write name and relations	at or false misconc	Date	Time	
date of signing Patient Surrogate/Guar	g this form, mentally s Signature / T	humb Impression	* Name  * MQ2 PREM /  (Write name and relations	at or false misconc	Date	Time	
Patient Surrogate/Guar (if applicable #)	g this form, mentally s  Signature / T  dian  Patient is una	humb Impression	* Name  * MQ2 PREM /  (Write name and relations	at or false misconc	Date	Time	
Patient  Surrogate/Guar (if applicable #)  Reason for	g this form, mentally s Signature / T dian Patient is una	humb Impression	* Name  * MQ2 PREM /  (Write name and relations	at or false misconc	Date	Time	
Patient  Surrogate/Guar (if applicable #)  Reason for	g this form, mentally s Signature / T dian Patient is una	Thumb Impression Thumb Impression Thumb Impression	* Name  * NAME  MRS. PREM *  (Write name and relations  nt because:	at or false miscond	Date  (0) (2) 28  (0) (2) 23	Time 18-00	
Patient Surrogate/Guar (if applicable #) Reason for surrogate conso	g this form, mentally s  Signature / T  dian  Patient is una	Thumb Impression Thumb Impression Thumb Impression	* Name  * MQ2 PREM /  (Write name and relations	at or false miscond	Date	Time	
Patient Surrogate/Guar (if applicable #) Reason for surrogate conse	g this form, mentally s  Signature / T  dian  Patient is una	Thumb Impression Thumb Impression Thumb Impression	* Name  * NAME  MRS. PREM *  (Write name and relations  nt because:	at or false miscond	Date  (0) (2) 28  (0) (2) 23	Time 18-00	
Patient Surrogate/Guar (if applicable #) Reason for surrogate conse	Signature / T	Thumb Impression Thumb Impression Thumb Impression	Name  * Name  MRS. PREM  (Write name and relations  nt because:	at or false miscond	Date  (0) (2) 28  (0) (2) 23	Time 18-00	
Patient Surrogate/Guar (if applicable #) Reason for surrogate conse	g this form, mentally s  Signature / T  dian  Patient is una	Thumb Impression Thumb Impression Thumb Impression	* Name  * NAME  MRS. PREM *  (Write name and relations  nt because:	at or false miscond	Date  (0) (2) 28  (0) (2) 23	Time 18-00	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate const  Witness  Interpreter (if applicable)  * Right Hand for Management of the surrogate const  * Right Hand	Signature / T  dian  Patient is unatent	Thumb Impression	Name  * Name  MRS. PREM A  (Write name and relations  Int because:  B. (anis)	at or false miscond	Date  10/12/28  10/12/23	Time 18.00	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate const  Witness  Interpreter (if applicable)  * Right Hand for M	Signature / T  dian  Patient is unated to the state of th	Thumb Impression Thumb	Name  * Name  MRS. PREM I  (Write name and relations  Int because:  B. (an) 8  atient is a minor or unable to give  e, potential risks and complice	at or false miscond  A  ship with patient)  consent  ations, intended b	Date  IO 12 28  IO 12 23  IO 12 23	Time 18.00 18.00	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate const  Witness  Interpreter (if applicable)  * Right Hand for Management of the surrogate const  1, the underst procedure const  1	Signature / T  dian  Patient is unated to the state of th	Thumb Impression Thumb	Name  * Name  MRS. PREM A  (Write name and relations  Int because:  B. (anis)	at or false miscond  A  ship with patient)  consent  ations, intended by to the patient / patient	Date  IO 12 28  IO 12 23  IO 12 23	Time 18.00 18.00	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate const  Witness  Interpreter (if applicable)  * Right Hand for Management of the surrogate const  1, the underst procedure const  1	g this form, mentally so Signature / To dian  Patient is unatent  Patient of the source of the source, and possible at the / she has understood to the source.	males   # Only if Pa	Name  * Name  MRS - PREM A  (Write name and relations  Int because:  B - Vanis  atient is a minor or unable to give  e, potential risks and complice  anned operation / procedure, to  fully as described in this documents	at or false miscond  ship with patient)  consent  ations, intended by the patient.	Date  Col 12 122  Col 12 12 2  Col 12 12 2	Time 18.00 18.00 post- e. I am	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate const  Witness  Interpreter (if applicable)  * Right Hand for Management of the surrogate const  1, the underst procedure const  1	Signature / T  dian  Patient is unated to the state of th	Thumb Impression Thumb	Name  * Name  MRS. PREM /  (Write name and relations  Int because:  B. (Can'i &  atient is a minor or unable to give  e, potential risks and complice  anned operation / procedure, if  fully as described in this documents	at or false miscond  A  ship with patient)  consent  ations, intended by to the patient / patient	Date  IO 12 28  IO 12 23  IO 12 23	Time 18.00 18.00	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate conse  Witness  Interpreter (if applicable)  * Right Hand for Management of the confident that	g this form, mentally so Signature / To dian  Patient is unatent  Patient of the source of the source, and possible at the / she has understood to the source.	males   # Only if Pa	Name  * Name  MRS. PREM   (Write name and relations on the because:  B. Vanis  atient is a minor or unable to give on the complete of the comp	consent ations, intended by the patient,  Reg. No.	Date  Coll2/22  Coll2/23  Coll2/23  Coll2/23  Coll2/23  Conefits, expected ent representative	Time 18-00 18-00 post-e.lam	
Patient  Surrogate/Guar (if applicable #)  Reason for surrogate conso  Witness  Interpreter (if applicable)  * Right Hand for Management of the consolident that	g this form, mentally so Signature / To dian  Patient is unatent  Patient of the source of the source, and possible at the / she has understood to the source.	males   # Only if Pa	Name  * Name  MRS. PREM /  (Write name and relations  Int because:  B. (Can'i &  atient is a minor or unable to give  e, potential risks and complice  anned operation / procedure, if  fully as described in this documents	at or false miscond  ship with patient)  consent  ations, intended by the patient.	Date  Col 12 122  Col 12 12 2  Col 12 12 2	Time 18-00 18-00 post-e.lam	



நோயாளி விலரங்கள் பெயர் :	: (Affix Label here)
VHID:	
பிறந்த தேதி:	பாலினம்:
சேர்க்கை தேதி:	
மருத்துவர்:	



# மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1. நோயாளி					
—— மேலேயும் கீழேயும் சரியான விருப்பத்	 தைத் தேர்ந்தெடுங்கள்)	பழத்தல்			
என்னை / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம்					
விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்	ட தகவல்களை நான் மு	ழுமையாக புரிந்துகொண்டேன்.			
செயல்பாடு/செயல்முறை		- '' -			
· · · · · · · · · · · · · · · · · · ·					
<del></del>					
இந்த ஒப்புதல் படிவத்தின் கீழே கொடு	க்கப்பட்ட செயல்பாட்டு ந	டைமுறையின் முழு பெயரி			
எதீர்பார்க்கப்பட்ட முடிவைப் பற்றி எ	என்னிடம் கூறினார். எல	ாங்களை விளக்கியுள்ளார் மற்றும் மாற்று கிகீச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து ன், இதனால் எனது மருத்துவர் அறுவை சிகீச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.			
கடுமையான சிக்கல்கள் ஏற்படல	ாம். தொற்று நோய், இ	யங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத நூத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.			
அடையாளம் காணப்பட்டுள்ளன விண்ணப்பிக்கலாம். கீழே சரிபார்க்	ா என்பதையும் நான் கப்பட்ட மயக்க மருந்து	மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே புரிந்து கொள்கீறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை			
		படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் நந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.			
🔲 பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாலையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை			
மாற்று மருந்து	நுட்பம்	இரத்த ஓப்டத்தில் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகின்றன			
முதுகெலும்பு இவ்விடைவெளி	<b>அ</b> பாயங்கள்	தொண்டைப்புண், குரல் வடங்கள், பற்கள், உதடுகள், கண்கள், செயல்முறை, நினைவக செயலிழப்பு, நினைவக இழப்பு, அயிலாஷைகள், நிரந்தர உறுப்பு சேதம், மூளை சேதம் ஆகீயவற்றின் போது விழிப்புணர்வு			
🔲 மற்றவை	நன்மைகள்	- ஆரம்ப மீப்பு - பதட்டத்தீன் நிவாரணம்			
முதுகெலும்பு அல்லது இவ்விடைவெளி / மயக்க மருந்து	எதீர்பார்க்கப்படும் முடிவுகள்	உடவின் கீழ்பாதீயில் உணர்வு அல்லது இயக்கத்தீன் தற்காலிக குறைவு அல்லது இழப்பு			
☐ மயக்க மருந்து / பொது மயக்க மருந்து	<b>நி</b> ரா <b>ர்</b>	ஊசி / வடிகுழாய் வழியாக செலுத்தப்டும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாயுக்கு வெளியே வைக்கப்படுகிறது.			
□ மயக்க மருந்து இல்லாமல் மாற்று மருந்து □ பொது மயக்க மருந்து	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தம்போதல், ஹெமடோமா, உள்ளூர் மயக்க மருந்து, நாள்பட்ட வலி, மயக்க மருந்து, மூளை சேதத்திற்கு மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை			
	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிட்யூவில் பாதுகாப்பாக விடக்கூடிய எபிட்ரி வடிகுழாய்களுடன் செயல்பட்டு வலி நிவாரணம்			
பெரிய / சிறிய நரம்புத் தொகுதி ப மயக்க மருந்துடன் / பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு அல்லது பகுதீயின் தற்காலிக இழப்பு			
	நூப்பம்	செயல்பாட்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகீல் மருந்து செலுத்தப்படுகிறது			
□ பொது மயக்க மருந்து □ IV பிராந்தீய மயக்கமருந்து	<b>அ</b> பாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெமடோமா, உள்ளூர் மயக்க மருந்து,மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூளை சேதத்திற்கு மாறுதல்			
முதுகெலும்பு / இவ்விடைவெளி மயக்கமருந்து மற்றவை	நன்மைகள்	— வவி இலவசம் — சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை			

நரம்பு மண்டலம் ம மயக்க மருந்த	muša ipašai					
		எதிர்பார்க்கப்படும் முழவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு இய	க்கத்தீன் தற்காலிக இ	វិសិក្ខាក់ ,	
🗌 மயக்க மருந்து இல்லாமல்		இராம	ஒரு டூர்னிக்கேயைப் பயன்படுத்தும் போது கை அல்லது கை நரம்புகளில் செலுத்தப்படுகிறத			
மாற்றுகள் 🔲 பெரிய / சிறிய	ப நரம்பு தொகுதி	அபாயங்கள்	தொற்று, வலிப்பு, தொடர்ச்சியான உணர்வின்	ள் <b>மை</b> , மீதமுள்ள வலி	, இரத்த காயங்க	ளுக்கு காயம்
☐ பொதுவான ம ☐ மற்றவை		நன்மைகள்	– வலி இலவசம் – சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை			
கண்காணித்த மயக (மயக்கத்துடன்)	க்க மருந்து கவனிப்பு	எதிர்பார்க்கப்படும் முடிவுகள்	சாதாரண தூக்கத்தைப்போன்ற கவலையும்		<b>ருகிறது</b>	
மாற்றுகள்		நுட்பம்	கையின் நரம்பில் மருந்து செலுத்தப்படுகிறத			
☐ பொதுவான மய ☐ முதுகெலும்பு / இவ்	கக மருநது !விடைவெளி மயக்க மருந்து	அபாயங்கள்	நீண்ட கால மயக்கம், காற்றுப்பாதை கட்டுப்ப	பாடு தேவை	_	
🔲 மற்றவை	<b>9</b> , 9	நன்மைகள்	கவலை இலவசம், ஆரம்ப கால வெளியேற்	ച്ത്യർ		
கண்காணித்த மயக் (மயக்கம் இல்லாமல்	 க்க மருந்து கவனிப்பு ல்)	எதீா்பாா்க்கப்படும் முடிவுகள்	கணினியில் மாற்றங்கள் இல்லை			
மாற்றுகள்   பொதுவான மய	uie perior	நுப்பம்	இல்லை			
🔲 இலேசான மய		அபாயங்கள்	நோயாளிக்கு வலி மற்றும் கவலை இருக்கல ———————————————————————————————————	dino		
் மற்றவை	<u> </u>	நன்மைகள்	ஆரம்ப வெளியேற்றம்			
பிறப்புக்கு முந்தைய	/ ஆரம்பகால குழந்தை	பருவ மயக்க மருந்	對			
			ர்மறை விளைவுகள் பொது மயக்க மருந்து / மி. நம் மீண்டும் மீண்டும் வெளிப்படுதல்	தெமான மயக்கம் / கர்ட்	rப காலத்தில் மற்ற	றும் ஆரம்ப
			ின் பிரதிநிதி, இந்த வடிவத்தில் கையெழுத்திட் வயதுக்கு மேற்பட்டவன் என்று இதன்மூலம் அ!		ாக ஒலி மற்றும்	எந்தவொரு
மேற்கூறிய செயல்பா	ாட்டிற்கு (எஸ்) / நடைமுல	<b>ுற (கள்) எனக்கு தெ</b>	ரிந்துவிட்டது. நான் தானாக முன்வந்து எனது	ு ஒப்புதலை வழங்குகி	മ <u>്</u> വാൽ	
டாக்டர் (டாக்டர்) டி. அ	Ii Ii Ii Ii Ii Ii II II II II II II II I	ட செயல்பாடு / நஎ	் நார்கள் செய்வதற்கு அறுவை சிகிச்சை	செயல்முறையைச் செ	சய்வதற்கான டா	க்டர் பெயர்,
			பாயங்கள் மற்றும் சிக்கல்கள் மற்றும் சாத்திய			
நான் / மேற்கூறிய (	இதன் எனி/பெயரிடப்பட்	. Granumathylain i	ரதிநீதி, இந்த வடிவத்தில் கையெழுத்தீடப்பட்ட	சேசி புரை ரீசியாக 19	. அண்டுகள் சிர	rionan unitrain
			ந்தந்து, இந்த விடிவத்தில் என்று மேலும் இத ன்றி ஒப்புதல் அளிக்கீறேன் என்று மேலும் இத			ואסוופן בוונטו
-	கையொப்பம் /	கட்டை விரல் பதிவு	* பெயர்		தேதி	
நோயாளி						நேரம்
நோயாளிகளின் பிரதிநித	a /		l l			நேரம்
பாதுகாவலா	56 / I					நேரம்
(பொருந்தும் என்றால்)			(நோயாளியுடன் பெயர் மற்றும் உற	றவை எழுதவும்)		நேரம்
(பொருந்தும் என்றால்) நோயாளிகளின் பிரதீந்	)		(நோயாளியுடன் பெயர் மற்றும் உற	றவை எழுதவும்)		நேரம்
நோயாளிகளின் பி <u>ரதீர்</u> சம்மதத்திற்கான	) B\$	5ல் அளிக்க முடிய	நோயாளியுடன் பெயர் மற்றும் உற வில்லை ஏனெனில்	றவை எழுதவும்)		நேரம்
நோயாளிகளின் பி <u>ரதீர்</u> சம்மதத்தீற்கான காரணம்	) B\$	தல் அளிக்க முடிய		றவை எழுதவும்)		நேரம்
நோயாளிகளின் பி <u>ரதீர்</u> சம்மதத்தீற்கான காரணம் சாட்சி	) த்தி நோயாளி ஒப்பு	தல் அளிக்க முடிய		றவை எழுதவும்)		நேரம்
நோயாளிகளின் பி <u>ரதீர்</u> சம்மதத்தீற்கான காரணம்	) த்தி நோயாளி ஒப்பு	தல் அளிக்க முடிய		றவை எழுதவும்)		நேரம்
நோயாளிகளின் பி <u>ரதீந்</u> சம்மதத்திற்கான காரணம் சாட்சி மொழிபெயாப்பாளர் (பொருந்தீனால்)	) நேரயாளி ஒப்பு				பண்களுக்கான இ	
நோயாளிகளின் பி <u>ரதீர்</u> சம்மதத்திற்கான காரணம் சாட்சி மொழிபெயாப்பாளர் (பொருந்தீனால்) * நோயாளி ஒரு சிறிய	) நோயாளி ஒப்பு ஹாக இருந்தால் அல்ல	நூ சம்மதத்தை வழ	வில்லை ஏனெனில் நிக்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான	ர வலது கை மற்றும் டெ		இடது கை
நோயாளிகளின் பிரதீந் சம்மதத்திற்கான காரணம் சாட்சி மொழிபெயாப்பாளர் (பொருந்தீனால்) * நோயாளி ஒரு சிறிய	) நேரயாளி ஒப்பு வராக இருந்தால் அல்ல மருத்துவர், இயல்பு, சாத	ந்து சம்மதத்தை வழ	வில்லை ஏனெனில் ங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட ந	ர வலது கை மற்றும் டெ நன்மைகள், எதிர்பார்ச்	கப்பட்ட பின் நன	ு இடது கை மடமுறைக்கு
நோயாளிகளின் பிரதீந் சம்மதத்திற்கான காரணம் சாட்சி மொழிபெயர்ப்பாளர் (பொருந்தீனால்) *நோயாளி ஒரு சிறிய நான் நியமிக்கப்பட்ட ப	ற்றும் திட்டமிடப்பட்ட மற்றும் திட்டமிடப்பட்ட	நூ சம்மதத்தை வழ த்தியமான அபாயர் செயல்பாடு/ நடை	வில்லை ஏனெனில் நிக்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான	ர வலது கை மற்றும் டெ நன்மைகள், எதிர்பார்ச் ரி / நோயாளி பிறதிநீச்	கப்பட்ட பின் நன	ு இடது கை மடமுறைக்கு
நோயாளிகளின் பிரதீந் சம்மதத்திற்கான காரணம் சாட்சி மொழிபெயர்ப்பாளர் (பொருந்தீனால்) *நோயாளி ஒரு சிறிய நான் நியமிக்கப்பட்ட ப	ந்தி நோயாளி ஒப்பு வநாக இருந்தால் அல்ல நருத்துவர், இயல்பு, சார மற்றும் திப்பமிடப்பட்ட கப்பட்டுள்ள தகவல்களை	ந்தியமான அபாயர் செயல்பாடு/ நடை எ அவர் / அவள் மு	ங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட ந மறைக்கு சாத்தியமான மாற்றுகள், நோயாள முமையாகப் புரிந்து கொண்டார் என்று நான் நட	ர வலது கை மற்றும் பெ நன்மைகள், எதிர்பார்ச் ரி / நோயாளி பிரதிநீத் ந்புகிறேன்.	கப்பட்ட பின் நன நீக்கு விளக்கியுள்	இடது கை நடமுறைக்கு எளார். இந்த
நோயாளிகளின் பிரதீந் சம்மதத்திற்கான காரணம் சாட்சி மொழிபெயாப்பாளர் (பொருந்தீனால்) *நோயாளி ஒரு சிறிய நான் நியமிக்கப்பட்ட ப வரும் நடைமுறைகள் ஆவணத்தீல் விவரிக்க	ற்றும் திட்டமிடப்பட்ட மற்றும் திட்டமிடப்பட்ட	ந்து சம்மதத்தை வழ ந்தியமான அபாயர் செயல்பாடு/ நடை எ அவர் / அவள் மு	ங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட ந மறைக்கு சாத்தியமான மாற்றுகள், நோயாள முமையாகப் புரிந்து கொண்டார் என்று நான் நட	ர வலது கை மற்றும் டெ நன்மைகள், எதிர்பார்ச் ரி / நோயாளி பிறதிநீச்	கப்பட்ட பின் நன	ட் இடது கை மடமுறைக்கு
நோயாளிகளின் பிரதீந் சம்மதத்தீற்கான காரணம் சாட்சி மொழிபெயர்ப்பாளர் (பொருந்தீனால்) *நோயாளி ஒரு சிறிய நான் நியமிக்கப்பட்ட ப	ந்தி நோயாளி ஒப்பு வநாக இருந்தால் அல்ல நருத்துவர், இயல்பு, சார மற்றும் திப்பமிடப்பட்ட கப்பட்டுள்ள தகவல்களை	ந்தியமான அபாயர் செயல்பாடு/ நடை எ அவர் / அவள் மு	ங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட ந மறைக்கு சாத்தியமான மாற்றுகள், நோயாள முமையாகப் புரிந்து கொண்டார் என்று நான் நட	ர வலது கை மற்றும் பெ நன்மைகள், எதிர்பார்ச் ரி / நோயாளி பிரதிநீத் ந்புகிறேன்.	கப்பட்ட பின் நன நீக்கு விளக்கியுள்	இடது கை நடமுறைக்கு எளார். இந்த
நோயாளிகளின் பிரதீந் சம்மதத்தீற்கான காரணம் சாட்சி மொழிபெயாப்பாளர் (பொருந்தீனால்) * நோயாளி ஒரு சிறிய நான் நியமிக்கப்பட்ட ப வரும் நடைமுறைகள் ஆவணத்தீல் விவரிக்க	ந்தி நோயாளி ஒப்பு வநாக இருந்தால் அல்ல நருத்துவர், இயல்பு, சார மற்றும் திப்பமிடப்பட்ட கப்பட்டுள்ள தகவல்களை	ந்தியமான அபாயர் செயல்பாடு/ நடை எ அவர் / அவள் மு	ங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட ந மறைக்கு சாத்தியமான மாற்றுகள், நோயாள முமையாகப் புரிந்து கொண்டார் என்று நான் நட	ர வலது கை மற்றும் பெ நன்மைகள், எதிர்பார்ச் ரி / நோயாளி பிரதிநீத் ந்புகிறேன்.	கப்பட்ட பின் நன நீக்கு விளக்கியுள்	இடது கை நடமுறைக்கு எளார். இந்த





# ANAESTHESIA RECORD



The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)			Every heart beat counts
T' MIS.PREMA T	Type of Surgery : ☐ Da	V Coro VI El	<del>`</del>
52/Female/MHI202381034			
09/12/2023/IPH202302466	Blood Group : Bto He		ms Weight: 66 Kgs
T Dr.ANBARASU MOHANRAJ	Pre-Operative Diagnos	sis: >v>/e	F-61-X / TZ DM / SHT
: 6	Proposed Surgery:	Anaes	sthetic Plan
ASA Grade: □ I □ II □ II □ IV □ V □ E	CARG	<i>5</i> 1	9A
	DMORBIDITY		Present Medication :
ANGINA DEPARTMENT	,		met xL
☐ DYSPNOEA ☐ SYNCOPE		OL	
- IVII	ASTHMA / COPD ☐ GERD HYPO THYROID ☐ CKD / N	IEDHDODATHV	
I = ==================================	STROKE/TIA 🔲 DRUGA		Anti Platelet Stopped on :
_	EPILEPSY   EPILEPSY		6.12.23
Physical Examination :	YSTEMC EXAMINATION	 	
☐ JAUNDICE ☐ PEDEL OEDEMA	CVC	CNS	s: 100
☐ CYANOSIS ☐ CAROTID BRUIT	RS: (G)	Others	3: ·   <b>6</b>
HR: 20 NIBP: 130/59	SP02:	97 1	TEMP:
INVESTIGATION  HB : 14.0 T.BILIRUBIN : 0.3 T3 :	3-8 SEROLOGY A	ANGIO DV	D - (LAD+RCA)
15 A 1	- ~ F		
TC : 11590 I.D. : 0.2 T4 :	Urine:	CG	
UREA : 23 D. : 0 · 1 TSH : .	3		
T-PROTFINS: 7.7	6.6	CXR (A)	
CREAT: 0.8 HBA1C:	Others:		
K+ : 3 .5 PTT/INR 10.8/0.9 RBS :.	E	ECHO 🛵	F-61 %
APTT : 24.6			, , , , , , , , , , , , , , , , , , ,
		•	
Teeth Bruk Leath (+) CAROTID DO	PPLER		
Mallampatti class I	٠.		
		· ·	<del></del>
Mouth Opening Neck Movement	٥	Other Opinion	s:
TM Distance			
Pre OP Instruction : NPO From:	12 mm		· ,
Pre Medication: T. Pro 44 my  T. Al prova 0.25 my  Night Before Surgery:	<sub> </sub>	lload Dassers	_
Night Before Surgery:	-	Blood Reservatio	•
2is morphine 5 mi	√ · 1.	PCV : (	
Day of Surgery 2:5 phenogen 12:5	my 11.m   F	FP :	CRYO:
Special Instruction :	0 1 v	Vhole Blood:	
Remarks:			
<del></del>	<u> </u>		<del>- 12  </del>
Anaesthetist Name with Reg.No. : Dr. P.	PRAVEEN	Signature	: T/

מ	ate:	Anaesthetis		,		Surgeo	n 4	4 1				esia Technique
<u>ر</u>		Anaesthetis	<u>s . s.lw.</u>	<u>M</u>	200			Ambar		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
PI	HE IN	IDUCTION AN	IAESTHE	SIA RECO	טאט	MONITO □NIBP	RS AND	EQUIPN		GENE	HAL ANAES	IHESIA
Pu	lse: <u>"</u>	6 mt BP: 15	131124434	<sup>38:</sup> फ्रिफ	<del>"</del>	TSECG SI			-	Pre O, Ra	oid Sequence	LW
Se	nsori	um: <u>ゝゝし</u> Completed:	<u>, , , , , , , , , , , , , , , , , , , </u>	 NI_	1					☐ Inhalation - A	rent used: 👂	software -
					. T	Gas Analy	_					neous Geontrolled
EQ	TO CO	An Shakeli	Mamo (	1001EK	ارداه	Disconne		Temperatur		AIRWAY MAN		9,5 Type:
Tin	)/ I no:	No. 30	): '43'57	<del>g A S S</del>		□Foley Cat			'	CL Grade: I	II / IV Secured at	:cm
-	ue		T SAFET			☐ TEE 4 (		Others:		CL Grade: I(II) I Any difficulties ar	d accessories:	Bongie
<del> -</del>						□ ¢vc type	10 C20	_ Site	730,	Throat Pack:		emoved
Po	sition	on Table: e points check	Section Section	400 d 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Standard	Asepsis	□usg Gu	idance	OTHER AIRWA		
		e politis check e: ⊡Yes, □N		ueu.v_ 16	SLINU	Complica	tions: 🗌 Ye	s <b>□</b> √No		☐LMA Type &	Size:	
		Beit: ☑Yes ☐				If Yes, det ☐ Arterial Li	tails:	200	0.		omy Face Ma	ask 🗌 Nasal Prongs
		g Blanket: 🗀 🖰		1		☐ Arterial Li	ne - Type:	Site:	syc ·	Others:		
		armer: 🗆 Yes				PVC Type	E>+Ug	Site: 16	megli	Antibiotic / Dose	e / Time	a a am
		ckings: Ye				— □PVC Type	o miszte	Site:	1507	og ceft	soli randou	9-20 m
	quen Yes∕	tial Compressi	on / Deco	npressio	n:	Others:		•	- America	Reversal of Ana		
┝╌	PROPO		· ·	<u> </u>					1	<del> </del>	<del></del>	
1	MIDAZ	OLAM	3	10/	e1		2.00		7			
	FENTAL MORPH		<del>                                     </del>	12%	75	50	<u>_</u>		75			
i	VECUR	MUINO	8'	3)	1	1	1_	ļ	1		1	
GS	ETOMII KETAM SUXA/F	DATE		<del>                                     </del>					-			
	SUXA/F	ROCURONIUM	ļ									
"		ACUBIÚMATRACURIUM SUFLURANE	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	٠,٠		\ \sigma			1			
	Air/N <sub>2</sub> O			<b>✓</b>	<i>-</i>	<u></u>	7	~~	^	$\overline{}$	1	,
_	Time	89	<del> </del>	42	3	120	30 1	· (k3	10	1230		
		200										
i	Systo	llic V 180	+++	╂┼┿┪	<del>-   -   -</del>	++-		<del>}                                    </del>	$\overline{}$	<del>                                     </del>		
	Diasto	olic_ A						1.				
Į.	Pulse	160	1,			+	<del>-  -  </del> -			<del>┨╺</del> ┼╸┼╶╂┈┼╸	++++	
		140	<del></del>									
ŝ		120	<del>                                     </del>	M		╋╌┼╌┼	-	<del></del>	┢┼┼	<del>                                     </del>		
SIGNS	Resp.	- ''		T V		44				M		
	Opera	ation 🔘	+++		<del>-</del>	$+$ $^{\prime}$ $^{\prime}$			<del>///</del>	+ + + + +	+ + + +	
VITAL		80	<del></del>									
		- 60	e   •   •	•		A 0 4	• •	e 9	0 1 6	<del>                                      </del>		<del>╎┤┤</del>
1												
ļ	Temp	40 X				+++			++		+++-	
		20										
•	-		+		++	+++		<del>                                     </del>			+	┝┼┼┼┼┼┤
~	SPO2		100%	100 1/1	Jog [/	100 %	1201	100 1/1	N 641	150°/2		
MONITOR	CVP PAP		<del>  6</del>	7 7	<b>-</b>	G'		6	<i>R</i> -			
8   8	ETCO, Urine O	utput	all a	25	عابو	35.	% > ≥	no ml	25	95		
ĮΣ											,	
i—	PH		71,39				-		7.419			
Ī	PCO,		421			1			34,19			
	Na'		املا						115.3			
ABG	K. HCL	<u> </u>	3.07						3.53			
Į₹	RBS LAC		1 ,						0			
<b>S</b>	BE HCO,		3.7						ار کھ			
							P -	1 5 24				
			l .	I		I		э .;и.	?	j		<u>.                                      </u>

.-

		START		STOP	FLUID TRA	NF	USED	BLOC	D PR	ODUCTS
ANAESTHE	SIA	8,30		12,15	CRYSTALOII		COLLOID		,	
PROCEDU	IRE	9,50		12,05	Makely 10	1			•	
СРВ	-	-OPCAB-					1		-	
AXC										7
CUF: MUF:									•	
	Н	EPARIN			L		SSURE MO	NITOR		
DOSE		TIME	_	ACT	PRE OP		<u>.                                      </u>		<del></del>	
125mg		101.27	-	<u> 363</u>	PA ·		RV		PC	WP
			_   -		ABP					
	Р	ROTAMINE			POST OP				, .	
DOSE		TIME.		ACT	PA		RV		PC	WP
_too mg		11:32		120			1 114		1	
INOTRO	PES & I	NFUSIONS			ABP	7				
DRUG	DOS	SE STA	₹T	END	DRUG		DOSE	STAR	T	END
DILUTION	(RAN	GE) TIM	E	TIME	DILUTION	(	(RANGE)	TIME	Ξ :	TIME
Novagrafine 4208 50 sol	105/17/14	Pmt 105/118	Int.	continued				^ •		
Adamalín Brog 150 ml	41743	02-101/1/	stut	Continued Stopped						
0.	70,									
	<del></del>									<del></del>
						$\vdash$	<u> </u>			
	<u> </u>								]	
REGIONAL DETAILS:	LANAES <sup>T</sup> Refere	THESIA YÉS / Pb	NO	n/ Bop/vacame	IABP: No	<u>ل</u>				
15 + 15	· 사 15 수	15		y, Ropivacalus fumral block	ECMO: אוע	_				
10 m of	1126./	buplraema	(I) -	funal block-	- •					
					TEE: いル					
REMARKS	/ CRITIC	AL EVENTS								
					ı					
				COLODIA.	. SAMUEL .	A :	Dr			
		D	: A. S	ĄMUEL SYLV	ESTEROPA		1	1 0		
ANAESTH	ESIOLOG	IST NAME[:	R	leg.₋No: 4357	n 1-		SIGNATURĘ	مريلا بط	,	

.

	~	POST OPER	ATIVE PLAN				
Transfer to: 🕡 🕏 CU	Other	s, specify:					
Arrival in Recovery / ICU  SpO <sub>2</sub> : 100 % HR:  ABP : 101 56 mmh  Conscious state: Seda	<mark>G&amp;∕</mark> Hg CV	beats/min Rhythn	n: Regular RR:	mmHg			
VENTILATOR SETTINGS:  RR 14/mt; TV & PEEP Smm Hg.	Volum	confort's	IONOTROP	res: *02/^\\	nt,		
POST OP ORDERS:  1) 30 ABG/chert x mg / Act  2) Weam of entire to when efelly assure							
MODIFIED ALDRETE'S SCO	RE (Scor	e against each criteria)	<del>-</del>				
CRITERIA	PA	RAMETER		Scale			
Activity, able to move,	4 extre	mities		2∕\			
voluntarily or on	2 extre	m <u>ities</u>		1 \			
command	No			0 .	Total Score :		
		breath deeply and co	<u> </u>	2/			
Breathing	<del></del>	ea, shallow or limited	breathing	1	Patient fit for discharge:		
	Apnea			0	□⁄ΥES □NO		
	Fully a			-2	\		
Consciousnesss	$\overline{}$	able on calling		1 '			
<u> </u>	unres	onsive 		0			
Circulation +20% of pre-anaesthesia level 2							
(Blood Pressure)		o 49% of pre-anaesthe		1 /			
<u> </u>		f pre-anaesthesia lev		0			
SPO <sub>2</sub>		ins SPO <sub>2</sub> >92% in amb ins SPO <sub>2</sub> > 90P% with		2/			
1		ins SPO <sub>2</sub> > 90% with O	<del></del>	0			
	1			U			
		Dr. A. SAMUEL S	SYLVESTER-	. :G1			

Anaesthetist Name & Reg.No.:

Signatute.



**N**Medway **Heart** 

#### Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)		
	: INSTITUTE OF CARDIO VAS	CULAR DISEASES
Mrs.PREMA T 52/Femalc/MHI20	ATION NOT	res
Name of Patient 09/12/2023/IPH20	)2302466 HANRAJ	Age:
UHID No.:	<u>                                     </u>	Sex:
Pre-Operative Diagnosis : CAD	DVD (God IN function	
Post-Operative Diagnosis: CAD (c	vo ( God ex function	
Operation Procedure     Off Puny	CABC × 2 graft	•
Lina	) LAO ."	·.
D.O. Operation 1 1 1 2 2 0	→ PDA	Please tick the type of procedure :
5.5. Speranon 111 11 2 2 5	<u> </u>	Closed ☑ Open □
Operation	Operation	Nature of
Commenced: 9.45	Completed:	12.05 Anaesthetic: General
Surgeons Dr. Ambarosu   Dr. P	ravees / PA. Kantuka	Perfusionist —
Anaesthetist Dr. Sylvestin / Dr	Afcetta	Nurse Mer Sujana
Incision Maha		•
Cannulation	Arterial	Venous
Carridiatori	Altonal	VOIIGUS
Oxygenator	Hedian stens	homy - Thymus disseled - vertical
Total CPB Time Po	icondebomy - Targets	anesed - LIMA and Lt sva havest
Total ACC Time Total TCA Time	Ü	tion - LIMA divided and purposed -
Findings and Relevant Details :	Mjocordom stebel	used with stabiliser - LIMA anostronos
WHA of good colobre and flow		anostronosed to PDA - Perisontes follo
~1.75mm	cleaned - Dera ap	plied - Nortelong with 415 mm pund
- Ira of good colibre - 4mm	is complete on or bened	1 - Protomère - Homostesii - Brown
agets:	,	ingenco and we have
AD - 175 Healthy	placed - Steen wm. 1. E	Despise No.6 Sheel whe - Hound
DA -1-5 Healthy.	docad in layer.	

•							
R	Α		LA			Cardiac Outpu	ıt _
R	V		LA			CI	-
	sys			SYS			
P	A	MEAN	ВР		MEAN		
	DIAS			DIAS			
Р	ACW						
Support:	tsoprin Dopamine Dobutrex		Adrenaline I A B P Others	Norto	0,02 4	y lkylmin	
POST-OP	ERATIVE INSTRU	ICTIONS :					
70 d	o - Arci,	Act. Ch	was draw				
			J				
	o						
	2 11 1						
	2. Iranoles	1 (1)	<del></del> -		<del></del>	<del> </del>	
<del></del> -	<del></del>	<del></del> -		<del></del> _		<del></del>	
Klood	lon - 200 x	nl					
Bland	transfusion - NI	1					
<del></del>	U 						
Drains :	Chest - 10 L+ Mediastinal - 10 Pericardial Others	Pleud					
·	()		<b>10: 5547</b> 6			Doto v volv	1
Surgeon:	Dx. XINGA	rasi Mol	HANRAT			Date :	2023

**POST-BY PASS HAEMODYNAMICS** 





#### **OPERATION NOTES**

Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd)

NAME:MRS. PREMA. T	AGE/GENDER: 52Y/FEMALE
UHID NO: MHI202381034	<b>IP NO</b> : IPH2022302466
DOA: 09/12/2023	<b>DOS</b> : 11/12/2023
SURGEON: DR. ANBARASU MOHANRAJ	ANESTHETIST; DR. SYLVESTER
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	PHYSICIAN ASSOCIATE: MS. KARTHIKA
SCRUB NURSE: MS. SUJATHA	

#### **DIAGNOSIS:**

DOUBLE VESSEL CORONARY ARTERY DISEASE

NORMAL LEFT VENTRICULAR FUNCTION (EF - 60%)

CLASS II - III ANGINA

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

DYSLIPIDEMIA

#### **SURGERY DONE:**

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2

LIMA TO LAD

**SVG TO PDA** 

#### **FINDINGS:**

Good myocardial contractions

No significant scarring

LIMA – 1.75mm, Good quality, good flow

SVG - 4mm, from left leg, Good quality

LAD - 2.0mm, Healthy target, Mid LAD plaques cut across

PDA - 2.0mm, Healthy target

Good distal run off in all the grafts

#### #9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959 (C) @medwayhospitals 🧗 @MedwayHospitals @medway-hospitals @medwayhospitals

1800 572 3003 Medway Centre of Excellence (Chennai)

Institute of Pulmonology

Mogappair

Kodambakkam

044-2473 4455

Kumbakonam 044-26530011 044-2473 4455 044-27426829

**Medway Group of Hospitals** 

Chengalpattu

Villupuram 04146-242000

**Heart Institute** 044 - 4310 8959





Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd)

#### PROCEDURE:

Median sternotomy. Pericardiotomy. LIMA and SVG harvested. Systemic heparinisation.

Heart positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD)

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the PDA artery with 7-0 prolene suture. (SVG TO PDA)

Aorta occluded partially. One 4mm hole was made on the aorta with aortic punch. Proximal anastomosis of vein graft done onto aorta with 6-0 prolene suture. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural tubes insitu

#### **SUPPORTS:**

She was shifted to ICU with inj. Nor Adrenaline 0.02µg/kg/min support.

**CONSULTANT SIGNATURE** 

Dr. Anbarasu Mohan Raj, MS, DNB M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

> Dr. ANBARASU MOHANRAJ , Reg. No: 55476

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

● @MedwayHospitals

(C) @medwayhospitals

in @medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

**Medway Group of Hospitals** 

Medway Centre of Excellence (Chennai)

MHI/HOSP/2022/118





Institute

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959

Double Vessel Coronar Arley Disson Vormal L' Function. O; alde Melliho Clan 12-12 Angine. Left Subclavian Left Internal Mammary Aorta - Left Main Coronary Circumflex **Obtuse Marginal** – Diagonal **Anterior Descending** Health tang 2 on Health transet Mid My plagme out amoss

hood myocardis contraction.

No significant 3 corring.

Left Internal Marring Artery (Lint) & Healthy

Saphenous Vein Compt.

(SV6) Conduit

Name No DRE	m · T	52/5	Date	e of Surgery <u>))</u>	01/2023	_ UHID. No. <u>^41</u>	1L JO 33 810
Operation Performed	OFF	PUMP	(p)Ri NAPy	Arurez	By Piras	Conford	SURGERS
(0P(12)x 2	Lina	_ 7υ	LAD:	5V1 11	PDA		<u> </u>





## PATIENT'S INFORMATION SHEET

NAME Mis. PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr. ANBARASŪ MOHANRAJ	AGE/SEX 721/P UHID NO  SURGEON ANAESTHETIST  DR. ANBARASU DR. PRAVEEN
DIAGNOSIS (In Capital Letters)	1. CORONARY ARTERY DISERSE  DOUBLE VESSEL DISERSE  2. GROOD LY FUNCTION EP-617.  3. T2DM  4. SHTTN  5.
· · ·	7.
PRESENT PROCEDURE/ SURGERY	CABOI
PREVIOUS PROCEDURE/ SURGERY	HID hemosshoidectomy done 2040s back
CONTACT NO. & RELATIONSHIP	1.9915 2928265 2. Hushard (yeel) 2.

## **MEDICATION HISTORY**

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1		T. ANOIT PLAT	2.5M4	Pln	1-0-1	
2		T METOPROLALXI		, -	-1-0-1	
3		T-GILADOR M2		Plo	12-0-12	
4				•		
5						
6						
7						
8						
9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	09.12.23	T. ANGEPLAT	2.5mu	Plo	1-0-1	
2	lί	T. PROLOMET XL	_\9. <i>F</i> im	- 1	1-0-1	
3			•			
4						
5						
6						
7						
8						
9						
10						

#### ANY RELEVANT INFORMATION:

	TILLY KEDDE THE TILLY				
Admission / OT Receival	Condition of the Patio	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
Date and Time:	3. Conscious / Semico	onscious / Unconscious			
From: To:	4. Febrile / A febrile	5. Intubated / Extubated			
Transfer Out	Condition of the Patie	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious / Semico	onscious / Unconscious			
From: To:	4. Febrile / A febrile	_	5. Intubated / Extubated		
Transfer In	Condition of the Patie	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious / Semiconscious / Unconscious				
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
1) Known Case of	Year	Months	Days		
Diabetic Mellitus	2 years.				
2) Known Case of Hypertension					
3) Known Case of Bronchial Asthma/COPD					
4) Known Case Of Others					
	☐ Yes	No No	,		
Denture	Permanent Fixation				
	☐ Temporary Fixatio	n: Present / Absent			
,	☐ Yes	□ Notknon	$\sim$		
Allergic Reaction : Drugs/Food	If you means mention a	bout Drug / Food Name	<b>:</b> :		
	☐ Yes	□ No			
Pressure Ulcer Present	If you means mention a		4 & Site:		

#### ANY RELEVANT INFORMATION:

					Sign With Date
Peripheral Cannulation	1. Site:	1. Inserted Da	te and Time	1. Removed on:	
	2. Site:	2. Inserted Da	te and Time	2. Removed on :	
	3. Site:	3. Inserted Da	te and Time	3. Removed on :	
Neek Line: IJL/EJL	Site:	Inserted Date	and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date	and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date and Time		Removed on	
Pressure Bandage	Site:	Inserted Date and Time		Removed on	
Drain Site	1. Mediastinal : Inser	ted Date and T	ime	Removed on	
	2. Pleural Right / Le	ft : Inserted Da	ate and Time	Removed on	)   
Urinary Catheterization	Inserted Date and Tin	ne	Removed or	1	
Nasal / Oral Gastric Tube	Inserted Date and Tim	ne	Removed or	1	
Intubation Date and Time	Extubation Date And	Time	Reintubatio	n Date And Time	
Other Information	10/12/23 10 per	Reserv	ation 3111	done z malalakehni	and the second



Mrs.PREMA T
52/Female/MHJ202381034
09/12/2023/IPH202302466
Dr.ANBARASU MOHANRAJ



## PATIENT'S INFORMATION SHEET

NAME	AGE / SEX	UHID NO		
CONSULTANT	SURGEON	ANAESTHETIST		
DR. ANBARASU -	DR. ANBAPASU	DR. SYWESTER		
DIAGNOSIS (In Capital Letters)	I. CAD- DND			
	2. NORMAL W SY	ISTOLIC FUNCTION		
	3. CHRADE T DIA:	зтои Дуз Ейнспон		
	4. NORMAL RY SYSTOUL FUNCTION			
	5. TRIVIAL MRITRIVIAL TRI NO PA  6. EF-61 1.			
,	7.			
	8.			
PRESENT PROCEDURE/ SURGERY	OPCABX ZGRAFT. LIMA -> LAP EVG -> PDA.	2023		
PREVIOUS PROCEDURE/ SURGERY	HEMORRHOIDEJOM	1 (20 YEARS BAUK)		
CONTACT NO. & RELATIONSHIP	1. 9952928265 1 IMR. JOEL CHUSBAND	2. 9840164694 (VC)  MRS. JOSEPHINE (Sister Input)		

## **MEDICATION HISTORY**

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	9/12/23	TAB. ANNIPAT	2.5mg	Plo	1-0-1	
2	9/12/23	TAB. PRIMER XL	4	Plo_	1-0-1	
3			~			
4			. ,	, -		
5						
6						
7				•		
8						
9						
10				Ž.		

	++N11+	PATELET STAPPED	mi bi	8.23		
S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	11/12/23	SUP SUCFALFATE SUCPENSION	10 mc	Plo	1-1-1	
2	11/12/23	NSB-LS-VOLIN	D.63 mg	1RH	<b>O</b> 6H	
3	12/12/23	T. FRUSSMIDS	to ma	Plo	1-1-0	
4	0/12/23	T. SPIRA NOLACTOWS	25 mc	plo	1-1-0	
5	12/12/23	T. BSPIEX FORTS	1 TAB	PD	1-0-0	
6	12/12/23	T. CCOPIDOGREL+ ASPIRIN	75 75 mg	Plo	0-1-0	
7	12/12/28	T. ATORVASTATIN	Home	Plo	0-0-1	
8	12/12/23	SUR CESTOAFFIN PLUS	15 mc	Plo	0-0-1	
9_	12/12/23	T. Dolo	650 MG	· plo	1-1-1	
10	12/12/23	T. METAPROLDI	25 ma	plo	1-0-1	

ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Pation 1. Stable / Unstable	ent:	2. Oriented / Disoriented	
Date and Time: 11/12/23 AT	3. Conscious / Semico	onscious / Unconscious		
From: CT To: STW	4. Febrile / A febrile		5. Intubated / Extubated	
Transfer Out	Condition of the Patie			
Date and Time: 12/12/23	1. Stable / Unstable		2. Oriented / Disoriented	
· · ·	3. Conscious / Semico	onscious / Unconscious		
From: SDICO To: 207	4. Febrile / A febrile		5. Intubated / Extubated	
Transfer In	Condition of the Patie	ent:		
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented	
	3. Conscious / Semiconscious / Unconscious			
From: To:	4. Febrile / A febrile		5. Intubated / Extubated	
1) Known Case of	Year	Months	Days	
Diabetic Mellitus	2 YEARS			
2) Known Case of Hypertension  3) Known Case of				
Bronchial Asthma/COPD				
4) Known Case Of Others				
		_	_	
	☐ Yes	No No		
Denture	Permanent Fixation	n .	•	
	☐ Temporary Fixatio	n : Present / Absent		
	☐ Yes	No No		
Allergic Reaction : Drugs/Food	If you means mention a	bout Drug / Food Nam	e:	
	· ·			
	☐ Yes	No No		
Pressure Ulcer Present	If you means mention a	_	4 & Site:	
			j	

#### ANY RELEVANT INFORMATION:

					Sign Willi
Peripheral Cannulation	1. Site: 12161HT	1. Inserted Da	te and Time	1. Removed on:	Date
•	METAVARPEL	11/12/23 AT	ठ छ । इ	15/12/02@lb	
	2. Site:	2. Inserted Da	te and Time	2. Removed on:	3/10
	3. Site:	3. Inserted Da	te and Time	3. Removed on:	
Neek Line : IJL / EJL	Site: PIGHT EJL	tilio 2027 Inserted Date	AT 08:35 and Time	Removed on	A.
	RIGHT BL	11/12/23 AT	8,35	13/12/23 at 11/10	10.
Arterial Line : Right/Left	Site: PIGHT	Inserted Date	and Time	Removed on	
	PADIAL	11/1423 AT	8.40	12/12/2023 00/0%	5000
Sheath Arterial / Venous:	Site:	Inserted Date	and Time	Removed on	
Pressure Bandage	Site: P-1	Inserted Date	and Time	Removed on	1
	RADIAL	12-112-12029	N 10:20	13.11.2505.0	3
Drain Site	1. Mediastinal: Inser	ted Date and T	ime	Removed on	
	+		$\int$	12/12/2003	N 1
	2. Pleural Right / Lei	ft: Inserted Da	ite and Time	Removed on	1202
	11/12/:	13 AT 11	<b>৯</b> ০	0 (2,00	
Urinary Catheterization	Inserted Date and Tim	ne	Removed or	_	1.0
	11/12/23 AT 8.4	5	13-12	13 @ 04.90	Total
Nasal / Oral Gastric Tube	Inserted Date and Tim	ne	Removed or	1	Meons
	11/12/23 AT 12.2	5	11/12/2	3@15:05	19
Intubation Date and Time	Extubation Date And		Reintubatio	n Date And Time	gene !
Other Information	40 CHEST F			<del></del>	
	CXR DONE ON		3		
	AU DOHE ON				
	SCREENING EUH	o Poncon	:- a=111	23	
	EWI DONE on				





# SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086 Medway . Heart Ínstitute

EVE MIS.PREMAT

52/Fernalc/MH1202381034 09/12/2023/IPH202302466

XAB (Clased HEAD) Location:	<u> LTOT</u>	Date & Time : 11 19 193 22.1	(m)
		<b>\</b>	

Name of the Procedure :	DECAB (Clased H	EACT)Location:CTOT	Date & Time : 11	19193
Does the Procedure involve	•			Dr.Anbarasu mohanraj
SIGN IN \$ - 30 Before Induction of Procedural S		TIME OUT 9:50 After procedural Sedation and before procedure		SIGN OUT 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 Procedura performing the Proced	al Sedation + Nurse + Technician + Doctor lure
Patient Confirmation	star performing the procedure)	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	ĹÍYes	Procedures	☑Yes	Name and site of all spedimens / Investigations Yes NA
Side	□Rt ZÎÎ □NA	Side	□Rt □Ct □NA	contirms labeling and sent to lab
	Clark	Expected Blood loss 300 ml	le flext	
Consent	☑Yes	Position Supreme	<b>⊠</b> Yes	Any recovery concerns:
Known Allergy	☐ Yes ☐ Not Cuen If yes, plaese specify	Consent  Required equipment and implants available	PYes □NA	If Yes, Pls. specify:
Difficult airway / aspiration risk	☑No ☐ Yes, equipment	Essential Imaging displayed	ØYes □NA	
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	-EYes □NA	$_{1}$
Possibility of hypothermia	☐ No ☐ Yes, warmer in place	Name of the Antibiotic given de CEROSING 1.5	m(0) 9:20	Any Equipment / instrument problem that needs to be
		Venous Thromboembolism Prophylaxis Provided	Yes □NA	addressed : ☐ Yes.☐ None ☐ If Yes, Pis. specify :
All concerned anesthesia equipment a	and medication check complete	Anticipated duration briefed	Yes	, , , , , , , , , , , , , , , , , , , ,
□Spo2 □ NfBP □ Other	s pls. specify	Anticipated blood loss briefed	☐Yes ☐NA	[ ]
Pre OP medication taken	☑Yes ☐ No	Adequate fluids and blood available	☐Yes ☐NA	I
		Team briefed on any critical or unexpected steps	☐Yes	Corrective action:
Required equipment for procedure available	☐Ýes ☐NA	For procedural sedation cases  Any patient specific concerns :	Yes Latione	Donak Chok, Just Weedle
procedure available	·	Intra procedure glycernic control	☐ Yes ☑ NA	
		Any concerns about sterility	☐ Yes ☐ None	Corrective action: Rowly Chole, Inscharch Lower All Coners
Anaesthetist Doctor giving Procedural Sedation (35%) DR SHEVEVER Date:\ Time:	Doctor performing the Procedure: DR-P	Date: COMMING		PIRHNAN Others Please Specify:  DO041 CTOP NURSED CHRISTINASD  Date: 11   0   0.3 CO   15   17   17   17   17   17   17   17
111111000	,   ,, , , , , , , , , , , , , , ,			



MIS.PREMA T
52/Female/MH1202381034
09/12/2023/IPH202302466
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/067



#### CONSENT FOR BLOOD / BLOOD COMPONENTS

A Blood transfusion is life saving medical procedure, prescribed by a physician. Blood can be given 'whole' but more often a component or combination of component is transfused. Among the most common components are:

Red Cells for bleeding or low hemoglobin

Platelets for bleeding or low counts

Plasma for restoring blood volume or providing clotting factors

Cryoprecipitate for special clotting factors

The Doctor has explained the benefits that are expected from my/the patients being transfused as well as the risk are:

- I have been informed the transfusion option available, which may include banked blood (allogenic) provided by voluntary donors or self-donation (autologous). If an emergency condition exists, banked blood will be invariably be used. Self-donation is possible if time permits.
- 2. I have been informed that despite careful screening in accordance with national regulations, there are rare instances of life threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risks. I also understand that unpredictable reactions may occur which include but are not limited to, fever, rash, and shortness of breath, shock and in rare occasions, death.
- Expected benefits of the transfusion may include minimizing shock, brain and other organ damage, hastening
  recovery and limiting blood loss, however, I understand that there are no guarantees offered as to the expected
  benefits.
- 4. I have had the opportunity to ask questions about transfusions, alternate forms of treatment, risks of non-treatment, the procedures to be used, and the relative risks and hazards involved and I believe that I have sufficient knowledge to make an informed decision.
- 5. I agree/Not agree the administration of blood and/or components in the interest of proper medical care, with my signature I give consent to administering blood products for myself or for the patients. I agree this informed consent may serve for consent to give additional necessary blood products for a time certain to end with this hospitalization or for the complete course of this illness. If I have been advised that the future need for transfusion blood products is quiet likely and possibly on a recurrent basis but still related to the same illness.

Witness	Patients name Patient signature Pressure
Doctor	or Guardians name
Date 10/12/12/2	Relationship to patient H. W. and

Informed consent not obtained because of a life threatening/emergency medical condition. I have provided the patient information sufficient to be considered informed consent and I have proceeded with ordering blood products to be administered in sufficient quantity to alter, improved or reverse a life-threatening/emergent medical condition.

Time: 18.00 Date: 10/12/23

Doctors Signature: Dr. P. PRAVEEN
Reg. No: 86510



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

நோயாளியின் பெயர் :

தேதீ :



## ஒப்புதல் : இரத்தம் / இரத்தத்தீன் பாகங்களை செலுத்துதல்

இரத்தம் செலுத்துதல் என்பது, மருத்துவரால் பரிந்துரைக்கப்படுகின்ற ஒர் உயிர் காக்கும் மருத்துவ செயல்முறையாகும். முழுமையான இரத்தம் அளிக்கப்படலாம் என்றாலும்,பெரும்பாலும் ஒரு பாகம் அல்லது பாகங்களின் கலவை செலுத்தப்படுகிறது. மிகப் பொதுவான பாகங்களில் கீழ்கண்டவை அடங்கும்.

வனறானும்.வப்பும்மபானும் ஒரு பாமை	அல்லது பாளங்களேல் கல்லைய எனதுத்தப்படுகற்று. மிக்பு வுறுதுவரல் பாகங்களில் கழக்ஸ்ட்டல்ல் அடங்கும்.
சிவப்பு அணுக்கள்	இரத்தப்போக்கு அ <mark>ல்லது</mark> குறைந்த <u>ஹ</u> ீமோகுளோபினுக்கு
த <b>்</b> டணுக்கள்	இரத்தப்போக்கு அல் <b>லது</b> குறைந்த எண்ணிக்கைக்கு
குருதிநீர்	இரத்த கன அளவை மீட்டமைப்பதற்கு அ <mark>ல்லது உ</mark> றைவு அம்சங்களை வழங்குவதற்கு
கீரையோபிரைஸிபிடேட்	சிறப்பு உறைவு அம்சங்களுக்காக
எனக்கு/நோயாளிகளுக்கு இரத்தம்	செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்
1. இரத்தம் செலுத்துவதில் கீடைக்க	8ன்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ   தானமனிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள
இரத்தம் (அலோஜெனிக்) அல்லது க	ஈயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கீ இரத்தம்தான் பயன்படுத்தப்பட
வேண்டியிருக்கும். நேரம் கீடைக்குட	ம் பட்சத்தில் சுய தானமனிப்பதற்கு வாய்ப்புள்ளது.
2. தேசிய விதிமுறைகளுக்கேற்	<sub>ງ</sub> ப கவனத்துடன் முன்சோதனை  செய்யப்பட்டிருந்தாலும். உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்ட்ஸ்,
ஹெபடைடிள் மற்றும் இதர வைரள்	கன் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நீகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையும்
நீக்குவது என்பது நடைமுறைக்கு 🤄	இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம். இ <mark></mark> வை
காய்ச்சல். பொரிப்பு. மூச்சுத்திணறல்.	அதிர்ச்சி மற்றும் அரிதான நீகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்கலாம்
என்பதையும் நான் புரிந்து கொண்டே	_ன்.
3. இரத்தம் செலுத்துவதன்	மூலம் எதிர்பார்க்கப்படும் நன்மைகள். அதீர்ச்சி. மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல்
குணமடைதலை தூரிதப்படுத்துதல்	மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம் என்றாலும், எதிர்பார்க்கப்படும்
நன்மைகளுக்கு உத்தரவாதம் ஏதும்	அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கீறேன்.
4. இரத்தம் செலுத்துதல், மாற்று ச	சிகீச்சை முறைகள், சிகீச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள். மற்றும் இதிலுள்ள
இடர்கள் மற்றும் அபாயங்கள் ஆகிய	பவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது, மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு
போதிய விவரங்கள் தெரிந்திருந்தன	என்று நான் நம்புகீறேன்.
5. முறையான மருத்துவ ப	ராமரிப்பின் பொருட்டு. இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனத
கையொப்பத்தின் மூலம் எனக்கு அ	ல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக
இரத்தப் பொருட்கள் செலுத்தப்படு	வதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத்
தெரிவிக்கப்பட்டிருக்குமானால், இந்	ந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தீல் முடிவடையும் வகையில்   அல்லது   இந்நோயின் முமுமையான
காலகட்டத்திற்கும் தேவையான கூடு	ந்தல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக
கொள்கீறேன்.	
	நோயாளியின் பெயர்
சாட்சி	நோயாளியின் கையொப்பம்
மருத்துவர்	
நேரம்	பாதுகாவலரின் கையொப்பம்
தேதி	நோயாளியுடனான உறவு
உயிருக்கு ஆபத்தான / அவசரக்கா	ல மருத்துவ நிலை காரணமாகத் தகவலறிந்த ஒப்புதல் பெறப்படவில்லை. தகவலறிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அளவிற்கு
நான் போதிய அளவு தகவலை 🤇	நோயாளிக்கு வழங்கீவிட்டேன். மேலும் ஓர் உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நிலையை மாற்றுவதற்கு
,	<sub>த</sub> க்குவதற்கான போதீய அளவில் இரத்தப் பொ <i>ருட்</i> களை வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான்
மேற்கொண்டுள்ளேன்.	
நேரம் :	

மருத்துவரின் கையொப்பம்......









# **CONSENT FORM - PHYSIOTHERAPY**

I, MYS-Prema the Patient or Peresentative of patient have (please tick the correct option above and below):  Read  I/We have been explained the current clinical condition of me/my patient  Been explained this consent form in Town   (Name of language) which I fully understand and understood the information provided about Operation / procedure
Post operative cardio Pulmonary Rehabilitation
(full name of <del>operation</del> / procedure given below in this consent form)
Brief description of the Operation / Procedure: DBES, chast percurion, Spironety eng
Active eng to Ble UL SU, Mabilisation.
I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are:  To Improve bung expansion and Lung Classice, To Improve.
Joint Rom, to Improve ADL.
I understand that all procedures carry certain risks. The potential risks and complications from this procedure:
Pain
I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:
<u> </u>
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 ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery, 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.

For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to

Dr. ARATH G.E. (name of doctor performing the operation / procedure) for carrying out the said operation / 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 #)	- Ralls	(Write name and relationship with patient)	11/12/23	(&:∞	
Reason for surrogate consent	Patient is unable to give consent	oecause:			
Witness	<u> </u>	B- leanifi	11/12/23	(8;00	
Interpreter (if applicable)					

<sup>\*</sup> 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 operation / 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
Consent obtained by	Grand	AKASH G.B	025L	11/12/23	(8700
Procedure performed by	Git Skel	AKASH- GI-B	0256	11/12/23	(g)



# Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



### IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints:			
clo chest Pain x 20 days			
<b>σ</b>			
Occupation: Heavy Activity Moderate Activity	/ Light Activity		
Past Medical / Surgical History:			
SIP-Hemorohoidectomy	20 yrs back)		
Klelo-DMX 27mg.			
On Observation:			
Built: Thin Fair Well Built Dobese   Postural Deviation	·		
Deformity: ☐ Yes ☐ No   Swelling: ☐ Yes ☐ No   Gait Deviat			
On Palpation:			
Tenderness: ☐ Yes ☐ No │ Warmth: ☐ Yes ☐ No │ Muscle spasm:☐ Yes ☐ No			
Oedema:□Yes ☐No   Crepitus:□Yes ☑No   Tone:⊡Norm			
	al 🗆 Abnormal		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING A A  Fall Risk Screening for Adults: Age more than 65 years	al 🗆 Abnormal		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING A A  Fall Risk Screening for Adults: Age more than 65 years	al □Abnormal  History of fall in last 3 months  Any neurological problem		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	al □Abnormal  History of fall in last 3 months  Any neurological problem		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	al  Abnormal  History of fall in last 3 months  Any neurological problem  nent and fall prevention protocol.		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	History of fall in last 3 months Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	History of fall in last 3 months Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	History of fall in last 3 months  Any neurological problem nent and fall prevention protocol.  Seizure, etc) Deranged mobility nent and fall prevention protocol.		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	History of fall in last 3 months  Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility nent and fall prevention protocol.  Brain Injury (if applicable): ▷ A		
Oedema: Yes No   Crepitus: Yes No   Tone: Norm  FALL RISK SCREENING	History of fall in last 3 months  Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility nent and fall prevention protocol.  Brain Injury (if applicable): ▷ A □ Traumatic □ Non Traumatic		

Spine Injury: Present Absent	<b>-</b>			
AIS:ISNCSCI SCALE:				
☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx				
Associated Injuries: Speech impaired: Yes To				
Voluntary Movements: ☐ Present ☐ Absent   Tone Modified: ☐ Hypotonic ☐ Normal ☐ Hypertonic				
ASHWORTH SCALE:				
☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit				
Balance: ☐Good ☐Fair ☐Poor   Co-ordination: ☐Good ☐Fair ☐Poor				
Functional Activities	•			
Self Care: ☐ Independent ☐ Dependent │ Bed Mobility: ☐ Independent ☐ Dependent				
Transfers: ☐Independent ☐Dependent   Ambulation: ☐Independent ☐Dependent				
FIM Score:				
Breathlessness (If applicable):				
Dyspnoea Grading Scale:				
Abnormal Breathing Sounds: ☐Wheezing ☐Stridor ☐ Crackles ☐Pleural Rub ☐ Pneumothor	ax Click 🗌 Stertor			
Abnormal Breathing Pattern:				
Pain Assessment: Pain: ☐ Yes ☐ No				
Pain Score: 7 100				
Tick whichever is applied: ☐ Numerical Rating Pain Scale ☐ Visual Analog Scale ☐ Wong	-Baker Faces			
Pain Scale Critical Care Pain Observation Tool FLACC				
Location: Clast pala Duration: 20 days Frequency: On soll Character: Tutentut				
Location: Clastophe Duration: 20 days Frequency: On salt Character:	: Tuten Part			
	: Tuterstart			
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness	: Julen Fut			
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing	: Tuterstar			
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness	: Tutenstart			
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing	: Tutenstar			
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing	Tulenitar			
□ Acute □ Chronic □ Burning □ Aching □ Radiating □ Numbness □ Sharp □ Cramping □ Stabbing □ Crushing  Aggravating Factors:  Relieving Factors:	: Tuterstart			
□ Acute □ Chronic □ Burning □ Aching □ Radiating □ Numbness □ Sharp □ Cramping □ Stabbing □ Crushing  Aggravating Factors:  Relieving Factors:	: Julin Fact			
□ Acute □ Chronic □ Burning □ Aching □ Radiating □ Numbness □ Sharp □ Cramping □ Stabbing □ Crushing  Aggravating Factors:  Relieving Factors:	: Julin Fut			

Examination (Please tick and mention abnormal findings only):					
☐ Range of M	lotion:				
Normal					
☐ Muscle Strength:					
Normal					
☐ Reflexes:					
ļ	Mormal	·			
Plantar Respo	nse: □Diminished ⊡Ɓrisl	k			
<b>I</b> Biceps: □Dir	minished ☑Brisk ☐Clonus	S			
Triceps: Dir	minished ☑Brisk □Clonu	s			
Supinators:	]Diminished ☐Brisk ☐Cl	onus			
Knee: □Dimi	nished ☐Brisk ☐Clonus				
Ankle: □ Dim	inished ੴBrisk □Clonus				
Sensation: /	nood				
Investigation	& Findings:				
CA	D-DVD, Normal 1	-u Sys. function, hoode I	Diostolic Dysa	action.	
I	Yormal Ru Sys Fnu	ation, Trivial Mr, Trivial	TR, NO PAH,	GF-61%	<b>6</b>
Physiotherap	y Management Plan:				
_ DBE; Enlowiged					
- Chest Permission done to BLE Chest wall					
	- Sorronely ex	g enlomyet.			
	- Active edg.	to Ble uc soll			
	- Mobilisation				
- To In prove ADL					
	Signature	Name	Emp. No.	Date	Time
Physiotherapist	J.vuf	J. VI) AYARAGAVAN	2102	11/12/23	

RE-ASSESSMENT FORM				
Date & Time	Fall Risk Score: Pain Score: 3 0  -DRE'S encourse -Chest percurian -Akom &'s to -Spirometry &  The: boocc -M ObilizationTO Emprane -TO Improve -TO Uean aut  Post Intervention Pain Score:	to the chert wall  ble of the chert wall  ble of the one of the opening of the opening  secretion  from  Apr  Lung Secretion  OPERATIVE OPEDIO		
	Signature	Name	Emp. No.	
Physiotherapist	JAK	Ramanathan-P	0260	





# Medway Hospitals®

The way to better health

MH/ PRINT / 0096 / PHY

Mrs.PREMA T

52/Fernalc/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

# PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
11/12/23	15;05	Sle uzayaragharan	G. Egleaf
		pt entulated	MH10256
		- Ky Moral Marai Suctioning	<b>,</b> 300
		done yielded thick would	
I		Sacretions	
1		- PT voice dear 4 audible	
		- pr Nebulized	
		- pt connected to Maisas	
		prongy (b2: 2 litres)	
		- Sprometry or emouraged	
		Insiboocc Exp: 600CC	
11/12/23	22:00	S/B Ramanathan -P	
		-DBE's encouraged	
		- Orest percursion to 18/1 Chest wall	
		MROM Go'S ED BIL UL 24	MHIOZEO
		- Spirometry Bris oncouraged	141111 (12.00
		Drs: 6000 Opp: 6000	
12/12/23	6,00	SB Ramanathan.p	
		-DBE's encounaged	
		- These percussion to Ble Chest wall	Strop
		AROM BIS to BIL ULZA	MHI OD 60
		Espisometry Ext encouraged	
		Zn: 600ce Op: 600ce	





# Medway Hospitals®

The way to better health

MH/ PRINT / 0096 / PHY

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

# PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
12/12/23	9:00	S B AKASH - DBex encourangly	Q1,B Alkar
1		- Sprondey sur encouraged  This: 600 co Exp: 600cc  - Chest percuseron to Ble  Chest wall  - Arom to Ble UL ILL	MH10286
12/12/23	17:00	SLR J.VIJAYARAGAUAN	
		- DBR's Enlormyed  - client aeminton done to Bli client wall  - Spiromety en enloringed  The Gooce Enp-600ce  - Active es to Ble ULSELL  - Patient mobilised to chair.	J.mj MMC-2102
12/12/23	22:00	Slos Ramanathan: P  -DBE's encouraged  -Chest percussion to Bk chest wall  - Alom Er's to Ble Uleu  -Spirameters Er's encouraged	MH10260
		-Spirametry Ex's Encouraped  Enri Boon Exp: 6000	





# Medway Hospitals®

The way to better health

MH/ PRINT / 0096 / PHY

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj

# PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
13/12/23	b <u>:</u> ∞	81B Romanathan P	
13/12/23	9700	- DRE'S encouraged - Chest perentission to Ble chest would - DROM A'S to BLE or 24 - Spignometry A'S encouraged - Ens: 600ce Gop. 600ce - Pt chain mobilized  SIB AKASIT - DREY ENCOURAGED - Spignometry RY ENCOURAGED - Spignometry RY ENCOURAGED - Chest wall - promise Blevelle  SIE J. VIJA PROCEEDAN - DE ES ENCOURAGE - Clest remandon do no to Ble clast wall - Spirometry En enburged - Spirometry En enburged - Spirometry En enburged - Active end to Blevel a cl - Patrot mollwared.	T. MHI 0256 MHI 0256
		,	





# Medway Hospitals®

The way to better health

PHYSIOTHERAPY TREATMENT CHART

MH/ PRINT / 0096 / PHY

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj

## 

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
14/12/22	lozoo	- Phei encouraged	G12-10256
		- sprometry enranged  Jew; Gooce Breps Gooce  Jew; Gooce Breps Gooce  - deet percussion to Ble  Chart anall  Aron to Ble ville  - prom to Ble ville  - prom to Ble ville	
14/12/23	16630	StB JWHY ARAGANAN  DBes Enlowinged  - Active End to Bu UC & Ce	
i		- chest nemmton done to Ble chest wall - Shiromety edg remonyel	J. my MMC-2102
15/12/23	10200	Jus-600ce Ext-600ce  StB_AKAGH  Der encouraged  Josonday air encouraged  Jusi 600ce Bapi 600ce  Cheet porcuerión to Ble  Client wall  ARom to Ble velle  - pt stain dent encouraged	R. F. Amag MH1025b





#### Every heart beat counts

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

### THE REPORT OF THE PART OF THE

### URINE ROUTINE ANALYSIS MICROBIOLOGY SHEET

DATE	98/11/23-		
COLOUR	DAJE VELLOW		
REACTION			
SPECIFIC GRAVITY	1.00		
APPEARANCE	CLEAR.		
ALBUMIN			
SUGAR	NII.		
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN	MORMAL	444	
PUS CELLS	4-6		
EPITHELIAL CELLS	1-2		
RBC	MIL		
CASTS	NIL		
CRYSTALS	Mic		
OTHERS	NIC.		

#### **MICROBIOLOGY-CULTURE REPORTS**

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





#### Every heart beat counts Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

### DIABETIC CHART

ACTUAL WE	EIGHT	66-2 kg HbA,c	6.6.		
PREVIOUS	DIABETIC I	MEDICATIONS T. GLADOR N	12-1-0-12 (615)		
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
3/12/23	12:15	74 mg/dl	1	Poln_	DR. HARL
	18-30	138 mgldl	T. Glador Moly	D 800 19:40	Goe 16820
1042/h	6.30	120 mg/ell.	T. Glades m2	8,00	K'M3Unth)
	12.30	FF MylaL		Down .	
	1g.30	- 87 mg 1d/	T. alador M2(1)	Dab: 1219	3- De 165208.
W 12/22	6-30	- 87 mg/d/ 125 mg/ou	T. a lador m2(1)	Men	
-					

### **INSTRUCTIONS FOR INSULIN INFUSIONS**

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION	
*	normal Saline (1u - 1 ml.)  Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 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.	
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.	
	nourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.	
	according to the lone migrage minim	251-300	Adjust Infusion rate to 6u / hr.	
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.	
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.	
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.	



12-30

18:30





DR. PRAVEEN

## **DIABETIC CHART**

ACTUAL WE	IGHT	<u>Ььку</u> дньа	de propiet		
PREVIOUS	DIABETIC I	MEDICATIONS T. GLAS	ORM2 42-0-42 (B	F)	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
223	12:30	175mg (d)	In HI ACTEAPID	Damy 0171 020	OR. SYLVESTER
12/23	15:15	157 mgldl.	Stopped	thoung,	Dr. praiser
11/12/23	19'30	156 mg 121		mana,	Do proven.
12/12/23	04,40	142 nigfall	TO CILADUR N2 Plo UNBON DE:30	-12-19	Dr. Proveen Jeyaun
12/12/22	1870	118 my loll		81/0203	'~ V
12.12-22		(\	T- CLAPORME 1/1	deform	DR-PROVEEL
13-12-23	06.00	V	T- GLADOR MO	dfor	OR-PROVED
	12.30	1/4 mig/dl		8	Day 165300
	18-30	120 mertal,	T. GLADOR M2 1/2	19.30	Dr. Proven
14/12/23		128 mgldi	7 GLADOR M2/2	9 19.30	DR. PRAVEEN

#### INSTRUCTIONS FOR INSULIN INFUSIONS

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION	
*	normal Saline (IU - 1 ml.) Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 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.	
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.	
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.	
	according to the lenewing / ligorithms	251-300	Adjust Infusion rate to 6u / hr.	
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.	
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.	
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.	







**Every heart beat counts** 

## **DIABETIC CHART**

	MIS.PREMA
Pa	52/Female/MHI202381034
Na	09/12/2023/IPH202302466
DO DO	Dr.ANBARASU MOHANRAJ
	PER INTERNAL DE CONTRACTOR LA CONTRACTOR DE LA CONTRACTOR

				_	
PREVIOUS	DIABETIC	MEDICATIONS 161A DO.	$R M_2 \frac{1}{2} - 0$	-1/2 (BF)	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
-13/12/20	6.30	120 mg/dL	T. GLADOR M2	9098 (700)	Dr. Proven
	12.30	98 mg ldl	-	A	KM 134559
	18.30	1 , ^ _ ,	T-Orladox ma y	19:30	K'10 1311 7779
16/12/23	6.30	128 mg/dl	T. GLADOR M3 1/2	Style (	Florious
	1250	90 mg/cd		Poln	Floring 165807

### **INSTRUCTIONS FOR INSULIN INFUSIONS**

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	normal Saline (IU - 1 ml.)  Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 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.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
		251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.



Ntpro bnp





Every heart beat counts

Mis.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

#### 

Lymphocytes	27.2		
Eosinophils	7.1		
Mono / Basophils	25 0.3		
E.S.R	_		

E.S.R	- '	l <u> </u>		
BIO-CHEMISTRY				
Urea	93			
Creatinine	10.64			
Sodium	139			
Potassium	3.53			
Bicarbonate	29			
Chloride	C18.11			

Magnesium				
Calcium				
Phosphorus				
LFT				
T.Bilirubin	0.38		_	
D.Bilirubin	のほ			
I.Bilirubin	0.25			
S.G.O.T	1+			
S.G.P.T	18-			
ALP	106			

GGT	22	٦.			
Total Protien	4.4				
S.Albumin	ませ				
CARDIAC ENZYMES	;				
Troponin I					
CKNAC - CPK		Ī			
CK - M.B. MASS				•	
LDH	•			•	

					•	1
Date	00 1 1 2					
COAGULATION	D8 11 12 3 -					- I
PT/INR -	108/12.0					
	0.9					
Eibrinogen DOTT  D Dimer	1 7-11.6			-		
LIPID PROFILE						
Total Cholesterol						•
Triglyceride						
H.D.L						
L.D.L						
VLDV			-			
THYROID FUNCTION	-					<del></del>
T.S.H	3.00					
T.3	.).WU				<del></del>	<del>   </del>
T.4	7 8				_	<del>                                     </del>
SEROLORY 9,2	<del>╶┤</del> ╧╅╃ ╮╸					<u> </u>
HIV	-			-		
HBsAg	-					
V.D.R.L	Montiv					
COVID 19	Flann	<u> </u>				
RT- PCR			-			
IgM	-					
lg lg		•				
HBA1C	7 1					
FBS/PPBS	6.6					
RBS						
S.AMYLASE	-				<del>-</del>	
S.LIPASE	-					υ
C.R.P						
PROCALCITONIN				_		
DDIMER						
S.Osmolality						
URINE						
Osmolality		_		-		
Spot - Na						
	,,					
	_	_			-	
<del></del>		_		<u>-</u> .		
<u> </u>		-	<u>-</u>			
				-		
			<u> </u>			
<del></del>	-				<del></del>	
<del></del>		<u> </u>		-		
		<del></del>	-		<del></del>	
<del></del>					<del></del>	
<del></del>	<del>  -</del>					
		_				
					, <u>.</u>	







Every heart beam Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

Dr.ANBARASU MOLLANG

#### **BLOOD GROUP**

B POSMIVE

### **INVESTIGATION SHEET**

Date	28/11/23	12/12/2022	13/12/23	15/12/22		
HAEMATOLOGY	19111		•	<u> </u>		
Hb	14.0	11.9	10.9	10.9		
P.C.V	H2.5	1 -11	,	<del>                                     </del>	_	
Platelets	71310000					
TLC	11590		_			
Polymorphs	ba. 9					
Lymphocytes	94.9	1				
Eosinophils	4.1					
Mono / Basophils	2,5 0.3					
E.S.R						
BIO-CHEMISTRY						
Urea	23	22	<i>ఖ</i> ვ	35		
Creatinine	0.64	0.60	0.50	02.50		
Sodium	139		137	137		
Potassium	9. <u>5</u> 3		3.45	3.39		
Bicarbonate	ત્રેવ		,			
Chloride	9 <u>\$</u> . 4					
Magnesium	, ,					
Calcium						
Phosphorus						
î LFT						
T.Bilirubin	0.38-					
D.Bilirubin	0.13					
I.Bilirubin	0.25					
S.G.O.T	17					
S.G.P.T	18					
ALP	106					
GGT		* *				
Total Protien	4.4 26					
S.Albumin	ના.મ					
CARDIAC ENZYMES	·					
Troponin I						<u> </u>
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Date	Delutes					
COAGULATION	28/11/23 10.8/100	_		· · ·		
PT / INR	10.9119.0					-"
Fibrinogen	,					
D Dimer Apn	91419					
LIPID PROFILE	- अमार्ग				-	
Total Cholesterol						
Triglyceride		<u>-</u>			-	
H.D.L		-				
L.D.L						
VLDV						-
THYROID FUNCTION						
T.S.H						
Т.3	3.00					
	78		-	<u> </u>		
T.4	निभ्र					
SEROLORY	<u> </u>		-		-	
HIV						-
HBsAg \						
V.D.R.L	NEVATIVE					
COVID 19						
RT- PCR (						
lgM						
lg						
HBA1C	bib					
FBS/PPBS	,, ,					
RBS						
S.AMYLASE						
S.LIPASE						,
C.R.P						
PROCALCITONIN						_1
DDIMER						
S.Osmolality	-					
<u>URINE</u>						
Osmolality						
Spot - Na						
	-					
1			<u> </u>			
	<del></del>	-	-			-
						-
	i		i			

•



(A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.PREMA T

Diagnosis:

Pal 52/Female/MH1202381034

Na 09/12/2023/IPH202302466

UH Dr.ANBARASU MOHANRAJ



## VITAL INFORMATION SHEET

Procedure:

MHI/IP/2022/074

Medway

Heart
Institute"

Every heart beat counts

BLOOD GROUP B' OSTAVE

Height in CM Weight in Kg.

141.5 cm | 66.2 kg

NO. OF DAYS DOA-1 DAY-1 DATE wolphs 6 10 2 6 1 HOUR 40.5° 39.5 39° 38.5 38 37.5° 37° 36° **PULSE** 1,00/ RESP 118/7/ 109/7 B.P. SPO2 **DAILY WEIGHT** 24 HRS INTAKE 1100au 24HRS OUTPUT goon 1860 ML BALANCE - ( KOM MOTION 3 Stopped on 6/12/23



, The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

---- MIS.PREMA T

Patiel 52/Female/MHI202381034 Name 09/12/2023/IPH202302466

UHID Dr.ANBARASU MOHANRAJ





Every heart beat counts

BSA: 1.61m2 BLOOD GROUP

ON ADMISSIÓN Height in CM Weight in Kg.

PPKB

**VITAL INFORMATION SHEET** 

OPCABX 24RAFTS LIMA -> LAD SVG-> PDA

Diagnosis:	C	<u>ae</u>	<u>-</u>	D	ſΣ	٠	1 E	F	_	Ь	1.	<u>J.</u>				_							P	roc	ed	lur	e :		.l.N SV:1	11 F	<u>-</u>	-)  2	<u> </u>	177) 3	' •										L		H	lu	M	_		_		b	Ы	<del>'</del> 83			_	_
NO. OF DAYS		Do	lS.		_	<u></u>	D.	<u>[</u> _	7_		P	0 /	0	1		F	>0	D٠	1	Ī.		Ρ	D D	) <u> </u>	N	Ē	ţ		D-																														L	
DATE		اللا	212	æ	Ī	<u>al</u>	12	2.3			Į	3	-1	2.	12	1	14	11	2	2	3	1,	5	12	<u> </u>	13	1	61	12	23	1																													
HOUR	2	6 10	2	6 10	2	6	10	2	6 1	10																						2	6	10	2	6 1	0 2	2 6	3 10	2	6	10	2	6	10	2	6	10	2	6 1	0 2	6	10	2	6 1	0 2	6	10	2	
40.5°	П	$\perp$	1	$\perp$			$\Box$		1	1	$\downarrow$	1	1	$\downarrow$	Ţ	T		L		П	$\downarrow$	$\dashv$	1	1	丰	$\downarrow$	L		1	1	T				ヸ	1		1	Ţ	T	T	1		$\square$	$\Box$	$\Box$		1	1	$\downarrow$	$\downarrow$	1		$\Box$	1	1				Į
40°	H	#	$\downarrow$	$\pm$		H	#	<u> </u>	#	+	$\dagger$	‡	$\ddagger$	$^{+}$	+	t	Ė	Ė			$\downarrow$	1	$\downarrow$	‡	‡	-			‡	‡	t				#	‡	$^{+}$	‡	‡	ŧ	ŧ	F						#	#	+	+	+			#	‡	Ļ		F	Ŧ
39.5°	H	#	#	$\pm$	Н	H	$\Rightarrow$	‡	#	+	#	‡	‡	‡	‡		L	L			#	1	#	+	+	‡			‡	‡					#	#	+	‡	t	ļ	ŧ	L	L	$\Box$				#	#	#	$^{+}$	‡	Ħ		#	‡	F		F	‡
39°	H	+	$^{+}$	$\pm$		H	$\dashv$	#	#	‡	#	‡	‡	‡	‡	L	Ļ	L		H	#	7	‡	$\downarrow$	‡	ļ				‡	L			$\exists$	#	‡	‡	#	‡	ļ	ļ				$\exists$	$\exists$		#	7	#	‡	+			‡	‡	+	<u> </u>	F	ŧ
38.5°	H	#	#	+		H		#	#	+	‡	‡	‡	+	‡	ļ					#	7	$\dagger$	‡	ŧ	+	F		Ŧ	+	F		H	$\dashv$	+	+	‡	╪	+	+	+	F					1	#	+	+	Ŧ	F	H		+	+	F		F	t
38'	H		+	+		Ħ	$\dashv$	1	1	‡	‡	7	1	+	+	ļ	F	H		$\Box$	7	7	‡	‡	‡	+	1	H	#	‡	F				7	+	‡	7	+	L				П	4		$\dashv$	7	1	7	+	1		$\dashv$	+	+	F		F	1
37.5°	H		$\mp$	$\mp$	<u>,</u>	H	N	7	7	‡	7	7	‡	+	Ŧ	-	-	F		H	1	7	ļ	‡	+	Ŧ	-	H	+	Ŧ	F				7	+	Ŧ	Ŧ	╀	F	F	F	-	H	$\dashv$			+	1	+	+	+	H	$\dashv$	7	Ŧ	F	F	Ħ	†
37°	H	+	$\mp$	7	<u> </u>	Y	╡		4	4	4	٩	+	Ŧ		F	0	F		•	-	4	9		4	1		1	+	$\mp$	╁			$\dashv$	7	7	╀	+	+	Ŧ	╀	H		Н	$\exists$			+	$\dashv$	$\dashv$	$\dotplus$	-	H		7	7	F		F	1
36.5°	Ħ	+	+	#		П		7	7	7	7	-			7	F				H	7	-	7	$\mp$	Ŧ	4	F	$\Box$	7	Ŧ	1				+	Ŧ	╁	1	Ŧ	F	F	F		Н	$\dashv$			7	1	7	Ŧ	Ŧ		$\exists$	+	+	1			1
36'				4			7	7	7	7	7	7	+	+	+	F					7	7	Ŧ	7	╀	1	1	H	+	+	F				7	+	-	7	Ŧ	1	F	F	1				$\Box$	7	7	7	+	+	F	$\Box$	7	+	+	H	F	1
PULSE			न्र	m	95	, by	) <b>~</b>	25	ĺ	4	9	9	•	76	61	18	4	m	C	19		88	m	5	1 8		3,	41	Jon.																															
RESP	Ц			mt	18	2Pm	٢.	2 <u>4</u>	m	H_	2	οl	4	<u> </u>	br	12	σĺ	m	å	24		λol	m		ھو	,	22	<u>)</u>	ч			L.	_	_	_		1			$\perp$		_			_											4			┖	_
<u>B.P.</u>	Н		lidi	34			14/				10	<u>И</u> Ь	1 8	<u>3H</u>		8	9/4	<u>65</u>	9	0/	<u>64</u>	W	17	<u> </u>		•	14	17	0			<u> </u>					$\bot$			<u>l</u> .			╀				_	4				_				$\perp$		_	╁-	_
SPO2	$\dashv$	<del>- i .</del>	100	<u> </u>	_	<u>r)</u>	_	9	1/							14	16,	<u>\\</u>		13	4	91	<u>:</u>	$\perp$	9.	<u>3</u> y.	<u> </u>	9/1	4			L					+						$\vdash$				_	4											+	_
DAILY WEIGHT	┨┤		<del>1</del> 44				26			<del>  [</del>			<u>'</u>  2:			╀					+			_			$\vdash$		_			$\vdash$					+						╁			_	_	$\dashv$					_		_				╁	_
24 HRS INTAKE 24HRS OUTPUT	1 1	<del>-211,</del>	_,				70								₩					W							╀					$\vdash$					+						╁	_				+				_	_						╁	_
BALANCE		723			<u> </u>		<u>ا ځ</u>								4					<u>~</u>		Q (	25	0	M	_	$\vdash$					_			_		+						╀╌					+				_		-					╀	
MOTION	╁┼	20	<u> </u>	<u> </u>	У		<u>او</u> مر			Π.		<u>,</u>		1/	4	╀	<u>-1</u> X		<u>υ</u> ν	<u>M /</u>	+			S	m	<u> </u>	╁╴					$\vdash$	_	_	_		+		-		_		+-					$\dashv$	_	_		_	_		_				╁	_





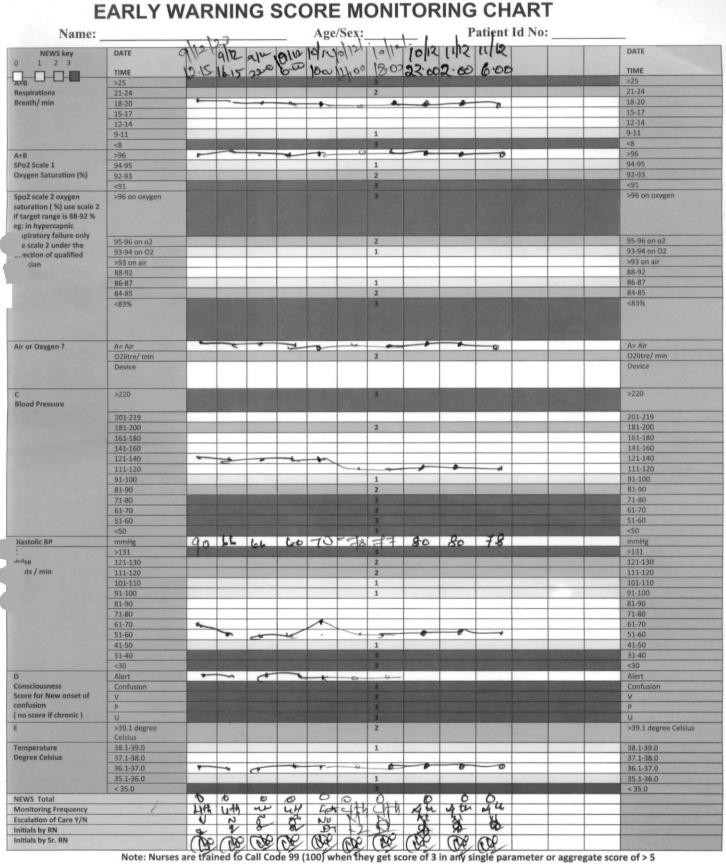
### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ







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	4	Every Hourly	
frequency	3	Every 2 <sup>nd</sup> Hourly	
	2	Every 4th Hourly	





Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ 



**Every heart beat counts** 

Name:			_	1		Age	504.	2. 1	-,1,	21.	atient	1	0 1	1 1	-
NEWS key	DATE	13/	13/2	13/2/	AIR	AIR	1419	14/	14/12	P 14/12 22:00	12/15	ISTR	15/12/	(3/14	DATE
	TIME	14-	1806	D-093	1.00	6000	10.00	111:00	13.00	27.00	2-60	6.00	1000	14.0	TIME
PB O	>25							3							>25
espirations	21-24			-		-0		2			- 0	-			21-24
reath/ min	18-20	-	-	_	-	- 4	-6	6		-	U	-	~		15-17
	15-17			-	_	-	_								12-14
	9-11							1	C-10-10-10-10-10-10-10-10-10-10-10-10-10-				17.00		9-11
	<8	100000	-	NAME OF TAXABLE PARTY.	CHICAGO .	PER COLUMN	SEC.	3		No.	50000	211123			<8
+B	>96	-	CA	- 0	0	-			-0	-		-6	8		>96
o2 Scale 1	94-95							1							94-95
xygen Saturation (%)	92-93							2							92-93
	<91							3							<91
oo2 scale 2 oxygen sturation ( %) use scale 2 target range is 88-92 % g: in hypercapnic	>96 on oxygen							3							>96 on oxygen
spiratory failure only	95-96 on o2							2							95-96 on o2
e scale 2 under the rection of qualified	93-94 on O2							1							93-94 on O2
nician	>93 on air														>93 on air
	88-92														88-92
	86-87							1							86-87 84-85
	84-85 <83%		-	-	Contract of the last	-	E STATE OF THE PARTY OF	2	2000	The Street	RECEIPED.		No. of Concession,	TO THE REAL PROPERTY.	<83%
	<03%														
ir or Oxygen ?	A= Air	-	-	0	-0	-5.	- 0		-	-,	-0	4			A= Air O2litre/ min
	O2litre/ min Device							2							Device
lood Pressure	>220		F 18					3							>220
	201-219					-									201-219
	181-200							2							181-200
	161-180														161-180
	141-160														141-160
	121-140			-	0					C4			-		121-140 111-120
	91-100	-						1	-		-		-		91-100
	81-90		Y					2				2000		100000000000000000000000000000000000000	81-90
	71-80	100000	1000000	NAME OF TAXABLE PARTY.	SERVICE SALES	10000		3		No.	THE REAL PROPERTY.	1000	-	Name and	71-80
	61-70							3							61-70
	51-60	W (225)						3							51-60
	<50		10000					3	, .			-			<50
astolic BP	mmHg	ST	167	72	SA	35	72	10	66	74	80	83	80	72	mmHg
	>131		1		25.00	SI BOARD	10000	3	TO SERVE			THE REAL PROPERTY.		2000000	>131
alse	121-130							2							121-130
eats / min	111-120							2							111-120 101-110
	91-100		1					1	1						91-100
	81-90	1./			(0)	-				-	-	-	-	-	81-90
	71-80			-	-	-				-					71-80
	61-70														61-70
	51-60														51-60
	41-50					1		1							41-50
	31-40							3							31-40
	<30				2			3	NAME OF TAXABLE			Park See	1	Day of the last	<30
	Alert				-	-	0			-	-	A	-		Alert
onsciousness ore for New onset of	Confusion							3							Confusion V
onfusion	V							3							P
no score if chronic )	U							3							U
	>39.1 degree							2				10000			>39.1 degree Celsius
	Celsius														20 1 20 0
emperature	38.1-39.0							1							38.1-39.0
egree Celsius	37.1-38.0			-	-	_			- Circ				-		37.1-38.0 36.1-37.0
	36.1-37.0 35.1-36.0							1		-		-			35.1-36.0
	< 35.0	-	THE REAL PROPERTY.	Name of	50000	100000	1000000	3	THE REAL PROPERTY.	Contract of the last	No. of Concession,		-	1	< 35.0
EWS Total		0	2	6	0	0	0.	0	9	0	0	0	0.	0.	
Monitoring Frequency		SH	377	ct	24	MA	1.5	415	EN.S	4 th	este	44	LIB	QH	
scalation of Care Y/N		1	M	N	IX	16	X	to	P	14	N.	N	N	1	
nitials by RN	AMERICA	17	15	28	8	عك	N	1	M	9	16	۵	John	1	
itials by Sr. RN		Sno	1.100	120	1109	50099	0	A 600	ng	cha	100	0000	AVAX	100	

Score and monitoring	4	Every Hourly
frequency	3	Every 2 <sup>nd</sup> Hourly
	2	Every 4th Hourly





#### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj





art beat counts

### EARLY WARNING SCORE MONITORING CHART

Name: _				Age/Se	x:	Patient Id I	No:
NEWS key	DATE	15/14/	5/216/21	Age/Se			DATE
1 2 3		12 000	100-001	00.00			TIME
HB	TIME >25	10.0			3		>25
espirations	21-24				2	THE RESIDENCE OF THE PARTY OF T	21-24
reath/ min	18-20	-	-				18-20
	15-17						15-17
	12-14						12-14
	9-11				1		9-11
	<8	1			3		<8 >96
A+B SPo2 Scale 1	>96 94-95				1		94-95
Oxygen Saturation (%)	92-93				2		92-93
on igen outer and the	<91	THE REAL PROPERTY.	COLUMN 1		3		<91
Spo2 scale 2 oxygen saturation ( %) use scale 2 if target range is 88-92 % eg: in hypercaphic	>96 on oxygen				3		>96 on oxygen
spiratory failure only se scale 2 under the	95-96 on o2		STATE OF THE REAL PROPERTY.		2	Name and Address of the Owner, where	95-96 on o2
rection of qualified	93-94 on O2				1		93-94 on O2
nician	>93 on air						>93 on air
	88-92				1.		88-92
	86-87				1		86-87
	84-85				2		84-85 <83%
	<83%						NO376
Air or Oxygen ?	A= Air	1-	7				A= Air
	O2litre/ min				2		O2litre/ min
	Device						Device
C Blood Pressure	>220				3		>220
	201-219						201-219
	181-200				2		181-200
	161-180						161-180
	141-160						141-160 121-140
	121-140						111-120
	91-100		-		1		91-100
	81-90				2		81-90
	71-80		CONTRACTOR OF		3		71-80
	61-70	1000000			3		61-70
	51-60				3		51-60
	<50				3		<50
Diastolic BP	mmHg	70	70 70	40 76			mmHg
	>131				3		>131
Pulse	121-130				2		121-130
eats / min	111-120				1		111-120
	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		The state of		3		31-40
	<30	W 100 100 100 100 100 100 100 100 100 10			3 200	CONTRACTOR OF STREET	<30
O Consciousness	Alert Confusion	-	7	•	3		Alert Confusion
Score for New onset of	V				3		V
confusion	P				3		P
no score if chronic )	U				3		U
	>39.1 degree				2		>39.1 degree Celsius
	Celsius						NAME OF TAXABLE PARTY.
Temperature	38.1-39.0				1		38.1-39.0
Degree Celsius	37.1-38.0						37.1-38.0
	36.1-37.0	2-	-	- 9	1		36.1-37.0
	35.1-36.0 < 35.0	-			1		35.1-36.0 < 35.0
NEWS Total	1 133.0		0 0	0			C 33.0
Monitoring Frequency		114	Ath Ath	4th lus			
Escalation of Care Y/N		H	NO NO	NON			
nitials by RN		M	dr dr	an as			
nitials by Sr. RN		= hO	- w. O. L. O.	20 120			

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	4	Every Hourly
frequency	3	Every 2 <sup>nd</sup> Hourly
	2	Every 4th Hourly



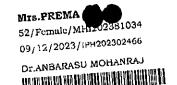
Mrs.PREMA T
52/Femalc/MH120238103,
09/12/2023/IPH20230246.
Dr.ANBARASU MOHANRAJ





Date From: 9 12 23 To: 10 12 23 Bed No: GUI											INTAKE & OUTPUT					
24 Hr	s : S	tarted Time		1 1		ime : 🕌	- 00	,			_	INIA			PUI	
NPO	Start	ed at :	r		NP	O Over	at:						CHA	KI.		
SHIF	T	RV.	lorning		Afterr	noon			Nigh	t		Restricted Fluid (RF)				
INTA	KE				500.				60	oM				-		
OUT			-	¥	400,					FON!						
Total	Intake	: lloomy			otal Outpu	ut: 9501	n)			Differen		<u>onl</u>				
		<del></del>	INTAKE	<u> </u>						רטס	PUT	(ml)	<b>/</b>			
Time	ime Oral Tube Intravenous Infusion Total Time Urine Vomitus N/G Aspirate Others Total R/N Sign E							Endorsed								
		recuiring	Type of Fluid	Additions	Amount	Total				Aspirate	Tube				by	
14 00	200	,				200	1.55	200					200			
<u>                                       </u>	ა ი∕0	,				400	رور عا	ton					B 00	١		
Tr. 30							19.30						4000			
Do;00		,				650	20:00						600		·	
20) (O						700	איוע	_					780			
21,30						850	6:40				_		950			
6>30						1100						ł		,		
						1100				Total	Bute	ke-	Hoor	10		
										Total	-	out -	950			
											_	lance		n		
														Hory		
			_								•			કાંજ		
									-							
													_			











				1450 ERRERING COCKE		_				_								
Date	Fro	m: 10/12-1	/h10	D: 11/17/M	. Be	ed No: L	( ·w ·	4				INITAL	/E 9		TIIG			
24 Hr	s : St	arted Time	:400		Ended T	ime : 千	wi)					INTA			PUI			
NPO	Starte	ed at :			NP	O Over a	at:			-			CHA	<b>XK</b> I				
SHIF	Γ	N	lorning		Afterr				Nigh			Restr	icted F	luid (R	F)			
INTAI	KE		500 N		<u> </u>	o M C			300									
OUTF			300 N		25<	<u>,⊃MC</u>			4000									
Total I	ntake:	710	some	<u> </u>	otal Outpu	ıt: / (	550 n	1		Difference		450M						
		1	INTAKE	<u> </u>		22		1		OU1	PUT	(ml)						
Time	Oral	Tube Feeding		Additions	,	Total.	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by			
ره. ع	200					.200	9:00	150					ไรจ					
11.ou						400	11.00	150					300					
120		ŀ				200	H-3c	300					<b>#0</b> 0					
14.14	•	ł.	_			600	8.22	J.S.2.					85 o					
16.10		ļ <u> </u>			_	750	21.45	250					1100					
16.12	حگ					300	2.30	250					1350	1				
图:45	<u>2000</u>					850	600	२००					1200	A) pel				
श्री ७०	1500	Ч				1000	<u> </u>											
<u> 2380</u>	loon	,				1100			TOTAL	INTAKE	ì	1400 pu						
0,00	pl					<u> </u>			TOTAL	<i>อบั</i> เРบั		155°ona			(B)			
	P														Sec.			
	<u>0</u>	<u> </u>					<u> </u>				·							
		<u> </u>					<u> </u>	,										
		1	l			1		I				1	I	1				



Mrs.PREMA T
52/Female/MHI20 13
09/12/2023/IPH2C2\_\_\_\_166
Dr.ANBARASU MOHANRAJ





Medway Hospitals  The way to better health (A Unit of United Alliance Healthcare Pv L1d)	MINIMUM NABA	Institu Every heart beat o	
Date From: // /2/23 To	): (2(12)2) Bed No:		INTAKE & OUTDU
24 Hrs : Started Time : ಳಬರ	Ended Time: チャロン		INTAKE & OUTPU
NPO Started at : 12 300	NPO Over at :		CHART
SHIFT Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE			

SHI INT OUTPUT **Total Output:** Total Intake: Difference: INTAKE (ml) **OUTPUT (ml)** Tube Intravenous Infusion N/G Drain **Endorsed** Time | Oral Total Time Urine **Vomitus** Total R/N Sign Feeding Type of Fluid Others Aspirate Tube by Additions | Amount









Date	Fro	<u>აო: გ</u>	12-23 To	o: 1411212	12/23   Bed No: 207							INTAKE & OUTPUT			
24 Hr	s : S	tarted Time	<b>3:</b> 7.00		Ended T	Time : ๅ֊	00					INIA			PUI
NPO	Start	ed at:			NP	O Over a	at:			Ģ			CHA	KI_	
SHIF	Г	N	Morning		Afterr	noon			Nigh	ıt			ricted F		F)
INTAI	KE					onmu		<u> </u>	350n	nL			2. A li	F	
OUTF						050mL		<u> </u>	1200						
Total I	ntake	: 1950 m			Total Outpu	1t: <u>285</u> 9	oml			Difference					
			INTAKE (	<u> </u>			<u> </u>	T 1			PUT (	<u>(ml)</u>	T======		
Time Oral Tube Intravenous Infusion Feeding Type of Fluid Additions Amoun						Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	ाठिता -	R/N Sign	Endorsed by
			Total into	alce		500m			701	al out	put .		600m)		
			1	Balance		-)100 n	13.30	200					800		
2.00	125		<del></del>	<u> </u>		625	16.00	২০১					(000		
3.45	125			<u> </u>		750	17.00	550			_		1550		
14.30	122	<del></del>	<del> </del>	<u> </u>		875	16.45	100					1650		_
5.30	285	·		<u> </u>	ļ	1100	19.00	300					18 <i>5</i> 0		
B.00	500	5	<del> </del>		<u> </u>	1600	१९२ ४०	308					ನಿಟಂ		
19.00	100	<del>                                     </del>	<u> </u>	<u> </u>	<u> </u>	1400	21-08	ನ೦೦			<u> </u>		2350	<b></b>	
21.60	182	<u> </u>	<u> </u>	<u> </u>	<u> </u>	1825	00.00	200				ļ	9220	<u> </u>	
5.30	195	;				1950	4.00	200					2750	<u> </u>	
							5.30	100					એ 85૦	<u> </u>	
						<u> </u>					total	intak	(e =	१९४	omL
												out			
											12	la la na	l ⇒ '	900m	L



MIS.PREMA T
52/Female/MH12023810309/12/2023/IPH20230246DI.ANBARASU MOHANRAJ





Every heart beat counts Bed No: 소이거 From: 14/12/23 To: 15/12/28 Date **INTAKE & OUTPUT** 24 Hrs: Started Time: す。のの Ended Time: 7.00 **CHART** NPO Started at: NPO Over at: SHIFT Morning Afternoon Restricted Fluid (RF) Night 2.4/1 tex/day INTAKE 4C0 roomc. 450M SOOML **OUTPUT** 200 650M -100 M Total Output: Total Intake: 1600 Difference: 1500ML INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Time | Oral Total Total **Vomitus** Others Feeding Type of Fluid Time Urine R/N Sian Aspirate Tube bv Additions | Amount 10.4 3 HUE 200 200 100 フコロいるり 100 000 8.15 100 112.00 000 10.10 1100 450 100 11.25 75 500 500 0.2 11.30 50 160 O 12.25 150 20C 950 141.01 Ino 250W B 1150 850 D100 1200m 1000 മെ 1350 100 2-30 200m 160 0 6-30 250m low 1000 19.30 150 1000 THITAKE 1200 TATAL 2100 2000 TOTAL 1400 00TP 07 600 L A.30 100m 1500



Mrs.PREMA T
52/Female/MHl202381034
09/12/2023/IPH202302466
Dr ANBARASII MOHANRA I







Date	T Ero.	n: 15 [2	10 D T	0:16 12/2	, D.	d No.					П	<del></del> -							
		rted Time		0:(6[[2]9.		ed No: 2				<del></del>		INTAI	<b>KE &amp;</b>	OUT	'PUT				
	Starte		1.00		Ended T	O Over							CHA	۱RT	,				
SHIF			 lorning	1	Afterr		at .	т——	Nigh	<u> </u>		Post	ricted F	luid (P	E/				
INTA								<del> </del>											
OUT	<del></del>		100	<del>-   -</del>	w / /~	booms. Frome					2.41Pters/day								
	Intake:		00 M	<u>'</u>	otal Outpu	it: 71.6	gom.	1	7001	Differen	.e.	e: -50m							
		<u> </u>	INTAKE		otal outpe	···	90,4				PUT								
<u> </u>	Γ.	Tube		nous Infusio	 on					N/G	Drain				Endorsed				
Time	Orai	Feeding	Type of Fluid	Additions	Amount	; jiotali	Time	Urine	Vomitus	Aspirate		Others	Total	R/N Sign	by				
6-45	(h <sup>0</sup>	-				ln 0	7-00	100			_		/pO						
4.60	1					250	10.30	200					300						
8-20	145					485	11-30	206			_		500	<u> </u>					
9-20	175					600	12-215	200					400						
22-00	300					d 00	13:45	ವಿ೦೦					9 <b>0</b> 0						
13.45	loo			_		1000	5.00	200					1100						
14.32	100					1100	16.30	പ്പാ					1300						
15.3	100					1200	18-25	250					1550	POR					
#F-00	100					1300	22.45	200					1800						
18:00	70					1315	5-50	250					<u> 265 o</u>	<u>.                                    </u>					
22:45	l '					1500			TOTO	TUTARE		2000 M							
2-00	200					1700			TOTAL	00TPU		DEGOM	·						
1-00	100					1800	<u> </u>					<u> </u>							
6-30	200					2000													



Mrs.PREMA T
52/Female/MHI202381034
09/12/2023/19H202302466
Dr.ANBARASU MOHANRAJ





Date	Fro	om: 16 [12]	2-3 To	o: 17 12/2	_3 B	ed No: 7						INITAI	/F 0	OUT	חוד
24 Hı	rs : St	arted Time	: 7,00		Ended 7	Γime : ໆ∢	<b>6</b> 0					INTA			PUI
NPO	Start	ed at :			NE	PO Over a	at:						CHA	AKI	
SHIF	T	N	lorning	-	After	noon	-		Nigh	t		Rest	ricted F	luid (RI	F)
INTA	KE		825							_		م و	413104	s da	1
Ουτι	PUT	l	340									_			)
Total	Intake	•			Total Outp	ut:				Differen	ce:				
			INTAKE	(ml)						OUT	<u> </u>	(ml)			
Time	Oral	Tube		nous Infusi	ion	Tiotal	Time	Urine	Vomitus	N/G	Drain	Others	575050	R/N Sign	Endorsed
	J	Feeding	Type of Fluid	Additions	Amount		inne	Office	voninus	Aspirate	Tube	Others	( (RELEA)	ION Sign	by
<b>130</b>	عود		1			200	6.44	350					35O		
	2000					ywa	10.30						750		
9-15			-	İ			11-100						950		
10-30					1	400	12-15					1	1250		
					<del>                                     </del>		(	200							
11.10		<del> </del>			<del>                                     </del>	775		<del> </del> -			<u> </u>		<u> </u> 	<del> </del>	
19 'B₁	50	ļ		<del> </del>		895						ļ			
		<del>                                     </del>						<del>-</del> -							
				<del>                                     </del>	<del> </del>	1	<b> </b>								
				<del> </del>	<del>                                     </del>				TOTAL	47.19	ALE	1 825	m		
						<u> </u>		<del>                                     </del>	TOTAL	, ,	PUT	1250	$\Gamma^*i$	-	
	<del>                                     </del>	<del>  -</del>			<del> </del>	1							Т :		
	<del>                                     </del>	<del></del>		<del>                                     </del>	<del></del>	<del>                                     </del>		<del> </del>	B	- LD-M C		<u> + X25</u>	my	-	
	I		I	1	1						1	1	I	< @-	I







#### Every heart beat counts Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

### 

### Department of Dietetics

### NUTRITION ASSESSMENT AND CARE PLAN FORM

agnosis:	agnosis; DM HTN/ CAD-DUD/ CADY BF- 61/											
	174)		Weight:Kgs	Food allergie	s: Yes/ No; if y	es, specify						
ligious (			Vegetarian	tvon Vege	etarian	, ,	□ E	ggetarian	☐ Jai	n		
et Presc	ription:	pero			ارسم	المفاد	Deret	tur, d	Label	tu dut -		
JBJE	CTIVE	GLOBA	AL ASSESSMENT	(ADULTS)		$\Diamond$	١,					
		(A) -	Patient's related Medical Histo	ry .						<u>-</u>		
		1)	Weight Charige (overall change	<del></del>	· · · · · · ·							
	_			□ 2				]4	I	s		
		6	No weight change/	<sn)< td=""><td>5-10%</td><td></td><td>10-</td><td>15%</td><td></td><td>&gt;15%</td></sn)<>	5-10%		10-	15%		>15%		
2)	γ΄,	Dietary Intake	Duration					<del>,</del>				
-	•		5/	□ 2	□ 3			4		<b>□</b> 5		
		Oral -	No change	Sub-optimal solid diet	Full liquid die moderate overall decre			po-caloric ald diet		Starvation		
		Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate			oo-caloric eds ,		Starvation		
	3)	Gastrointestin	nal Symptoms-Duration:	1	ı		1					
	-		9-	<b>□</b> 2 · ·	<b>3</b>	• , .	_ 🗆	4		<b>□</b> 5		
		4	No symptoms	Nausea ,	Vomiting / moderate GI		Día	rrhoea		severo anorexia		
	41	f	apacity (Notifition related functional impa	in and the same	symptoms	- 1	1		<u> </u>	<del> </del>		
	4)	Functional Ca	pacity (Netrition related functional unipa	Timent) Duration;	<del></del>	,						
l.,		/	None /Improved	Difficulty with	Difficult		Light activity	Bed / chair -				
. :	: ,			ambulation normal activity						ridden with no or little activity		
^ 5	5)	Co - morbidity	(Oisease and its relationship to nutrition									
'			□ 1	. 🗆 2	□ 3		<u></u>	<u> </u>		Usry severe		
			Healthy	Mild co - morbidity	mor	erate co- oldity/ age years		• severe co- morbidity		Very severe multiple co - morbidity		
	8)	Physical exam	nination	•					············			
	1)	Decreased fat	t stores or loss of subcutaneous fat									
			□ <u>1</u>	□ 2	□ 3			<b>-4</b>		□ 5		
			Normat	Mild	Moderate			•		Severe -		
	2)	Sign of muscle v	wasting									
			<u> </u>	□ 2	□3			<b>□</b> 4.		<b>□</b> 5		
			Normal	Wild	Moderate				•	Severa		
To	otal Scora = Su	m f above 7 com	ponents	ı								
	1									<u> </u>		
Nutritional Status : Based on this patient is												
		Weil Nourished Moderately Mai			(15 to 18)		<i>p</i> <					
1		Severely Malno			[15 to 18]		- (1			<del></del>		
		1	<del></del>							<del></del>		
Nu	utrition interv	endon:			-							
		سيو 🗆			☐ Enteral		☐ Parenteral			<del></del>		
Die	et counselling		Dr.	-	□ No							
Frequency of re-assessment: Weekly						☐ Fort - night		☐ Monthly				
En	nteral / Parent	erai	Daily			Calorie count:	Yes	D.Homin				
							1					

Dietitian Signature / Name / Date / Time:

Maria Catherine John
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
9 hzfu,	A syean sed funde come & do chis pain wer arressed to be well rouished as evident by LUA.	, <b>,</b>
	Kloba Drelmeno) DND	e sy distribution of the second of the secon
	Educated the patriot and farming and box calcular, he fat now tout, high	
	pussin, dialsetur dit. Empfid en sur font mean E low glymnic control.	Matia Catherine John Senior Dietitian
11/12/m,	Patrick shipted to OT for sugary CAD	<b>(</b> )
	sur. With airtiate on diabetu; lipid dut as per dorbi's achim	Maria Catherine John Senior Dietitian
12fizhi, www	Potrict vivid & stepdorm us. Horr bren. Potrict bevalled dealister; liquids well. Can inter a high perioding soft soid, dealister dut.	Maria Catherine John Senior Dietitian
<u>.</u>	notifated boat were.	

The Control Sanders



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

### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



## Department of Dietetics



### CARE PLAN FORM - A

	CARE PLAN FORM - A	· · · · · · · · · · · · · · · · · · ·
DATE AND TIME	DIETITIAN NOTES	SIGNATURE
13/12/n1 12100	betwit aid & woud- Recupsid on the dut enter this. Frotisated & earl well	Maria Catheri No Jole
16/12/23/	Oral intale is good. But modification and claim cation does. Helicated Head we peal intale is good. Educated the	Maria Cathering Senior Dietitian
roses Refusfor	patient and family or 1600 calours, of for 1600 rate, high pusher, dialisation of small or sm	3
	font mean & low framer could be sure.	Alaria Catherine Joh ( Schior Dietitian
	Dit bout gien en dir dap-	
, , ,		





### INTRAOPERATIVE NURSING RECORD

#### Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ Consultant: DD ANBARS U Date of Surgery: 11 12 2 Name of Surgery OD(AB ( (LOSED HEART) Stretcher Other Mode of Transfer to OR Bed Anaesthesia Type : Epidural ☐ Spiral MAC DGEN Regional... Position : Lithotomy Prone Supine Right Down Left down Lateral Other Pressure Protection Pad Headrest Sand Bag Pillow Axillary roll Eye protection Chest roll Cvsto/Gvn ☐ Shoulder roll ☐ Sling Boot Stirrups/Leg Holder Laem rest padded / Secured R Arms tucked / padded-☐ Nil $\Box$ R $\prod L$ Other (Specify)----Chlorhexidine Prep Providone Iodine Skin preparation in OT Lodophor scrub Others (specify)---Alcohol Prep Pad Loacation 1 flugh Bipolar : Monopolar Electrocautery Location ----Tourniquet Applied Time ----- Released Time -----Applied Time ----- Released Time -----Applied Time ------ Released Time -----Other equipment used : Surgeon DR: ANBARASU Asst. DR: PRAVEEN JALICUMAR Personal Anaesthetist DR-SYLVESTER Asst. Type of Specimen : Pathology Permanent Frozen Time sent -----Lab Time of report -----☐ Cytology ☐ Microbiology ---- Time sent -----

☐ Biochemistry

Name; Page RADHIEA

Date & Time 11 12 23 Q 215

	2& →	He	Pleura diasteri		<del>-</del>	_	_		D 9 68	<u>}</u> _
Count		He	diasteri							
Count	ecord 🗥	N. 01.44		ľ	<del></del> _				Dey s	sb
		neary	latusa	Lion I	Due 10	y Chirs	ry lle 7	r Fole	yes ca	theter (
	Raytex Sponges	Gauze Lined	Gauze Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	Needle	Circ. Nurse sign	Scrub Nurse Sign
Pre-op	emel	Come	_		$\rightarrow$	Perrect	Cornel	Comul	2350	Surjoid 0125
Change over	orrect		-			cornect	Δ.	Connel	239	Sujah 0126
First closure count	oxest	(or & rex	,			(0) 2 22	Coprex	Correct	D( y	848AL 0195
Final closure count	se ent	col feet				(02 2 exx	COR NOW	CORPE	Q1.4	Sypull 0125
Count Correct			•							
orrective action	taken				<b></b>					
			4							
rgeon informed										
		<b></b>	<b>= = -</b>							
ressing / Cast In		۱ ۸۰	T8 : 04.0	W D0	ue wit	h Prima	pone f	leg D	ussing	Done
essing / <del>Cast In</del>	nmobilize	r Chest	Jum	7			_ ~.			
ondition of patie		of surger	_	Stable		Fair	☐ Crit			
ansferred to:	ICU			Patient I	Room 🗀	CCU	□ Reco	overy Ro	om	
rub Nurse Signa										
ime: SUJAT ite & Time: 11	12/23 12/23	5 0 12	35							



Mis.PREMA T

52/Female/MHI202381034

re)

09/12/2023/iPH202302466 Dr.ANBARASU MOHANRAJ

#### PSYCHOLOGICAL WELLBEING REPORT

Date: 18/12/23

Time: 11.00am.

Unit: 207A

Clinical diagnosis:

Surgery/Procedure: OPCABX & graff

Impression:

Depend affect

- depend oriented

- due & childhers filled concern.

- firancial contrails (t)

- feequent ceying meth.

- hypothie courseling provided encouraging

thirte of alternatives for bady of sely case.

Employee ID: HHO275PSY

Signature of the Psychologist:





### Mis.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

NURSING ADMISSION ASSESSMENT (ADULT)
Date of Admission: 912 23 Time of Arrival: 12.15 Mode of Admission: Walking Wheelchair Stretcher
Accompanied by Relative: Yes No If Yes, Name of the Relative:
Relationship with Patient: Herson's Name: No. Sock Relationship: Husband
Contact No.: 9953928265 Primary language spoken: Tamil English Indian International
Interpreter needed: Yes No
Patient status: Conscious Unconscious Disoriented   Patient Vulnerable: Yes No
Menstrual History: LMP: Menopause: Years bruck 15400 book piles
Medical History: DM / HTN / Co - Morbility:Yes If yes specify  Drugs History: Antiplatelet (Specify) Ap State of 10 2
30 112 07 07 07
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: 97.4°F)   Pulse / HR: 70 (beats/min)   BP: 130 90 (mmHg)
Thespiration: 2 (breaths/min)   SpO <sub>2</sub> : 9 (%)   CBG: +μ (mg/dl)   Height: μ1.ς(ems)   Weight: 66.2 (kgs)
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known
If Yes, specify: UNKnown
Pain: Yes No. If Yes, Score: 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: Diabetic Cult
Dietician Informed: Yes No. If Yes, mention the Name: 12 Country Time: 12.3>
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 Wurses Call Bell Television Light Controls Telephone
Functional Assessment:
Particular Assessment Remarks Outcome
Visual Impairment Yes No
Hearing Impairment Yes No
Chewing Difficulty Yes Mo

Daily Activity Of L	iving:	<del></del>							,		
Activity		Independe	ent				De	pende	nt -		
Bathing	<u>.                                    </u>		/								
Dressing			, -		H		<del>                                     </del>	∺			
Eating					-		<del></del>	∺			
Walking					Ħ		<del> </del>	∺	<del></del> _		
Toilet Use			-		<u> </u>			旹			
Pressure Injury Ri	iek Aeene	sment: Brad	en Scale				<u>.                                    </u>				
Sensory Percep		Score _	Moisture		Score	Dogr	ee of Activit		Score		
No Impairment	11011	Score	Rarely Mois		30016		s Frequently	<u>y</u>	Score .		
Slightly Limited		3	Occasionali		3		s Occasiona	lv	3		
Very Limited		2	Very Moist	,	2		Fast		2		
Completely Limit	ed	1	Constantly I	Moist	1	Bed I	Fast		1		
Mobility		Score	Nutrition		Score	Frict	ion & Shear		Score		
No Limitation		4	Excellent		N	No a	pparent prob	olem	/3		
Slightly Limited		3	Adequate		3	Pote	ntial Problem	1	2		
Very Limited		. 2	Probably In-	Adequate	2	Prob	lem Present		1		
Completely imme	obile	1	Very Poor		1	<u> </u>			_		
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: Action needed: Yes No Pressure injury present at the time of admission: Yes No   If yes, Location: Grade: Size:   Witnessed by: Signature: Relationship:											
	•		E FALL ASSES	<u>-</u>	-						
Fall Risk Assess	sment (Mo	dified Mors	e Scale):					,			
Variables								Nun	neric Value		
History of falling	(immediate	e or within 6	months)				No	<u> </u>	_B		
	<del></del>						Yes	<del> </del>	25		
Secondary diagn	iosis (≥ 2 i	medical diag	nosis)				No Yes	<del> </del>	15		
		<del> </del>	· · · · · · · · · · · · · · · · · · ·	<u> </u>			tes	-			
Ambulatory Aid None / Bed Rest	/ Murse As	ecict							8		
Crutches / Cane		30101							15		
Furniture	•								30		
The second		- win 11. / To				-	No		8		
Intravenous Ther	ару / пера	arın Lock / 10	ibes insitu	_			Yes		20		
<b>Gait</b> Normal / Bed Re	st / Wheel	Chair							8		
Weak	`					<u>-</u>		<u> </u>	10		
lmpaired	Impaired 20										
Mental Status											
Oriented to own Overestimated or		mitations			-			1.			
		manons						<del> </del>	10		
Medications includes PCA / o	niates ant	iconvulsants	. anti-hyperter	nsives diuret	ics, hvnno	tics	No	}	0 /		
	Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics Yes										
Score Interpretation	core Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk  Total Score										

As per the score, tick the following appropriate	boxe	es:		
Familiarize the patient with the immediate surrounding.  Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all times.  Keep the call bell, bedside table, water, glasses withint.  Remove excess equipment or furniture to make a clear.  Keep the patient's bed in the low position at all times ex.  Feach fall-prevention techniques, such as sitting up for Bed wheels should be locked.  Encourage family participation in the patient's care.  Ensure that floor of the bathroom is dry and not slippen.  Review medications for potential side effects that can p.  Use safety belts during movement in wheelchair.  The patients are not ambulated by themselves. They are Medium risk interventions.  Tie yellow fall risk tag in the bed and Wheel chair / Stretch Make sure that proper transfer precautions are instituted 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 effection in the patient to a patient's care.  Do not leave patients unattended in diagnostic or treatmed. Accompany the patient while going to bathroom.  Advice the patient to use grab bars near the toilet, bathly Make sure the family and other visitors understand the 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 nurse. 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). If appropriate, consider using protection devices: safet.	bed for all he pa path cept c a mod romo re to b cher sted for tor ects ment a tub, au restric ses' st	tient' during ment te fal e am or he level areas nd sh	s eas g pro s before ls avy of of s mowers	ocedure ore rising from the bed  ted only with assistance or debilitated patients in a  consciousness, gait and
Initial Assessment to Special Needs and Vulnera	bilit	v of	Pa	tient:
	т т	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	t			
Patients whose immune system is compromised				
Patient with infections and communicable diseases		1		
Does the patient have implants	$\vdash$			-
Has tracheotomy been done	$\vdash \vdash \vdash$	/	$\vdash$	<del> </del>
Has colostomy been done		-	r	· · · · · · · · · · · · · · · · · · ·
Any other potential needs of the patient		1	ľ-	

	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.	Assign a s	core		Parar			1105. 1		assig	n a scc	ore or -2 ii (+23) iii j	т —	Yes / No		Score
1	Active cancer	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)							┼—	$\overline{}$	No	30010			
2	Bedridden red										<u>,                                     </u>	1-		No	
3		>3 cr	n compare						ıred at	10 cm	below tibial tubercle		Yes 🗍	No	
4	Collateral (no	nvario	ose) super	ficial v	eins	prese	nt (Asse	ess for bot	h legs)				Yes 🗍	Ŋo	-
5	5 Entire leg swollen (Assess for both legs)									Yes 🗌	No				
6	Localized ten	derne	ss along th	e deep	ver	ous s	ystem (A	Assess for	both le	gs)		Yes No			
7	Pitting edema	, grea	ter in the sy	mptor	nati	cleg (/	Assess f	or both le	gs)		_		Yes	No	
8	Paralysis, par	esis, c	or recent pla	aster ir	nmc	bilizat	tion of th	e lower ex	tremity	(Asses	ss for both legs)		Yes 🗌	No	
9	Previously do	cume	nted DVT (	Assess	for	both le	egs)						Yes	No	
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  Tick the score obtained (✓)								inal Sco	re						
HICK	tne score on	itaine	!a ( <b>√</b> )	✓					Actio	n Take	en		Date		Time
Low	Risk	-	2 to 0												
Мос	derate Risk		1 to 2						_						
Hig	h Risk	;	3 to 8												
Per	sonal Belong	gings	/ Valuab	les:			_						_		
Valua	ables		escriptio	n		Vith tient		Patient's endant			Signature of the atient's Attendant		Rema	arks	
Dent	ures		ipper□Lo oth 및110			_				•				_	
Hear	ing Aid		tight □Lo Íil	eft											
• •	glasses / act lens	□Y	′es □M	0/											
Jewe	ellery	ΠY	′es □N	0											
Othe (spec	r valuables														_
Rep	ort (List of X-	ray, I	ECG, lab ı	eport	s re	taine	d with t	he nurse	):						
		1	1			T				_				_	
	ent /		Sign.	سردا	_	Na	ime	rel			Emp. No.  Relationship	T	Date	_	ime
Pati Nur	ent's Attend	ant	So	_		+	-	10	<del></del> -		flus hund	٠.	12/23		30,
<b>—</b> —	In-Charge	$\dashv$	100			+		2018ho			0072	9/	12/23	ſ <u></u>	130 127





#### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

L Dr.ANBARASU MOHANRAJ



	PATIE	ENT CLINICA	L HANDOVI	ER RECOR	D FOR NU	RSES	
Date: 🔾	12/22	Shift: I	Morning Evenin	g Night	_		
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: AD — DVD PEWS Score:- r day: al line day: Right:_	Left:- Day: Day: MDR: ∐Yes ☑완경.	GCS:   C   L POD: - Central line   VIP Score:	days: - ·	·	
В	Type of s Allergies On room	iROUND surgery: if any:	M Air	Date of surg			
A	BP: 10 Control of the second s	ore: Depair Scale  Score: Minimal Risk: 23  e Ulcer Scale for Healing	used: PIPPS / CRIES  k Protocol: Low  3-19 At Risk-Mild Risk  (PUSH): Yes No	/ FLACC / Wong-Bal / Medium High k: 18-15 Moderate Ri	66.2 (kgs)   BMI: ker FACES Pain Rat sk: 14-13 ☐ High Risk Dressing done: ☐ Ye	c: 12-10□Sever	:6 / CPOT :e Risk: 9-6
R	Referral Pending Pending Pending Critical v Changes Pending	medications: medication indent: lab reports / Investigation ralue alert and its correct is in nursing care plan: follow-up orders:	tions:	'	e: ABG	_	
Handover o		Signature	Name	ncthini ah Grace	Emp. No.	Date	19:30
Document	endorsed	The state of the s	Hann	WI NEUNE	0103	M/12/22	08:00

·	NU	JRSES PROGRESS NOTES				·
Date & Time		Observations / Action		Signa	ture with Er	np. No.
9 12 23	Admi	QQion Notes				
(A)	( Activity	A ASTON TO THE STATE OF THE STA			-	
12.15.	=> patient	today Admic	noi 08			
	1 ( ) 1		W-11	4	<u>.</u>	
	BeJ.					
	-> patient (	Conocious Sori	ented			
	Spatient	vital Origins	3			
	Chella	d & Pelorde	J	<del></del>		
16.00	=> Medical	tion given sad	8 per-			
	drug C	hart (	V	,		
	s pattent	CAG CID Corp.	ied			
	Yonda	y plan for				
	'OBEC	0 0			-	
	-> patient I	To Chart Monite	ored.			
18.30	& patient	· Vital Signs				
	Chelled 8	Perorded		$\overline{}$	_	
19.32	-> patient	handing over	40_	1	_	
-	/ Night	duty Stee	lf	- ' '	_	
	Murse					
		· · · · · · · · · · · · · · · · · · ·				
		<del></del>			-	
	<u> </u>	<del></del>				
·						
		·		-		
<del>.</del>						
<del></del>						
	Signature	Name	Emp. No.		Date	Time
Document endorsed by	· (Do	Danaraero -	0005		10/12/23	og!od





### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu Mohanraj



### PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:91	2/03	Shift: Morr	ning Evening A	light ·	, · · ·		
S	NEWS / F Ventilator Periphera Ryle's Tui Urinary C	S: CAD-DVD  PEWS Score: D  day: Il line day: Right: Lef  be: Yes No Day atheter: Yes No Day	<i>/</i> :	GCS: (5() POD: — Central line VIP Score: pecify organic	days:		,
В	Allergies On room	ROUND  urgery: —  if any: NOILD JOSUG  air / oxygen: On John  its / New Symptoms in last s	alleegy (Not know hitt:	Dațe of surg קר) IV fluids on fl			
A	Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>97√</u> °F)   Pulse <u>o (70 (</u> mmHg)   SpO₂: <u>9</u>	Height: 4 (complete (compl	ms)  Weight: C / Wong-Balım ∐High ⊒ Moderate Ri:	66-1(kgs)   BMI:_ ker FACES Pain Ratir sk: 14-13 □ High Risk: Dressing done: □ Yes	3 3 .   Ng ng Scale / NR 12-10   Seven	S / CPOT
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:	_/~				
		Signature	Name		Emp. No.	Date	Time
Handover g		Hay	11	iraie	0105	10/12/23	7130
Handover to		5.9	5 Dowardh	acheni	0212	10/12/13	7.30
Document (	Haorsea	(12)	I Whate	marero.	0005	10112123	$\omega < 0$

	N	JRSES PROGRESS NOTES			ı
Date & Time		Observations / Action	s	Signature with E	mp. No.
9/12/23	Nigl	it duty notes			
19:30	Patient has  Joon Even  a hemodyn  Condition	rding over taken ing duty Staff amically & table	vîn	Hay Ows	· · · · · · · · · · · · · · · · · · ·
20200	Vital Signs	Checked & Reu	moled	Hay	> .
21:00	Due deugs deug Chaet	all given as per		Hoy	· · · · · ·
		Sleeping well		Hay 005	
2:00	Patient ,	is Sleeping well Complaints		Hay Dios	
6:00	Patient Vita Recorded Ilo chaet	I signs Cherked Mountained	2	Hay	· ·
7:00	Patient he Morning du	anding over gives	n to	theyows	
	. 1	,			
	Signature	Name	Emp. No.	Date	Time
Document endorsed by		Manaeane.	0005	+	08 <sup>°</sup> .80

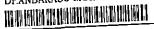




# Patient Natella (Alii. 1 - 1 - 1 ) MIS.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





	PATIE	INT CLINICAL	HANDOVER	RECOR	D FOR NUF	RSES			
Date: 0	12/2	Shift: Mor	ning Evening [	Night	· · · · · · · · · · · · · · · · · · ·	*			
S	Ventilator Periphera Ryle's Tu Urinary C	s: (A) DVD PEWS Score: r day: al line day: Right: be: Yes No Da Catheter: Yes No Da	•	GCS POD: Central line of VIP Score: specify organis	days:	•	`		
В	Type of s Allergies On room	ROUND  urgery:  if any: Drug Allovies (N  air / oxygen: RA  nts / New Symptoms in last	<b>†</b>	Date of surg	, <sup>-</sup>	•			
A	ASSESSMENT  Vital Signs: Temp: 98 (°F)   Pulse / HR: 78 (beats/min)   Respiration: 20 (breaths/min)  BP: 1070 (mmHg)   SpO <sub>2</sub> : 78 (%)   Height! 4 (cms)   Weight: 6.2 (kgs)   BMI: 33   Jrg/m 1  Others:  Pain Score: 910 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 No No Wound Dressing done: Yes No No No Drains:								
R	Referral of Pending Pending Pending Critical volumes Pending Pending	medications: medication indent: lab reports / Investigations: alue alert and its correction in nursing care plan: Yes follow-up orders:	s:	•	o:				
		Signature	Name	<del></del> ,	Emp. No.	Date	Time		
Handover (	<u> </u>	5.9	5 Dowach	achini	0212	10/12/2	12.30		
Handover t		1 Ar	H. Manth	ni	0/70	101223	Þ.3:		
Document	endorsed	(00)	Diana	our's	0005	10/12/23	14-30		

	NU	IRSES PROGRESS NOTES			`
Date & Time	C	Observations / Action	:	Signature with E	np. No.
10/12/23	Mouning	buty Notes		-	
7.30 =	Night Duty S	tall	n	5 Da	
8.03	paraided.	dication Gener. Iran CABG. To short Chadle	red e	5 Dj.	
12-30	=> Pt handin	g one guien to		5 Di	
					· ·
Document endorsed by	Signature	Name	Emp. No.	Date	Time







### Mrs.PREMA T 52/Female/MH1202381034 09/12/2023/1PH202302466

dt.anbarasu mohanraj



Date:	10/12/	እ.ዓ. Shift: Morn	ning Evening Ni	ght	<del> </del>			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CALL : DV D  PEWS Score: -  day: day: lline day: Right:- Left be:	t: <sup>—</sup> ":	GCS:\S\S POD: Central line o VIP Score: ecify organis	days:			
В	On room		Air	Date of surg				
A	ASSESSMENT  Vital Signs: Temp:   CF)   Pulse / HR:   C (beats/min)   Respiration:   (breaths/min)    BP:   OF   F (mmHg)   SpO <sub>2</sub> :   OF (mmHg)   Height:   OF (mmHg)   SpO <sub>2</sub> :   OF (mmHg)   Height:   OF (mmHg)   OF (mmHg)   Height:   OF (mmHg)   OF (mmHg)   Height:							
R	RECOMMENDATION  Referral doctors:  Pending medications:  Pending lab reports / Investigations:  Critical value alert and its corrections:  Changes in nursing care plan: Yes INO. If Yes, modified care plan date:  Pending follow-up orders:  Special instructions if any:  Tomorrow  Plan CABC							
	-	Signature	Name		Emp. No.	Date	Time	
Handover g	iven by		A. Klampri	n i	0170	In laba	19:30	
Handover to	aken by	dy	A. ALBINIU	2	008£	10/12/23	1930	
Document endorsed		(0)	Dlonge	2000	0005		02:00	

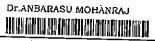
Date & Time    Document   Carlon   Carl	NURSES PROGRESS NOTES									
12.80 patient taken over from Morning duty Otalif  Number Patient Carsciens Soriented  Alient Vital Signs cheered a  Perorded.  16.00 per Preparation Jone  Preparation Jane Correct  Taken  Spatient Is Chart Monitored  18.30 patient Vital Signs  Chelend & Rienrand  19.30 patient tanding over to  Number Patient Janding	Date & Time		Observations / Action	Sig	nature with E	np. No.				
Signature Name Emp. No. Date Time	10 12 23	Ferning  Ferning  Auron  Nurse  Datient  Perorde  Medient  Arug Cha  Traparal	Diservations / Action  Let y Note  Let y Note  Let y O  Let y  Let	sm. ( talf  talf  is tad  is tad  jestod q  Jens  lone	gnature with En	mp. No.				
Signature Name Emp. No. Date Time	,	Spatient Spatient Chelod Spatient Nurdo	Is Chart Moni- Vital Signs & Reproduct handing over	1						
		<del> </del>	Name	Emp. No.	Date	Time				
		Signature	D'arranaire.	0005						







### Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466





	PAHE	INI CLINICAL F	ININDOAEU UECC	אחט רטת אטח	IOEO :	, ,				
Date:	12/हेंग.	Shift: 🗔 Morn	ing Devening Night		,	· 				
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	EWS Score: day: I line day: Right: De: Yes WNo Day atheter: Yes WNo Day	VIR. Sco	line days:	; <sup>3</sup> .1	÷.				
В	Type of si Allergies On room	round  urgery:  If any: NGP  air / oxygen: ON Perm A  ts / New Symptoms in last si	AR IV fluids	surgery:	% # ***	s				
A	ASSESSMENT  Vital Signs: Temp P   Pulse   HR: OC (beats/min)   Respiration: D (breaths/min)  BP: 10   C (mmHg)   SpO <sub>2</sub> : (%)   Height: (cms)   Weight: (kgs),   BMI:  Others:  Pain Score: Pain Scale used: PIPPS   CRIES   FLACC   Wong-Baker FACES Pain Rating, Scale   NRS   CPOT Fall Risk Score: Pain 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: D   NA 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: TMRW PLAN CAS 9									
		Signature	Name	Emp. No.	Date	Time				
Handover g	given by	94	A - ALBINUS	oo &f	11/12/23	7.00				
Handover t	aken by		. 0	27	11/12/23	07:15				
Document endorsed		(%)	Diagranau	0005	11/12/23	OG!OD				

	NURSES PROGRESS NOTES	·			,
Date & Time	Observations / Action		Signati	ure with E	mp. No.
10/12/23	MIGHT DUM NOTES			4.	
19.00	Patient handover taken		-	AL.	
	from the evening di	uty	_	00/8s.	
	Stable.				
			~	<del></del>	
२०,००	Due medications are go	ven	7	000 80	
	to the patient.				
				<del>{                                    </del>	
2200	ortalgons are checked	2	<i>y</i>	1000	
	elcorded	-^, 1			
					<del></del> -
6.00	2/6 chart is ramai	ied	7	0081	
7 00	Patriout handoves que	is	· · · c	<u> </u>	_ ,
	to the Morning duty		7	008	
	steeds	1	`.		
	. Co handed our To pa	<del> `</del>		<u> </u>	
7*	Attender Get-edy.	`	lelle	er	
	Superusia and of straffice Meager overt is Tage	$\delta$	,		
Sarsofm	Superistan and of Straff:				
	Meagy Ment in Things	<u>/</u>	Sel	100	
	A ATH A A A A A A A A A A A A A A A A A				
				_	
, , , , , , , , , , , , , , , , , , ,		,			I _
Document		mp. No.		Date	Time
endorsed by	De Dienarano	0005		11/12/23	be <sup>100</sup>



Dr.ANBARASU MOHANRAJ RECONSTRUCTION OF A LOCAL PROPERTY OF A LOCAL

	Ni	URSES PROGRESS NOTES				_
Date & Time		Observations / Action		Signa	ture with E	mp No.
11.12.23	<u> </u>	ECEIVAL REPORT	-			
(a)	Patient Received From D Sheet	To CTOT With Blue Op File	And Case	_		
8:30	ECG: \ ECHO:	X-RAY:   ANGIO CI	D: ]	_		
	CT FILE: -					
	Patient Posted For Procedi	ure: CABN			MA	
	Under Anesthesia: (ハギ)			~	1800.	
	Allergy Status: Not KN					
-	Known Case Of: CAD-	- Etfort angina, 14Pe 14	DM,		_	
	Past Surgical History:	emorrholdectory-20	you back	_		
· · ·	VITAL SIGN: TEMP: 370	HR: SJIDMSPO2: 901. BP: 16	09/1 <del>717 mm.ly</del>	_		
	CTOT S	SHIFTING REPORT				
		To SICO With Blue Op Fi	le And			
	Case Sheet Along With *Surgery Safety Check Lis				<u>-</u>	
1/2/22	*Intra Operative Record					
e	*Nurses' Record *					
, \5	ECG: \ ECHO:	X-RAY: ANGIO CD	or Atte	nda n		
1/4	CT FILE: —				<u> </u>	
	Patient Posted And Unders Under Anesthesia: \ Gr	went For Procedure: O PCAI3 (C)	ased h	eart		
	Procedure: orcal3	Hall			X du	31
	Drain tube size and placem	nent: 28FV	tern			_
	Pacing wire placement: Pro		عور	<del>`</del>		
	Implants:			· <u> </u>		
	Cautery burn/skin peeling/ Site:	towel clip mark: Present/Ausent				
	VITAL SIGN:	PO2: 1 - V BP: 112 /- Town U			<u> </u>	
•	TEMP: 3-F' HR: 54 SPO2: 100 × BP: 110 form Hg					
	Notes:					
		<del></del>		_		
	Signature	Name	Emp. No.		Date	Time
Document endorsed by	Ose _	(Kristinas	0036		11/2/27	_t21s





### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu Mohanraj



FATILITI OLIMIOAL HAMDOVLIT NECOND I ON MONSES								
Date: 11	12/200	Shift: Morr	ning Devening D	Night				
S	Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	atheter: 📿 Yes 🗌 No 🛮 Day	POIDI t: - v:	GCS: ET POD: ÞØ\$ Central line da VIP Score: Ø specify organisn	15			
В	Allergies i On room	ROUND urgery: のPCABスタが if any: NKDA air / oxygen: On VT its / New Symptoms in last s			y: 11/12/202		<b>~</b> ,	
Α	ASSESSMENT  Vital Signs: Temp: 14-5 (°F)   Pulse / HR: 65 (beats/min)   Respiration: 20 (breaths/min)  BP: 13-60 (mmHg)   SpO <sub>2</sub> : 100 (%)   Height: 14 (cms)   Weight: 66 (kgs)   BMI: 33.3141m <sup>2</sup> Others:Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  Fall Risk Score: 65 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 Ho NA  Current diet: 1100 Drains: And And And And And And							
R	RECOMMENDATION  Referral doctors: DR. (Proveen)  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:							
Handover g	iven by	Signature Moana	Name	1	Emp. No. 0236 .	Date (\ \ 1.2\362]	Time	
Handover to	aken by	JA.	A ILA	(	8019	11/12/23	19.50	
Document (	endorsed	V	In	cihi	00%	12/12/2	9. u	

	NU	JRSES PROGRESS NOTES		•	1	1
Date & Time		Observations / Action		Signa	ture with E	mp. No.
11/12/2023	trand one fak	on, Patient 18 on				
12:30'		alred with volume a	rbod.		. <u>-</u>	
		otroper. In Dopum				
		ine . Support.		_		
<u>.                                    </u>		. Abdoman soft.		SM	ده محمو	27G.
	ABOI, RBG to			S' W	الم بسمع	276
12:45 /	Inj. KCR Jone	of FV Started	-			
12)45.	1	2011 Pr Started.		Mea	ne 02276	
-	Patient Wears	ing Stalted.		S. M	2009 00	76
01:30.	l	alt munitered.		Sim	ړ٥٩معه	<del>26</del>
	: Patrent family	y sean The patien	<del>J</del> .	Sim	22na 0	286
14:00.	Patient 18 on	Pressure support	_	_	<del>_</del> .	
	ventilation.	· · · · · · · · · · · · · · · · · · ·				
15:00	ABGI taken.	Sean by DR. silverte	<u>.</u> .	Inc	مرد م	76
		aconste 10ml Ivgi.		Iγι	02 جمعو	<u> ۶</u>
15:05.	Extubated.	Nehulization given,		<u> </u>		
15:30,	Hasayrings 22	tglien, orchaughe	<u>5√</u> ·	1200	19 00E	16
16:00	ABGI taken,	·		mo	00000	<u> </u>
1800.	DR, Mareon ac	suiced to start.			_	
	Inj. Fentanys	Infusion started		Mao	ne 027	e
1800.	Janyly Sean	Infusion stacked the patient in to cussigned		me	029	<u> </u>
1930	Hand over gino	in to cusigned				· · · · · · · · · · · · · · · · · · ·
	Strets			me	کلاه ویر	77
		·				
				· !		
				·		
	<u> </u>	T.,				T
Document	Signature   N	Name	Emp. No.		Date	Time
endorsed by		· Anau	0.00	٤	12/12/2	9 20





### Mis.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ 110 HU 181<u>1 181 HU 181 HU 181 LU 181 LU 181 HU 18</u>1 A



PATIENT CLINICAL HANDOVER RECORD FOR NURSES										
Date: \\	Date: 11/12/23 Shift: Morning Evening Alight									
S	SITUATION Diagnosis: (AD DVD, DM, SHTN)  NEWS / PEWS Score: POD: 0 DD Ventilator day: Central line days: D D Peripheral line day: Right: Left: Ryle's Tube: Yes No Day: VIP Score: VIP Scor									
B	BACKGROUND  Type of surgery: DDCAB X Q CRAFTS Date of surgery: 11/12/2023  Allergies if any: NkDA  On room air / oxygen: ON 02 2 CITIMN IV fluids on flow: CABILYTE  Complaints / New Symptoms in last shift: —									
A	ASSESSMENT  Vital Signs: Temp: 98 [ °F   Pulse / HR: 89 (beats/min)   Respiration: 23 (breaths/min)  BP: 27   55 (85)   mmHg)   SpO <sub>2</sub> : 10 0 (%)   Height: 41 (cms)   Weight: 55 (kgs)   BMI: 33 2 (kg lm 2 - Others:									
R	RECOMMENDATION  Referral doctors: DR. PRAVEEN  Pending medications:  Pending medication indent:  Pending lab reports / Investigations:  Critical value alert and its corrections:  Changes in nursing care plan: Yes \( \subseteq \text{No. If Yes, modified care plan date:} \)  Pending follow-up orders:  Special instructions if any:									
		Signature	Name	Emp. No.	Date	Time				
Handover g	jiven by	the	ASUA.C	୦୦। ୩	12/12/23	07.15				
Handover t	aken by	9	Sounder jume	වරාදු	12/12/03	7:15				
Document of	endorsed	V	Lhan usu	2005	12/12/25	9.2				

NURSES PROGRESS NOTES									
Date & Time	Observations / Action	Sigr	nature with E	mp. No.					
11/12/23	Took over the petient in a Lemodynamicale	/	_						
10,20	State Condition, Nil ionohopic support	/   #	3						
	- patient 13 Courious, Oriented, afeliles	υ	μ						
	- patient consumed ligned diet	-	<u> </u>						
	_Abbuliection administrated, and spiro		්ර 						
	nuty exercise done by patient	<u> </u>	A .						
	- galtent Leursdynamin Usle-								
న్ని,అం	-patient Condition updated to Dr. Aubaran								
	- pateout is sleeping Comfostable			,					
i i	- No Complaints of pain		<del></del>						
ou;∾	- patient had dips of waler	٠, حمد	, 						
0५३०	- Blood Sample Collected and land for.	·	_	:					
	louter une by ateon								
	-oral Caregiven	4	<u>A</u>	-					
£.60	- Bath given ennj met wipes	10.	<del></del>	_					
<u> (</u> .7	- Could live during done	- 100 - 100	<u> </u>						
	- u Cath diesen j done	·   \							
	- Mebilischen solvewistened and spromety	_   +	ha						
	done by patient	-							
624	= AB4 doie as voutine le 3.6 mml	_, •							
	by potessium Chlorde Dong Courtion Started		<u></u>						
6,40	- highborndrendene tappured and Stopped		DE 15						
01.10	-patient housed over to aronny duty			-					
0111	Staff		<u> </u>						
<u> </u>									
<u> </u>			<del></del>						
	Signature Name Emp.	No.	Date	Time					
Document endorsed by	A Amai si	 >b/	12/12/2	9.00					
GINGUISEU DY			MIAN.	<u> </u>					

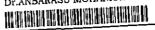




# MIS.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Date;	21121200	Shift: ☐Morr	ing □Evening □Nigh	it	- 1			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAb IDVD PEWS Score: Art day: Not all line day: Right: Melomal Lef be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	PC Ce	CS: 15 US DE: DS POD entral line days: D P Score: 0 5 ify organism:	······································			
В	Allergies On reem	urgery: a PCABX 2UP	. IV	ite of surgery: (((12/202	<b>1</b>			
A	ASSESSMENT  Vital Signs: Temp: 12-1 (°F)   Pulse / HR: 11 (beats/min)   Respiration: 1-1 (breaths/min)  BP: 14-14-14-14-14-14-14-14-14-14-14-14-14-1							
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: Dr. Dreween medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: instructions if any:	LWI1	plan date:	, ,			
		Signature	Name	Emp. No.	Date	Time		
Handover (		gr_	Sanduspur	mu 0002	12/12/28	12:30		
Handover t	aken by	Suffe	SURANUA	·( 0223	12/12/23	13:00		
Document endorsed		```\	- Ans	1 h 0065	13/12/25	9.4		

	NU	JRSES PROGRESS NOTES	• • •			′ ,
Date & Time	(	Observations / Action		Signat	ture with E	mp. No.
10/10/20028	Morning Do	TY REPORT ON 1211	2 <u> 2D23</u>			
7:00-18:00						
7:00		garon Joma hen	v			
	miray Stable					
-	1 · 1 i	o fooy dir. On				
<u> </u>		iae Mong He - 83bpr		•		
	Į į	my ch smong spoz		1		
	Bilateral air c	antry @ lungi au (	Year	V0012	<u> </u>	
	Andomen legt s	sowel Sound @, (Perl	boneco			
	Warm Pullation	-ferro				
			· · · · · · · · · · · · · · · · · · ·			
7:30	Stelminrad mealice	ount as per order.	_	1		
नः भह	Parent hed	min order toler ate	ما	10012	<del>-</del>	
-	weu.	<u> </u>	•			
	<u></u>					
€!30	Pairent had	food ordly tolerated	well.			
		······································		A 1992	<u>L</u>	
<u> </u>	Selministed m	editating as per probe		Ů		
-	<del></del>					
C0,01	Selmind	webulum ou for order.	and	-		
	Spring seonis			9x	~	
			•			<u>`</u>
lb:w	_	bras In remod, si		01-		
	thore a no	Drag & from no	Sire	Qb.	ข_	
		<u> </u>				
ptao	1	h 100 oozig @ gwm	ha	0005		
	St to			7000	_	
	·		-		_	
	Signature	Name	Emp. No.		Date	Time
Document	Oignature	, ,	Emp. 140.			
endorsed by		Langu	000	S	13/1/12	7.00





### Mis.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

dr.anbarasu mohanraj



	PAIL \ \	INI CLINICAL I	IANDOVER RECOR	D I ON IYON	IJLJ			
Date: \2	12/2	Shift: Morn	ing Vevening Night					
S	Ventilator Periphera Ryle's Tul Urinary C	S: CDD - DVD ST PEWS Score: — day: — Il line day: Right: MSTACH Left be: ☐ Yes ☐ No Day ratheter: ☐ Yes ☐ No Day	POD: YOU  Central line  D2	0 - I days: D2 0   5				
В	Allergies On room	urgery: OPCABX 201	lV fluids on f	ery: 11/12/23 low: NLC				
A	ASSESSMENT   Vital Signs: Temp: 98 (°F)   Pulse / HR: 8b (beats/min)   Respiration: 22 (breaths/min)     BP: 130   FO (mmHg)   SpO <sub>2</sub> : 98 (%)   Height: 4 (cms)   Weight: 6b (kgs)   BMI: 33.2   m <sup>2</sup>     Others: 850   Others   Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT     Fall Risk Score: 50   Fall Risk Protocol: 0   Low   Medium 4   Migh     Braden Score: 0   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): 0   Yes 0   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   No 0   NA O T     Current diet: 80   Solid diet   Drains: 1   No 0   NA O T     Current diet: 80   Na O T							
R	Pending Pending Critical va Changes	medications:  medication indent:  lab reports / Investigations:  alue alert and its corrections:	— — No. If Yes, modified care plan date	);				
11		Signature	Name	Emp. No.	Date	Time		
Handover g			SUGANYA.CO	0023	12/10/03	19:30		
Handover ta		" " " " " " " " " " " " " " " " " " " "	JURIA COALA-S-N	0112	12/14	19.36		
Document e	endorsed	V .	aman'	2005	13/22/21	9.00		

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
12/12/23	EVENING DUTY REPORTS ON	
13/00	a Took original Postions is in	
	haemodynamically stable Condition	84
	Cout sapport on RA 3981, Ble aimag	52913
	entry @ lung clear, Abdomen Soft,	
	borold sound mand, peipheis	
	warm of puls felt:	
142.00	* patient Consumed Boni Soft	
	died & all due modicine gren	84
	as poe drug chart.	92.1)
16:00	* T. Carix - wet due to Mordpul	
17:00	- Due dose of Aldactone	
	given as poe drug chart	0103
174:00	Dr. Ahmeane Came B	
	Seen the patient to adice	
	to shift the patient to ward on	() N
	tonopous.	3.
18:00	- Allender Came & Soon the	
1015	patient.	<u> </u>
18:20.	a patient mobilized outof	
19:20	bed & Spirometer given	241 .
19,20		82/10
_	Red Conting to reconscipranically	
	CO-1000 CINCOLOX,	
_		
-	Signature Name Emp. No.	Date Time
Document endorsed by	De 2000	3/12/14 7.00





#### MIS.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Date: 12.	12-25	Shift: Morn	ing Evening 1	Night				
S	Periphera Ryle's Tu Urinary C	S: CAD PEWS Score: 10 VD / 12 day: — al line day: Right: MGTALEfi be:	RPAC(D2)	GCS: US POD: T Central line of VIP Score: specify organis	%-			
В	Allergies On room	ROUND urgery: のりしみお x 2 なん if any: 人人 air / oxygen: の人 ペタ nts / New Symptoms in last sl		IV fluids on fl				
A	ASSESSMENT  Vital Signs: Temp: 98 (°F)   Pulse / HR: 93 (beats/min)   Respiration; 20 (breaths/min)  BP: 16/70 (mmHg)   SpO <sub>2</sub> : 98 (%)   Height: 14 (cms)   Weight: 66 (kgs)   BMI: 33 2 kg/11/3    Others:							
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan:  Yes follow-up orders: enstructions if any:		care plan date				
Handover g	iven by	Signature	Name	47 - S.p	Emp. No.	Date 12/12/29	Time	
Handover ta	aken by	Jan	Soflinga You	y. 4	0265	13/12/28	7.30	
Document e	endorsed	_X	(gran	- a12'	0023	13/12/28	9·w	

	NURSES PROGRESS NOTES		_	, , <u>, , , , , , , , , , , , , , , , , </u>
Date & Time	Observations / Action	Signa	ture with E	mp. No.
12-12-13	MOR MIGHT DUTY REPORT			
19.30	patient- recieved from			
	mag evoning duty considers			
	oir sepon and Spo. 96% delening	<u> </u>		
	inhart, doerning a you adoquate.			
	afeliarile.	<u> </u>		
20-00	patient had diet due dougs	1	de to	232
	'giveh	<b></b>		
21-00	du drugs given			
QQ-00	who given spionometrony done	-	1	
£ 3.00	patient sleeping com factable	1	m/02	<u> </u>
© R+00	poblant hemocly in au carly send	4	,	
04.30	sample terkon far exampro	7 2	torn	
95.00	masning mou given			
	mosilized to chara	-	2-1-0	ru
05.34	rebulization given	<u> </u>	1	
	Splanneton given		7000	
06-30	Lend dynamically 8 terble RBS checkers	7	<del>2</del> ,	
07-80	paulient hemicalynasically stable	1 -	70Lgc	
	hud over given to east duty	-		
	· · · · · · · · · · · · · · · · · · ·	1		<del></del>
		<u> </u>		'
		-		
	····			
-		<del> </del>		
				-
	Signature Name Emp. N	<u> </u>	Date	Time
Document endorsed by	Anni o	ر ار	12/25	9,00

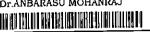




### Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





	FAIIL	IN CLINICAL I	IANDOVEN	ILOO!!			İ		
Date: പ്ര	12/23	Shift: 🖳 Morr	ning Evening 1	Night					
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: CAO- TVD PEWS Score: day: line day: Right:MetcCef be:	<b>/·</b>	GCS: 11 POD: 11 Central line of VIP Score:	ols				
B	Allergies On room	ROUND urgery: OPC43メ2Gef if any: NK air / oxygen: On voom nts / New Symptoms in last s	air	Date of surg					
A	ASSESSMENT  Vital Signs: Temp: 18.6 (F)   Pulse / HR: 16 (beats/min)   Respiration: 20 (breaths/min)  BP: 105 6 (81) (mmHg)   SpO <sub>2</sub> : 91 (%)   Height: 141 (cms)   Weight: 66 (kgs)   BMi: 33.2 kg   mm  Others: 30   ScA   16   mm  Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50   Fall Risk Protocol: 10   Low   Medium   High  Braden Score: 11   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): 19es   No 19NA   Wound Dressing done: 19es   No 19NA   Current diet: 19   Severe Risk: 19   Orains: NIC   No 19NA   Orains: NIC   No 19NA   No 19NA   Orains: NIC   No 19NA   Orains: NIC   No 19NA								
R	Referrated Pending Pending Pending Critical value Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:	·	•	: <del></del>				
		Signature	Name		Emp. No.	Date	Time		
Handover g	iven by	<u> </u>	Sathiya Yan	×	0065	13/12/23	11:50		
Handover t	aken by	los	Paulen		603	13/12/23	11.55		
Document of	endorsed	2	dn	am'	0003	13/12/21	12.00		

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
13/12/23	Took over the patient is heamodynamically	
7.30	stable condition with mill supports.	Salliepa
	Patrent is consigous and oriential.	(10265
8:10	Patient had food orally and weel	
	toleratio.	
8:20	Patient voided yound of wome.	
8:30	Medicines are given as fex orders.	Battyr
9.00	Nebulization and spirometers	()0268
	exercise given for palient.	
11:10	Remoned IJy & ESV as per	
	Gréleis.	
11:50	Slifted the patient to 201 is	
	Stalde condition:	
	Ho the thedianes, Care files.	: Salinga
	and lait bag. & old (B)	()0265
	Received Notes	
_		
11.55	- Intiat leceiving patient is	
		fost n
	Lemody Manicely Stuble - Ind poo - R-F-D.2 littlay	
	-Ind poo - R-F-Q,2 [Hday	·
		0.41
13-00	- Patriot handed ours to evening	Pobla
	dity Steff	
<u> </u>		
	<u></u>	
	Signature Name Emp. No.	Date Time
Document	d. Linau 200	> 13/142 9.00
endorsed by	d / / / 200	> 13/1412 19"





Patier	MIS.PREMA T
Name`	52/Fcmalc/MHI202381034
UHID:	09/12/2023/IPH202302466
DOD.	D. ANDADASU MOHANDA

DOAS MINIMAN MINIMAN CONSU



identification entire e

Date:	12	Shift: Morn	ing □Evening □N	Night	i			
S	Ventilator Periphera Ryle's Tul	EWS Score: day: I line day: Right: De: Yes J-No Day atheter:	:	GCS: DE POD: [] Central line of VIP Score: Copecify organis	days:-	·		
В	Allergies	urgery: TOABX 2G	i Air	Date of surg	ery: H   12 년 골. ow: -		:	
A	ASSESSMENT  Vital Signs: Temp: OF (°F)   Pulse / HR: & (beats/min)   Respiration: (breaths/min)  BP: (mmHg)   SpO; (mmHg)   SpO; (mmHg)   Height: (cms)   Weight: (kgs)   BMI: 23.2 kg   Mm Others: (hgs)   BMI:							
R	Pending Pending Pending Critical va Changes Pending	IMENDATION	) NII	care plan date	e:			
Handover g	iven by	Signature	Name	<b>0</b>	Emp. No.	Date	Time 19:3a	
Handover to	aken by	<u> </u>	A. anoth	a	0127	13/11/23	19.30	
Document endorse						1. 1. 1		

NURSES PROGRESS NOTES								
Date & Time	(	Observations / Action		ignature with E	np. No.			
13/12/23	Evenir	rg duby No	100					
(a)	· =	= ()	-	·				
13.00	= tretient	taken over 1	rom.					
	Morning	a duty Stal	f					
	Nerse							
	-s patient	Conscious gore	ontod	<u> </u>				
	& tationt	vital Signs						
	Chodod &	Penraled.						
11100	=> Medical	tion given as	per t	<b>-</b>				
	drug Char		V	-				
16.00	-> Mbulite							
	- Si patient	- Mobiliked	_ cer 1/ - 1					
	& Addient	T/o Chart M	onitorcal					
	- Satient	vitel Digne						
	Choudel 6	Reforded V						
19.30	-> putient	handing over	10	E Tu	·			
· 	Might	- Cluty V Stab	P					
	Mur80							
		<del></del> -		-				
	· · · · · ·	· 		<del>.</del>				
				<u>-</u> _				
		-						
	,	<u> </u>						
				·				
		<del></del> ,						
	Signature	Name	Emp. No.	Date	Time			
Document				- 1 6				
endorsed by	· Nall paris	Nalini	0024	13/12/23	1918			





Pat	Mrs.PREMA T				
	52/Female/MH1202381034				
Naı	09/12/2023/irH202302466				
UHI	Dr.ANBARASU MOHANRAJ				
DOI	Dimino monning				



F	PATIE	NT CLINICAL H	IANDOVER F	RECOR	D FOR NUF	RSES	,.
Date: 43	12/2	ള Shift: ☐Morn	ning Evening D	light ,			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD-DVD PEWS Score: 0 day: — Il line day: Right: Mo Lef be:	Hpal :: D3 :: R: _Yes _No. If Yes, s	GCS: S S S S S S S S S S S S S S S S S S	days: 0		
В	Allergies i On room	ROUND urgery: の P C A B メ え if any:  ル k D	lol -	Date of surg	ery: 14/12/2-3 ow: _	· .	,
A	ASSESSMENT  Vital Signs: TempQ  (°F)   Pulse / HR:68(beats/min)   Respiration:60(breaths/min)  BP: _0  60(mmHg)   SpO_2:0/6 (%)   Height:14(crns)   Weight:66 (kgs)   BMI:3332  9  m^2  Others:  Pain Score:/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  Fall Risk Score:SOFall Risk Protocol:LowMediumHigh  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						
R	Pending Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan:  Yes follow-up orders: mstructions if any:	<i>U</i> /	care plan date	3:		
<u>-</u>		Signature	Name		Emp. No.	Date	Time
Handover gi	_	<u>A</u> i	A. Ani-	ha	0122	14/12/23	7.30
Handover ta		2	U.D	rula	Ola	Whan	420)
Document e	ndorsed	Nager	N)alistí		<b>φ</b> ο ς μ	11/12/23	7/30

NURSES PROGRESS NOTES						
Date & Time		Observations / Action	Sig	nature with Emp. N		
	NI	GHT DUTY Notes		<del>, ,</del>		
	<del>-</del>					
13 12 23	· · · · · · · · · · · · · · · · · · ·					
19.30	> patient	rand over taken of	yom ,	All OFF		
<u> </u>	Evening	duty Staffe				
		<del></del>				
	=> patient	constious and oxi	ionted			
	n Ó	10 0	<del></del>			
20.00	> medica	ution given as p	ey			
	chieg chos	<u>t</u> t		<u> </u>		
2200	A 212 L. 1.05 0	blon given to the t	) <u> </u>	H 5011		
<del>22</del> 00	-> Mebuura	cion fiven to the 1	7	5411		
,	> patient.	seil voidod				
23.00	> patient	sleep well				
5.30	⇒ patient	vital signs chec	ked			
	So SUPCOSITO	, /)				
6.00	- Nebuliz	ation given to the	Pt \$	Vi.		
<u></u>		goromed well	`   6	515		
<u> </u>	> pt u	philized well	. + -			
6.30	> I/o Ch	aget monitoging	<u> </u>			
7.00	⇒ pt hand	l over given to	Á	11		
	Monning	duty staffs		W-		
-		-				
-						
		:				
Document	Signature	Name	Emp. No.	Date Time		
endorsed by	Naleronzi	Maleini	0024	13/12/257-5		





	Mrs.PREMA T
Nam	·52/Female/MHI202381034
UHII	09/12/2023/IPH202302466

DDB. Dr.Anbarasu Mohanraj DDA Con:



	FAIIL	IVI CLINICAL I	IANDOVENIN	LOOII		IOLO	
Date:	14/12/2	Shift: Morn	ing Evening Ni	ght	· · · · · · · · · · · · · · · · · · ·	·	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD-DVD PEWS Score: O day:— I line day: Right: Mettless Left De:	↓ :	GCS: US UP POD: (I Central line of VIP Score: Corecify organis	tays: 10	·	
В	Allergies On room	ROUND urgery: じかみ メ えいで if any: いたのみ air / oxygen: On でのm の its / New Symptoms in last sl	χ, ' ι	Date of surge	ery: 1416123 ow: _		
A	ASSESSMENT  Vital Signs: Temp:						
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:		are pian date	: <del>-</del>		
		Signature	Name		Emp. No.	Date	Time
Handover o	given by	. 8	U. Devila	·	1018s_	14/10/20	12-8-
Handover t	aken by	gent De	Man 20.	,,	0172	14/12/8	12.17
Document (	endorsed	(100)	Diana	nai	2000	14/12/23	14:00

NURSES PROGRESS NOTES							
Date & Time	Observations / Action	Signature with Emp. No.					
14/10/23	Morning duty Notes						
(a)	,	<u> </u>					
700	-> partient hound one tector from						
	niegal duty Staff						
450	-> patient propert						
	-> perficul Normal vital cings 2 pt						
	3 stepp	000					
Sw	-> persion l'edicition given au par						
	dury chaff.						
10:00	-> parient Nebilizeation given						
	-> perficit & suell stoup						
	-> protiont (D) ripul sierces cheur						
11.00	-> Pt 76 mmosow Seiture removed	,					
	plaen						
11-30	-> persent \$10 chent	A					
22.20	- 2-partient herner nue given to	609					
	Evening oluty steh						
	·						
	· · · · · · · · · · · · · · · · · · ·						
		<u> </u>					
		ï					
	· · · · · · · · · · · · · · · · · · ·						
	· · · · · · · · · · · · · · · · · · ·						
		<u> </u>					
Deaument.	Signature Name Emp. N	o: Date Time					
Document endorsed by	Nalejon palené bo	24 14 12 77 30					





Pat	Mis.PREMA T
Nai	50 / Romala / MU1202381034
: UH	09/12/2023/iPH202302466
חטי	Dr.ANBARASU MOHANRAJ
DO.	
601	la



Every heart beat counts

PAT	ENT CLINICAL H	HANDOVER RECOR	D FOR NUF	<b>RSES</b>	1
Date: 14/12/25	Shift: Mor	ning Devening Night			
Diagno NEWS Ventila Periph Ryle's Urinan	Tube: ☐ Yes ☐ No Day / Catheter: ☐ Yes ☐ No Day	y: VIP Score: a	days: _		
B Type of Allergi	GROUND f surgery: OPCABX 2 ( es if any:                       em_air/loxygen: Oh                     aints / New Symptoms in last s	Air IV fluids on fl	ery:	·	
Vital S BP: C Others Pain S Fall R Brade	s:	Drain	ker FACES Pain Ratin sk: 14-13 ∐High Risk: Dressing done: ∐Yes	NP:	S / CPOT e Risk: 9-6
Referr Pendid Pendid Critical Chang Pendid	ng follow-up orders: —	ENOIS Yes, modified care plan date		, k <sup>‡</sup> , •	Tomore
	Signature	Name	Emp. No.	Date	Time
Handover given by	<del>- / \</del>	A.Narthini	0172	Hillppa	
Handover taken by	T 94.	A. ALBINIUS	0088	1/12/23	—- <u>;</u> ——
Document endorse	ed 110 l	Malieré	00.24	14/12/15	19-20

NURSES PROGRESS NOTES							
Date & Time		Observations / Action		Signature with E	mp. Ņo.		
الما الما	-voning	duly Notes					
	=	= () =					
12.30	-> Datient	taken over from	m				
	Mornina	arty Stalt	1	0 序			
	=> Datient	Canscinus & oxio					
	'\	rital Signs Chel	bod 8		<u>.</u>		
	Poenrod	THAT CLOTE CITE	<u> </u>				
11100	-> Medicatio	n given as to	er dru				
191,000	Chart	The factor was the	M. Cru	- TI			
16:00		iation given					
	-> Doitient	Mobil Told us	2ll -	Q			
	J	Chart Monitora	A .	(a)  'y			
18.30	d' Dationt	vital Signa		_			
	Cherod 8	Pelorded	-				
19.30	2 Dation	handing over	40	, ,			
ι ι	1 Night	duty Otal	P				
	Murd.		υ . -	P.			
				# 10-			
					(		
		<u> </u>			· <del></del>		
	<u> </u>				1		
Document	Signature	Name	Emp. No.	Date	Time		
endorsed by	n 1 alo:	h) alini	6016	14/12/7	4.30		







P<sub>i</sub> Mrs.PREMA T Ni 52/Female/MHi202381034 Ul 09/12/2023/IPH202302466



Every heart beat counts

Date:	14/12/	<u>1</u> ন্দু Shift: ☐Morr	niṅg	<del>iht</del>			
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	S: CAD → DVV  EWS Score: O  day: I line day: Right: → L  Lef  De: □ Yes □ NO Day  atheter: □ Yes □ NO Day	rDol Fo	COS: 15/COD: 1/1 Central line of the Core: colify organis	days: —		
В	Allergies i On room	ROUND urgery: のどれ メ 3 9 f any: NKDA air / oxygen: OK) Rのの ts / New Symptoms in last s	M AIR IV	ate of surg	_		-
A	BP: <u>J3o (</u> Others: Pain Sco Fall Risk Braden S	re:Minimal Risk: 23-19 & Ulcer Scale for Healing (PUS)	(%)   Height: (A) (cms  : PIPPS / CRIES / FLACC ;  tocol:	s)  Weight: /Wong-Bak 	k: 14-13 □ High Risk: ressing done: □ Yes	g Scale / NR 12-10□Sever	S / CPOT
R	Pending I Pending I Pending I Critical va Changes Pending I	MENDATION loctors: — medications: — medication indent: — ab reports / Investigations: lue alert and its corrections: in nursing care plan: — follow-up orders: — astructions if any:   Hb ,	— : ☑No. If Yes, modified car	·	:		
		Signature	Name		Emp. No.	Date	Time
Handover g		777	A- ALBIN	148	0088	15/12/28	7.00
Handover ta	ken by	Pos	Pavither		00 Fr	15/12/2	720
Document e	endorsed	Nac	Valeisi	_	0024	15/12be	4- 38

	NU	JRSES PROGRESS NOTES	_		
Date & Time		Observations / Action		Signature with Em	ıp. No.
A/12/23	NIGH	T DUTY NOTER			
Allar	` <del></del> -	· — — — — — — — — — — — — — — — — — — —		·	
19-00	Patient 1	handover take	4	dela	
ļ <u> </u>	from the	e evering d	uty	- 160 8,	
	Stable. Pa	e evening d	se.		
2000	Due med	ication are		Aye	
	Due med quen to	The patient	لح ا	04 % V	
			_		
22.00	irlale igue	are checken	1 2	Auf	
	recorded	<u> </u>			
6-00	7/6 cho	et is Name	<del>r</del> uied	0 87	
		<del></del>		· I	
7.00	Patient	handover ga	eir	Alf-	
	to one 1	rousing dult	}	OP1	
	s capel	<u>.                                    </u>		<del></del> -	
			-		-
1					
\			_		
	· · · · · · · · · · · · · · · · · · ·			<u> </u>	
				-	
	, ,				
,	Signature	Name	Emp. No.	Date	Time
Document endorsed by	n/ceo ports	Nalihi			ا مید
31.231334 by	1 1/10024	10 QU L	007	1/2 10/23	7,36



ŧ





Mrs.PREMA T
Pal 52/Female/MHI202381034
Nai 09/12/2023/IPH202302466



Consultant:

Every heart beat counts

		NI CLINICAL P	IANDOVER	IECOND FOI	n NUN	SES	l
Date: / 9	र्गरहा	Shift: Morn	ing Evening N	light			
S	NEWS / f Ventilator Periphera Ryle's Tul	s: CAO - DVO PEWS Score: O day: al line day: Right: Left be:	<i>r</i> :	GCS: 15 15 POD: 454 POD Central line days: VIP Score: 0 pecify organism:			
В	On room	ROUND  urgery: DRAB X 2 Ge A  if any: NEDN  air / oxygen: RA  nts / New Symptoms in last s	13.1	Date of surgery:	112/2		
A	ASSESSMENT  Vital Signs: Temp: 47-Y°F)   Pulse / HR:						
R	Referral of Pending Pending Pending Critical vo Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:		care plan date:			
		Signature	Name	Emp. N	lo.	Date	Time
Handover (		Sofozin	lo-lia	uja Os	4 C4	15/12	12-30
Handover t	aken by	$\mathcal{A}$	A-Nlunuthi	0/7	10	15/12/22	12.30
Document	endorsed	Na98624	no lieu	60;	≥ <i>. J</i> 1	15/10/5	12-26

	NU	JRSES PROGRESS NOTES			1
Date & Time		Observations / Action	Si	ignature with Er	np. No.
15/12 h	Noemi	of duly			·
				<del></del>	-
7-30	p+ case	Sile take ouen	tooin		
	highet duty	S/n colice pr			<del></del> -
	Coustoles. a	ud orienled			
_				Sollow	
8.00	'	is are Checked	-	<del></del>	_
	and leas		<del> </del>		
d-00	ĺ	edications are		9800f02219_	
	Birron-			<del></del>	
10.00	•	Chart are She	ctaly		(
1	maistauco			10.0	
11.00	area to	ed Clean Cali	(	gref o Dug	
2-30	<b>,</b>	o yell blouch	1.64		
16-311		i Eleavering de			
	1	pt coursons	<i>J</i> 1		
-	aus ours			Reefor u	
,					
			, ,		
					-
				<del></del>	
·	<u> </u>	<del>-</del>			
·	Signature	Name	Emp. No.	Date	Time
Document endorsed by	Nagozh	Nælevi	002-4	15/12/	[2- <del>3</del> )
Citable by	1V-0624	Natile	1 00 7-4	19/12	للاستضا



Handover taken by

Document endorsed

Nas





Patien Name: UHID:

D08:

- Mrs.PREMA T 52/Female/MHI202381034 6: 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



(A Unit of United Alliance Healthcare Pvt Ltd)

DOA: \_\_\_\_ary heart beat counts

0222

0024

	PATIENT CLINICAL HANDOVER RECORD FOR NURSES						
Date:	15	D 2 3 Shift: ☐ Morn	ing Evening Night				
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CA A D V D  PEWS Score:— day: Il line day: Right: Left be: Yes No Day eatheter: Yes No Day	r: VIP Score: (	ok'	·	,	
В	Allergies On room	ROUND  urgery: OPUBX 2G  if any: NIKDH  air Toxygen: ON KOOM  ats / New Symptoms in last si	Air V IV fluids on f	ery:11/12/23 low: —		·	
A	ASSESSMENT  Vital Signs: Temp: 9   (°F)   Pulse / HR:						
	RECOM	<u>Diàbetic C</u> IMENDATION	4.00				
R	Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date				
		Signature	Name	Emp. No.	Date	Time	
Handover o	given by		Ac Nanthini	0/10	10/12/23	19.23	

NURSES PROGRESS NOTES							
Date & Time		Observations / Action	Signa	sture with Emp. N			
15/10/03	- Fyenu	ing duty Notce					
<u>(a)</u>							
12:30	=> pultoint	taken over from					
	Morning	duty 9 dta	/ <sub>2</sub> /	<u> </u>			
	Nurse		70				
	s patient (	Conscious gorien	tod				
	/	- ,	iled E				
	/ Perordod	0					
14.00-	-> Modication	n Guien as por	-	- <b>)</b>			
	drug	Chart		<del>T'</del> 			
16.00	= Neblelist	ation quen		) <del>[</del>			
	S 710 C	part Mohitord	P 1/2	r 			
	& patient	Mobili Led as	0//	<u> </u>			
18.30	2) putiont	Vital Signa	,				
	Chered &	Recorded					
19.30	-s patient	harding over	to 1/2	·			
<i>.</i> 	/ / / light	Rt dudy ofa	Af I				
	Murso.						
, <del></del>							
<u>.                                    </u>							
			-				
	· · · · · · · · · · · · · · · · · · ·						
	Signature	Name	Emp. No.	Date Time			
Document	orgnature						
endorsed by	Na 260211	Nalisio	0249	12/12/ 2.			







# Par Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

DC DT.ANBARASU MOHANRAJ
CO COMPANIA COM



every heart beat counts

### PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Uł

	, , ,	IN OLIMOAL II	IAINDOVEILI	ILCOIII		OLO	ì
Date: )5	12/23	Shift: ☐ Morn	ing Evening D	ight	· .		
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	:: .C.A.D. C.PV D EWS Score: day: I line day: Right: Left be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day		GCS:\S\S POD: DO D Central line of VIP Score: Of pecify organis	- <u> V</u> days: _ 		
B	On room	ROUND urgery: 0 P CABX 2 CH & f any: NKD A air / oxygen: RODM , d ts / New Symptoms in last sh	બ	Date of surge	ery: 11   12   2 <u>.3</u> ow:		
A	BP: 120 Others : Pain Sco Fall Risk Braden S	re: O Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	(%)   Height: A-  (c : PIPPS / CRIES / FLAC otocol: □ Low □ Mediu ] At Risk-Mild Risk: 18-15	ms)   Weight: C / Wong-Bak Im ∐High ∏ Moderate Ris	cer FACES Pain Ratingsk: 14-13 High Risk:	33 vækg g Scale / NB 12-10⊟Seven	S/CPOT
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:  Referral doctors: Pending medications:  N 1  N 2  N 3  N 3  N 4  N 4  Pending follow-up orders: Special instructions if any:  N 3  N 4  N 5  N 6  N 7  N 7  N 8  N 7  N 8  N 8  N 8  N 9  N 9  N 9  N 9  N 9							
<u></u>		Signature	Name	-	Emp. No.	Date	Time
Handover given by		_di	A. ant	hg	0122	16 12 23	7.30
Handover taken by		8	H. Deis	lace	0(9)	Colph	42
Document endorsed		Nal	Nalegi		0024	16/04	ન. જી

NURSES PROGRESS NOTES							
Date & Time		Observations / Action		Signature with Emp. No.			
	Nto	HT DUTY notes					
	<del></del>						
15 12 23							
19.30	> Patient	hand over taken		æ.			
	John E	hand over taken vening duty atal	ls	6 <sup>1</sup>			
	<b>1</b>						
19.40	' '	conscinus eurol 08					
20.00	=> Mpdloco	Hon given ous	Den	A			
	dyna c	ANHE	<del>/                                    </del>	OU			
-	COLLEGE		_				
22.00	⇒ Alehuli?	cation given to the	ia D+				
	7 ACDVAI	- 302 ( VII ) - 11					
23.00	> patient	hemodynamianl	u stable	A T			
	( ( )	The state of the s	1	. OV			
6,00	> Nebuliza	tion given to the	Pt				
b. 30	> Tlo Phas	nt monitoring					
	7 2 0 01(00	Vecentry					
7.00	> D+ have	over given to					
	Moning du	ty staffs					
		,					
			-				
		,					
		<del></del>					
			-				
·	Signature	Name	Emp. No.	Date Time			
Document endorsed by	Naloo,	Lides	0240	15/12/00 4.00			







### Pati Mrs.PREMA T Nai

52/Female/MHI202381034 09/12/2023/IPH202302466

DOI Dr.ANBARASU MOHANRAJ DO: Cor



very heart beat counts

UH

			IANDOVER RECOR	D FOR NUF	15E5	
Date: 16	[12/20	Shift: Morr	ing Evening Night			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CHO DV PEWS Score:  day: al line day: Right: Lef be: Yes No Day catheter: Yes No Day	y: · · · VIP Score:	days: —	<b>5</b> 1	·
В	On room	urgery: OPCABX 29	IV fluids on f	ery: [1][2-12->		•
A	BP:	ns: Temp: (°F)   Pulse  (°F)	/ HR:	eb (kgs)   BMI: Sker FACES Pain Ratingsk: 14-13  High Risk: Dressing done: Yes	33. 2 kg/ ng Scale / NB 12-10⊒8ever	S+CPOT
R	Referral of Pending Pending Pending Critical vo Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	Ni l Mo. If Yes, modified care plan date deey clischerye	e: pla	-	
Handover	given by	Signature	Name M. Dailor	Emp. No.	Date	Time
Handover taken by		Nal	10. If dieda	02 1.0.	10 10 10 10 10 10 10 10 10 10 10 10 10 1	12 - 1
Document of	endorsed	\WX\	Diaerander	5000	16/12/25	(4:00

	N	URSES PROGRESS NOTES				ı
Date & Time		Observations / Action		Signate	ure with E	mp. No.
16/10/25	Morn	ing duty notay				-
		<u> </u>				
4.40	-> patient b	and over taken	from			
	Night chity					-
<u>-</u>	-spection .	womel diet				
40	-> patient	is stoble quited six	45	•		
	cholbell.					
8 w		Modicition gion a				
	1 2	to day dichang	plam.			
9-50	, -	to sand cheeply				_
	1	is well Sleep & put				<del></del> i
10.2	<u> </u>	1) with sings	cholt			
		Mosi tu gran				
11-12	-> profired	To chart year				
12-50	-specticed	hard our stion	<u>a</u>	35		
	evening clut	y 37°47				
	Dischan	ae Notes				
16/12/23						
12.30	=> P4 % +a	Men over from my	ng	aul	<u> </u>	
	duty Staff.		1	200		
	[ ]	ows ordented.				
	> P+ had a					
14.00	3 Dua madi	• •	doctor	Gal		
	order.			Tras		
15.00	> Today B	lan Dls., Billing alos	real.			_
16.00	) Dischange	Summery Explained	to			
	the pattende			$\bigcirc$ $\downarrow$		
	Dir line &	10 band Romoner		Cogar		
	Signature	Name	Emp. No.	<u> </u>	Date	Time
Document	_					
endorsed by	Natonzzy	Il-Lidiya Noleni	0093	2)	16/12/23	R7 . W





# ADULT NURSING CARE PLAN

MIS.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Initial Date: 9 17 123	Time: 10 · So	Modified Date: Time:				
Reason for Modification:		Diagnosis: CAD - DV D				
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 E pt had a @ Boet  N Pt had noomal	Out of an Hay		
OXYGENATION  Room Air  Nasal Cannula / High Flow O2  Mask  BiPAP / CPAP	No other respiratory abnormalities Patient respiratory rate will remains	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 O₂ saturation and pulse rate  If any O₂ abnormalities detected inform immediately to	M			
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician  Place patient with proper body alignment for maximum breathing pattern  Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	e pt on Room dir	91 519t		
	. ,	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	N Stable on soom aix	How .		
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	М			
Parenteral Nutrition Others:	,	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	E The chart maintained	Buj Stas		
, ·	\`\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	E MOUNTOL DE TOT OTTHOSTATIO CHANGES	N Ilo Chaet Maintaine d	Hoy 005		



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	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	М	
Otners:	Patient will use safety measures to minimize potential for injury     Patient will demonstrate the use of adaptive devices to increase mobility	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)	Ept well mobilized	Can too
		· · · · · · · · · · · · · · · · · · ·	N Pt Mobilized well	Hay Scor
ELIMINATION  ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bewel movement ☐ Urination	Patient will have normal elimination pattern  Patient will control of urinary in-continence or urinary retention,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	M	
☐ Others:	control of bowel incontinence, and regular elimination patterns	<ul> <li>☐ Observe voiding accessories as foley's / silicone catheter</li> <li>☐ Check placement before feeding</li> <li>☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order</li> </ul>	E PH SEIF voided.	010
	_	and follow proper protocol  Check for malena / constipation / urinary retention	N Pt chad normal elimination Patteen	Hory
SKIN INTEGRITY  Maintain normal skin integrity  Pressure points site assessment HAPI DPI  GRADES OF PRESSURE	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	M	
INJURY  GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	•	<ul> <li>Manage moisture, clean and dry skin</li> <li>Maintain adequate nutrition and hydration</li> <li>Proper application of medications and dressing</li> <li>Follow doctors and TVN order properly</li> <li>Monitor the healing status</li> <li>Educate patient and family members about further skin care</li> </ul>	E p4 traintained @	Ost Stats
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			Patient Irad  N normal Skin Integrity	thy





Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care	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 EPt well n Pt groomed well	Out Jay
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  E Pt 1D band  Checked  N ID band present	Gay o.o.
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 provided  Lomfortable postition  N	Qui as
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 -  E Pt virtab oxe  Decelhed  N Pt virtal signs  all stable	Car at o
PSYCHOLOGICAL / SPIRITUAL SUPPORT  Spiritual Needs Bellefs / 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	<ul> <li>□ Pray or encourage the patient to pray</li> <li>□ Use inspirational words</li> <li>□ Respond to spiritual needs as they arise</li> <li>□ Evaluate spiritual needs</li> <li>□ Encourage verbalization of feelings / therapeutic touch</li> <li>□ Provide empathy and reassurance</li> </ul>	M	

Patient Specif Problems / Ne		Measurable Goals	<del></del>	Nursing Interventions		Evaluation		Sign Initia
COMMUNICATION Verbal Non-verbal Sigh language Others:		Patient will communic with positive feedbac		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patier or prognosis in the patient's presence	nt's condition	M E Well	·	(Osu)
	•					. Patient	unicuted well	الم
SPECIAL INTE  Medication  Wound care  Isolation  Ostomy Care	ERVENTIONS	To manage on time		Double check for high alert medication  Observe and report any medication reconstruction  Provide proper measures of wound cate of the proper measures of wound cate of the polices and protocols of any explain to the patient / family	action re	M		
□ Blood / Blood   transfusion □ Fluid tapping □ DVT Managem				Check for cross matching and typing, to ensure compatibility     Practice strict asepsis while transfusing blood or blood products and fluids		E	-	
Others:	,			☐ Monitor DVT score and continue treatr as per doctors order	nent	n Due	deugs given	to
t	Signature		Name		Emp. ID		Date	Time
Endorsed by	Now (	2000.0	'n	Nali. P	<i>0</i> 00		9/12/2=	ءٍ . إ

.





# ADULT NURSING CARE PLAN

Mrs.PREMA T
52/Femalc/MH1202381034
09/12/2023/iPH202302466
Dr.ANBARASU MOHANRAJ



	<u>.                                    </u>						
Initial Date: 10 (2) 23	Time: 8100	Modified Date: Time:	-				
Reason for Modification:		Diagnosis: CAD - DVD					
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  Tortion + had DM diet.  In Pt had Indiese	5.Da			
OXYGENATION   Room Air   Nasal Cannula / High Flow O,   Mask     BiPAR / CPAP   Ventilator   Tracheostomy   Others:	☐ Patient ABG levels will return to and	<ul> <li>☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises</li> <li>☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order</li> <li>☐ Utilise pulse oximetry to check O₂ saturation and pulse rate</li> <li>☐ If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>☐ Place patient with proper body alignment for maximum breathing pattern</li> <li>☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> <li>☐ Note for changes in level of consciousness</li> <li>☐ Send sputum for culture and sensitivity based on physician order</li> <li>☐ Maintain clear airway by suctioning or encouraging patient with successful coughing</li> </ul>	patient 18  En Prom Air  NPHONROOM AR-	5 % S			
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 p+ If a chat maintained  E Chair MonHorcot  N Montor 1/oched	S. Sign			

<u>`                                    </u>				
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 Ptient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	<ul> <li>☐ Encourage regular ambulation ROM exercise</li> <li>☐ Apply Anti-Embolic stocking / SCD</li> <li>☐ Evaluate the need for assistive devices</li> <li>☐ Assess the safety of the environment</li> <li>☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse)</li> <li>☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)</li> </ul>	M Pt Mobilized well  [Fatient Mobilized  1221  N Patient Mobilized  Nece	u A A
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 sell voided  Normal Elimination  Exattern  N Mormal Climter  Traction	S S S S S S S S S S S S S S S S S S S
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  Intermittent Assisted  Dermatitis  Pressure injury / blisters site care given  Others:	Patient will maintain normal healing status Patient will discharge with intact skin integrity		M Pt Slan is Nome Integrity  Maintain Mormal  E Kin integrity  Marken Noons  N Slain.	592h

			<del></del>	
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	mp+ good, rygions maintained Fatisit (121) 9 200 mo In Pf Worfoonjel.	5. Otto
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)	MP+ ID Band checked  FJO band prosent  N JO band prosent	5927 2008
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	
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	MP+ V/S clecked?  Recorded  VI-a! Signs  Chernol & Peroxdod  N Monitor VItch.	2.50
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  Allogical  Support to the pt.	

L...

		_			400			
Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
☐ Verbal ☐ Non-verbal	☐ Non-verbal ☐ Sigh language		☐ 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  Estopol communication		5.B.	
						N PH Speed	Comuses.	9008r
☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care	☐ Wound care Isolation		<ul> <li>□ Double check for high alert medication</li> <li>□ Observe and report any medication reaction</li> <li>□ Provide proper measures of wound care</li> <li>□ Follow hospital polices and protocols of isolation and explain to the patient / family</li> </ul>		MP+ Due	Juan Juan	5.8	
Blood / Blood p transfusion Fluid tapping DVT Managemi				<ul> <li>☐ Check for cross matching and typing, to ensure compatibility</li> <li>☐ Practice strict asepsis while transfusing blood or blood products and fluids</li> <li>☐ Monitor DVT score and continue treatment</li> </ul>		Medicatio	drug Chart	
			_	as per doctors order	_	n Modera	hous la	Took
	Signature		Name		Emp. ID		Date	Time
Endorsed by	N ga_QQ	<u>004</u>	<del>to</del>	Lidajo S. Nalius	<u> </u>	<del>-</del>	10/12/25	4-8¢
	_	,		J -		,		













52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



consunant:



### **ADULT POST-OPERATIVE NURSING CARE PLAN**

	ADOLI I OOI-	OI ENATIVE NOTISHING OAL				
Initial Date: 11/12/20	22. Time: 9.00	Modified Date: Time:				
Reason for Modification:		Diagnosis: CAD-TOVD.				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
PAIN  Comfortable Position  Pain Scale  Pain Score  Others:	Patient will have less pain	Evaluate location, character, quality and severity of pain  Administer pain medication as prescribed and as needed  Observe for any changes in vital signs  Maintain proper positioning of patient  Assist or turn patient every two hours  Assess incision area for redness, heat, induration, swelling, separation and drainage  Non-Pharmacological therapy	M  E Patient is on  Seniconsciou.  N patient panishone	C. MOON CANG.		
OXYGENATION  Room Air Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☐ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M  E Retient is on  E Ventilator. Vitals  N Du 02 2 ht she is  Comfortile.			
ANXIETY  Increased Pulse Rate Anxious Look .	Patient will cope properly with his illness and react positively to his surroundings	□ Explain all procedures to patient or family member in simple language they understand     □ Encourage and support patient while increasing anxiety level     □ Help patient to cope with outcomes of surgery     □ Keep patient in comfortable position in bed to enhance sleep	M E VA.			
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	□ 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  E Adviced for  Innobity  N Draen public, policut  is on bed put	8. 256 92.46 18. 2001		





<u> </u>	<u> </u>	,		
-Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE  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  Portient is on Fut.  E kabily les	S' MOON
			N Intske and output	70011
RISK OF INFECTION Prevent Infection Others:	The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Pestrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care	M A sente technique	
		☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered	E follows.	BINDU
		☐ Administer antiblotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons  N	E followed.  N flephic presentions Alephic presentions	Also U
RISK OF FALL ☐ Giddiness ☐ Independent State	The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed	M	
Dependent State	· .	☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	E located position.	8,000
			Newed Safety presention	AL S
SKIN &WOUND CARE  Observe REEDA	The patient will have intact skin while staying in the hospital and	Gheck all drains from the operation site more frequently	M	
☐ Oozing ☐ Foul Smell	on discharge	Provide wound care as ordered  - Minimize pressure  - Provide adequate nutritional support	E Surgical RIG 15	Simoni.
		☐ Report signs of poor healing or trauma to doctor	N lo som four Surject	# 19
DIET & NUTRITION NPO Soft Diet	Patient will have adequate nutrition with no nausea and vomiting	Encourage patient to consume prescribed diet  Record amount of food consumed  Provide high calories, high protein diet as prescribed	М	
☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds		☐ Monitor patient's weight     ☐ Administer supplemental vitamins and minerals     as prescribed     ☐ Administer parentral or TPN per protocol if dietary	E Patrut is on NPO	2,000mg
		needs are not met through oral intake  Report abdominal distention, large gastric residual volume or diarrhea to doctor	N patient Consumed lyred dut.	JA.

Patient Specifi Problems / Ne		Measurable Goals		Nursing interventions		Evaluation		Sign & Initials
CARE OF CAT		maintained catheters, drains etc		maintained catheters, drains etc  Understand the description of the control of th		M E A Sept telle		Coord Once
DISTURBED B	DISTURBED BODY IMAGE  The patient will demonstrate initial acceptance and to newly body image		□ Note non verbal body language, negative attitude and self talk     □ Note emotional reaction (grieving, depression, anger)     □ Acknowledge and accept expression of feeling of grief and hostility		M - U			
OBSERVATION  ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ GCS ☐ Blood Sugar		☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality		M  E with Ito chart munitored  N Houndemanically		gimoni exis for	
Patient Family / Guardi Diet Disease proces Infection contro	☐ Family / Guardian others ☐ Diet knowle ☐ Disease process modalit ☐ Infection control / PPE modific		are-giver / uate treatment	Provide proper education regarding follo Insist on importance of hand hygiene Explore action, reactions and adherence Provide clear, thorough, and understanding safety precautions. Explain to perform activities / skin care the by concerned doctor Use the teach-back technique to determing understanding regarding importance of the service about medication able explanations at recommended ne the patient's	M E		,	
☐ Personal Safety ☐ Treatment Regi	1		, ·,			N freatment regnieur		AL
ANY OTHER N	ANY OTHER NEEDS				M '			
					E			
				N		·		
	Signature		Name		Emp. ID		Date	Time
Endorsed by	Y			Annu-	0009		13/n/25	9.00

,

-

ı,

2









### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



#### ADDIT POST-OPERATIVE NURSING CARE DI AN

ADULI FUST-OPERATIVE NORSING CARE FEAR						
Initial Date: 12/12/12023	Time: ∠µ0	Modified Date: Time:				
Reason for Modification:	3	Diagnosis: CAD	· · · · · · · · · · · · · · · · · · ·			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions		gn & itials		
PAIN  ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others: /	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs Maintain proper positioning of patient Assist or turn patient every two hours Assess incision area for redness, heat, induration, swelling, separation and drainage Non-Pharmacological therapy	M Administrad medicatines tax as par order  E Pronded Confortate  Discotor  N Administrate  Discotor  N Administrate  Discotor  Oding as per order	W.		
OXYGENATION  Afoom Air Oxygen Hood  Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment Check oxygen saturation Perform suctioning if needed Ventilator settings as per physician orders Monitor rate, depth of respiration Administer oxygen and nebulizer therapy if needed Encourage spriometry, deep breathing and coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	M Steenly Sprimary Hoom  E On RA. Spor 98%.	Maria Maria		
ANXIETY  Increased Pulse Rate Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	<ul> <li>□ Explain all procedures to patient or family member in simple language they understand</li> <li>□ Encourage and support patient while increasing anxiety level</li> <li>□ Help patient to cope with outcomes of surgery</li> <li>□ Keep patient in comfortable position in bed to enhance sleep</li> </ul>	M E	·		
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	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 Parent à hang Dress  (annot be mobilized to  E Safety measures  N porovided safety  Magazines	002 2 1 1 1 1 1 1 1 1		





-Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE  Ofal 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 Monitor Intake and output Chart  E Monitored I/o Ohad  N Manilared I/o charl-	84 Sola Sola Sola Sola Sola Sola Sola Sola
RISK OF INFECTION Prevent Infection Others:	☐ The patient will be discharged with no hospital acquired infection	□ Use aseptic technique in all aspect of patient care     □ Restrict visitors and use appropriate PPE     □ Meticulous hand washing before and after patient's care     □ Inspect wound for signs of infection, purulent drainage or discoloration     □ Administer antibiotics as ordered     □ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M lue araptic fectionium  auaspeau of pour raid o  E Aseptic technique  followed  N used a reptic  N arecautions	Som Suffer
RISK OF FALL  Giddiness Independent State Dependent State	☐ The patient will have safe, free from fall hospitalization		M - Bide railso	Syl
SKIN &WOUND CARE  Observe REEDA  Oozing Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	□ Check all drains from the operation site more frequently     □ Provide wound care as ordered     □ Minimize pressure     □ Provide adequate nutritional support     □ Report signs of poor healing or trauma to doctor	ME	A DST H OY
DIET & NUTRITION  ☐ NPO ☐ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☐_Patient will have adequate nutrition with no nausea and vomiting	Encourage patient to consume prescribed diet  Record amount of food consumed  Provide high calories, high protein diet as prescribed  Monitor patient's weight  Administer supplemental vitamins and minerals as prescribed  Administer parentral or TPN per protocol if dietary needs are not met through oral intake  Report abdominal distention, large gastric residual volume or diarrhea to doctor	M Pakent had food ordy  Folorand wer  E  N pakent-on fully  diel- polerand	400n





Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign'& - Initials
CARE OF CAT DRAINS, ETC.		Patient will have pater maintained catheters,		Check the catheters, drains etc frequently Cobserve I/O Chart Watch for any symptoms related to kinke blocked tubes Maintain adequate cleaning and dressing	d or	M Mainte	and dreag	2011 2212 Wor
DISTURBED B	ODY IMAGE	☐ The patient will demo initial acceptance and body image		<ul> <li>Note non verbal body language, negative and self talk</li> <li>Note emotional reaction (grieving, depression of for grief and hostility</li> </ul>	ssion, anger)	M		
OBSERVATION  ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	N	Patient will have norm of vital parameters	nal range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M Pamenti Grabe c E Movitor N Mouita	red Vital	dim L Sylfs More
HEALTH EDUCATION Patient Patient Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications Infection control / PPE Medication Educate about TAC level and immunosuppressant Personal Safety Treatment Regimen Others:		Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medication Provide clear, thorough, and understandable explanations regarding safety precautions. Explain to perform activities / skin care that recommended by concerned doctor Use the teach-back technique to determine the patient's understanding regarding importance of treatment		Moderny re		Jan Star		
ANY OTHER N	IEEDS		. <u></u>			M E N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by			C	Mau.	0005		13/12/23	9.0





#### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

### ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 13/12/2	3 . Time: \$ .00	Modified Date: Time:			
Reason for Modification:		Diagnosis: C40 - DVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions .	Evaluation	Sign & (Initials	
PAIN  ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	Patient will have less pain	□ Evaluate location, character, quality and severity of pain     □ Administer pain medication as prescribed and as needed     □ Observe for any changes in vital signs     □ Maintain proper positioning of patient     □ Assist or turn patient every two hours     □ Assess incision area for redness, heat, induration, swelling, separation and drainage     □ Non-Pharmacological therapy	M Prozvided Comfortable pocition for pahents  Emportable (1811ion to the N compostable position to	he off	
ØXYGENATION	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment Check oxygen saturation Perform suctioning if needed Ventilator settings as per physician orders Monitor rate, depth of respiration Administer oxygen and nebulizer therapy if needed Encourage spriometry, deep breathing and coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	M Patient is on room air  Perbent 18 on From Air  N pt is on Room, what	Aî RIL	
ANXIETY	Patient will cope properly with his illness and react positively to his surroundings	<ul> <li>□ Explain all procedures to patient or family member in simple language they understand</li> <li>□ Encourage and support patient while increasing anxiety level</li> <li>□ Help patient to cope with outcomes of surgery</li> <li>□ Keep patient in comfortable position in bed to enhance sleep</li> </ul>	M NA E	Soi es	
MOBILITY <sup>7</sup> ☐ 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	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 Provided Safe environment.  Eterlaint Mabilized  ce 2011  N Pt Well Mobilized	Sind Sind Sind Sind Sind Sind Sind Sind	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE  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	Monitored Ito every hour.  EMONITORAL I/O Chart  N monitored I/O Chart	20 E E C C C C C C C C C C C C C C C C C
FISK OF INFECTION Prevent Infection Others:	The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	Mitalioned aceptais  Mitalioned aceptais  Mitalioned aceptais  Lochniques  Nuse exeptic  Techniques to the pt	912 90 E
RISK OF FALL  Giddiness Independent State Dependent State	The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed Remove clutter, keep items patient needs within reach Avoid movement out of bed after surgery for 46 hours Review patients' medication like narcotics and hypotensive agents Offer urinal or bedpan to the patient if needed	m followed risk fall prevention.  El-ollowed risk fall  I dollowed Misk fall  Prevention	2)2 (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4
SKIN &WOUND CARE  Observe REEDA Oozing Foul Smell	The patient will have intact skin while staying in the hospital and on discharge	□ Check all drains from the operation site more frequently     □ Provide wound care as ordered     □ Minimize pressure     □ Provide adequate nutritional support     □ Report signs of poor healing or trauma to doctor	M Skin is Entail.  E  N	20261
DIET & NUTRITION  □ NPO □ Soft Diet □ Semisolid Diet □ Solid Diet □ RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	Encourage patient to consume prescribed diet  Record amount of food consumed  Provide high calories, high protein diet as prescribed  Monitor patient's weight  Administer supplemental vitamins and minerals as prescribed  Administer parentral or TPN per protocol if dietary needs are not met through oral intake  Report abdominal distention, large gastric residual volume or diarrhea to doctor	Frenchaged the potent to adequate diet. Ettient had 10tt diet N pf had om diet	18 A 10

.

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation	<i>N</i>	Sign & Initials
CARE OF CAT DRAINS, ETC.		☐ Patient will have pater maintained catheters,		Check the catheters, drains etc frequently Observe I/O Chart Watch for any symptoms related to kinke blocked tubes Maintain adequate cleaning and dressing	d or	M Obs gend Seif vo ha No chart	illy on didng or the Monitograph	Ai PIL
DISTURBED B	ODY IMAGE	☐ The patient will demo initial acceptance and body image		Note non verbal body language, negative and self talk Note emotional reaction (grieving, depression of for grief and hostility	ssion, anger)	M ALA E NA		dista
OBSERVATION Vital Signs GCS Blood Sugar Others:	N	Patient will have norm of vital parameters	nal range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		701	vitals q	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )
HEALTH EDUCATION    Patient   Family / Guardian   Diet   Disease process   Infection control / PPE   Medication   Educate about TAC level   and immunosuppressant   Personal Safety   Treatment Regimen   Others:		Patient / Family / Gua Domestic Partner / Ca others will gain adequ knowledge regarding modalities and life sty modifications	are-giver / uate treatment	Provide proper education regarding follow Insist on importance of hand hygiene Explore action, reactions and adherence Provide clear, thorough, and understandar regarding safety precautions.  Explain to perform activities / skin care the by concerned doctor  Use the teach-back technique to determine understanding regarding importance of the	about medication able explanations at recommended ne the patient's	Edouated  Model & d  plan  E Hoalth  N Health	regarding rection colation Education	And Air
ANY OTHER N	EEDS					М		
						E	,	
						N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by	1	,		Anau.	Ovoz		13/12/23	9.00

1.









Pal	MIS.PREMA T
: Nai	52/Female/MH1202381034
UH	09/12/2023/IPH202302466
DO	Dr.ANBARASU MOHANRAJ
DO.	
Cor	370 JOIN PART BING (THIN 3 DING LITTOR LINET TROUGHT IT DIT LITE LIAN ALL

MHI/NUR/2022/112

Medway
Heart
Institute

Every heart beat counts

# **ADULT POST-OPERATIVE NURSING CARE PLAN**

Initial Date:  4  1 23	Time: 8 ⋅ 0 · 0	Modified Date: Time:			
Reason for Modification:		Diagnosis: CAD - DVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
PAIN  ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	Patient will have less pain	□ Evaluate location, character, quality and severity of pain     □ Administer pain medication as prescribed and as needed     □ Observe for any changes in vital signs     □ Maintain proper positioning of patient     □ Assist or turn patient every two hours     □ Assess incision area for redness, heat, induration, swelling, separation and drainage     □ Non-Pharmacological therapy	M pt bradiel  E Comfordabl politie  Dation had journet  N pt was pry	Son Alle	
OXYGENATION  Room Air Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	□ Provide well ventilated environment     □ Check oxygen saturation     □ Perform euctioning if needed     □ Ventilator settings as per physician orders     □ Monitor rate, depth of respiration     □ Administer oxygen and nebulizer therapy if needed     □ Encourage spriometry, deep breathing and coughing exercises     □ Monitor amount, viscosity, colour and odour of sputum if present	M pt room air Elliont 18 on from Air N Spoz- 95-0/2	Sur Sur Sur Sur Sur Sur Sur Sur Sur Sur	
ANXIETY Increased Pulse Rate Anxieus Look	Patient will cope properly with his illness and react positively to his surroundings	□ Explain all procedures to patient or family member in simple language they understand     □ Encourage and support patient while increasing anxiety level     □ Help patient to cope with outcomes of surgery     □ Keep patient in comfortable position in bed to enhance sleep	M pt . Anocious Look  E _  N -	200	
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	□ 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 p + Mobile freely  Entirely Mobile freely  N pt Mobilized	Dog Day Day	



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☐ Intravenous ☐ Enteral Nutrition	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	Mp+ electrolytes Fluid	8 our
☐ Parenteral Nutrition☐ Others:			Monitoral Interesponting	- Da
			N I/o chart	Set
RISK OF INFECTION Prevent Infection Others:	☐ The patient will be discharged with no hospital acquired infection	☐ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and	M Pt Infection	Stor
		after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered	Use asoptic technique  to the pat	
		CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	N No erele of confection	QUE DOOK
RISK OF FALL. ☐ Giddiness ☐ Independent State	The patient will have safe, free from fall hospitalization	□ Keep bed on low position     □ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed	M pt Position	D 192
Dependent State		□ Remove clutter, keep items patient needs within reach     □ Avoid movement out of bed after surgery for 46 hours     □ Review patients' medication like narcotics and hypotensive agents	E _	
		Offer urinal or bedpan to the patient if needed	N ~	
SKIN &WOUND CARE  Observe REEDA Oozing	The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered	M \$ + intent stein	800
Foul Smell	on dissilar ge	☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	E	
		Treport signs of poor frealing of trauffia to doctor	N —	
DIET & NUTRITION  NPO Soft Diet Semisolid Diet	Patient will have adequate nutrition with no nausea and vomiting	☐ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patients weight	M 107 om plot	Da
Semisolid Diet			Fretront had Dry diet	Q.
		needs are not met through oral intake  Report abdominal distention, large gastric residual volume or diarrhea to doctor	N Pt had DM diel	27





Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
CARE OF CAT DRAINS, ETC.		Patient will have patent, properly maintained catheters, drains etc		Check the catheters, drains etc frequently Observe I/O Chart     Watch for any symptoms related to kinke blocked tubes     Maintain adequate cleaning and dressing	ed or	M pt xuit	chart -	A Des
DISTURBED B	DISTURBED BODY IMAGE  The patient will demonstrate initial acceptance and to newly body image		<ul> <li>Note non verbal body language, negative attitude and self talk</li> <li>Note emotional reaction (grieving, depression, anger)</li> <li>Acknowledge and accept expression of feeling of grief and hostility</li> </ul>		M E N			
OBSERVATIO  Vital Signs GCS Blood Sugar Others:	☐ GCS ☐ Blood Sugar				M pt vite EVITAL Sign N Vilal Sign Chi	usung 1 08 90 Porondood give ove	The second	
HEALTH EDUCATION Patient / Domestic Partner / Care-giver / Others will gain adequate knowledge regarding treatment modalities and life style modifications  Personal Safety Treatment Regimen Others:		re-giver / late treatment	Provide proper education regarding follow Insist on importance of hand hygiene Explore action, reactions and adherence Provide clear, thorough, and understands regarding safety precautions.  Explain to perform activities / skin care the by concerned doctor  Use the teach-back technique to determinate understanding regarding importance of the	about medication able explanations at recommended ne the patient's	M p 1 edus plus E Health (1) N Health(	owen	A Aco	
ANY OTHER N	IEEDS					M E N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by	Nas	0021		S. Nalein	0024		14./18/23	12-3€

 $\gamma_{ij}$ 





## **ADULT NURSING CARE PLAN**

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Initial Date: 15/12/2	23 Time: 7.00	Modified Date: Time:			
Reason for Modification:		Diagnosis: CAD - DUP	Diagnosis: (AD - DVP		
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 p+ takes of diet belief had DM diet N p+ had Dm diet	Self Soll	
OXYGENATION   Room Air   Nasal Sannula / High Flow O,   Mask   BiPAP / CPAP   Ventilator   Tracheostomy   Others:	Patient will have normal O₂ 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 O₂ saturation and pulse rate □ If any O₂ 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 ou loany auxi  pataint is  on from Air  N Pt is on Room Air	Solori Fr	
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 you alcely you'd  E Moniford I/o Chart  N monitored I/o Chart	Asily Single	

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 P-tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ Enchurage 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 P+ mobilized  E patient Mobilized  N P+ well	Sech i
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	□ Epcourage fluid intake □ Æncourage 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 D V or clind  parteur  Normal Elimination  E pattern  N pt seef voided	A STA
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 Decreased   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	Maintain Normal  Raintain Normal  Normal  Normal  Normal  Normal  Normal  Normal  Normal  Normal  Normal	7 3 3 10 3 10 3 10 3 10 3 10 3 10 3 10 3

, '

1 1

	· · · · · · · · · · · · · · · · · · ·		·	, , , , , , , , , , , , , , , , , , ,
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  Bed Bath  Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	☐ Encourage patient to do dally bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene	M Self Balt	Jeyn
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	Extremt uxell granmod.	P
·			'n pt well groomed	部上
SAFETY Check ID Hand V care EJV	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient  Raise side rails	M ID Band P	Jel.
CENTRAL LINE Side rails Others:		□ 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)	I Do bund present	R
		·	N ID band present	4
COMFORT AND SLEEP Pain Control	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	M pot Sleeped	Ffi
☐ Steep Patterns ☐ Others:		Monitor pain scale / sleep pattern     Provide pharmacological and     non-pharmacological therapy	E —	
<u> </u>			N	
OBSERVATION  Vital Signs GCS Blood Sugar	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	M for wetals der Chechech recon	dsele,
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	EVITAL Signs Chellod & Pelordod	
			n vital Gigns	
PSYCHOLOGICAL / SPIRITUAL SUPPORT	Patient will achieve spiritual needs Patient will be able to control his	Pray or encourage the patient to pray Use inspirational words	M Checked & ovecouted	<u> </u>
☐ Spiritual Needs ☐ Bellefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	feeling toward his illness Patient will maintain normal psychological pattern	Respond to spiritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	PS/thological Suppor	
		<u> </u>	N psychological suppour	021L

1 1 r

Patient Specif Problems / Ne		Measurable Goals	<del></del> -	Nursing Interventions	Nursing Interventions			Sign & Initials
COMMUNICA  Verbal  Non-verbal Sigh language Others:	1	Patient will communi with positive feedbac	cate effectively k	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patien or prognosis in the patient's presence	nt's condition	Etood Com	us al municated	Seof Dir
SPECIAL_INTE  Medication  Wound care Isolation  Ostomy Care Blood / Blood transfusion  Fluid tapping DVT Managem Others:	products	☐ To manage on time		Double check for high alert medication  Doserve and report any medication re Provide proper measures of wound ca Follow hospital polices and protocols and explain to the patient / family Check for cross matching and typing, compatibility Practice strict asepsis while transfusin blood products and fluids Monitor DVT score and continue treatr as per doctors order	action re of isolation to ensure g blood or	M Dro o  Modication  Las por  N Modical	usclication good n Junen - charg Charr	Sel.
	Signature		Name		Emp. ID	1 - 1 - 1 - 1	Date	Time
Endorsed by		(B)	N	annon.	000	) <del>ý</del>	16/12/23.	10,00





# ADULT NURSING CARE PLAN

Pati	Mrs.PREMA T
Nam	52/Female/MHI202381034
UHII	09/12/2023/IPH202302466
; DOB	Dr.ANBARASU MOHANRAJ
: DOA	
Con	<u> </u>

MHI/NUR/2022/044

Medway
Heart
Institute

Every heart beat counts

Initial Date:   b   12   2   3	Time: 8.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD ~ DVD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION  ☐ Keep NPO ☐ Regular Diet	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M p+ 10 while sery	8/
Others:	requirements in accordance to his activity level and metabolic needs		Е	
			N	
OXYGENATION  Room Air  Nasal Cannula / High Flow O <sub>2</sub> Mask  BiPAP / CPAP	Dom Air asal Cannula / High Flow O₂ ask PAP / CPAP Patient ABG levels will return to and remain within normal limits    Patient ABG levels will return to and remain within normal limits   No other respiratory abnormalities PAP / CPAP   Patient respiratory rate will remains within established limits   Utilise pulse oximetry to check O₂ saturation and pulse oximetry		m p+ room ain	3 B
☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician  Place patient with proper body alignment for maximum breathing pattern  Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	E	
		<ul> <li>Note for changes in level of consciousness</li> <li>Send sputum for culture and sensitivity based on physician order</li> <li>Maintain clear airway by suctioning or encouraging patient with successful coughing</li> </ul>	N	
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	mp+ electroty Plu	900
☐ Parenteral Nutrition ☐ Others:		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	E	
		I Worker Dr for Orthostatic Granges	N	

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 ☐ P_tient will use safety measures	☐ 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	M p+ will blosstrue	Si
Li Others.	to minimize potential for injury  Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse)  Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E	
		·	N	
ELIMINATION  Catheter, bedpan, urinal  Nasogastric tube Bowel movement	Catheter, bedpan, urinal Nasogastric tube Patient will control of urinary in-continence or urinary retention, Urination  pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence.    Encourage fibre diet intake   Encourage early ambulation   Report any abnormalities to physician   Observe voiding accessories as foley's /		MP+ 13 Delurity Paffen	82
Others:	and regular elimination patterns  silicone eatheter  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	E		
			N	
SKIN INTEGRITY  Maintain normal skin integrity Pressure points site assessment HAPI OPI  GRADES OF PRESSURE	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity		M pa leauster (N) Steetes	
INJURY	□ Proper application of medications and dressing     □ Follow doctors and TVN order properly     □ Monitor the healing status     □ Educate patient and family members about further	E		
. ☐ Intermittent Assisted     ☐ Dermatitis     ☐ Pressure injury / blisters site     care given     ☐ Others:			N	

1

, 1

٠-

	· · · · · · · · · · · · · · · · · · ·			•
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  Bed-Bath Assist-Bath CBD Care	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care 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		Deve
☐ Others:	weakness or needs	Apply moistanzing solution	N	
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	M p+ Ilo Band	Da
Others:		Follow restrain policy (if needed)	N	
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	Mpt comports  E	No.
OBSERVATION  Vital Signs GCS Blood Sugar	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	M pr vital sings	Ba
Others:			E	
	Patient will stay clean and well-groomed   Patient will demonstrate tilestyle changes to pared self-care needs   Patient-will recognize individual weakness or needs   Patient-will recognize individual weakness or needs   Patient-will recognize individual weakness or needs   Patient-will recognize individual weakness or needs   Patient-will recognize individual weakness or needs   Patient-will have no life-threatening situations   Patient will have no life-threatening situations   Provide proper invasive line care   Patient will werbalize / or through behavior-adout pain relief and adequate sleep   Patient will werbalize / or through behavior-adout pain relief and adequate sleep   Patient will have normal range   Provide clean calm and restful environment   Provide privacy at all time   Provide privacy a	N		
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs	Patient will be able to control his feeling toward his illness	☐ Use inspirational words ☐ Respond to spiritual needs as they arise	М	
☐ Anxiety and Copying Pattern☐ Identify Stressors☐ Others:		☐ Encourage verbalization of feelings / therapeutic touch	E	
			N	

Patient Specif Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATO Verbal	TION	Patient will communic with positive feedback	cate effectively	☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		M p+ will	community	<b>8</b>
☐ Sigh language ☐ Others:				No negative speaking about the patient's or prognosis in the patient's presence	condition	E		
						N		
SPECIAL INTERVENTIONS  Medication  Wound care  Isolation  Ostomy Care  Blood / Blood products transfusion  Fluid tapping  DVT Management  Others:		<del>-</del>		Double check for high alert medication     Observe and report any medication react     Provide proper measures of wound care     Follow hospital polices and protocols of i		M pt Modi	ation gran	&m
			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		E			
					N			
	Signature		Name		Emp. ID		Date	Time
Endorsed by	NaOo	024	ς.	Nalia	د و ه	<b>₽</b> ₩	16/12/23	4-30
								•

٠, -





Mrs.PREMA

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

Date: €

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time	: =	K	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	A. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		2	
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	1.	3	
MOBILITY ability to change and control body position	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		+	
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. Afequate 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			3	
FRICTION	Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independent strength to lift up completely during move. No or chair			3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE	23	20	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:		Hey	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initlal & Emp. No. of Sr. Staff Nurse:	UCLS-	New	امرلا





#### Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

12 23

Date: 70

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time	10 M		N 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	A: 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 Molst Skin is usually dry, linen only requires changing at routine intervals		H	7
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	Ι.,	J.1	4
MOBILITY ability to change and control body position	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		7	A
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	4	4
FRICTION	1.Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. No or chair		3	ر می	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE	23	93	22
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	200	<b>P</b>	Das
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	1919	Dal-	





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

#### Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj





#### Date: 11/12/27 11/12/23/201223 BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time: 12:39 14.2 2 0 SENSORY 1. Completely Limited 2. Very Limited 3. Slightly Limited 4. No Impairment Unresponsive (does not moan, flinch,or PERCEPTION Responds only to painful stimuli. Cannot Responds to verbal commands, but Responds to verbal ability to respond grasp) to painful stimuli, due to diminished communicate discomfort except by cannot always communicate discomfort commands. Has no sensory level of consciousness or sedation OR mouning or restlessness OR has a deficit which would limit meaning-fully to or the need to be turned OR had some 2 2 pressure-related limited ability to feel pain over most of body sensory impairment which limits the ability ability to feel or voice pain or sensory impairment which limits ability to discomfort to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort 1. Constantly Moist 3. Occasionally Moist 4. Rarely Moist 2. Very Molst MOISTURE Skin is kept moist almost constantly by Skin is often, but not always moist, Linen Skin is occasionally moist, requiring an Skin is usually dry, linen only degree to which perspiration, urine etc. Dampness is must be changed at least once a shift extra linen change approximately once a requires changing at routine 2 skin is exposed detected every time patient is moved or intervals to moisture turned 1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently Confined to bed **ACTIVITY** Ability to walk severely limited or non-Walks occasionally during day, but for very Walks outside room at least degree of existent. Cannot bear own weight and / or short distances, with or without twice a day and inside room physical activity must be assisted into chair or wheelchair assistance. Spends majority of each shift at least once every two hours in bed or chair during waking hours 1. Completely immobile 2. Very Limited 3. Slight Limited 4. No Limitation MOBILITY Does not make even slight changes in body Makes occasional slight changes in body Makes frequent through slight changes in Makes major and frequent ability to change or extremity position without assistance or extremity position but unable to make body or extremity position independently changes in position without and control body frequent or significant changes assistance position independently 1. Very Poor 2. Probably inadequate 4. Excellent 3. Adequate Never eats a complete meal. Rarely eats Barely eats a complete meal and generally Eats over half of most meals. Eats a total of Eats most of every meal. more than any food offered. Eats 2 servings eats only about 2 of any food offered. 4 servings of protein (meat, diary Never refuses a meal. NUTRITION or less of protein(meat or dairy products) per Protein intake includes only 3 servings of products) per day. Occasionally will refuse Usually eats a total of 4 or usual food meat or diary products per day. day. Takes fluids poorly. Does not take a a meal, but will usually take a supplement more servings of meat and intake pattern liquid dietary supplement OR Is NPO and / or Occasionally will take a dietary when offered OR Is on a tube feeding or diary products. Occasionally maintained on clear liquids or IV's for more supplement TPN regimen which probably meets most eats between meals. Does than 5 days of nutritional needs not require supplementation 2. Potential Problem 1. Problem 3. No Apparent Problem Moves feebly or requires minimum Requires moderate to maximum assistance Moves in bed and in chair independently and has sufficient muscle in moving. Complete lifting without sliding assistance. During a move skin probably strength to lift up completely during move. Maintains good position in bed **FRICTION** against sheets is impossible. Frequently slides to some extent against sheets, or chair & SHEAR slides down in bed or chair, requiring chair, restraints or other devices. Q TOTAL SCORE Maintains relatively good position in chair frequent re-positioning with maximum assistance. Spasticity, contractures or or bed most of the time but occasionally Initial & Emp. No. agitation leads to almost constant friction slides down of Staff Nurse: Initial & Emp. No.

of Sr. Staff Nurse:







52/Femalc/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



Every heart beat counts

(A Unit of United All	liance Healthcare Pvt Ltd)		THE ASSESSMENT OF BUILDING WATER AND ASSESSMENT OF THE PARTY OF THE	- Every	Teart t	I S I JA	
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time	: 1 <u>213</u> : 1810	200	13(2)
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	Livery 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		2	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 Molst 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		2	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 leas twice a day and inside room at least once every two hours during waking hours	1 —	2	- 2
MOBILITY ability to change and control body position	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 frequenchanges in position withou assistance		2	
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 o more servings of meat and diary products. Occasionall eats between meals. Does not require supplementation	2 d y s	V	2
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 independent strength to lift up completely during move. Nor chair		13	2	3
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:		K	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\

S.No. : 22





#### Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/iPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

(A unit of united Alli	lance Healthcore Pyt Ltd)		Ten in the part is a second of the second of	Dat	e: 12	Lix	2
	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Tim		<u> 2</u>  N	<u>-2.</u>
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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 verba commands. Has no sensor deficit which would lim ability to feel or voice pain of discomfort	y it	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst 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 on requires changing at routir intervals		3	
ACTIVITY degree of physical activity	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. Wałks 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 lea twice a day and inside roo at least once every two hou during waking hours	m   ∖	3	
MOBILITY ability to change and control body position	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 freque changes in position witho assistance		3	
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 mea Never refuses a mea Usually eats a total of 4 more servings of meat ar diary products. Occasional eats between meals. Do not require supplementation	I. or or or ly es	3	
	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independent strength to lift up completely during move. No or chair	ly and has sufficient muscl Maintains good position in be	e 3	3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices.  Maintains relatively good position in chair or bed most of the time but occasionally slides down		TOTAL SCOR		19	, ,
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No		1 ^	H . 10





Pat Mrs.PREMA T

Nat 52/Fernale/MHI202381034

UH 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

PROBLEM OF DESCRIPTION OF THE PROPERTY OF THE

-----



12 23

Every heart beat counts

Date:

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RIS	SK Date:		12 E	2 <u>3</u> N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	Respo comma deficit ability to	. No Impairment esponds to verbal ommands. Has no sensory eficit which would limit bility to feel er voice pain or iscomfort		Ç	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst 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	Skin is require:	A. Rarely Moist Skin is usually dry, linen only requires changing at routine ntervals		77	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	Walks of twice a at least	. Walks Frequently Valks outside room at least wice a day and inside room It least once every two hours luring waking hours		1	4
MOBILITY ability to change and control body position	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	Makes change	4. No Limitation Makes major and frequent changes in position without assistance		4	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	Eats m Never Usually more s diary preats be	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	4-
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. I or chair	iy and h Maintains	as sufficient muscle good position in bed	ß	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or				TOTAL SCORE	23	D_3	23
	agitation leads to almost constant friction	slides down			Initial & Emp. No. of Staff Nurse:	Ein.	RAP.	3
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6		Initial & Emp. No. of Sr. Staff Nurse:	000 062 A	Naca	110





Pati Mrs.PREMA T

Nan 52/Fernale/MHI202381034

UHI 09/12/2023/IPH202302466

DOI Dr.ANBARASU MOHANRAJ



Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK						数	12	23
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 commands. Has deficit which w ability to feel or vo discomfort	verbal no sensory rould limit		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 Molst Skin is occasionally moist, requiring an extra linen change approximately once a day	4. <b>Farely Moist</b> Skin is usually dry, linen only requires changing at routine intervals		9	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			41	4
MOBILITY ability to change and control body position	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			1	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	4	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	assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair	3. No Apparent Problem  Moves in bed and in chair independent strength to lift up completely during move. I or chair	ly and has sufficie	ent muscle lition in bed	3	3	3
					AL SCORE	1	23	
					Emp. No.		图	A.
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6						200	Na	J.V.





Pa Mrs.PREMA T

Ng 52/Female/MHI202381034

U) 09/12/2023/IPH202302466

DC Dr.ANBARASU MOHANRAJ





Every heart beat counts

Date: 6

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Date:	16 12	12	23 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	1		
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			
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	0.4		
MOBILITY ability to change and control body position	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			
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	م		
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some attent against sheets,	3. No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	y and has sufficient muscle Maintains good position in bed	194		
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices.  Maintains relatively good position in chair or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	200		
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	Val.		





#### MIS.PREMA T

52/Female/MHl202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052

Every heart beat counts

PAIN RE-ASSESSMENT 8	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.
9/12/2	3 0/10	No pain	-	1		Op las	(1)
16.30	ماره	, I , o	ł	-		Code	(100)
oxiB				<b></b>		Hout	(100 coo)
				Patien	t is Steeping	Harlows	(D)
601213 600	olw	Nopain				Hay	( ) S
10-02	0/10	No pain				5.9	(No)
11:00	Olio	No pair				P	(Do
13.00	) 10	No pain		_	_		(To oces
200	0/0	No rein	-			Looks .	o no s

Date & Time	Pain Score	(dull, achy, sh	n Character arp, stabbing, shooting, ferred / radiant pain)	Duration	Location / Site	]1	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
\$60	%	N	opair		<b>-</b>	<b>,</b>		2000	0005
6.00	%0	XX	o pain	_				Art	10005
					P#	IN SCALES	<u> </u>	<u> </u>	
(28 week	PIPPS s to <u>&lt;</u> 38	,	or less = Minimal to no - 12 = Mild pain - Provi • 12 = Moderate to seve	de comfort me		no		1	· · · · · · · · · · · · · · · · · · ·
(38 we	CRIES eks - 2 m					of gestation. A maximal score gesic administration is indicate	e of 10 is possible. If the CRIES score is > ed for a score of 6 or higher.	4,	
	ACC Sca		: Relaxed & comfortab	e, 1-3; Mild d	Iscomfort, 4-6: Mode	erate discomfort, 7-10: Severe	discomfort / paln / both		
Pain	-Baker FA Rating So ars - 12 ye	cale `	O 2 No Hurts Little Bit	4 Hurts Little Mare	6 Hurts Evan More	8 10 Hurts Whole Lot Worst	Numerical Rating Scale (age  0 1 2 3 4 5  None Mild Moderate	6 7 8	years) 9 10
Observa	cal care F ition Tool itor / com	Pain (CPOT) (CPOT) (Natose)	OMPLIANCE WITH VE	Absence of m NTILATION (in Subated patien Relaxed, 1 - Te	novements or normal   ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restle I - Tolerating Ventilator or Movem rmal tone or no sound, 1 - Sighir anse, Rigid	essness / Agitation nent , 1 - Coughing but tolerating, 2 - Fightir ng, Moaning, 2 - Crying out, sobbing	g ventilator (or)	
	harmacol terventior	ogical C	cutaneous Stimulation a Thermal Therapies (no le	and massage: onger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and menta ubbing / Massage the skin old application; H - Hot application referntial therapy   Psycho-soc		ınseling; L - Family	y counseling
Pharmac	ological I	nterventions :	s per doctor's prescrip	otion					







N 52/Female/MH1202381034 U 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052



Every heart beat counts

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.
1/3/30		CPOT.		1.3		MO94	· Roges
13/30		, CPOT				World	
15,70	70	, Actuy poin.	12,260	Sternum	Pharnacological maragement	Mean .	N gov)
430	110	Achy Pain.	15sec	Back.	Phounacological management given.	Meer	Vags
1930	400	Dull pain	5-10 bu	1 tenun	Mon-phaemarohyical management	Alexander Services	l'2013
21,30	410	Duli paui	Llone	Sternun	proveded Compostable position	- ANIC	Nous
23.30		-	- Pa	bout is sleepe	uj Comfortatuj	HI OOII	Novos,
12/12/2	> -	<u>-</u>			uj Comfestatuy	热	Koos
08.30	ĺ	<b></b> .			epunj Comfostally	the soil	Read

Date & Time	Pain Score	(dull, achy,	sharp	Character , stabbing, shooting, ed / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
12)12/2 (5.30	400	7	all	pam	LIShe	Menum lower pan	prouded lowfostable poerhor	fly 1011	1000)
7:30	21.0		hy	PALN	£10/se	10 Scapella	Non-Phormacological Antervention	4002	N 600)
9:30	140		)   	paw	۷.6/۱	@scopula,	-> Phannaulyral Marayrum dua.	dun	1 SOW
<b>.</b> .	•	CO.				Surgial	-> Mon-pharmail Mamoyement duno	don	V 200
11130	1/10		N.	) AUV	GOOL	<u> </u>	IN SCALES		
(28 week	PIPPS (s to <u>&lt;</u> 38	weeks)	7 - 1	less = Minimal to no 2 = Mild pain - Provid = Moderate to sever	de comfort me				
(38 we	CRIES eks - 2 m	onths)					of gestation. A maximal score of 10 is possible. If the CRIES score is $>$ 4, esic administration is indicated for a score of 6 or higher.	1	•
	ACC Sca nths - 7 y	_	0: R	elaxed & comfortabl	e, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		
Pain	-Baker FA Rating S ars - 12 ye	cale		0 2 No Hurts Little Bit	(OO) Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m  Numerical Rating Scale (age m	ore than 12 7 8	9 10
Observa	cal care F tion Tool tor / com	(CPOT)	CON VOC MUS	IY MOVEMENTS: 0 - MPLIANCE WITH VEI FALIZATION (non-Int SCLE TENSION: 0 - F	Absence of m NTILATION (I ubated patter Relaxed, 1 - Te	ntubated patients): (	position, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting v rmal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	ventilator (or)	
	harmacol tervention		Cute Ther	ineous Stimulation a mai Therapies (no k	i <b>nd massage</b> onger than 15	: E - Positioning; F - R to 20 minutes): G - C	<ul> <li>- Music; D - Physical and mental exercisers</li> <li>- Bubbing / Massage the skin</li> <li>- Bubbing / Massage the skin</li> <li>- Shortwave diathermy</li> <li>- From the skin of th</li></ul>	eling; L - Family	counseling
Pharmac	ological i	ntervention	s as p	er doctor's prescrip	tion				<u> </u>

i







52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052



Every heart beat counts

Date & Time	Pain Score	Pain Character (duil, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
13'.8 <sub>0</sub>	1/10	Dul pain -	LIO Res	Steinin	Non-pharmacotycal interention given	100 B	of pools
12,30		•		Back.	Non-pharmacological interestran Opinas	273	ff gws
181.80	١	<b>,</b>		Steinin	Non-pharmacological intenention gives	8413	
20.50	1/1D			slornum	nhouma cologiant intervention done	det.	doos
22. 3D	2/10	Achy pain	LF-1050	: bitck	nton phormacological intorvention done patient slepping comportable	1.	- gordy
00.30	ofw	-	_		patient sleeping comportable		- Novy
07·20	ofio		· <b></b>		patient sleeping count as Lable	021	- Hours
04-30	olio	~			patient sleeping compactable	dy	
06.30	410	Dull pain	5860	slennum	alon phasma vological	def	2005



Date & Time	Pain Score	(dull, achy	ain Character , sharp, stabbing, shooting, ,, referred / radiant pain)	Duration	Location / Site		Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.				
13 W/33 8.30	1 10	Du	Il ache	IS See.	Surgica) lite	Pharmaeologica done.	) intervention	0265	N1006024				
10.30	1/10	Dall	ache	NE.	Eurgical Este.	Non-pharmac		0265	Dalon				
₩· <b>©</b>	10	10 ul	pain	10-5 Øec.	Surgical Dile		ical Management	R	Nagao2 L				
l3-00	10	n Ott	11 Dain	10-5 800	Dogical Osite	Comportable ARe pad	position to	7	Na I oon				
	(				PA	IN SCALES							
(28 wee)	PIPPS (s to <u>&lt;</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	le comfort me		n			·				
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal scor	re of 10 is possible. If the CRIES score is > ted for a score of 6 or higher.	4,					
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe	discomfort / pain / both						
Pain	-Baker F <i>I</i> Rating Se ars - 12 ye	cale	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating Scale (age in the latest section of the latest se	<del>                                     </del>	years) 9 10				
Observa	cal care F tion Tool ttor / com	(CPOT)	BODY MOVEMENTS: 0 - COMPLIANCE WITH VEI VOCALIZATION (non-Int MUSCLE TENSION: 0 - F	CIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing DY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation MPLIANCE WITH VENTILATION (intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) CALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing ISCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain									
	harmacolo tervention		Cutaneous Stimulation a Thermal Therapies (no lo	nd massage: enger than 15	E - Positioning; F - Reto 20 minutes): G - Co	- Music; D - Physical and ment ubbing / Massage the skin old application; H - Hot applicat erferntial therapy   Psycho-so		nseling; L - Family	/ counseling				
Pharmac	ological l	ntervention	is as per doctor's prescrip	tion									

.





**PAIN RE-ASSESSMENT & MONITORING CHART** 



Patient Patalla (Affin Labal bara)

Mrs.PREMA T

52/Fernalc/MHI202381034

09/12/2023/IPH202302466

DO Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/052



Every heart beat counts

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbling, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
14/12/13 6.00	ollo	No pain	1	-		011L	Nation
10.0	0/60	no pain	_			800	120024
<u> 1100</u>	ylo_	Dull pain	ens of	Surgical Site	Tharmacological Management Guien	R	Napaon
8 CD	/ 1/10_	A		Burgilal Site	Comportable position to the P+		Nale
Q-00	0/10	. V	_	_		Sof.	Dog
નિચે છે ૧-૦૦	O/w	No Pain	j	_		Sopo	p) a 2 602
S-D 0	1.	Mo Path	_		_	A.T.	Malan
6.00	୍ଠୀତ	No pain		_		Stoff.	Næloozi
<u> </u>	0/10	No Duin	_			A.	Nelec

Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
13-100	0/0		lo pair				A.	Na OScos
22.60	0/10	n.	o pain	_	_	-	A)	Nalon
8.00 16/12/2	o(1b	-	no pain	-		· .	1921 021	N200021,
دو،٥٥	0/15	ν./	o dain		,		P.	na คอา
			Ţ,		P/	AIN SCALES		
(28 week	PIPPS (8 to <u>&lt;</u> 38	l weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on		
(38 wed	CRIES eks - 2 m	onths)	The CRIES scale is used further pain assessment	l for infants > should be ur	than or = 38 weeks idertaken, and analg	of gestation. A maximal score of 10 is possible. If the CRIES score is $>$ 4, esic administration is indicated for a score of 6 or higher.		
FL	ACC Sca nths - 7 y	le				rate discomfort, 7-10: Severe discomfort / pain / both		
Pain	-Baker F <i>i</i> Rating S ars - 12 y	cale ·	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age mode)  8 10 Hurts Worst None Mild Moderate	re than 12 7 8	9 10
Observa	cal care i tion Tool tior / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (in ubated patler Relaxed, 1 - Te	novements or normal Intubated patlents): 0 Ints): 0 - Talking on no Inse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting vermal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	entilator (or)	,
	harmacol tervention		Cutaneous Stimulation a Thermal Therapies (no lo	i <mark>nd massage:</mark> inger than 15	E - Positioning; F - R to 20 minutes): G - C	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy   <b>Psycho-social therapy/counselling:</b> K - Individual Counse	ling; L - Family	counseling
Pharmace	ological i	ntervention	is as per doctor's prescrip	tion				

- , i , i



MIS.PREMA T
52/Female/MH1202381034
09/12/2023/IPH202302466
Dr.ANBARASU MOHANRAJ



## **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

	-g-ra 00010 01 . II (120) III paramotor 1001 1 to 0,	1	1 - 1-	li des		p	T	<del>                                     </del>
	Date	7112	10/12/2	प्राध्य		<u> </u>		
	Time	15.20	6:00	6-00			-	<del> </del>
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	В				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	Þ				
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)	O	ס	٥				
5	Entire leg swollen (Assess for both legs)	0	0	P				
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	rO				
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)	b	0	0				
9	Previously documented DVT (Assess for both legs)	10	0	0	<del></del>			
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	٥				
	FINAL SCORE	Ð	0	Ø				
Low R	isk: -2 to 0   Moderate Risk: 1 to 2   High Risk: 3 to 8	Low	لها	Low				
	DVT prophylaxis started	□ Yes ☑ No	☐ Yes √⊒∕No	☐ Yes ☐ No				
	Signature & Emp. No. of RN	ON TOPS	Hay	d de				
	Signature & Emp. No. of Sr. RN	( <b>V</b> )	W K	CO V	-			





# Mts.PREMA T 52/Femalc/MHI202381034 09/12/2023/iPH202302466 Dr.ANBARASU MOHANRAJ



## **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	11/3/37	12/12/2	13-12-2	14 12 22	מלפוף בן	16 12 2	
		12720	06.00			ス と と と と と と と の と の に と の に と の に り に り に り に り に り に り に り に り に り に		
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	O	۵	D	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	41	41	_+1	+1	+1	11	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	O	8	0	0	O	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	Ð	G	0	Ð	0	
5	Entire leg swollen (Assess for both legs)	ථ	Ø	0	Ø	<u></u>	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	O	Q	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0	<b>(</b> D)	0	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	Ø	0	Ø	Ð	Q	
9	Previously documented DVT (Assess for both legs)	ଚ	O	0	Q	0	O	
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	Ð	Ò	0	0	0	
	FINAL SCORE	H	+	+1	4	ナし	4)	
Low R	lisk: -2 to 0   Moderate Risk: 1 to 2   High Risk: 3 to 8	1255L	, 200	-Wap	MOD	MOD	MoD	
	DVT prophylaxis started	□Yes ₽No	□Yes □No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	Yes No	□ Ye
	Signature & Emp. No. of RN	9286 May	. 4 30	Design	ST.	Stoom	And	
	Signature & Emp. No. of Sr. RN		$\sqrt{\Lambda}$	$^{\wedge}\sqrt{.}$	May	1002 h	Nole	_



## Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



#### Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





## MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		9/12	alizh?		10/12/2	town				
TAITAMICS	Time	12:30	20:00	8.00	17/102	2000				
History of falling	No	· O	VB/	ے	9	<b>(</b> 0	0	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	<sup>,</sup> 0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	115	15	45	15	15	15	15	15	15
Intravenous Therapy /	No	10	10/	6	0	40	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID				/	ł					
None / Bed Rest / Nurse Assist		0	19	-8	9	سور	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		.9	10	۰۵	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							<del></del>			
Oriented to own stability		سق	0	0/	9/	ا م	Ο.	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics,	No	0	0	0		0	•			
laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants,		0	·	<del>                                     </del>	0		0	0	0	0
anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	[15/	15	15	15	15
Total Score		00	30	30	30	30				
Low Risk (0 - 24)										
Medium Risk (25 - 44)		30			V					
High Risk (45 or above)										
Signature & Emp. No. of RN		Opples	thank	5.50	13/3-	6046				
Signature & Emp. No. of Sr. RN	٠	(Oge	(B) (	OF S	<b>B</b> ox					
	٠	ŏ - :	24: Ľow	Risk; 2	5 - 44: N	ledium I	Risk; 45	or abo	ve: High	Risk

INTERVENTIONS  Tick as per the Risk Score  Low Risk Interventions (0 - 24)  Familiarize the patient with the immediate surroundin Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all timal patients regardless of age  Keep the call bell, bedside table, water, glasses with patient's easy reach  Remove excess equipment or furniture to make a path  Keep the patient's bed in the low position at all times of during procedure  Teach fall-prevention techniques, such as sitting upmoment 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 slipped Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	ngs of bed nes for nin the a clear except o for a	>50 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		8.00	100					
Low Risk Interventions (0 - 24)  Familiarize the patient with the immediate surrounding Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all time all patients regardless of age  Keep the call bell, bedside table, water, glasses with patient's easy reach  Remove excess equipment or furniture to make a path  Keep the patient's bed in the low position at all times of during procedure  Teach fall-prevention techniques, such as sitting upmoment 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 slipped Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	ngs of bed nes for nin the a clear except o for a	シンソンソンソン		800	100	1 1				
Familiarize the patient with the immediate surrounding Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all time all patients regardless of age.  Keep the call bell, bedside table, water, glasses with patient's easy reach.  Remove excess equipment or furniture to make a path.  Keep the patient's bed in the low position at all times eduring procedure.  Teach fall-prevention techniques, such as sitting upmoment 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 slipped. Review medications for potential side effects the promote falls.  Use safety belts during movement in wheelchair.  The patients are not ambulated by themselves. They be ambulated only with assistance.  Medium risk interventions (25 - 44).  Apply all the low risk interventions.	of bed nes for nin the a clear except p for a	ンソンソン								
Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all timal patients regardless of age  Keep the call bell, bedside table, water, glasses with patient's easy reach  Remove excess equipment or furniture to make a path  Keep the patient's bed in the low position at all times eduring procedure  Teach fall-prevention techniques, such as sitting upmoment 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 slipper Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	of bed nes for nin the a clear except p for a	ンソンソンソン								
Keep the two side rails in the raised position at all time all patients regardless of age Keep the call bell, bedside table, water, glasses with patient's easy reach Remove excess equipment or furniture to make a path Keep the patient's bed in the low position at all times of during procedure Teach fall-prevention techniques, such as sitting up 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 slipped Review medications for potential side effects the promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions	nes for nin the a clear except p for a	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \								
All patients regardless of age Keep the call bell, bedside table, water, glasses with patient's easy reach Remove excess equipment or furniture to make a path Keep the patient's bed in the low position at all times eduring procedure Teach fall-prevention techniques, such as sitting upmoment 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 slipped Review medications for potential side effects the promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions	nin the a clear except p for a	\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \								
Keep the call bell, bedside table, water, glasses with patient's easy reach  Remove excess equipment or furniture to make a path  Keep the patient's bed in the low position at all times eduring procedure  Teach fall-prevention techniques, such as sitting up 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 slipped Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	a clear except p for a	>> > > > > > > > > > > > > > > > > > > >			\ \ \ \	, ,				
patient's easy reach Remove excess equipment or furniture to make a path Keep the patient's bed in the low position at all times of during procedure Teach fall-prevention techniques, such as sitting up 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 slippe Review medications for potential side effects the promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions	a clear except p for a	> > > > > > > > > > > > > > > > > > > >			\ \ \	, ,				
Remove excess equipment or furniture to make a path  Keep the patient's bed in the low position at all times of during procedure  Teach fall-prevention techniques, such as sitting up 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 slipped Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	except p for a	ンンンン			<b>\</b>		<del></del> -			<del>                                     </del>
path  Keep the patient's bed in the low position at all times of during procedure  Teach fall-prevention techniques, such as sitting up 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 slipped Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	except p for a	ンシン			<u> </u>	· •				
Keep the patient's bed in the low position at all times of during procedure  Teach fall-prevention techniques, such as sitting up 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 slippe Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	p for a	\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\					ı	I '	I
during procedure  Teach fall-prevention techniques, such as sitting up 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 slippe Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	p for a	ンソソ			,					
Teach fall-prevention techniques, such as sitting up 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 slippe Review medications for potential side effects that promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions	ery	\ \ \		<del></del>	I 🗸				-	
Bed wheels should be locked Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippe Review medications for potential side effects the promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions		\(  \tau \)				· .				
Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippe Review medications for potential side effects that promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25-44) Apply all the low risk interventions		\ \ \		*						
Ensure that floor of the bathroom is dry and not slipped Review medications for potential side effects that promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions		<u></u>								
Review medications for potential side effects the promote falls  Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25-44)  Apply all the low risk interventions						-	_			
promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions	at can		<b></b>		_/					
Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions				'	ļ					j
The patients are not ambulated by themselves. They be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions						<u> </u>				ļ
be ambulated only with assistance  Medium risk interventions (25 - 44)  Apply all the low risk interventions					-			<b> </b>	<u> </u>	
Medium risk interventions (25 - 44) Apply all the low risk interventions	are to	./			/ <i>i</i>					
Apply all the low risk interventions					\ \	\				
		\	1							
Tie yellow fall risk tag in the bed and Wheel chair / Stre	etcher	L.	<u> </u>				<del></del> -	-	<del> </del>	<del> </del>
Make sure that proper transfer precautions are inst		<u> </u>	<u> </u>						<del> </del>	<del> </del>
for heavy or debilitated patients in a bed or wheel of							-			
on a toilet seat		<b>–</b>							]	
Use restraints and bed monitors as ordered by the do	octor	V	./							
Allow the patient to ambulate only with assistance										
Consider peak effects of the medications that effects	s level			,		_				
of consciousness, gait and elimination when pla	anning								<u> </u>	
patient's care						-	_	ì		<u> </u>
Do not leave patients unattended in diagnos	stic or									
treatment areas		V				· ·			ļ	<del> </del>
Accompany the patient while going to bathroom	- 4  - 4 - 1 -	<b>-</b>						 		——
Advice the patient to use grab bars near the toilet, ba and shower	atntub,									
Make sure the family and other visitors understar	nd the	<u> </u>		-	,	/_				-
restrictions mentioned above	ilu tile	<i>-</i> -				_				
High-risk interventions (45 or abovc)	_								<u> </u>	<del> </del>
Apply all the low and medium risk interventions		]	•						#	
Tie red fall risk tag in the bed, wheel chair and stretche	er	Ì								
Locate the high-risk patients in a room close to the n		<u> </u>	_	,						
station				,,						<u> </u>
Answer these patients call bells as quickly as possible	e									<u> </u>
Provide a commode at bedside (if appropriate)							<u> </u>	<b></b>		<b>├</b> ──
Urinal/bedpan should be within easy reach (if approp		<u> </u>		<del>,/</del>						<u> </u>
Encourage family members or other visitors to sta	y with									
them If appropriate, consider using protection devices:	safoh/	<del>                                     </del>	-				<del>-</del>	<del>                                     </del>	<del> </del>	<del>                                     </del>
belts	oalely	·			ــــــــــــــــــــــــــــــــــــــ					
	# DNI	MOVAK	yast	5.927	1.	1	<u> </u>	<del>                                     </del>	<del> </del>	
Signature & Emp. No. of		W. C.	( ) ( ) ( ) ( ) ( )	27	POTT	( Car		[		—
Signature & Emp. No. of Sr	r. RN	(0°C)	(V) \	BO.	~ 80T	(201)			í	l .
1		- Z440	alv			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		<u> </u>		



The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



#### MIS.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

## 



MHI/NUR/2022/046

Where heart best never stons...

## MODIFIED MORSE FALL RISK ASSESSMENT CHART

	•				<del></del>	,	<del></del>	·					
Variables	Date	110/23	14/2/23	12/0103	12/12	12/12	13/12/23	13/12	2-13 12/2	14/12/-			
	Time	2520	19.30	\$!00	13,00	20-00	වු:න	HIM	20.00	800			
History of falling	No	<b>(6)</b>	9	0	(6)	0	4	کا ا	سوراً	_0_			
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25			
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0			
(≥ 2 medical diagnosis)	Yes	(15)	<b>1</b> /5	15	15	15	1.15	<b>15</b>	_15^	15			
Intravenous Therapy /	No	0	0	0	0_	0	0	0	0	0			
Heparin Lock / Tubes Insitu	Yes	(20)	20	20	20	20	20	20	20_	<u>3</u> 0-			
AMBULATORY AID					$\sim$								
None / Bed Rest / Nurse Assist		(0)	9/	9	(o)	0	9	ρ	0	ے			
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15			
Furniture		30	30	30	30	30	30	30	30	30			
GAIT					0		_		-				
Normal / Bed Rest / Wheel Chair		(0)	8	D	(0)	0/	0	o o	9	٥			
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	핤	0	(O)	0	0_	9_	0_	مر			
Overestimated or forgets limitations		(15)	( <del>5</del> )	45	15	15	15	15	15	15			
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0	0	0	0	0	0	0	0	0			
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	(15)	15	15	(15)	15	15	15-	,15	15_			
Total Score		65	65	БК	50	(V)	50	So	50	50			
Low Risk (0 - 24)				_									
Medium Risk (25 - 44)		`		-		7		-					
High Risk (45 or above)		V.	1		V	1	K	1	<b>\</b>	V			
Signature & Emp. No. of RN	Signature & Emp. No. of RN												
Signature & Emp. No. of Sr. RN		خياكما		V				Q.	76	de			
		0 <b>0</b> - 2	24: Þðŵ	Riski)2	5 - 445N	1edium	Risk; 45	or abo	ve: High	Risk			
	-	T		7	0.0	$\alpha$	- 19						

INTERVENTIONS Trick as part the Risk Score  Time    19   20   32   3, 30   12, 10   3, 10   15, 10   3						<del> </del>					
Time (p.19) (p.39) (p.39) (p.30) (p.10) (p.30) (p.10) (p.30) INTERVENTIONS	Date	(/2/2)	13/12/2	12/12/03	23	12/2	13/12/23	12/2	ુ ાશો મ	4' 15-	
Low Risk Interventions (0-20) Familiarize the patient to use call bell before getting out of bed Keep the two side ralls in the raised position at all times for a patients regardless of age Reep the call bell, bedside fable, water, glasses within the patient's patients regardless of age Remove excess equipment or furniture to make a clear patient seap reach Remove excess equipment or furniture to make a clear patient seap reach Remove excess equipment or furniture to make a clear patient seap reach Remove excess equipment or furniture to make a clear patient seap reach Remove excess equipment or furniture to make a clear patient seap reach and the low position at all times except during procedure Remove excess equipment or furniture to make a clear patient seap reach and the low position at all times except during procedure Remove excess equipment or furniture to make a clear patient seap reach and the low position at all times except during procedure Reach tell-prevention techniques, such as sitting up for a moment before rising from the bed end where the seap reach and the re		Time	12:30	19.39		12:00	٥٥.٥٥	8:0	161.07	2000)	رب. چئچ
Familiarize the patient with the immediate surroundings Remind the patient to use call bell before getting out of bed Keep the tow side ratis 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 Resp 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 Ensure thartfloor of the bathrooms dry and not slippery Review medications for potential side effects that can promote falls Use safety belts during movement in wheelchair Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They are to be ambulated only with assistance  Wellow the patient surferventions The 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 no a tolist sead.  Use restraints and bed monitors as ordered by the doctor Allow the patients and bed monitors as ordered by the doctor Allow the patients 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 consclourness, gait and elimination when planning patients care  Do not leave patients unattended in diagnostic or treatment areas  Accompany the patient wind with a services to the nurses' station  Fire delta risk tag in the bed and dispressive or the patients on the facts level of consclourness, gait and elimination when planning patients care  Do not leave patients unattended in diagnostic or treatment areas  Fire relatins to use grab bars near the tallet, bathtub, and shower  Make sure the family and other visitors understand the restrictions menioned above  High-risk intervantions (Go or above)  High-risk intervantions (Go or above)  Fire	Low Risk Interventions (0 - 24)		<u>'</u>	1		٠,٠,٠			78.1	. /	
Remind the patient to use call betilbefore getting out of bed Keep the two side raise in the raised position at all times for all patients regardless of age Keep the cash belf, 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 Reach ell-prevention techniques, such as sitting up for a moment before rising from the bed Bod wheels sirould be locked Encourage family participation in the patient's care Ensure that floor of the battroom is dry and not slippery Review medications for potential side effects that can promote fails Uses safety belfs during movement in wheelchair The patients are not ambutated by themselves. They are to be ambutated only with assistance Modifficially in the bed and Wheel chair / Stretcher The patient's first they only in the bed and Wheel chair / Stretcher They sellow fall fisk tag in the bed and Wheel chair / Stretcher They sellow fall fisk tag in the bed and Wheel chair / Stretcher Allow the patient to ambutate only with assistance Use restraints and bed monitors as ordered by the doctor Allow the patient to ambutate only with assistance On not leave patients unattended in diagnostic or treatment areas Accompany the patients unattended in diagnostic or treatment areas Accompany the patients unattended in diagnostic or treatment areas Accompany the patients unattended in diagnostic or treatment areas  Accompany the patient to use grab bars near the totelt, balthub, and shower  The relatinsk tag in the bed, wheel chair of one of the patient scare  Answer these patients call belies a equickly as possible Answer these patients call belies a equickly as possible Answer these patients call belies as function to such as the patient's care  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN		inas .	/	/					$\langle \cdot \rangle$		1 ~
Keep the two side ralls in the related position at all times for all patients regardless of age  Keep the call belt, bedside table, water, glasses within the patients 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 sixting 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 sligppery  Ensure that floor of the bathroom is dry and not sligppery  Ensure that floor of the bathroom is dry and not sligppery  Ensure that floor of the bathroom is dry and not sligppery  Ensure that floor of the bathroom is dry and not sligppery  It period to the state of the control of the contr				<u> </u>							
all patients regardless of age Keep the call belt, bedside table, water, glasses within the patients easy reach Remove excess equipment or furniture to make a clear path Keep the patients bed in the low position at all times except during procedure Teach fell-prevention techniques, such as sikting up for a moment before ising from the bed Bed wheels should be locked Encourage family participation in the patient's care Ensure that flood to be locked Encourage family participation in the patient's care Ensure that flood be locked Encourage family participation in the patient's care Ensure that flood be locked Encourage family participation in the patient's care Ensure that flood be locked Encourage family participation in the patient's care Ensure that flood be locked Encourage family participation in the patient's care Ensure that flood with a salistance  Les safety belts during movement in wheelchair The patients are not ambulated by themselves. They are to be arrobulated only with assistance  Mediturn sight interventions (25-42) Apply all the low risk interventions The patients are not ambulated only with assistance  Mediturn sight insk tag in the bed and Wheel chair / Stretcher Make sure that proper transfer precautions are instituted of rheavy or debilitated patients in a bed or wheel chair or on a tolietseat  Les restriatis 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 Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Consider peak effects of the medications that effects level Co						_		-	V		
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 sing 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 tisk 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 tolds reset User restraints and bed monitors as ordered by the doctor Allow the patient to ambulate only with assistance Consider peak effects of the madications that effects level of consciousness, gait and elimination when planning patient's care Do not leave patients unattended in diagnostic or freatment 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-Hisk flag in the bed, wheel chair or station Tie red fall risk tag in the bed, wheel chair or station The red fall risk tag in the bed, wheel chair or station The red fall risk tag in the bed, wheel chair or station and the madium risk interventions Tie red fall risk tag in the bed, wheel chair or station are the family and other visitors understand the restrictions mentioned above High-Hisk flag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' station The red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' station The red fall risk tag in the bed, wheel chair or the red fall risk tag in th				/						$\sim$	_
Flemove 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 flath-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  Preview mediciations 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  Mediturn lask interventions (254-4)  Apply all the low risk interventions  Tile yellow fall risk tag in the bed and 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  Or on a toilet seat  Use restraints and bed monitors as ordered by the doctor  Allow the patient to ambulate only with assistance  Do not leave patients unattended in diagnostic or treatment areas  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, bathrub, and shower  Make sure the family and other visitors understand the restrictions mentioned above  High-risk interventions (55 or shove)  Apply all the low and medium risk interventions  The restrictions mentioned above  High-risk interventions (65 or shove)  Apply all the low and medium risk interventions  The restrictions mentioned above  High-risk interventions (65 or shove)  Apply all the low and medium risk interventions  The restrictions mentioned have be added the restrictions mentioned above  High-risk interventions (65 or shove)  Apply all the low and medium risk interventions  The restrictions mentioned above  High-risk flag in the bed, wheel chair and stretcher  Locate the high-risk patients in a room close to the nurses' all per participations are all per participations and the restrictions mentioned	Keep the call bell, bedside table, water, glasses w	ithin the							/		
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 shing 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 (26-44) Apply all the low risk interventions as ordered by the doctor Make sure that proper transfer precaudions 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 ambulated only with assistance Consider peak effects of the medications that effects level of consciousness griat 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 will be going to bathroom Advice the patient to use grab bars near the toilet, bathtub, and shower  High-lisk interventions (45 or above) Apply all the low and medium risk interventions Tier red fall risk fatig in the bed, wheel chair and stretcher Locate the fight-risk patients in a room close to the nurses' station Answer these patients call belis as quickly as possible No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode at bedside (flappropriate) No Provide a commode a	patient's easy reach			/					<b>V</b>	,	
path Keep the patient's bed in the low position at all times except during procedure  Izeach flat-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 stippery  Review medications for potential side effects that can promote falls  Use sately belts during movement in wheelchair  The patients are not ambulated by themselves. They are to be ambulated only with assistance  Medium risk interventions (25-41)  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 an toilet seat.  Use restraints and bed monitors as ordered by the doctor Allow the patient to ambulate only with assistance  Oronsidor peak effects of the medications that effects level of consoidor peak effects of the medications that effects level of consoidousness, gait and elimination when planning patients care  Do not leave patients unattended in diagnostic or treatment areas  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 tho toilet, bathrub, and shower  Make sure the family and other visitors understand the restrictions mentioned above  High-risk integrity that is a room close to the nurses' station  Answer these patients call belts as quickly as possible  Provide a commode at bedside (if appropriate)  None will be patient to a patient to a patient search of the patient will be going to bathroom  Advice the high-risk patients in a room close to the nurses' station  Signature & Emp. No. of RN  Signature & Emp. No. of RN  Signature & Emp. No. of RN  Signature & Emp. No. of SR RN	Remove excess equipment or furniture to make	a clear									
during procedure  Teach fail-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  Meditum fisk interventions (25-40) Apply all the low risk interventions Tie yellow fail 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 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 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 (35 or above) Apply all the low and medium risk interventions Tie red fall lisk 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 belts as quickly as possible Provide a commode at bedistide (frappropriate)  Virial/bedparks about do within easy reach (frappropriate) Virial/bedparks and virial members or other visitors to stay with them Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN	path		,	· .	,				•/		
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 betts during movement in wheelchair The patients are not ambulated by themselves. They are to be ambulated only with assistance Medimnisk interventions (25-24) 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 or on so toilet seat 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, bathrub, 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 belts as quickly as possible Provide a commode at bediside (fiappropriate) New York A. New Y	, , ,	s except	Γ_	/						~/	
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 Medimnisk interventions (25-4) Apply all the forw risk interventions Tile yellow fall, risk tag in the bed and Wheel chair / Stretcher Make sure that proper transfer precautions are instituted Allow the patient to ambulate only with assistance Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patients 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, bathrub, 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 Tire 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 belts as quickly as possible Provide a commode at bedisting (if appropriate) New York A. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. R. N. N. N. R. N. N. R. N. N. R. N. N. N. R. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. R. N. N. N. N. R. N. N. N. R. N. N. N. N. N. N. N. N. N. N. N. N. N.			Ĺ <u> </u>								
moment before rising from the bed Bed wheels should be locked Encourage family participation in the patients care Ensure that floor of the bathroom is dry and not slippery Review medications for potential side effects that can promote falls Use safety betts during movement in wheelchair The patients are not ambulated by themselves. They are to be ambulated only with assistance Meditum right indeventions (25-41) 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 patients care On 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 tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' Tie red fall risk tag in the bed, wheel chair and s		up for a	_								
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 Medifurn risk interventions (25-4) 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 patients 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 Make sure the family and other visitors understand the restrictions mentioned above Make sure the family and other visitors to the nurses' station Answer these patients call belts as quickly as possible Name and the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' station Answer these patients call belts as quickly as possible Name where patients call belts as quickly as possible Name Answer these patients call belts as quickly as possible Name Answer these patients call belts as quickly as possible Signature & Emp. No. of Sr. RN Signature & Emp. No. of Sr. RN Signature & Emp. No. of Sr. RN									<u> </u>		
Ensure that floor of the bathroom is dry and not slippery Review medications for potential side effects that can promote falls  Use safety betts 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 bad 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 patients 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 belisk as quickly as possible Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)  Via Provide a commode at bedside (fappropriate)											
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 Meditum 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, bathrub, and shower Make sure the family and other visitors understand the restrictions mentioned above Make sure the family and other visitors understand the restrictions mentioned above Make sure the family and other visitors understand the restrictions mentioned above Make sure the family and other visitors or the nurses' of the patients of the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' of the patients with 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) Via A. A. A. A. A. A. A. A. A. A. A. A. A.										_~_	
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  The 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 belts as quickly as possible  Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients call belts as quickly as possible  No Answer these patients as the famil		<u> </u>			ļ						
Use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They are to be ambulated only with assistance  Mediturn fisk interventions (25-44)  Apply all the low risk interventions (25-44)  Apply all the low risk interventions (25-44)  Apply all the patient 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 patients 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 meditum risk interventions  The patients call bells as quickly as possible  Provide a commode at bedside (if appropriate)  Urinal/bedpan should be within easy reach (if appropriate)  Night appropriate, consider using protection devices: safety belts  Signature & Emp. No. of RN  Signature & Emp. No. of Sr. RN	•	hat can								~/	
The patients are not ambulated by themselves. They are to be ambulated only with assistance  Mediumrisk 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 thouse 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)  Linia/bedpan should be within easy reach (if appropriate)  Finedurage family members or other visitors to stay with them  If appropriate, consider using protection devices: safety belts  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN	<u> </u>									1	
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 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)  Virinal/bedpan should be within easy reach (if appropriate)  No Provide a commode at bedside (if appropriate)  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN		-								_	<u> </u>
Apply all the low risk interventions (25-44) Apply all the low risk interventions rie 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 User 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 to use grab bars near the toilet, bathtub, and shower Advice the patient to use grab bars near the toilet, bathtub, and shower High-risk interventions (45 or above) Apply all the low and medium risk interventions Te 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)  NA NA NA NA NA NA NA NA NA NA NA NA NA N	·	ey are to		/							
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 thouse 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 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)  Via poppy all the low and medium risk interventions Signature & Emp. No. of Sr. RN Signature & Emp. No. of Sr. RN Signature & Emp. No. of Sr. RN											
The 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  User 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' of the patient shall bells as quickly as possible  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)  Frod NA  NA  NA  NA  NA  NA  NA  NA  NA  NA	· · · · · · · · · · · · · · · · · · ·		_							<b>\</b>	
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' of a commode at bedside (if appropriate)  Nor Make and Make an				<u> </u>			-				
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 patients 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 abovc)  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				/						<u>~</u>	
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 abovc)  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	t to the second of the second		_	_							
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)  Provide a commode at bedside within easy reach (if appropriate)  Provide a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode at bedside within easy reach (if appropriate)  Find a commode easy bedside within easy reach (if appropriate)  Find a commode easy bedside within		Chail Oi								~	1
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		doctor	<del></del>						./	/ <b>\</b> /\	
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)  Fincourage family members or other visitors to stay with them  Signature & Emp. No. of RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN		100101		/				-	<del>-</del> ~		
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		cts level				_			-		
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-riskinterventions (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)  WAR MAR MAR MAR MAR MAR MAR MAR MAR MAR M	'		_		Ì '				./		
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 Sr. RN  Signature & Emp. No. of Sr. RN				/							
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)  Fincourage family members or other visitors to stay with them  If appropriate, consider using protection devices: safety belts  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN		ostic or									
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  Signature & Emp. No. of Sr. RN			· ·	/							
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  Apply all the family and other visitors understand the restrictions understand the restrictions understand the restrictions mentioned above  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher  Apply all the low and stretcher  Apply all the low and	Accompany the patient while going to bathroom			/							
Make sure the family and other visitors understand the restrictions mentioned above  High-risk interventions (45 or abovc)  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  Signature & Emp. No. of Sr. RN	Advice the patient to use grab bars near the toilet, I	oathtub,									1
restrictions mentioned above  High-risk interventions (45 or abovc)  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	and shower			V					)	<b>&gt;</b>	
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  Signature & Emp. No. of Sr. RN	Make sure the family and other visitors underst	and the								\ <b>\</b>	
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  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN	restrictions mentioned 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  Signature & Emp. No. of Sr. RN	High-risk interventions (45 or abovc)			1/					/		
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  Signature & Emp. No. of Sr. RN  ARR  NA  NA  NA  NA  NA  NA  NA  NA											
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  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN				Ĺ <u>´</u>					V		
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  Signature & Emp. No. of Sr. RN  AND  NA  NA  NA  NA  NA  NA  NA  NA		nurses'	ฟล		NA	20	1		./	<b>✓</b>	
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  Signature & Emp. No. of Sr. RN  Signature & Emp. No. of Sr. RN			-12	NA		•	-				
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  Signature & Emp. No. of Sr. RN		ole						MA	. /	- 4/	
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					<del>                                     </del>			ĺ	·/		11
them  If appropriate, consider using protection devices: safety belts  Signature & Emp. No. of RN  Signature & Emp. No. of Sr. RN		<u> </u>	NA	NA_	<del></del>	NH-	$\overline{}$		~/		
If appropriate, consider using protection devices: safety belts  Signature & Emp. No. of RN  Signature & Emp. No. of Sr. RN		tay with	NA	NA_	W	NA	Wn	NM	\ /	✓.	い
Signature & Emp. No. of RN Signature & Emp. No. of Sr. RN		u oofoti.	<del> </del>	<del> </del>	· ·	,,		/	7		
Signature & Emp. No. of RN Signature & Emp. No. of Sr. RN		s. sarety	NA	/	/	<b>V</b>		\ V'	\ \ \		1
Signature & Emp. No. of Sr. RN   \ \   \   \ \ \ \ \ \ \ \ \ \ \ \ \				W		4A	7.	h. 2	<del>\Q</del> \1	<u> </u>	<del>ያ</del>
Signature & Emp. No. of Sr. RN   \ \   \   \ \ \ \ \ \ \ \ \ \ \ \ \	Signature & Emp. No.	ot RN	W>26	. 4	drop	2 cape	1	\)703 \bar{bar}	1-3	Y 3%	I TO
	Signature & Emp. No. of	Sr. RN		المر ا	1	ŀ ∧	1/00		Vicini	Now	1 5 W
60 00 00 00 00 00 00 00 00 00 00 00 00 0			***	Ň	W	Î.	1>	2722	A. 4		2"."
			00V>	032	การ	001>	مركز و	$\nu^{\nu}$			
			`	v	•	•			•		



## Medway Hospitals The way to better health (A Unit of United Alliance Market

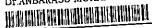
(A Unit of United Alliance Healthcare Pvt Ltd)



### Mrs.PREMA T

52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/046



## MODIFIED MORSE FALL RISK ASSESSMENT CHART

Date Time	14/24	14/12	15/2	15/2	15/2/	16/12000			
Time					_	71		<del>                                     </del>	
	111.00	22.0°	500	jy.∞	50.00	80			
No	9	7	0	0	9	8	0	0	0
Yes	25	25	25	25	25	25	25	25	25
No	0	0	0	0	, 0	0	0	0	0
Yes	15	15	15	15	<b>1</b> 5	_15	15	15	15
No	0	0	0_	Ò	0	0	0	0	0
Yes	20	20	20	20	20⁄	20	20	20	20
<u> </u>	\$\sqrt{ \chi}		9	9	9	0/	0	0	0
	15	15	15	15	15	15	15	15	15
	30	30	30	30	30	30	30	30	30
				1	,	·			
	2	٩	9	B	9/	<b>_0</b> _	0	0	0
	10	10	10	10	10	10	10	10	10
	20	20	20	20	20	20	20	20	20
<del>                                     </del>								-	
	سو	•	0	9	9/	اسفرا	0	0	0
	15	15	15	15	15	15	15	15	15
No	0	0	0	0	0 /	0	0	0	0
Yes	15	15	15	15	15	15	15	15	15
	50	50	50	Co	50	20			
1									_
1									
	V	· /		V					
<u> </u>	TA	att	Bel	Jah.	A. L.	905N			
<del></del>	<b></b>	- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1-	7 N-		1200				
	Yes No Yes No Yes No Yes	No	No	No	No	No	No	No	No

		1, 1	,	<b>,</b>		\ 0	1	_	`	
INTERVENTIONS	Date	11/12/2	3,4/2	16/14	15/17	15/12	16/24			
Tick as per the Risk Score	Time	111.06	22.00	800	171.08	10.00	80	<del></del>		
1 - Fill (44 1) - (0 - 0.0)		P-1.0.	1,4.	80	THU	~		<u> </u>		
Low Risk Interventions (0 - 24)					l	, •			]	
Familiarize the patient with the immediate surround										<u> </u>
Remind the patient to use call bell before getting ou										
Keep the two side rails in the raised position at all t	imes for		ا ہر. ا		]					
all patients regardless of age					<u> </u>					
Keep the call bell, bedside table, water, glasses w	ithin the					~				
patient's easy reach								<u> </u>		ļ
Remove excess equipment or furniture to make	a clear				]	_ <b>_</b>	1	l	1	
path				-						<b>!</b>
Keep the patient's bed in the low position at all times	except .		<b>〜</b>						İ	
during procedure		_			-			ļ	ļ	-
Teach fall-prevention techniques, such as sitting	up for a		<u>-</u>			$\sim$	,			
moment before rising from the bed						<u> </u>	5	<b> </b>	}	<b>.</b>
Bed wheels should be locked	_	-					<u> </u>	<del></del>	-	<del> </del>
Encourage family participation in the patient's care		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-		-4			!		
Ensure that floor of the bathroom is dry and not slip					- 4		~			
Review medications for potential side effects t	hat can				]	$\checkmark$				
promotefalls			, _		$\vdash$ $\checkmark$			<b> </b>	<u> </u>	
Use safety belts during movement in wheelchair								<b> </b>		ļ
The patients are not ambulated by themselves. The	ey are to		ا ہر. ا		}					
be ambulated only with assistance		, ~								
Medium risk interventions (25 - 44)	_					$\overline{\mathcal{A}}$				
Apply all the low risk interventions		<u> </u>								
Tie yellow fall risk tag in the bed and Wheel chair / Si		\ <u>\</u>	~							
Make sure that proper transfer precautions are in			- !		<b>.</b>			[	Į.	ļ
for heavy or debilitated patients in a bed or wheel	chair or				~					
on a toilet seat						_		ļ		
Use restraints and bed monitors as ordered by the	doctor	<u> </u>	~					ļ }		
Allow the patient to ambulate only with assistance		/	<u>, , , , , , , , , , , , , , , , , , , </u>			_<_	6	ļ		
Consider peak effects of the medications that effe		/	-			_				}
of consciousness, gait and elimination when p	lanning					$\nearrow$				
patient's care						_	/			
Do not leave patients unattended in diagno	stic or		ار							
treatment areas		ļ <u> </u>		<u> </u>		<del>,</del>			ļ	
Accompany the patient while going to bathroom			<u></u>				$\sim$			
Advice the patient to use grab bars near the toilet, i	oathtub,	/	ار. ا			//				
and shower					$\square$			_		
Make sure the family and other visitors underst	and the	,	ار. ا		١. ١	_/	<b>\</b>	}	}	ŀ
restrictions mentioned above				/			_	}	!	
High-risk interventions (45 or above)		1./	- ,					<del> </del>	<u> </u>	
Apply all the low and medium risk interventions		<u> </u>		<b>_</b>			<del>                                     </del>	<u></u>	<u> </u>	
Tie red fall risk tag in the bed, wheel chair and stretc	_	$\vdash \checkmark$			$\vdash \checkmark$		<u></u>		<u> </u>	ļ
Locate the high-risk patients in a room close to the	nurses'	_/	ا ہے، ا	/	ل	· <b> </b>	_ `		]	
station	-1-	\ <u> </u>	ļ	/		<del></del>		<del> </del>	-	
Answer these patients call bells as quickly as possil	ole	<b>-</b>		//	$\perp 4$	<u> </u>		ļ		
Provide a commode at bedside (if appropriate)		<del>                                     </del>	\ <u>\</u>			<del>.</del> /	-		-	<del></del>
Urinal/bedpan should be within easy reach (if appro		<b>⊢~</b>			-	<u> </u>		ļ		<u> </u>
Encourage family members or other visitors to s	tay with			. /		· ~	<u> </u>			
them	n pofet :	<del>                                     </del>					-	ļ	-	
If appropriate, consider using protection devices	: sarety	′			//	/	!			
belts		<del>\</del>	de	a.		(\$0 -d	<del> </del>	<del>                                     </del>	1	-
Signature & Emp. No.	of RN	(X)	X550	CONT.	MAK	9/2	1000m			
Signature & Emp. No. of	Sr. RN	nindo	Nate	11000	Nagy	NinDe	A Palla			
		IN A SEW		LINA ACTOR	~ 600	بهلات	<u>'''∨                                  </u>	<u> </u>	1	

Œ

•

١.



**Rehabilitation Techniques** 

Ã.,





### Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.Anbarasu mohanraj



PATIENT										OR	D		
	illed by con		ed d	isci	plines. U	lse k	ey b	_				;	
Barriers to	Learning							_	Plan t	o A	ddr	es	s Factors
None	☐ Vision	1 / He	arin	g lin	nitations	;			] Use	of Ir	iterp	rete	er
Limited Reading Abilities	Physi	cal b	arrie	rs					] Edu	cate	fam	ily	
Religious / Cultural Factors	Langu	iage	barr	iers					Sim	ple L	ang	uag	е
Congnitive Limitations - unable to	Lown	notiv	ation	1 / d	esire to	learı	n		Writ	ten l	nstu	ıctic	ons
understand and follow directions	-								<b>→</b>	-			
Completed By : Date (10/2) Tim	1e (2+ °	, O		lurs	e Signa	ture	::_		205	-			
<u> </u>									<u> </u>				
Learning Record						_		_		_			
Need	Date	L	Visit	1	Date		Visit	2	Date	\	/isit	3	Signature
	12.30	L	Р	0	10/16	L	Р	0		L	Р	0	
Disease					•								Doctor
Information on		Γ		Γ			П						11:10
Disease / Diagnostics	l l	0	Юħ	6		p	00	J			<b> </b>		18/100
Treatment		Τ	1										
Medications		Γ											Doctor / Nurse
Information on Safe and		Π		Γ									(h)
Effective use of medicines		h	or			p	on	J					Sign X
☐ Information on drug / drug and		-											
drug / food interactions		ח	on		ŀ								
☐ Discharge Medications		π											
Surgical Instructions													Nurse
Pre - Operative Instructions		. (1)	6D			þ	on	J					andread
Post - Operative Instructions		A	Γ										-900°
(Wound / Dressing Care)													
Pain Management													Nurse
Reporting of pain													
Pain Management													
Safe and effective use of medica													Doctor / Nurse
Equipment (if required)													
Name of Equipment		1					_					_	

Need	Date	\ 	/isit	1	Date	\	/isit	2	Date	\ \	/isit	3	Signature
		L	Р	0		L	P	0	16/12	L	Р	0	
Nutritional Suidance									, 10				Dietician
Diet Instruction for patients at Nutritional risk		r	ÐΛ	၁	-	ļ		<b>-</b>		P	<b>⊃</b> ¢∕	þ	Menorine John Serior delitia
Diet advice for home				-		4		1					Nurse
Discharge Planning													
☐ Self care													
Follow up												L	
Reporting Concerns Immunizations													
Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation						,			1.7	•			Doctor
Weight Control													
☐ Exercise													
☐ Hypertension												L	
☐ Other Risks													
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	ration, '												
	<del>-</del>		_			٦ 							
Reports Given :													
Given Pendin	g N	NA							Give	n	Per	ndiı	ng NA
Discharge Summary		_	ı	Diet	Advice				<u> </u>				
ECG Report			_ (	CT S	Scan Re	port	ŧ				_		i
Doppler Report	_				Scan Fil	٠ ١		'					
X-Ray Report					IO Repo			•					
X-Ray Film					asound		ort	•					
Compact Disk		,				_		\		_			
				,		Т		7					
Name of Attendant / Patient :							Sig	nati	ure :				
Name of Discharge Nurse							Sign	nati	ure\				







# Mrs.PREMA T 52/Female/MHI202381034 09/12/2023/IPH202302466 Dr.ANBARASU MOHANRAJ



, ovnovnem. ; Every neart beat coun

PATIENT Assessment						DUC.					OR	D		
Assessment To be Barriers to			3 <b>0</b> 1111	eu ui	SUI	Jilles. 0	36 n	ey io	_		<u>о</u> А	ddr	es:	s Factors
None	П	Vision	/ He	aring	— a lin	nitations	<u>—</u>	-	┢	Use	of Ir	 nterp	rete	<del></del> Эг
Limited Reading Abilities	情	Physic								Edu				
Religious / Cultural Factors	厅	Langua							匸	Sim	ple L	ang	uag	e
Congnitive Limitations - unable to	厅					esire to	 learr	,	一	Write				<del></del>
understand and follow directions	广								一					
Completed By : Date th 12/2023 Time	ne	19.	20	<u>&gt;_</u> ,N	lurs	e Signa	ture	·:_		Mes	σνc	२ ०%	285	<u>G</u>
Learning Record  Need Date Visit 1 Date Visit 2 Date Visit 3														
Need	.	Date	١	∕isit	1	Date	١	/isit	2	Date	ļ١	/isit	3	Signature
	Ì	11/2/2	L	Р	0	12/12/5	L	Р	0	13/21	L	Р	0	
Disease														Doctor
☐ Information on														
Disease / Diagnostics			-	<del> </del>						<b> </b>	ြ	O.D	$ \sqrt{ }$	
☐ Treatment			_		H		B	0.0	1		1		Ť	
Medications	$\Box$						-		F	-	0	DD.	$\overline{}$	Doctor / Nurse
☐ Information on Safe and					П		Q	aO			3			MODIFICAL!
Effective use of medicines			-						ľ			an	$  \sim$	
☐ Information on drug / drug and					П						1	1		
drug / food interactions			-		-				┝╌	<b> </b> -				
☐ Discharge Medications			_		F		_			-				Gen.
Surgical Instructions														Nurse
Pre - Operative Instructions			-								1			
Post - Operative Instructions									./					
(Wound / Dressing Care)	ľ		5	OD		·	الح	Оъ	ľ		لما	3	V	
Pain Management							رك	Ð	57		a		$\Box$	Nurse
Reporting of pain	$\Box$		1	OD	V	_	D	00	$\overline{A}$			ටා	$\checkmark$	
Pain Management	$\Box$		\ ر	υP		,	ی	96				)a)		
Safe and effective use of medica	al le		7		П						4		П	Doctor / Nurse
Equipment (if required)		_ <b>_</b>	چ.	OD	7		اڪ	0 <i>P</i>	٧		D	ට	$\bigvee$	
Name of Equipment														
Rehabilitation Techniques		. 4	<b></b> -		П							ļ		

Diet Instruction for patients at Nutritional risk   Son	Need			Date	١	Visit	: 1	Date	$\lceil \cdot \rceil$	/isit	2	Date	\ \	/isit	3	Signatur
Diet Instruction for patients at Nutritional risk   Son S   Son S   Po S   Son S   Son S   Po S   Son S   Son S   Son S   Po S   Son S					L	Р	0		L	Р	0		L	Р	0	
Nutritional risk  Diet advice for home Discharge Planning Self care Follow up Reporting Concorns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other 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 Discharge Summary Discharge Summary CT Scan Report CT Scan Report CT Scan Film Schop Report CT Scan Film Ultrasound Report Compact Disk  Name of Attendant / Patient: Signature:	Nutritional Guidance															Dietician
Diet advice for home	Diet Instruction for Nutritional risk	patients at	t	-	S	ON.	S		s	20	J		P	PN.	5	Senior Dietitaro
Self care   Follow up   Reporting Concerns	Diet advice for hom	e			-	-	-	-	_	-	F		-	$\overline{}$	F	
Follow up   Reporting Concerns   Immunizations   Parenting education   Others   Risk Factor Reduction   Doctor   Risk Factor Reduction   Doctor	Discharge Planning															
Reporting Concerns Immunizations  Parenting education Others Sinsk Factor Reduction Smoking Cossation  Doctor  Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other 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 Discharge Summary Diet Advice ECG Report CT Scan Report CT Scan Film X-Ray Report X-Ray Report LECHO Report Ultrasound Report Any Other Report Signature:  Name of Attendant / Patient:  Signature:	Self care															
Immunizations	Follow up				L.											
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 Relation 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  CT Scan Film  X-Ray Report ECHO Report  X-Ray Film Ultrasound Report  Compact Disk Any Other Report  Name of Attendant / Patient : Signature :		s														
Risk Factor Reduction  Smoking Cessation  Weight Control  Exercise  Hypertension  Other Risks  LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other  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  Discharge Summary  Diet Advice  CT Scan Report	Parenting education	n					П								Г	
Smoking Cessation  Weight Control  Exercise  Hypertension  Other Risks  LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other  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  CT Scan Film  X-Ray Report ECHO Report  X-Ray Film Ultrasound Report  Compact Disk Any Other Report  Name of Attendant / Patient:	Others	-	Ì				П			Г						
Weight Control   Exercise   Hypertension   Other Risks   Care Relation   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	Risk Factor Reduction															
Exercise   Hypertension   Other Risks   Discharge Summary   Discharge Summary   CT Scan Report   CT Scan Report   CT Scan Film   CT Scan Fi	Smoking Cessation	l		_												Doctor
Hypertension   Other Risks   Determined   Other Risks   Determined   Other Risks   Determined   Other Risks   Determined   Other Risks   Determined   Other Risks   Determined   Other Risks   Determined   Other Risks   Determined   Other Risks   Other   Other Risks	Weight Control															
Other Risks   LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	Exercise			_												
LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	Hypertension			1												
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 CT Scan Film X-Ray Report ECHO Report X-Ray Film Ultrasound Report Compact Disk Any Other Report Name of Attendant / Patient:	Other Risks															
Given Pending NA  Discharge Summary Diet Advice  ECG Report CT Scan Report  Doppler Report ECHO Report  X-Ray Film Ultrasound Report  Compact Disk Any Other Report  Signature:	·	*														
Given Pending NA  Discharge Summary  Diet Advice  ECG Report  CT Scan Report  CT Scan Film  X-Ray Report  X-Ray Film  Compact Disk  Name of Attendant / Patient:  Signature:			:													
Given Pending NA  Discharge Summary  Diet Advice  ECG Report  CT Scan Report  CT Scan Film  X-Ray Report  X-Ray Film  Compact Disk  Name of Attendant / Patient:  Signature:			€				_									
Given Pending NA  Discharge Summary Diet Advice  ECG Report CT Scan Report  Doppler Report ECHO Report  X-Ray Film Ultrasound Report  Compact Disk Any Other Report  Signature:																
Given Pending NA  Discharge Summary Diet Advice  ECG Report CT Scan Report  Doppler Report ECHO Report  X-Ray Film Ultrasound Report  Compact Disk Any Other Report  Signature:																
Discharge Summary	Reports Given :															
Discharge Summary		Given	Pending	, ,	NA							Give	n	Pe	ndii	ng NA
ECG Report CT Scan Report CT Scan Film ECHO Report ECHO Report Ultrasound Report Any Other Report Signature : Signature :	Discharge Summary_					ı		-	ı							
Doppler Report CT Scan Film  X-Ray Report ECHO Report  X-Ray Film Ultrasound Report  Compact Disk Any Other Report  Name of Attendant / Patient: Signature:						_ (	CT S	Scan Re	port	t			_			
X-Ray Report  X-Ray Film  Compact Disk  Any Other Report  Name of Attendant / Patient:  Signature:									_							
X-Ray Film  Compact Disk  Any Other Report  Name of Attendant / Patient :Signature :	• •		-		$\overline{}$	_ \	ECH	IO <sup>.</sup> Repo	ort			_				
Compact Disk Any Other Report	-		· <del></del>			_				ort						
Name of Attendant / Patient :Signature :	•	:					_									
	Compact Disk		·			_ ′	niy	Other I		<i>)</i> [ [			_			
									\			-				<u>-</u>
Name of Discharge Muses	Name of Attendant /	Patient :	<u> </u>						_	Sig	nat	ure :				
Name of Luccuarde Nurse Aignature :	Name of Discharge	Nurse								Sia	nafi	ure :				







52/Female/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





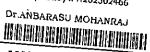
#### PATIENT AND FAMILY EDUCATION RECORD

						plines. U				<i>N</i>			٠,	
Barriers to	Le	arning								Plan t	o A	ddr	es	s Factors
None		Vision	/ He	aring	g lin	nitations	;			Use	of Ir	iterp	rete	er
Limited Reading Abilities		Physic	al b	arrie	rs					] Edu	cate	fami	ily	
Religious / Cultural Factors		Langu	age	barri	ers				Ш	] Sim	ple L	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ d	esire to	learr	1	Ш	] Writ	ten l	nstu	ctio	ns
understand and follow directions										0				
Completed By : Date full Tin	ne	8,00	D	N	lurs	e Signa	ture	:		- V	<b>2</b> 01	_		
		_												-
Learning Record							_	_		<u> </u>	_			
Need		Date	۱	/isit	1	Date	3١	/isit	2	Date	<u>}</u> \	/isit	3	Signature
		14/12/	Ĺ	Р	0	15/18/	L	Р	0	19/13/,	L	P	0	
Disease									L					Doctor
☐ Information on														
Disease / Diagnostics								_						
Treatment			Q	8	>	_	ם	OB)	G		Ø	OP	S	
Medications		_	P	00	V		P	007	U		Q	æ	ی	Doctor / Nurse
☐ Information on Safe and														J
Effective use of medicines ·											L			Oh.
Information on drug / drug and														
drug / food interactions			$\square$	වා	$ oldsymbol{igsigma} $		<b>b</b> (	20)	U		Q.	8	ပ	
☐ Discharge Medications			<b>V</b>											
Surgical Instructions														Nurse
Pre - Operative Instructions														
Post - Operative Instructions														
(Wound / Dressing Care)	_													
Pain Management														Nurse
Reporting of pain				a	V		Ø	μD	V		ብነ	හ	V	
Pain Management			Ę	9	1		D	රිව	$ _{\prime\prime}$		9	ව	ঠ	-13/7
Safe and effective use of medica	1		1								,			Doctor / Nurse
Equipment (if required)														
Name of Equipment														
Rehabilitation Techniques						1								

Need	Date	\	/isit	1	Date	١.	/isit	2	Date	\	/isit	3	Signature
		L	Р	0		L	Р	0		L	P	0	
Nutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk		7	g	?	-	(	161	0		ŋ	á	7	Mario Catinerina DA
Diet advice for home						4				Į	8	$ \mathcal{C} $	Nûrse letitian
Discharge Planning													
☐ Self care													
Follow up	1							Ш					
Reporting Concerns Immunizations													**.
Parenting education													
Others													
Risk Factor Reduction													
Smoking Cessation						•							Doctor
☐ Weight Control													
☐ Exercise													
Hypertension					1								
Other Risks	-				,								
LEARNER (L) - P-Patient, M - Mother,	F-Fathe	er, S	-Spo	ous	e Othe	r					(	Stat	e Relationship
PROCESS (P)- OD - Oral Discussion,	D- Dem	ons	trati	ΩD	W- Wri	itter	n Ma	ter	ial				
	1												
OUTCOME (O) - RD - Return Demons	tration,	V - 1	/erp	aliz	ea und	aers	tano	ain	3				
Written Material given and explained	(if any)												
	-			_									
													ļ
<b>3</b>					7								
* *													
	-				_		_						
Réports Given :													
Given Pendir	ng N	NA							Giver	1	Per	ndir	ng NA
Discharge Summary				Diet	Advice				V				
ECG Report			_ (	CT S	Scan Re	por	t		•				
Doppler Report	,		_		Scan Fil	_							
X-Ray Report					O Repo				\ /	_			
7					asound		art						
X-Ray Film						_				/	abla		
Compact Disk	$-^{\nu}$		<b>- '</b>	чпу	Other F	(epc	σπ			_	$\dashv$	<u> </u>	<del>,                                    </del>
	e\											M	
Name of Attendant / Patient :			_		-		Sig	nat	ure :		4		
Name of Discharge Nurse	land	<b>.</b>	'n	•			Sigi	nati	ure ·	Y			
A	yord'	nı	1))				~.9			江			
									-	T.			



52/Female/MHI202381034 09/12/2023/IPH202302466





## **IN-HOUSE TRANSFER FORM**

Pari	t A (to be filled by Nu	rses)					
Date	e of Transfer: 13 12 2	3 Time: _/\	150 Tr	ansferred	from: <u></u>	POICU To:	207
Diag	gnosis:	-TUP					
Vita	Il Signs: Temp: <u>98.6</u> (°F	-)   Pulse / HR:	24	(beats/n	nin)   BP: <u>/ 2</u> 2	ন <u>গ্রোণ</u> (mmHg)   Resp	iration: 22 (breaths/min)
Pari	t B (to be filled by Ph	ysicians)	Any Critic	al Investig	gations:		
_	Check for			Trai	nsferring Docto	or	Receiving Doctor
	piratory (Breath sounds)	Clear	Crepitat	tion F	Rhonchi O	thers:	Yes No
	omen 	Soft	Tender		Distended O	thers:	Yes No
Hear	rt Sound ————————————————————————————————————	Normal [	Feeble			<u> </u>	Yes No
CNS		Consciou	us U Or	riented	GCS Sco	re:	_ Yes No
	Surgical Patients oplicable)	Surgical Site:	Heal	thy S	oakage 0	thers:	Yes No
		Prese	nt Medic	ation (for	Medication R	econciliation)	
S. No.	Current Medic	cation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	SIR SUEBLEBTE	is Sucpenion	DWL	Plo	[- -	13 12 23 27 7.30	□¥es □ No
2	N2B.LEVOLIN		0.63mc		1-1-1-1	13/12/23/20 9.50	√ Yes □ No
3.	T. FRUSSMID	<u>, 2</u>	HO mce	Plo	1-1-0	12/12/23 2 8.30	☐Yes ☐ No
1 <u>4.</u>	T. SPIRANOLA	+CTDNS	25.00	Plo	1-1-0	12/232 10.00	☑ Yes ☐ No
5.	T. BEPLEX FO	RTE	1-TAB	Ph	1-0-0	13 12 23 07 8.50	
<u>b.</u>	T. CLOPIDOLERELY	-ASPIRIN	75 75mg	Plo	0-1-0	12/12/23 at 14.00	√Yes ☐ No
7	T. ATORVASTA	TIN	to ma	Plo	0-0-1	12/12/23 21.00	☐Yes ☐ No
δ.	Syr. CREMPFF	IN PLUS	15mi	plo	0-0-1	थि। १३ वर्ष था.00	☑Yes ☐ No
9.	T. DOLO		PZDWa		1-1-1	13 12 23 2 8 30	☐ Yes ☐ No
10.	T. MSTAPROL	OL	25 m	Plo	1-0-1.	13 12 23 2 9.00	☑Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Additional De	tails (	if any):						
Patient Condit	tion:	Stable [	Sick-nee	d urgent care   Othe	ers:	_		
	Sign		Name		Reg. No.	Date		Time
Transferring Doctor		8	DR.	Praveen	0265	13	12/23	11.54
Receiving Doctor		2		Dro. Ayang	168268	131	12/23	1221
Part C (to be f	illed l	by Nurses)						
Check for				Transferring Nurse	<del></del>			ng Nursi
Drains		Chest A	bdominal	Others: NtC			Yes	No No
Respiratory		Air Way Type: 1 Oxygen Therapy		Tracheostomy Others Yes via:	6:li/m	 in	Yes	i 🗌 No
NG Tube / Oral		Yes No	For Fe	eding Gastric Suction	Fluid Restriction		Yes	□ No
Foley's Catheter		Yes Yo					Yes	No No
Intravenous Acc	ess	Peripheral Li	ne 🗌 Cen	tral Venous Line Others	<u> </u>		Yes	i ☐ No
Pressure Injury		Yes Wo	If Yes, give	e details:			Yes	i ∐ No
Score		Fall Risk:	WELLS:	NEWS / PEWS:			Yes	No No
Patient Belongin	igs	Yes No	If Yes, give	e details:			Yes	No No
Handover Detail	s			Record explained: Yes   nanded over: Yes   No			Yes	i ∐ No
Patient Attendar	nt	Yes No	If No, give	details:			Yes	□ No
Additional De	tails (	if any):		<del></del> -			_	
			. •					l
								J
	Sign	<u> </u>	Name		Emp. No.	Date		Time
Transferring Nurse				ya Nanj.M		13/1	2 23	11.55
Receiving Nurse		A		ya Vanj.M malem:	0265	13(1	2/23	12 '- 00



52/Female/MHJ202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





## Inter Disciplinary Team Rounds (IDTR) Checklist

	<u> </u>		<u> </u>				
Date: 9/12/23	Time: \	2.30	)				
Checklist	Yes	No	NA	Ac	tion / Remarks		
MEDICAL	· 			·			
Daily Consultant Visit					_		
Plan of care discussed							
Discharge Planning	X						
Others if any	X						
NURSING		_		<del></del>			
Safety Precautions Ensured		7					
Care of Lines and Tubes							
Infection Control Measures		7					
Skin Care		7			<u> </u>		
Response to assistance							
Others if any	K						
DIETICIAN							
Diet Adequate	V	,			<u> </u>		
Special Request	<u>/</u>						
PHYSIOTHERAPIST	Ļ						
Available for Assistance for Activities of Daily Living		7 					
Others if any							
PATIENT CARE SERVICES							_
Room Cleaning satisfactory							
Room Amenities Adequate						<u> </u>	
Billing Update available							
Non-Availability of any service							1
Spiritual Needs (if yes specify)							-
Others if any							
- <del>-</del>		ln	ter Dis	sciplinary Team Members	-	-	
	Signatur	e A		Name	Reg. / Emp. No.	Date	Time
Doctor	N. J	1.20	<u> </u>	Dr. Hari Nigness	181100	9/12/23	12.30
Nursing Staff	<u> (</u>	¥		B. Van R	0/95	9/12/23	12.30
Dietician			4	, Warla Camerine John	2/01	alubu	13200
Physiotherapist	(4.8.	Theg		AKASH G.E	0256	11/2/23	15:30
Patient Care Service Staff						1	





Every heart beat counts

| Mrs.PREMA T | 52/Female/MHI202381034 | 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

## 

## HOME MEDICATION USAGE FORM

Allergies:	Nil	-					
Diagnosis:	AD.						
Prescribed drug	name		name brought t/ Attender	Dose	Freq.	Qty.	Batch No. & Expiry date
Angispan		Angip	lat	2-5mg	BD	( 60 nt	A 252330
Glados	Ma	Glade	R Ma	500/2mg	& BD	9	U301747
Angispan Glador Prolomet	XL	Paolom	lat or Ma et XL	12-5	BD	2	GTE 1094A
	7 7 7						
	<del></del>						
	Si <sub>2</sub>	gnature	Name	<u> </u>	Emp.	No.	Date & Time
Doctor		A.	かんって	yers	1632	08	09/12/230
Clinical Pharmacist		AD.	Dn-7 J. Anie	sha	MHZ	0151	9/12/830

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.

\ <u></u>	Signature/ Thumb impression	Name	Date	Time
Patient	T. Preares	T. Paema	9 (2) 23	11:15
Guardian		(Name and Relationship with the Patient)		

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff	Jafo249.	U-Bdiga	9/12/23	17-14

MHI/HOSP/2022/110



(A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.PREMA T

52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ





Every heart beat counts

### **WOUND ASSESSMENT CHART**

	T -			<del> </del>	<del></del>			<del></del> i
DATE	K/2/2)	16/12						]
SITE OF WOUND		,						
CHEST		1						
LEG L/R	LEE	Left						
ABDOMEN								
SACRAL REGION								
'{EEL								
OTHERS								
SIZE OF THE WOUND					_			
SUPERFICIAL / DEEP IN NATURE	ļ				_			
PRESSURE Specify system used :								
RISK FACTORS Specify system used :	DW	HTN	Age	Obesity				
WOUND TISSUE TYPE(S) PRESENT								
necrotic								
slough								
<del></del>								
undermining								
		_						
undermining					_	_		
undermining granulation								
undermining granulation overgranulation	0 0 1							
undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S)								
undermining granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated								
undermining granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema								a o o o o
undermining granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous								
undermining granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis							0 0 0 0 0 0 0	
undermining granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis blistered								
undermining granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis							0 0 0 0 0 0 0	

## WOUND ASSESSMENT CHART

EXUDATE AMOUNT	-		_					
none	무		· -					
evidence of some moisture		, _						
evidence of significant flow								
EXUDATE			1			-		
serous								
sero - sanguinous			_ `	, <u>.</u>				
Purulent			<u> </u>					
ODOUR		-	ı	T .				
none	,						<u>,</u>	
some evidence of odour			_					
significantly malodorous								
PAIN AT WOUND SITE								
(nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)	1-2	17/	•					İ
INFECTION SUSPECTED*		, .				ŗ		
SWAB SENT	,							
ANTIBIOTIC THERAPHY								
		Ш	Ц		<u> </u>			
BLOOD GLUCOSE / URINE ANALYSIS					□ ·			
<u> </u>			,		<del></del>	-		
PATIENT / CARER TO DO DRESSING		<b>¬</b>		,				
		Oxa	•					
SIGNATURE	17	70°	•					
*SIGNS & SYMPTOMS OF WOUND INFECT  • Pytexia • excess exce	W	ر فع کی آجانی		ID INFECTION		booling to al		
<ul> <li>licalised pain</li> <li>erythema</li> <li>offensive</li> </ul>	odour	● frag	4	ue bleeds ea		healing is sl		inicipated









## **FAMILY COUNSELLING FORM**

CONSU	LTANT- DR.	ANBARAS	DIAGNOSIS- ATD-DVD.			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
l			patient present condition Explained for the family members, is treatment process, need of Icu stay. and visiting how.	C	Mic	F 112236
12/2	eld Justery	MR. JOEC JOHN JOEC	> Explained about patient Condition  - a would shifting then Viritor  ) policy explained.		The state of the s	112236







Every heart beat counts

## **VIP SCALE (VISUAL INFUSION PHLEBITIS)**

Mrs.PREMA T

PATIENT NAME:

52/Female/MHI202381034

09/12/2023/IPH202302466

AGE / SEX:

DT.ANBARASU MOHANRAJ

IP No. / UHID No

Ward / Bed No. S (W:03.

#### ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

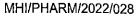
					,		_
DATE	TIME	SITE (R)-ETL	SCORE	DESCRIPTION	ACTION Flushed	FOLLOW UP	S/N EMP No.
	12:30	Right Net geoupe	19 <u>5</u>	Patent	fourhed	. Done.	8-MOON 0276
1/12/23	19.30	RIGHT METACARD	EL 0/5	PAMEINM	LALUSE FUSUED	No licinis of philipatus	How !
			Į			, 	
12/12/13	স্থ:১০০	Pilleti Mestarappal	্র চ	A UNBLE PATEN	MUH NZ	NO SIYNX OT PHUBBITIC	73022
	13100	RIUHT METACARIEU	0 5	PATENT HEAUTH	FWSHER		Strong
	20.00	MGTACARIN	10/5	IV LILL PATEN	FLUSHED	NO SIGNEOF	Lyon,
	8.00	P WETACARPA	20	PATENTS HEALINW	A TUTHED	DAI DISCERNATION	Ja.
12/12/13	14.00	R-1	zla	Patent	flush	Observation	n Pr
	20.00	watarospa	0 5	patent	dusted	naitoureeda	A: A:
1	ষ্টক	meraly	06	pateent	fluste	Obsauation	86m
A/12/23	))) <u>,</u> 00	ixela Corb	210	patent	Sush	Observation	-18/14
<u> </u>	22.00	METUCUEDI ME	0/5	Patent	flushed	observation	19601
. میلا	3-00	Reference	015	patie-	fleal	Observation	, 8ef
(m) (1)	1400	Ptola Carpo	0/5	Pritiont	flish	Observation	43/2
	6.00	#		IV Lin	e Po	noval Q 6.0	
	,-						
-		. –					
,		<u> </u>					
							. <u> </u>





52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj





## **MEDICATION ADMINISTRATION RECORD**

Drug	Chart:	of	ì		Heigi	nt (cms):	141-5cm	Weigh	t (kg): <u>6</u>	6.2kg	
		KNOWN MEDICINE AL	LERGIE	S (if NO	ONE is co	onfirmed,	write NKDA ir	1 box 1)			
Drug De	etails	_NEDA.	Descri	otion of A	Allergy			V. Name	or's Sign: Sign: Si	gnuh	
D	осто	RINSTRUCTIONS					AFF INSTRUC	CTIONS			
2. Write ii 3. Sign a 4. No pre	n BLOCK nd enter escription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	3. For ne follow 4. Standa Q8hrly 11:00h	. Nurse in-charge should verify drug chart on daily basis . For new prescription, follow the timings of doctor's prescription on Day 1 only, and the follow standard timings . 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, 22:00ce Only / Premedication Drugs							
		Stat / C	once O	nly / P	remed	_		<u>-</u>			
Date	Time	Drug		Dose	Route	Sign.	Reg. No.	Sign.	Administere Emp. No.	d Time	
2.23	9301	n T. ALDRAX		0.28	nu Plo	K'g	_ 134659	<b>A</b>		21.30	
2.23	7-00			Homi	ایا	vb_	1347779	<b>A</b>	0088	शॐ०	
<u>. 93</u>	4 FM	THIS MORPHANIS	<u> </u>	5m4	IM	K/802	13417567	AZ	<u>୧</u> ୦୦୫୫	700	
2.23	TAM	ING. PHENERAL	h	2.15m	n IM	K.go	_ 134569	A	0088	子硷	
\ 											
		·					<u> </u>				
:											
				I .							

Clinical Pharmacist Medway Heart Institute

REGULAR PRESCRIPTIONS To be filled in by Doctors only Time 4 **DRUG NAME** T. ANDIPLAT Dose Route Frequency 8-00 2. Sy P10 1-0-1 Dr. Sign & Reg. No. / Seal Start Date & Time 9/12/23,1PM Stop Date & Time 6.00 Additional Info: DRUG NAME T. PROLOMET XL Route Dose Frequency 8.00 1-0-1 12.54 Dr. Sign & Reg. No. /, Seal Start Date & Time 9/12/23, 1PM Stop Date & Time 2000. Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** 'Route Dose Frequency Start Date & Time Dr. Sign & Reg. No. / Seal 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:

Date →

To be filled by Nursing Staff only. Sign and time given

Date	Time	Diet	Signature	Reg. No.	Date	Time				Signature	Reg. No
1/12/23	IPM	Low Salt law fort	NIA	181100				·	-		
0/12/2	Aam	DIPO	KND	134,559	-			· ·	<u> </u>		
228	sam	NPO	Mo	134559							
, ,				<u>'</u>					· ·		
	<u> </u>				_		<u> </u>		_ ·	-	
		•					•	•			

.

\_ - - -

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse		Emp. No.	Initials
	Morning	<del></del>				Morning				
9 00	Evening	1. Northeire	. 0140	A	·	Evening				
Alple	Night	U. Dwila	Olh	&c		Night		-		
10/12/12	Morning	Douarthais hine	0212	5		Morning	· · · · · · · · · · · · · · · · · · ·			
10/2/2	Evening	A. Mandrini	0/70	A	٠	Evening	<u></u>			
10/2/2	Night	A · ALRINCIS	0088	Ø		Night				
	Morning					Morning				
	Evening		_			Evening				
	Night					Night				·
	Morning	· ·				Morning			-	
	Evening					Evening				Ţ
	Night			,		Night				





52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ







Every heart beat counts

## MEDICATION ADMINISTRATION RECORD

Drug Chart: 2 of 1 Height (cms): 41 Cm Weight (kg): 66 kg -												
•		KNOWN MEDICINE	ALLERGIE	S (if NO	ONE is c	onfirmed	, write NKDA i	n box 1)		·		
Drug Details				Description of Allergy					Doctor's Sign:			
						Sperie						
1	NK	:DA ·	}	NIL.					Name: DR-PRAVEEN			
				-					JEYAKUMAK Reg::No.::  2236.			
<u> </u>	R INSTRUCTIONS	<del>-   '</del>										
<del> </del>		<del></del>		NURSING STAFF INSTRUCTIONS  1. Check entries in every section to avoid omissions								
Use generic name when prescribing drug     Write in BLOCK LETTERS, clearly and legibly			3. For ne	Nurse in-charge should verify drug chart on daily basis     For new prescription, follow the timings of doctor's prescription on Day 1 only, and then								
_		MCI registration no. or apply sea should be altered / overwritten	4. Standa		gs: Q24hrly		)12hrly: 10:00hrs, 2:			ırs,		
		rmat when writing time					9:00hrs, 14:00hrs, 3 00hrs, 06:00hrs, 10			22:00hrs		
		Stat	/ Once O	nly / P	remed	ication	Drugs				Ì	
Date	Time	Drug		Dose	Route	Doctor		Administered				
						Sign.	Reg. No.	Sign.	Emp. No.	Time	l	
11/10/22	141,20	THE MYOPYROLD	T2	Sism	ιV	8	112236	84	0223	14700		
11 12/28	15;00	JHJ. CALCIUM GIL	10	IV	Ç	112236	S. Warn	0276	15:00			
112/23	1650	BUPRENOR PHINE PATCH			FD.	8	112236	Smert	0276	16.50	1	
18/12/27	22:00	T-EWRPIELN	_	75 mg	PO	5	112236	JA	0019	39.00		
x 12/0	19:2	DULLAL EXSI	1PD)ATM	Q <sub>M</sub>	P/R	100	134 659	.04	0195	19.30		
			1 1 Wal-16	<del>7</del> .	1/12-					· · · · -		
								<del> </del>		<del>'</del>		
		-	<del> </del>					<del>                                     </del>		<u> </u>	l	
			<u> </u>	.,					,	 		
 										ļ		
			·									
					V.		,	,		<u> </u>		
					_				<del> </del>			

Date → To be filled by Nursing Staff only. Sign and time given **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time 4 23 29 4.6 **DRUG NAME** Clinical Pharmacist Medway Hearl Institute ন্তি THI PARALETAMOL Dose Route Frequency 1900 suk 15:00  $\mathbb{K}$ - 1-1 lgm Start Date & Time Dr. Sign & Reg. No. / Seal م، بحير Dr. Praveen Jeyakumar 11/12/23 AT 15:00 λß 23,00 @ Reg. No:112236 Stop Date & Time 12/12/29 177130 Additional Info: **DRUG NAME** <del>น</del>เรอ SYP. SULPALFATE SUSPENSION Clinical Pharmacist Medway Heart Institute Route Frequency Dose 13.30 lomi Plo -1 - 1Start Date & Time Dr. Sign & Reg. No. / Seal 1930 190 Dr. PRAVEEN JEYAKUMAR 11/12/23 AT 19:30 19.30 Stop Date & Time Reg. No:112236 0/ 0 Additional Info: gy-Hete 5,00 **DRUG NAME** 400 4,00 Clinical Pharmacist Medway Heart Institute 5-00 MEB. ENOSAL BUTA MOL Dose Route Frequency 0.00 10.00 Thin 1-1-1-Hall Orb3mg Dr. Sign & Reg. No. / Seal Start Date & Time 11/12/23 AT 15.15 16.00 Dr. PRAVEEN JEYAKUMAR 40 Stop Date & Time Reg. No:112236 र्जुंग ०० Additional Info: **DRUG NAME** l'Ats, 8:00 RUSEMIDE Clinical Phominal Medway Heart Inchlute Dose Route Frequency Plo 1-1-0 Homa Dr. Sign & Reg. No. / Seal Start Date & Time 100 16,0 12/12/23 AT 8:00 Dr. PRAVEEN JEYAKUMAR 16:00 Stop Date & Time Reg. No:112236 04 Additional Info: **DRUG NAME** (B.PM 00:00 SPIRONALAGONE AB. 10.00 Route Frequency Dose Plo 1-1-0 Sma Start Date & Time Dr. Sign & Reg. No. / Seal Ros حمل 12/12/23 AT 10:00 Dr. PRAVEEN JEYAKUMAR 17:00 Stop Date & Time Reg. No:112236 111/23@8.01 Additional Info:  $\omega$ Area In-charge Nurse Signature:

To be filled by Nursing Staff only. Sign and time given Date → REGULAR PRESCRIPTIONS To be filled in by Doctors only Time 🕹 **DRUG NAME** B:00. l'AB. BEPIEX FORTE ! Clinical Pharmacist Medway Heart Institute Route Frequency Dose 1T4B Plo -0-0 Start Date & Time Dr. Sign & Reg. No. / Seal 91 12/12/23 @ 8:00 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112236 0 Additional Info: **DRUG NAME** CLOPIDOGREL TAB + ASPIRIN Chaical Pharmadist 14:0914.05 Route Frequency Dose Forg 14:00 0-1-0 Dr. Sign & Reg. No. / Seal Start Date & Time 12/12/29 @ 14:00 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112236 ∞/ Additional Info: **DRUG NAME** Clinical Pharmacist Medway Heart Institute ATORVASTATIH Route Frequency Dose Plo 0-0-Homa Start Date & Time Dr. Sign & Reg. No. / Seal 18/12/23 @21:00 Dr. PRAVEEN JEYAKUMAR af Stop Date & Time Reg. No:112236 24:00 Additional Info: **DRUG NAME** فساح CREMAEFIN Dose Route Frequency 15m1 0-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal 12/12/23/02/100 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Q/ Reg. No:112236 21.00 21:00 Additional Info: **DRUG NAME** DOROCETANOL 8:00 Dose Route Frequency 10 650 MG 1-1-1 Start Date & Time Dr. Sighraveen Nevaronar 4:00 12/12/23/14:00 Reg. No:112236 Stop Date & Time 20,00 Additional Info: 30.61 SO:01 Area In-charge **Nurse Signature:** ഷാ

Clinical Pharmacisty (Medway Heart Institute)

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

REGU	LAR PRESCRIP	TIONS I	Date →	To be	filled b	y Nurs	ing Sta	only.	Sign a	nd time	given
	filled in by Doctor		Time <b>↓</b>	1212	13/17/2	14/12	45/2	16/12/		1	[-
DRUG NAME				9:00	4.50	61.08	9,00	9-15			
T' 17 En	PROLEZ (SETA	LOLY	9:00	d'	<i>y</i> .	90%r	77	<b>360</b>		,	
Dose 25mg	Route ↑	Frequency		<u> </u>		. <b></b>		V U			
Dr. Sign & Reg.	1775年の別録を表現										
Neusl Dr. F	(AK <b>ยทาม</b> - Reg	Stop Date & Time	21,00	21-0	984	947	21.00				
Additional Info:			]	财	al or	21.00	10 P	Ì			
DRUG NAME						9.00	8.35	8-40			Γ
T. FR	nzehid e		840			8/5	180	980	,	_	
Dose 40mg	Route Pé	Frequency					ر 		; 		
Dr. Sign & Reg.	No. / Seal	Start Date & Time									1
8 12236		Stop Date & Time	<u></u>	,							
Additional Info:		<u> </u>						<u> </u>			
DRUG NAME	ROMO LACFONE		Q.01		>	88/m	\0\ \0\ \0\ \0\	84 10.00			
Dose 25mg	Route Po	Frequency									
Dr. Sign & Reg.	No. / Seal	Start Date & Time	1								
112234		Stop Date & Time	<u>·</u>		, 						
Additional Info:		-	7	-			[	1		[	
DRUG NAME					<b>-</b>						
Dose	Route	Frequency	7								
Dr. Sign & Reg.	l No. / Seal	Start Date & Time	+								
		Stop Date & Time	<u> </u>								
Additional Info:			7	<u> </u>		<b> </b> -		<b> </b>	<u> </u>	1	t
DRUG NAME	,		<del>                                     </del>			ļ					
Dose	Róute	Frequency		ļ					 		
Dr. Sign & Reg.	No. / Seal	Start Date & Time	-	 			· •	HEYAK	- MESSAS	  -55	
	Stop Date & Time				<u> </u>		F. 18 16		. u/y 'b'		
Additional Info:		<u> </u>	1	<u> </u>		<u> </u>		'a			
Area In-charge Nurse Signatur	e:			0	<b>V</b>			1	****		

Clinical Pharmacist

To be filled by Nursing Staff only. Sign and time given Date -> **ANTIMICROBIALS** 12/12 To be filled in by Doctors only Time ↓ **DRUG NAME** 530 5.20 INT CEFURNIME Dose Route Frequency IV 1-0-1 159m Start Date & Time 대한23 AT 9:40 Stop Date & Time 나다나 사용· & 17.30 Reg. No:112236 Additional Info: **DRUG NAME** Frequency Route Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Route Frequency Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Route Frequency Dose 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:** 

	<u> </u>	<u> </u>			<del></del>	RESCRIPTION AND ADM Additive Drug				ctor	Adn	ninistratio	
Date	Time	Intravenous Fluid	Volume	Rate / Duration	Route	Name	Dose	Range	Sign.	Reg. No.		<del></del>	T
11/12/23	12:30	KABILYTE	500ml	300milho	IV			_	<b>}</b> -	112236.	12 20	15,30	9119
11/12/23			500ml	100 - 200 milus	73		_	,	٤	112236	15:30	18:30	MU4 0236
11/12/63		KABILYTE	500m L	100 m UHR	IV.			_	۴	(122.36	16-30	Q1.30	My N
11/2/23	Q1.3>	KABILYME	Som	100 mllm	<u>I</u> V				8	112236	01.30	5.30	盐
				_									
					•								
		<del></del>										<del></del>	
			<del> </del>			<u> </u>	<del> </del>						-
		<del></del>	-			,						-	-
							<del> </del>						
		<u> </u>	1	-			+						-
			<u> </u>										<u>B</u> ,
													10 13

		Intravenous.	37-1	Rate /			Additive Drug			Do	ctor	Adn	ninistratio	<b>}</b>
Date	Time	Fluid	Volume	Duration	Route		Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
11/12/23	79°30	NS 0194.	50ml	1 million	I <sub>N</sub> _	The A	JOR - AD DENAIIME	dima	ACC FIDE	ξ	11226	12:30	6.45	
14/12/23	12:30	NS 0.91.	50mi	a.5milwi	TV	INT	POTASSIUM CHIORIDE	Domin		&	אנמוו	12:30	14.30	9726 May
11/12/2	120.20 <u>.</u>	NS0.91.	Homi	amphu	Ju .			HOTU	Acc TO UBY	. 8	111236	12130	15,00	
11/12/23	18.00	NS 0.97.	20mL	IMLIHR	DV .	エバユ・ヒ	CENTANYL	200mig		ç	1125/	18:00	4.30	אינט אינט א
12/12/123	6.40	No.9%	Soul	South	20.	og. cul	MASKUM CHORIDE	Some	_	8	11724	Ьічо	8130	
13/12/23	91.50	NP.02M	50m)	sond hr	N	Luy. P	othermy	20 mEq	J	8	172226	9.30	10:30	1
							,							
<i>}</i> 1•													•	
Í														

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
11/12/23	13:06	Npo.	8	112226					
12/12/22	<u> 2:00</u>	liquid diet	8	11226			<u>.</u>		
12/12/28	8'.co	Semiotid diel					0		,
14/0	8:00	Sensold dust	BRIET	183573					,
							,		
									-

### **NURSE IDENTIFICATION RECORD**

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

		1 (to be entered by an the m	37000 777077	00 111 0011	711770101	mg moun	cations presented in the charty		
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning	•			15/14,	Morning	Parthea	00%	Ry
lillahs	Evening	MEENLA ' '	0246	means	وداداك	Evening	- V	619+	Oef.
11/12/23	Night	ASHAC A	0019	-JA	15/12/23	Night	A- Anitha	0211	<u>s</u>
12/12/28	Morning	Soundontounde		1 6	16/12/1	Morning	10- Lequie	0249	20D
12/12/23	Evening	Quany J. a	0223	Early	11.00	Evening	J - J	1	0.54
12.11-29	N 87 1- 8	BURYALACA. 8.P	0232	art		Night	,		
12 12/23	Morning	Bathiya Vanj. y	0265			Morning			
13/12/	Evening	usabila.	06	8		Evening		,	
13/12/23	Night	A. ALBINOUS	008-8	Ĭ		Night	\	(	
12/12/2	Morning	4, Dila	0102	8		Morning			
14/12/23	Evening	B. Vanis	0195	Ch		Evening			1
4/12/27	Night	A. ALBINIUS	००५८	ے کی		Night			(1)

OPLABX & bIRAFTS

LIMA-7 IAD

SUM-7 PP4 Medway Hospitals®

The way to better health (A Unit of United Alliance Healthcare Pot Ltd)





	Mrs.PREMA T 52/Femalc/MHI202381034					MHI/ICU/2022/076
Name	09/12/2023/IPH202302466 Dr.ANBARA\$U MOHANRAJ				•	Sheet No.
UHID N			A	ge	Sex	
Blood G	roup	Height		Weight	BSA	_
	B POSITIVE	Hille	21	66491	H-him	A

CURCICAL PROCEDURE.

DATE OF SUDGEDY 11441

DOCT OR DAY: 10 a

SURG	ICAL PR	OCEDU	RE:					DA	re of su	JRGERY	: 11/12	poss		PC	ST-OP D	DAY: D	$\simeq$	
						VENTIL	ATORS P	ARAMET	ERS						.BLOOD	GAS		
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	ΜV	ITV	ETV	FiO <sub>2</sub>		рН	PCO <sub>2</sub>	PO <sub>2</sub>	HCO <sub>2</sub>	SAT%	BE
111212	12:20	VIVI	14		શ્રેમ. D	μÓ		7-1	<u>500</u>	Hah	501.	12,20	7.401	36.4	86.2	22.6	96.6	-2.2
	2,35	SELVA	12.0	20.0		5.0			50n	·	50-1					_	Α,	
	13,00	Simy	10.0	16:0		5.0			<i>5</i> 00		501,							
	13:39	SIMU		12.0		5.0			500		50%							
	LH'.90	PS		tο		2.0			500		504	14,38	7.376	भ०न	1866	23.1	99.3	2.1
	505		Pani	ENT	HAD		ExTU	RATE!	<u> </u>									
	15:30		Nas	almo	gs: 2	1415				-	24							
					J							16:30	7-37	40.6	19.2	22.7	98.2	- 2.1
	17;30		Nouse	lpn	٠ ٩٤:						241	hn .						
						_												
	<u> </u>																<u> </u>	

CRITICAL CARE FLOWCHART

#### **NEURO**

#### **EYES** Spon-4 Opens to speech-3 Opens to pain-2 Remains closed-1

#### **VERBAL**

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

#### MOTOR

Br-Brisk

SI-Sluggish

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

**CAPILLARY REFILL** 

#### **MOTOR ARMS/LEGS**

S-Strona Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

#### **PUPILS SCALE (mm)**

•	•	• (	
1	2	3	4
	5	6	
	7	8	

#### **PUPILS REACTION**

Br-Brisk	
SI-Sluggish	
O-Absent	

#### **CARDIOVASCULAR**

O-Absent	O-Absent
HEART SOUNDS	NECK VEINS
S1 S2	JVP
M-Murmur	N-Normal
Rb-Rub	In-Increased
G-Gallop	
SM-Sound muffled	

# **EDEMA**

**D-Dependent** G-Generalised ent

# **VEINS**

SHUNT NUMBER Valve Replaced / Shunt +Present O-Absent

VALVE CLICK/

**D-Distented** 

**LIVERSIZE** 

N-Normal

E-Enlarged

#### **PULMONARY**

WORK OF BREATHING	SUCTION
Ab-Abdominal	ET-Endotracheal
TA-Thoraco-abdomial	N-Nasal
L-Laboured	Or-Oral

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

#### **GASTROINTESTINAL**

BOWEL SOUNDS	NGT POSITION
+Present	Air injected
O-Absent	+Heard in Abd
	O-Absent
	GA-Gastric contents aspirated
	Dr-Dependent Drainage
ABDOMINAL TONE	CASTRIC RESIDIAL

#### GASTRIC RESIDUAL So-Soft G-Green **B-Bleeding** F-Firm Y-Yellow C-Coffee ground Tn-Tender **Ob-Obese**

OPCABX 261MFTS LIMA-7 IAD

SUM-7 PDA Medway Hospitals

The way to better health
(A Unit of United Alliance Healthcare Pyl Ltd)





		rkeWA T cmalc/MH12023	81034	]	HI/ICU/2022/076	
Name		2/2023/IPH2023 NBARASU MOHA				Sheet No.
UHID No.				Ð	Sex	$\bigcirc$
Blood Group	В	Posetivi	Height	Weight hbrw	BSA 1.b1m²-	Α

SURG	ICAL PR	OCEDU	RE:				_	DA	TE OF SI	URGER\	: ul	12/202	-3	PC	ST-OP I	DAY:			
			_		,	VENTIL	ATORS P	ARAMET	ERS						BLOOD	GAS	, ,		]
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO₂		рН	PCO <sub>2</sub>	PO <sub>2</sub>	HCO₂	SAT%	BE	
เปเลโลล	22.30	Q <sub>M</sub>	Boom	DN	02	MASA	e pre	мцз			2 UT								-
																			-
								_											
		i																	
			_											<del></del> -	ļ				
	05.00	On	ROOM	_4R								6.24	7.470	37.9	68.9	27.0	94.9	3.4	
								]				_							<u> </u>
			_														_		
			_					_											

#### **NEURO**

# EYES Spon-4 Opens to speech-3 Opens to pain-2 Remains closed-1

#### **VERBAL**

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

#### **MOTOR**

Br-Brisk

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

**CAPILLARY REFILL** 

#### **MOTOR ARMS/LEGS**

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

#### **PUPILS SCALE (mm)**

•	•	
1	2	3 4
	5	6
	7	8

#### **PUPILS REACTION**

Br-Brisk SI-Sluggish O-Absent

#### **CARDIOVASCULAR**

SI-Sluggish O-Absent
HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

# EDEMA

D-Dependent G-Generalised O-Absent

#### **NECK VEINS**

JVP N-Normal In-Increased

#### VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

#### **PULMONARY**

WORK OF BREATHING	SUCTION
Ab-Abdominal	ET-Endotracheal
TA-Thoraco-abdomial	N-Nasal
L-Laboured	Or-Oral

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

#### **GASTROINTESTINAL**

BOWEL SOUNDS	NGT POSITION
+Present	Air injected
O-Absent	+Heard in Abd
	O-Absent
	GA-Gastric contents aspirated
	Dr-Dependent Drainage

#### **ABDOMINAL TONE**

So-Soft F-Firm Tn-Tender Ob-Obese D-Distented

#### **LIVERSIZE**

N-Normal E-Enlarged

#### GASTRIC RESIDUAL

G-Green B-Bleeding Y-Yellow C-Coffee ground OPUB & QUIRAFTS LIMA-7 LAD

SUM-7 PDA.

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





	Mrs.rke#IA T 52/Female/MH1202381	.034	,	М	HI/ICU/2022/076
Name	09/12/2023/IPH202302 Dr.ANBARASU MOHAN				Sheet No.
UHID No.				Sex	<b>③</b>
Blood Group	B POSITIVE	Height	Weight んとめ	BSA 1.6122	Α

SURGICAL PROCEDURE:

DATE OF SURGERY: 11/12/2023 POST-OP DAY: 72/100

30110		CEDU	INE.					DA	E OF 30	JRGERT	1111	21 2U2 <u>2</u>	<u>.</u>		131-OF L	JAY: 'Y&	1400	
		السلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط المسلط							BLOOD	GAS								
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ΙΤV	ETV	FiO₂		pН	PCO <sub>2</sub>	PO <sub>2</sub>	HCO₂	SAT%	BE
12/12/23	1:30		10 N	<b>{</b>	DOM		die		_									
					,												-	
	_		 															
													_					
					_													_
				•	_					<u> </u>				_				-
	_								_						_			
									_									
-																		
					_										_			

#### **NEURO**

#### **EYES** Spon-4 Opens to speech-3 Opens to pain-2 Remains closed-1

#### **VERBAL**

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

#### **MOTOR**

Br-Brisk

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

**CAPILLARY REFILL** 

#### **MOTOR ARMS/LEGS**

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

#### **PUPILS SCALE (mm)**

•	•		
1	2	3	4
	5	6	
	7	8	

#### **PUPILS REACTION**

Br-Brisk
SI-Sluggish
O-Absent

#### **CARDIOVASCULAR**

**EDEMA** 

SI-Sluggish O-Absent	G-Generalise O-Absent
HEART SOUNDS	NECK VEINS
S1 S2	JVP
M-Murmur	N-Normal
Rb-Rub	In-Increased
G-Gallop	
SM-Sound muffled	

**D-Dependent** G-Generalised

#### EINS **VALVE CLICK/** SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

Ob-Obese

**LIVERSIZE** 

N-Normal

E-Enlarged

**D-Distented** 

#### **PULMONARY**

WORK OF BREATHING	SUCTION
Ab-Abdominal	ET-Endotracheal
TA-Thoraco-abdomial	N-Nasal
L-Laboured	Or-Oral

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

#### **GASTROINTESTINAL**

BOWEL SOUNDS	NGT POS	SITION
+Present	Air injecte	
O-Absent	+Heard in	Abd
	O-Absent	o contonto coniratod
		c contents aspirated dent Drainage
ABDOMINAL TONE		
So-Soft	GASTRIC	RESIDUAL
F-Firm Tn-Tender	G-Green Y-Yellow	B-Bleeding C-Coffee ground

В

52/Female/MHI202381034

		09/12/2023/IPH202302466	i		_			
Sheet No.	Name	Dr.Anbarasu mohanra.			1			
$\mathcal{O}$	UHID No	830 (F) 100 (B) 010 010 100 (B) 100 (B) 100 (B) 100 (B) 100 (B) 100 (B) 100 (B) 100 (B) 100 (B) 100 (B) 100 (B)	1444		A	ge	5	Sex
D	Blood Gr	oup		Height		Weight		В

DOSMIVE





MHI/ICU/2022/076



-				ВІОСНІ	EMISTRY					VITA	L PARAN	METER:	<del>s</del>			CARDIA	AC ASSIST	DEVICE	
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao <sub>2</sub>	RR/MT	N RP	TEMP°F	Abd™G	TIME	IABP		PACEMAKE	R SETTING
'				1	SUGAR	1	111412	2,002	SOUNDS	Oa0 <sub>2</sub>	10001	ואון	I EIVII I	Abu O	11191	RATIO	DURATION	RATE	MODE
Medez	12;20	13.6	137	3.43	0,90		10:20		ct.	109	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Phis°r						
					,		12:30		cv	1001.	10		i i			1			
							14,30		<u>دب</u>	1001.	18								
							15.30		cr	991.	18		97.5F						
	N4.38	13.5	138	3.78	0.85		(6:30		CL	(00%,	20 .								
							1730		CC	100%.	29	١							
							18.30		cr	१च्डी	26.	'						_	_
	16:30	14.0	139	3.77	0.99		1930		cv	100%	25					_			
` 2 <sub>4</sub> ,							20.33		ch	1001	su rest		98 F						
							21.30		u	160)	الما وه								<u> </u>
								İ											

BSA

1. bime

HIUM boken

Patient is ful awake at 12:35 Pm.





	SHIFT	D.	AY	EVE	NING	NI	GHT
	TIME		12.20	16.30	18':30		
	EYES		ep	ч	H		
NEURO	VERBAL		cP_	લુ૧	5		
	MOTOR		up	5	6		
	ARMS R/L		UP.	5+	St		
	LEGS R/L		CP	s <del>4</del>	SE		
PUPILS	R.SIZE/REACTIION		4	B~	3mm		
PUP	L.SIZE/REACTION		4	By	360 cm		
H.	HEART SOUNDS		3132	g112	5,52		1
/Ino	VALVE CLICK		<u>-</u>		_		
CARDIO-VASCULAR	CAPILLARY REFILL		Br	<i>Б</i> √	BR		
RDIC	EDEMA		b	O	0		
ర	NECK VEINS		H	N	7		
ARY	WORK OF BREATHING	_	14	44	TA		
PULMONARY	SUCTION		-		<u>.</u>		
PUI	SECREATIONS	<u>.</u>			-	·····	
 	BOWEL SOUNDS		+	-	+		
STIN	ABDOMINAL TONE	_	Sct-	باط	Safe		
INTE	N/G POSITION		Mens	Ruenz			
GASTRO INTESTINAL	GASTRIC RESIDUAL						
GAS	LIVER		N	K)	(1)		

	SHIFT	D,	AY	EVE	NING	NIC	3HT
	DESCRIP.OF URINE		4	1	مات		•
G.U.	PD - FUNCTION		)	ı	_		
	DRAINAGE		_	1	-		
	PD - SITE	·		1			
	COLOUR		1	į	J		
	Sx WOUND-CHEST		ال	4	ر ا	_	
	LEG		J	3	CL		_
SKN	DRESSING		6	97	DT		
	PRESSURE SORE-SITE		ĺ	ţ	}		
	AREA		1	l	1		•
	DRESSING CONDITION		વ	4	00		
	POSITION CHANGE		QUH.	au	Q24		
MISCELL	CHEST-PHYSIO		ELION	15 P	180 S		
MIS	ACTIVITY		PE	120 0	PE		
			ABP CUP	\$ 5	ARP		
	S/N NAME		Pavena	nem	Means		
	TIME		12,20	16.30			
	SIGNATURE		Dany	Men	10296 10296 10297		

Mrs.PREMA T

52/Fcmalc/MHI202381034

09/12/2023/IPH202302466

Sheet No.

Name

Dr.ANBARASU MOHANRAJ

UHID Nc

UHID Nc

Blood Group

В





MHI/ICU/2022/076



	BIOCHEMISTRY VITA								ITAL PARAMETERS					CARDI	AC ASSIST	DEVICE			
DATE	TIME	115				BLOOD	TIME	ETCO,	BREATH				TEMP°F	A L 49710	T13.4F	IABP			RSETTING
		Hb	Na	К	Ca SUGAR	BLOOD	1 IIVIE	E1CO <sub>2</sub>	BREATH SOUNDS	<b>-</b>	RR/MT N		TEMPT	r Abd G	I IIVIE	RATIO	DURATION	RATE	MODE
							22.30		u	100)	15/wt								
							93.30		ડ		16/wt	1	98.ÎF						
							وي. دو. ه		ત	100%	allut	-							
							01.30		u	100)/	17 met								
						,	02.30		cl	100%	18/mt								
					<u> </u>		0330		디	(09).	19 met								
12/12/2	4.40	,			142		04.30		Cl	10%	aelmr		98.7 8						
12/12/2	6·24	14.1	134	2.61	1.01		02. do		c)	97%	18/w-t								
							66.5°		u	96/.	المداحة								
																			<b>!</b>

Sex

BSA

1.61m2

Weight

hbrn

Height

HIM

PASITIVE

CRITICAL CARE FLOWCHARM





	SHIFT	DAY	EVENING	NIC	SHT
	TIME			005	04.00
	EYES			H	19
NEURO	VERBAL			5	5
Ä	MOTOR			V	ما
	ARMS R/L			SIS	واد
	LEGS R/L			s1s	3/5
PUPILS	R.SIZE/REACTIION			3131	3 Bx
PUF	L.SIZE/REACTION			381	3131
١R	HEART SOUNDS			9132	3152
CUL	VALVE CLICK			-	_
CARDIO-VASCULAR	CAPILLARY REFILL			By	Bs
RDIO	EDEMA	_		0	0
S	NECK VEINS			7	N
ARY	WORK OF BREATHING			TA	TA
PULMONARY	SUCTION				_
PUL	SECREATIONS				-
AL	BOWEL SOUNDS			7	7
STIN	ABDOMINAL TONE			S	٩
INTE	N/G POSITION				_
GASTRO INTESTINAL	GASTRIC RESIDUAL				
GAS	LIVER			N	7

	SHIFT	DAY	EVENING	NIGHT
	DESCRIP.OF URINE			क्राक क्रि
G.U.	PD - FUNCTION			411
	DRAINAGE			ptic -
	PD - SITE			MIL -
	COLOUR			
	Sx WOUND-CHEST			4
	LEG			cl cl
SKN	DRESSING			०४ ०४
	PRESSURE SORE-SITE			ANL MIL
	AREA			
	DRESSING CONDITION			-  -
	POSITION CHANGE			0211 0214
MISCELL	CHEST-PHYSIO			spr spr
SIM	ACTIVITY			P2 P2
				ABS ABS
	S/N NAME			ASHAL AKHAK
	TIME			00.00 400
	SIGNATURE			地地

-- F=-1

		52/Fep	REMA T	81034			
Sheet No.	Name	O. 1815	2023/IPH2023 BARASU MOH	ANRAJ			
<u> </u>	UHID No.	MMM	III III III III III III III III III II			ge	Sex
В	Blood Group		Dazeni		Height	Weight	BSA





MHI/!CU/2022/076



BIOCHEMISTRY VITAL PARAMETERS							CARDI	AC ASSIST	DEVICE	1									
DATE	TIME	НЬ	Na	к	Ca SUGAR	BLOOD	TIME	ETCO <sub>2</sub>	BREATH SOUNDS	Sao <sub>2</sub>	RR/MT	N,BP	TEMP°F	Abdº™G	TIME	IABP	DURATION		R SETTING MODE
					555741			_					<del>                                     </del>			KAIIO	DURATION	KAIE	MODE
12112113							-1:30		u	ATY	Hlmr		9871			_			
							3:30				المال م								
,							9,30				32ln1 -								
							10:30		a	994	BIM							_	
`							11:30		u	a6%	LUNGT	(24)							
							12.30		d	927	्रह्रीव्ये								
							13:30		d	[	aalmt	112	37 gs [	<u> </u>					
							144:30		d	lab-1	<u>ಇ</u> ತ್ತಾಗಿಸ	温量	40)			,		<u> </u>	
							15:30		()	93-1	25/2	1220	83)		-				
							16:30		cl		Zalnt								`
																	_		
			1																

CRITICAL CARE EL OWICHART





	SHIFT	D	AY	EVE	VING	NIC	 SHT
	TIME	2:00	12:00	161,00			
	EYES	4	H	44			
NEURO	VERBAL	5	6	5			_
	MOTOR	4	6	6			-
	ARMS R/L	St-	215	Rho			
	LEGS R/L	12	21	5/8			
PUPILS	R.SIZE/REACTIION	ala	3h _	2/00	_		
PUF	L.SIZE/REACTION	31m	37	3/20			
¥	HEART SOUNDS	2.32	SU-	5,52	_		
CUL	VALVE CLICK		_				
CAŔDIO-VASCULAR	CAPILLARY REFILL	<b>₽</b>	121	BY			
 KDIC	EDEMA	10	v	บ			
	NECK VEINS	7	N	N			
IARY	WORK OF BREATHING	-TA		di			
PULMONARY	SUCTION	t	_	_			
ID.	SECREATIONS				_		
₩	BOWEL SOUNDS	4	4	+			
STIN	ABDOMINAL TONE _	1014	lot	Soft			
INTE	N/G POSITION						
GASTRO INTESTINAL	GASTRIC RESIDUAL			_			
GAS	LIVER	7	-\ \	N			

	SHIFT	D	AY	EVE	NING	NIC	3HT
	DESCRIP.OF URINE	q	3	c		/	
G.U.	PD - FUNCTION		:	1			
	DRAINAGE	1	-	_			
	PD - SITE			_			
	COLOUR	_	ر	1			
	Sx WOUND-CHEST	ฮ	وا_				
	LEG	つ	J	7			
SKN	DRESSING	01	5	9			
	PRESSURE SORE-SITE	Nil	NY	NIC			
	AREA			1			
	DRESSING CONDITION	ĺ	<b>@</b>	_			
	POSITION CHANGE	Q21	)     	Q2H			
MISCELL	CHEST-PHYSIO	Z BA	Univ	28 2 P R			
MIS	ACTIVITY	P5	JR.	PE 1015			
		# 3 F	ARM	NiBe			
	S/N NAME	drojan	Por	Sugar	21		
	TIME	23,00	120,0	16.00			
	SIGNATURE	Voon o	<u> </u>	SH SH			

RECEIVED THE PATLENT FROM DT 0:- 12.25
OT URNE: - 300MI

Medway Hospitals®						
The way to better health						





	Mrs.PREMA T		1			·•
	52/Female/MHI202381034				М	HI/ICU/2022/076
Name	09/12/2023/IPH202302466		-			Sheet No.
	Dr.Anbarasu Mohanraj		:-		<del></del>	
UHID No.	UHID No.				Sex	0
Blood Gro	pup	Height	_	Weight	BSA	C
	B POSITIVE	Vilon	1_	bokg	1.61m2	

		UR	INE		CI	IEST D	RAINA	E	_	GAS	TRIC	LAB S	AMPLE	TOTAL					_	1
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	MK	יארשי	0-0200	, u		
11/12/23	12:20														KAE	JUTE	HOR-AD	KUL	H. Auten Aolsto	
	13:30	150	150			70		70	70			٥،٥	2.0	222	გღე	dan	1.0	25:0	2.0	
	14.30	150	300			50		50	lao				ನಿ. ರ	Haa	მიი	Hao	1.0	श्रह्म व	ನ್ನಿಂ	
	5-30	80	380				-		120				2,0	502	100	500	110		_	
	16:30	60	440			20		20	140				2.0	582	100	600	1.0			25mi
1	1730	70	510			20		20	(60				2.0	672	200	৪৯৩	1.0			LENZES
	18.30	100	610			20		20	180				2.0	792	200	1000	1.0			1,0
	19:50	90	100			<i>3</i> 0		30	210				2.0	912	100	1100	1-0			1.0
	20.30	100	800			20		20	230				20	to s 2	too	1200	1.0			100
 I	21.30	80	885			ઢ		8	250				20	1132	100	1300	1,0			1,0

SPECIFIC OBSERVATIONS/PROBLEMS

AUT! MASE

DATE	TIME

GENIT	<b>TOUR</b>	INA:	RY I	(GU)
-------	-------------	------	------	------

 $\cdot \zeta$ 

GL	INTOURNACT (GU)							
	PD		<b>COLOUR</b> Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine			
URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale	Oz-Oozing G-Gaping	Al-Antibiotic Irrigation			
CL-Clear T-Turbid Stained HC-High Coloured	Dr-Draining B-Blocked SITE	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled D-Dusky J-Jaundice	Op-Open I-Infected	mgaton			
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discolorat	ion	<b>SITE</b> S-Sacrum	PRESSURE SORE  AREA  R-Redness	DRESSING / Rx IR-Infra Red			
	MISCELLANEOUS		Sc-Scapular	BD-Black discoloration	DU-Dueodem			
OISITION CHANGE Su-Supine RL-Right lateral LL-Left Lateral  ACTIVITY PE-Passive exercise Am-Ambulated	DC-Deep N-Nebuli: TRANSD PARAME ABP-Arte RAP-Rigi PAP-Pulr	t percussion breath & cough zer DUCER ZERO	CONDITION H-Healing SCo-Status quo S-Sloughing LINES / TUBES O-No redness, s R-Redness at sit Sw-Swelling at s Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	welling, no leak, no air te ite	E-Eptoin dressing B-Betadine dressing EU-Eusol sitz bath ST-Sofra Tulle			

SKIN

Medv	vay Hospitals	,					
The way to better health							
(A Holt o	f United Alliance Healthcare Pvt Ltd)						





	•	male/MHI2023810 2/2023/IPH2023024		MHI/ICU/2022/076				
Name		ibarasu mohanr			Sheet No.			
UHID No.	_ 1514 1411 111	<u> </u>	,e	Sex	<b>D</b>			
Blood Group	Ð	POSITIVE	Height	Weight	BSA I.him²	С		
	<u> </u>	L0211111	HAIDM	bbkgs	I I O LYYP			

002 M 25min LAB SAMPLE VOLUME. INFUSIONS CHEST DRAINAGE **GASTRIC** URINE TOTAL OUTPUT ANT WITH 4150 500/22 DATE TIME TOTAL AMT TOTAL RT.PL. LT.PL. MED PERIC HR.T G.T. AMT. TOTAL AMT. 11 12 23 22.30 955 1300 75 .30 1.0 .30 280 20 1237 1.0 1300 1.0 පිහ 23.30 1038 2.0 1317 lio 280 12/12/23 00.30 120 1155 10 G01 [TP4] IND 10 10 290 200 Coul 1567 100 01,30 1255 1500 100 310 2:0 1.0 10 20 20 KABRUMPE 1405 0237 120 औ० 100 1600 1.0 1.0 1217 20 200 0230 100 1505 30 330 1847 1700 30 100 1.0 0.1 7,0 (50 1952 350 ०४ ६६ मध 1585 20 100 1800 1.0 20 1.0 12092 100 1900 390 1685 yο 70 6.1 05.82 100 HO 0.8 1900 0.5 2233 40 430 0630 100 но 10 1785

Mrs.

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME
í	

## **GENITOURINARY (GU)**

Gi	ENITOURINARY (GU)			ORIN	
	PD		<b>COLOUR</b> Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine
URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale	Oz-Oozing G-Gaping	Al-Antibiotic Irrigation
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	mgallon
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice		
BS-Blood Stained HA-Haematuria	C-Clean R-Redness			PRESSURE SORE	
ri/ ( riacinatana	BD-Block discoloration	n	SITE	AREA	DRESSING / Rx
	MISCELLANEOUS		S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E-Eptoin dressing
<b>OISITION CHANGE</b>	CHEST PH	YSIO	OC-Occiput	SP-Skin Peeling	B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral	V-Vibrator CP-Chest p DC-Deep b N-Nebulize	reath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
ACTIVITY	IN-INGDUIIZG	1	CONDITION		
PE-Passive exercise Am-Ambulated	<b>TRANSDU</b> PARAMETI ABP-Arteria		H-Healing SCo-Status quo S-Sloughing		
	PAP-Puľmo	Arterial Pressure onary Arterial Pressure	LINES / TUBES	CONDITION	
	LAP-Left A	rterial Pressure	O-No redness, s R-Redness at sit Sw-Swelling at s Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	d d	

SKIN







Name  Dr.ANBARASU MOHANRAJ  UHID No.  Blood Group  Height Weight BSA  C	Mrs.PKE.mri '1 52/Female/MHI202381034 09/12/2023/19H202302466			М	HI/ICU/2022/076
Blood Group Height Weight BSA C	Name DE ANBARASU MOHANRA	t	 	_	Sheet No.
	UHID No.	<u>                                     </u>	, ge	Sex	3
13 FOSITIVE HALLOM LOURS LIGHT	Blood Group B PasiTive	Height	1.	BSA 1.61m²	С

		UR	RINE		CI	HEST D	RAINAC	E		GAS	TRIC	LAB S	AMPLE		NOL	WE	INFU	SIONS		
DATE	TIME	АМТ	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT			1000			
12/12/23	7130	130	130			20		50	20				ļ	160			26-0			
	8130	00]	<b>3</b> 30			10		_10	3n					260			26.0			
	9130	120	400			20	-	20	60				<u> </u>	450			_	_		
	10130	250	400					1	60					700						
	11:30	(45)	4100						60					<u>ঙ্</u> ভত					_	
	12-30	20	toro		ļ				50					1060						
	13:30	No	1120						50					1170				_		
	124:30	100	(220						50					1270						
	15:30	೩೦೦	[420						50					1470						
	16:30	150	1570						50					1620						

SPECIFIC OBSERVATIONS/PROBLEMS

DATE_	TIME
12/12/23	10,000

B) PADIAL DITTERIAL LINE LEMONED (BLO DY, XNBARAGU)

1

#### **GENITOURINARY (GU)**

GE	INITOURINART (GU)			Oran	•
	PD		<b>COLOUR</b> Pk-Pink	SURGICAL (SX) WOUND C-Clean	<b>DRESSING</b> B-Betadine
URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale	Oz-Oozing G-Gaping	Al-Antibiotic Irrigation
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	mgation
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice		
BS-Blood Stained HA-Haematuria	C-Clean R-Redness			PRESSURE SORE	
	BD-Block discolorati	on	SITE	AREA	DRESSING / Rx
1	MISCELLANEOUS		S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E-Eptoin dressing
<b>OISITION CHANGE</b>	CHEST P	HYSIO	Oc-Occiput	SP-Skin Peeling	B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral ACTIVITY		t percussion breath & cough	CONDITION	D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
	TRANSD	UCER ZERO	H-Healing		
PE-Passive exercise Am-Ambulated	PARAME ABP-Arte		SCo-Status quo S-Sloughing		
	PAP-Puľn	nt Arterial Pressure nonary Arterial Pressure	LINES / TUBES	CONDITION	
	LAP-Left /	Arterial Pressure	O-No redness, s R-Redness at si Sw-Swelling at s Dr-Draining D/c-Discontinue P-Positional HL-Heparin Locl	site d	

HL-Heparin Lock B-Blocked SKIN

	Mrs.PREMA 52/Female/M 09/12/2023/	HJ2023810	)34	••		
Name	Dr.Anbarasu	MOHANR	AJ	,	SI	neet No.
UHID No.	_ 100 1841 1051 1114 (10 0 1841 A	<u>                                      </u>		3ex		0
Blood Group	B bases	Height	Weight	BSA		D





MHI/ICU/2022/076



FLUID ASSESSMENT (contd.)

#### **HAEMODYNAMICS**

#### **Blood Group:**

					(00																			_
DATE	TIME	-	INFL	ISIONS	(contd.		TOTAL	N/G	ORAL	TOTAL	TOTAL	HR/mt	RYTHYM	ет	ABP	MAP	RAP	LAP/	PERI	PP	со	CI	SVR	
DATE	I flat	_				Misc	TOTAL	AMT.	TOTAL	INTAKE	BALANCE	Indin	IVI IIIII	31		MAP	IVAF	RAP	FLKI	R/L	00	5	341	
111212	12,20					19						73	Qiam	0.08	106/ 154	<b>∃</b> 0			too i	म(क				
	la.an					3,0	3010			230	+8	1	Sinus		122	82	14	l	Cool	fif				
	14:30			į		2.0	3010			1160	438	74	SINI	0:01	103/	80	12	_	World	44.				
	15:30			th		2,0	3.0			563	183	18	Sinus	0,0	1257 54	76	ō		Wau	++ .				
	16:30					2.0	3.0			666	+84	91	Stucre	0.06	122/ 58	79	6		new	++				١.
	17.30					2.0	3.0	50	80	919	247	84	Siveri	0.06	1341	84	5		We	++	ſ			- Consol 17-17-1
	18.30					2.0	4.0	50	100	1173	+ 381	' '	Street	1	86	75	5	ı İ	vm	4-4				5
	1930					ત્ર•૦	3.0	<u>೩5</u>	125	1301	+389	89 !	luar	٠ <u>٠</u> ٠,۵	127/64	४५	م		Mari	++		-		]
	20.35					2.0	મ્,જ	too	225	1505	473	95	2010	0,00	133	90	8		von	44-				
	21.30					2-5_	4,0	75	৫১১	1684	+ 552	94	รเพาร	0:00	134	90	8		uzu	44-				

STAT DRUGS
TIME

14:20

Thy. Myopy ROLATE 205 MC IVESTAT QUEN

Blo DR. Synsster)

URINE:

TOTAL INTAKE:

TOTAL OUTPUT:

TOTAL BALANCE:

(Blo DR. Sylvester)

(Blo DR. Sylvester)

CRITICAL CARE FLOWCHART

P.T.O.





	DAY	EVENING	NIGHT
PATIENT CARE	-		
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND		_	
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE		89	_
B.P.		125/62.	

DATE	TIME	REMARKS / PLAN
		•
	,	

		<del></del>					
INFUSION PU	MPS	WOEDTIO:	<del></del>	INTELLIGION!			
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
7.5mm Et Tube	FIXED AT SOM		1			P	R
NU TUBE		111223	1			P	R
<u> </u>	部	111223	)			P	P
AKTUNE	PAD PAD	111223	١			P	p
PERIPHEM	PF DOB	1112/23	1			P	1
MEDIA		11/2/23	3			P	12
Pleural	Ú	11/12/23	1			P	Į.
2-TUBIHH		11 12 28	1			₽_	
OL-TUBINU		11/12/23	1			P	P
TR-Dome		11/12/23	1			P_	P
IN EXTH		11/12/23	)_			P	P
MARUEL		11/12/23	1			P	<u>j2</u>
<del>-</del>		li .					
				_			
<u> </u>							
					_		
-							

52/Female/MHI202381034 09/12/2023/IPH202302466

Name	Dr.ANBARAS				s	heet No.
UHID No.			vge	Sex		2
Blood Group	B Postonia	Height	Weight	BSA		D





MHI/ICU/2022/076



lealthcore Pxt Ltd) Every heart beat counts

FLUID ASSESSMENT (contd.)

#### **HAEMODYNAMICS**

Blood Group:
--------------

TEOD ACCESSINENT (CONTAIL)															Bioga Giogli								
DATE	TIME		INFU	SIONS	(contd.)	Nrse	TOTAL	<b>├</b> ──	/ORAL	TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP		PP R/L	СО	СІ	svR
1/12/2	২২ঞ						40		300	1688	+	18	Sincs	0.02	129	85	7		wam	o <u>†</u> .4-	_		
	23.30					2.0	4,5	50	350	1742	425	8 म	SINUS	0.02		৪ ৭	7		wau	44-			
	20.32					ಫಿ.0	4.0		કેન્ટ	1846	+ _\$99	79	SIMO	וסיקי	137 67	90	9		coam	44-			
	01,30				,	ని.0	4.0		300	1950	4 283	85	SINUS	0100	15h 66	98	٦		Craw	-1-			
	02.30		_			20	4,0	75	<u> 375</u>	2129	412	86	enne	0.02					waen	4+			
	O\$-30					ನಿಂ	4,0		<b>3</b> 76	2233	386	85	Graves	0.01	133	82	ь		യവം	44-	,		
_	0430				· 	<b>2</b> .0	4,0		375	2537	385	88	Sinu	0.02	135	89	6		ധാഷം	44			
	05.z	_				200	3.0		375	<u> </u>	350			פיטין			8		wan	41			
	OC. 3 x					ನಿನಾ	2,5	50	425	2494.5	261.5	96	2012	002	142	97	5		تعسر	11			<u> </u>

STAT DRUGS TIME

AT 2200 T. ELOSPIEN HEMY PLOSTAT

PREVIOUS DAY ..... HRS

TOTAL INTAKE:

**URINE:** 

DRAINAGE:

**TOTAL OUTPUT:** 

**TOTAL BALANCE:** 





. .

	DAY	EVENING	NIGHT
PATIENT CARE		1	
BATH			
ORAL CARE			/
EYE CARE			/
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			_
WOUND			~
CEN.LINE			
I.V.SET			/
TUBINGS			/.
HUMIDIFIER H2O			(
ELECTRODES			/
ALARMS VERIFIED			
VENT - HUMIDIFIER			<u>.                                    </u>
-SETTINGS			
HRT.RATE			89 your
B.P.			123/72 Cum

B.P.	IE .		123/12 Cum
		DEMANDIO (DI ALI	-
DATE	TIME	REMARKS / PLAN	

INFUSION PU	MPS	-					
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
7,5mm ETTUBE	PIXEP 200m	11/12/23	١			•	1
NGTUBE		11/12/23	1				
エブレ	RF	11/12/23	1			<u> </u>	P
ART HNE	RAD	11/12/23	ł				P
PERLLINE	RET	11/12/28	ı				p
MEDIA.		11/12/23	(				, p
LEFTPUE	2 <sub>P</sub> i	11/12/23	1				P
S-TUBIHOT		11/12/23	1				P
02-TURING		11/12/23	1			<u> </u>	Ď
TR-DONE		11/12/22	\				'n
IV EXT		11/12/23	(			_	P
MAQ UET		11/12/23	1				, -
七ル	Rt	n/12/23.	ł				D
) 		<u>-</u>					
		<u>-</u> .					
	'es	-					

	Mrs.PREMA T	Ĵ	
Name	52/Female/MHJ202381034 09/12/2023/IPH202302466		Sheet No.
UHID No.	Dr.Anbarasu mohanraj	Sex	
Blood Group	B POSITIVE Height Weight bleps	BSA I.blan2	. <b>D</b>





MHI/ICU/2022/076



Every heart beat counts

#### **HAEMODYNAMICS**

#### **Blood Group:**

		INF	SNOISL			1	ORAL	TOTAL	TOTAL		Dictional					LAP/		PP			01/15	
DATE	TIME			nus	TOTAL	AMT.	TOTAL	INTAKE	TOTAL BALANCE	HR/mt	RYIHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	R/L	CO	CI	SVR	
1211212	71:30			2.0	24.0	loo	lpo	102	48	82	SINUL	<u>0</u> 03	147/ 163	93	8		Warm	4.				
	£120			2.0	29.0		Loo	152	िठ	84	Stru	D <u>0</u> 3	(143) AD	9.5	£		Warm	4				CRITICAL
	9:30			2-0	2.0	160	260	304	144	1	ZI WI				a		CNOWY	<u> </u>				E E
	10:30			2-0	2, 0	(SD)	400	452	<u> </u>	86	SLNU	D-0-1					Non	++				CAF
	ીાક્ર			• <u>.</u>		900	600	662	200	81	Sim	<b>D</b> -07					MONEU	<u>}-1.4-</u>		_	_	1
	12:30					50	640	102	1		l	l					৩থ্রত	++	,			80
	13:30					100	750	802	368	<u>8</u> 5	Struu	0,04	-				ww	+-7	,			CAREFLOWCHART
	14130					loo	850	902	3,8	91	\$1 N	0.10			,	1	æ	4-1				~
	15,39					150	1000	1052	418	38	Sinu	010					oen	++-		_		
	6.30					200	200	1252	368	73	عرس	0.08					w	44				

STAT DRUGS TIME

PREVIOUS DAY 18 HES TO MINKS

DRAINAGE: 430 ml TOTAL INTAKE: 2494,5 ml

URINE: 1785 ml TOTAL OUTPUT: 2233 ml

TOTAL BALANCE: + 261.5 ml

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			_
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE	23bpm	85 bm	
B.P	160 maby	118/72	

-

D.3 .		(DUTINICIONAL (18) The	
		mult	
DATE	TIME	REMARKS / PLAN	
,			
		<u>.</u>	

INFUSION PU	MPS							
LINES/TUBES	SITE	INSER DAT		DAYS	INFUSION/ DRAINAGE		Y EVE	NIGHT
IJV _	RT		123	2		P	P	 <del> </del>
ART LINE	RI	). 11 /12	123	2		Ρ	R	ļ
PERI. LINE	Ri		2/23	2		· P	.P	ļ
MEDIA		11/12	2/23	2	_	<u> </u>	R	
PLE-UKA	LT	11/62	123	2		ρ	R	<u> </u>
3-TUBINU	•	11/13	-123	2		ρ	IR.	ļ
DA JUBIHU		11/12	23	2		ρ	<u> </u>	
TR.DOME			2/23	2	<u> </u>	ρ	R	ļ
TV FATAL		11/12	123	2			1	<u> </u>
*		+_						ļ
	-			ļ				ļ
					_			
			_					<u> </u>
					_			<u> </u>
								ļ
							$\bot$	<u> </u>
			_					<u> </u>
								<u> </u>
							_	<u> </u>
								ļ
		ı						







52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj

WILLIAM DE STANDARD S

# INTERMEDIATE CARE FLOWCHART

A

UHID NO:

AGE:

SEX:

(D)

SURGICAL PROCEDURE:

POSTOP DAY: POD -T

OPCAB X 2 GRAFTS

LIMA -> LAD

SVG->PDA.

Dos | 11:12:2023

FLUID REQUIREMENT: 2-4 Willday.

1	DATE	UR	INE	CH	IEST D	RAIN	AGE	TOTAL	LUIDS		ORAI	_/ R.T.	TOTAL	TOTAL BALANCE		
,	& TIME	н.т.	G.T.		AIR LEAK	H.T.	G.T.	TOTAL OUTPUT		I		H.T.	H.T.	G.T.	INTEKE	BALANCE
3/12	123												ιt©	100	100	100
	8:30 	400	HWO					400					100	200	مرد	200
	9.30		<b>ी</b> ७0					400	2010				100	300	<i>3</i> 00	[00]
	10.30		1800					400	50			50	100	Ąю	450	250
	11.30	200	600					600				50	œ	भङ	500	100
								_								
					,									,		
	į															
	SPEC	IFIC O	BSERVA	TIONS/	REMAR	KS	_		MEDICATION / DRUGS							
						,			_							







52/Fcmalc/MH1202381034 09/12/2023/IPH202302466

Dr.ANBARASU MOHANRAJ

# INTERMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

SURGICAL PROCEDURE:

POSTOP DAY : POD -I

OPCAB & 2 GRAFTS

LIMA -> LAD SVQ ->PDA-

FLUID REQUIREMENT: 2.4 let loay

DOS | 11:12:2023

DATE	UR	INE	С	HEST C	RAIN	AGE	TOTAL		I.V. F	LUIDS		ORAL	√ R.T.	TOTAL	TOTAL
& TIME	H.T.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				H.T.	H.T.	G.T.	INTEKE	BALANC
121225		2).				<b>-</b>	٠ - د د					6	11. 10	11.4-0	210
17:30	150	1720				50	470				ı	200	1400	1452	318
18120	100	1220	<del> </del>			50	1870					150	1550	1402	2-3
[o] - 3	75	1895	-			हेळ्	19145	-				-	1177	1602	34
20-30	70	1961	_			50	2025						1500	1601	412
£1-30	100	2065	-			50	21LS-					150	1700	1752	36
77.70	600	Abs				20	225						1700	147	463
J.3.30	120	2215				50	2335	(00			100	B	186	01902	- 43.
00.PJ	108	2085				JO.	2435	ره٥			200		हामा	2002	48.
জ ∙30	WO	2482	•			50	25.85	(୭७		·	১০০		1457	2102	432
0Y.20	80	2515				65	2655	ĮVO			400		175	2202	413
08.31	ſοο	2665	_			ζυ	2715	ાજ			500	II	で付り	2307	413
04.30	100	276	5			56	20815							2402	
05.3	)	2765	-			50	2815					100	1950	2502	313
<b>०६</b> ३०		276	_			50	2815						[%0	2501	513







52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj 

## INTERMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:



BLOOD GROUP: B' POSITIVE

HEIGHT:

141 cm WEIGHT: 66 Eys

B.S.A: 1.bl m2

HAEMODYNAMICS .									P. PARAMET	rers	INVESTIGATIONS /		
ТЕМР	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	INVESTIGATIONS / OTHER DATA		
08. V	9b	Ryvi	0.08	69	81	warn	++	೨৬	c)	947	On room air		
	юс	Q4m	Pord	123 60	<del>8</del> 6	wayon	++	اسلوا	d	935.	"		
	<del>86</del>	<u> </u>	0.03	102	79	bzuen	4+	30/m	d	95×	/1		
	82	gnu	0.03	122	91	waem	-)+	14/14	cl	94%	"		
	81	BAW	0. <u>05</u>	111	86	10cum	ifot-	funlos	- d	43%	r		
			, ,										
				•									
				-									
				_									
						_							
									•				
				_									

PREVIOUS DAY - HOURS

DRAINAGE SOM

URINE 2765

TOTAL INTAKE 2502 m/

TOTAL OUTPUT REPLIEN

BALANCE - 3/3 M)







52/Female/MHI202381034 09/12/2023/IPH202302466

Dr.Anbarasu mohanraj

188 (UN 1881) (UN 8888 1991 (UN 1881) (BANGE 1888 199

# INTERMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

BLOOD GROUP: B' POSITIVE

HEIGHT: 141 cms

WEIGHT: 66 kggs

B.S.A: 1.61 m

HAEMODYNAMICS .									P. PARAMET	ΓERS	INVESTIGATIONS /		
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA		
9795	90	Slry	010	113	82	سما	n ++	30/mt	<u>c </u>	96%	On	Room	Air
<u> </u>	97	كاس	0,10 	103	74	loan	+++	31 /2	cl	95/			
	92	કે <b>રા</b> નેગ્ર	_ დ-დ	11 <u>b</u> 174	&D	Wblo	, eter	30/W	- c1	લુકુપ્			
	94	sulv	0.07	117		- wan	44	20/1	cl	297			
_	PS	arly	0-04	121	94	waya	++	20/4	_ el	937	_		
985	86	צואטן	002	12/80	96	was	44	20/nJ	_	937	_		
:		शर्भाष्ठ	0.04	11.270	P. <b>9</b>	waam	++	22h,		93),			
	86	מאנצ	0 06	Å.		walm	++	20/4	4 01	941			
	92	Julis	too	112	₽L	Mark	ナナ	dahl	- 4	43%			
	વવ	Sidvo	0.09	35	81	พญพ	4	20/	. c)	947			
	aus	Stalu	£0.03	0 3	#	wer	++,	Zolul	- 0	9251			
94-1	Hor	stulu	15.09	106	Jo.	New	47	19h	2	95%	<u>.                                    </u>		
	99	sidu	009			·		24)W	01	941			
	<b>ሚ</b> የ	Statur	( )	(82	81	work	ન ન	204	el	94%			÷ '
PREVIOUS DAY - HOURS													

DRAINAGE

URINE

**TOTAL INTAKE** 

**TOTAL OUTPUT** 

**BALANCE**