

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



Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/1PH2024000049

Dr. ANBARASU MOHANRAJ



MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Anbarasu Mohanraj Speciality: CTVS

Advised Date & Time: 07/01/2024 @ 9:45

Provisional Diagnosis:

CABG - D VD

Reason for Admission: ☐ Medical Management ☒ Surgical Management

☐ Others (please specify details) _____

Admission Type: ☐ Day Care ☐ ER ☒ Ward

☐ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):

CABG

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

Expected Duration of Stay: 1-7 days

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

Payer: ☐ Self ☒ Insurance ☐ Others: _____

INSURANCE

Instructions to Nurse (if any):

Investigations
vitals monitoring

Any other Instructions (if any):

Doctor's Signature

Dr. Anbarasu Mohanraj

Reg. No: 55476

Reg. No.

55470

Date

07/01/2024

Time

10:00

For admission desk staff only:

Room Category:

☒ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others 202

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

07-1-24

9:44

07-1-24

9:44

Source:

☐ OPD

☐ ER

☒ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time

[Signature]

[Signature]

0192

07-1-24

9:44

DR. ANAND K. SINGH
07-1-24

ADMISSION FORM

Marital Status	Full Address	Telephone Number
	N' Block NO: 425, Thiru. vi. ka	8754413982
Occupation	Quarters, Teynampet, Chennai - 18	8610974485
Referred from	Date of Time of Admission	Date & Time of Discharge
Dr. Anbarasu	7/1/24 at 9:45	14/01/2024
		Total No. of Days
		8 days.
UNIT	MLC ☐ Yes ☒ No If Yes AR No. :	
Cardiothoracic		

FINAL DIAGNOSIS	ICD Code
Double Vessel Coronary artery disease.	I25.1
CAD - unstable Angina.	I20.8
Normal Left Ventricular Systemic Function	I50.1
Uncontrolled Type II diabetes mellitus ^{Ef - 50%}	E11.6

DATE	OPERATION / PROCEDURES	ICPM Code
10/01/24	Off Pump Coronary artery Bypass Grafting Surgery (OPCAB) x 2 Grafts: LIMA to LAD, SVG to PDA (Endarterectomy)	36.12 99.00

DATE	TYPE OF ANESTHESIA
10/01/24	☒ GENERAL ☐ SPINAL ☐ LOCAL ☐ REGIONAL ☐ EPIDURAL

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

Dr. Anbarasu Mohanraj Reg No: 55476 Signature of the Consultant	Signature of Medical Records Officer
---	--------------------------------------

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.


செவிலியர் கையொப்பம்

Signature of Admitting Nurse

தேதி

Date

07/11/24


எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian


உறவுமுறை (Husband)

Nature of Relationship

GENERAL CONSENT FOR ADMISSION

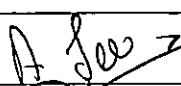
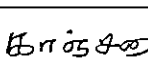
I, Jeeva, the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

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

- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.
- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.
- I also consent to receive communication on treatment related information via text messages and e-mail as per the details provided at the time of registration.
- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.
- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient		JEEVA.A	07/1/24	9:44
Surrogate/Guardian (if applicable #)		(Write name and relationship with patient)	07/1/24	9:44
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		(Sister)	07/1/24	9:44
Interpreter (if applicable)				

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



ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

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

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						
Doctor	Signature	Name	Reg. No.	Date	Time	
	<i>[Signature]</i>	Dr. Porawen	112231	10/1/24	12:00	

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS				MARK ✓ AS APPROPRIATE	
1	Stable hemodynamic parameters				✓	
2	Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent					
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					
6	Presence of distal pulses					
7	No signs of bleeding and hematoma at puncture site					
8	End of life care pathway chosen					
Doctor	Signature	Name	Reg. No.	Date	Time	
	<i>[Signature]</i>	Dr. K. Anusuya	134555	12/1/24	10:30	



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DISCHARGE SUMMARY

IP No.	: IPH2024000049	D.O.A	: 07/01/2024
UHID	: MHI202481615	D.O.D	: 14/01/2024
Name	: Mrs. JEEVA.A	Room No.	: 209
Age / Gender	: 54Years / 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: 10.01.2024

DIAGNOSIS:

DOUBLE VESSEL CORONARY ARTERY DISEASE

CAD - UNSTABLE ANGINA

NORMAL LEFT VENTRICULAR SYSTOLIC FUNCTION – EF: 50%

UNCONTROLLED TYPE II DIABETES MELLITUS

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2 GRAFTS: LIMA TO LAD, SVG TO PDA (ENDARTERECTOMY) DONE ON 10.01.2024

BRIEF HISTORY:

Mrs. Jeeva. A, 54 years old female, a known case of Uncontrolled Type II diabetes mellitus, Unstable angina, Double vessel disease, Normal LV systolic function, has come for CABG. Patient was doing well with medications till 20 days ago, when she developed chest pain – retrosternal, compressive type, radiating to left shoulder. H/o angina exertion – 2 months. Initially, she went to Royapettah Government Hospital on 31.12.2023 where she was diagnosed as CAD - Unstable angina. She was treated with DAPT, statin, LMWH and other supportive medications. She was advised Coronary Angiogram. She then went to Kilpauk Medical College and Hospital on 01.01.2024 and underwent Coronary Angiogram which showed Double vessel disease. She came to Medway Heart Institute on 05.01.2024 and 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 Palpitations, Syncope or Swelling of Legs. No H/O CVA, CKD, BA or Hypothyroidism.

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

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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IPNO: IPH2024000049

NAME : Mrs. JEEVA.A

UHID : MH1202481615

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP - 97.3° F
 HR - 92bpm
 BP - 110/60mmHg
 SPO₂ - 98% in room air
 CVS - S1S2 (+)
 RS - BAE (+)
 Abdomen - Soft, BS (+)
 CNS - NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	13.0	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	39.7	39-52	%
TWBC	8830	4000 - 10000	Cells/Cumm
NEUTROPHILS	66.9	40-70	%
LYMPHOCYTES	25.7	20 - 40	%
EOSINOPHILS	3.6	0 - 6	%
MONOCYTES	3.1	0 - 6	%
BASOPHILS	0.7	0 - 2	%
PLATELET	295000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Cells/Cumm
Urea	23	14 - 40	mgs/dl
Creatinine	0.54	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na+)	136	135 - 145	mmol/l
Potassium (K+)	4.64	3.4 - 5.5	mmol/l
T. Bilirubin	0.50	0.2-1.0	mg/dl
D. Bilirubin	0.15	0.00 - 0.4	mg/dl
I. Bilirubin	0.35	0.4-0.6	mg/dl
S.G.O.T	23	<38	U/L
S.G.P.T	25	<41	U/L
ALP	128	Adult: 42 - 141	U/L
GGT	41	Male : 10 - 45 Female : 5 - 32	U/L
Total Protein	7.1	6.0 - 8.0	gm/dl
S. Albumin	4.2	3.5 - 5.0	gm/dl

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NAME : Mrs. JEEVA.A

UHID : MHI202481615

IPNO: IPH2024000049

PROTHROMBIN TIME	10.6	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. Systemic Embolism : 3.0 - 4.5 INR	
INR	0.8		

HBA1C	11.8	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 (HbA1c is an index of your blood sugar control for the past (3 months)	%
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T.S.H	221	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	uIU/ml
T3	98	"Adult : 60 - 152 New born - 4 days : 96 - 730 1 - 11 Months : 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	10.7	"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 – 78bpm, sinus rhythm, No significant ST – T changes.

ECHO: EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 58ML, ESV: 29ML, EF: 50 %, AORTIC GRADIENT – MAX GRADIENT – 5 MM HG, MEAN GRADIENT – 3 MM HG, ALL CHAMBERS NORMAL SIZED, PARADOXICAL SEPTUM, ADEQUATE LV SYSTOLIC FUNCTION – EF: 50%, 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.

CXR: PA film, lung fields clear

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(A Unit of United Alliance Healthcare Pvt Ltd)

NAME : Mrs. JEEVA.A

UHID : MHI202481615

IPNO: IPH2024000049

COURSE IN THE HOSPITAL:

Mrs. Jeeva.A, 54 years old female, was admitted with above mentioned complaints. She underwent **OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2 GRAFTS: LIMA TO LAD, SVG TO PDA (ENDARTERECTOMY) ON 10.01.2024**. She was shifted to SICU with stable hemodynamics and Inj. Nor adrenaline 0.02µg/kg/min supports. She was extubated on the same day (10/01/2024) at 17.00 pm. Drains were removed on POD1 (11/01/2024). She was shifted to ward on POD 2 (12/01/2024). Suture removal was done on POD4 (14/01/2024). Patient course in the hospital was uneventful. Her medications are optimized and she is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR - 89/min BP - 110/80mmHg
SPO2 - 94% in room air

POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	11.2	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
Urea	19.0	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 ⁺)	134	135 - 145	mmol/l
Potassium (K ⁺)	4.09	3.4 - 5.5	mmol/l

ECG: 92/bpm, sinus rhythm, No significant ST -T changes.

ECHO : S/P CABG, ALL CHAMBERS NORMAL IN SIZED, NO REGIONAL WALL MOTION ABNORMALITY, ADEQUATE LV SYSTOLIC FUNCTION – EF : 54 %, MILD RV SYSTOLIC DYSFUNCTION, RV TDI : 8 CM/S, TAPSE: 12MM, ALL VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 5 MM HG, MEAN GRADIENT – 2 MM HG, TRIVIAL MR, MILD TR, NO PAH, MILD LEFT, MINIMAL RIGHT PLEURAL EFFUSION, NO CLOT / VEGETATION / PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, lung fields clear, no effusion.

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

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IPNO: IPH2024000049

NAME : Mrs. JEEVA.A

UHID : MH1202481615

ADVICE MEDICATIONS:

Sl. NO.	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. TICABID (TICAGRELOR)	1 TABLET	90MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. ECOSPRIN (ASPIRIN)	1 TABLET	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB.ROSUVAS (ROSUVASTATIN)	1 TABLET	20MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2 WEEKS
6	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
7	TAB. PREGALIN (PREGABALIN)	1 TABLET	75MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
9	TAB. LOPERAMIDE	1 TABLET		1	0	0	ORAL	AFTER FOOD	SOS
10	TAB. CIPLOX TZ (CIPROFLOXACIN + TINIDAZOLE)	1 TABLET	500MG / 600MG	1	0	1	ORAL	AFTER FOOD	X 3 DAYS
11	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	1 MONTH.
12	SYP ALEX PLUS (DEXTROMETHORPHAN HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
13	TAB.ANIXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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0884-2333367Heart Institute
044 - 4310 8959Institute of Pulmonology
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(A Unit of United Alliance Healthcare Pvt Ltd)

NAME : Mrs. JEEVA.A

UHID : MH1202481615

IPNO: IPH2024000049

DIABETIC MEDICATIONS:

SL NO	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. GLIZATO (GLICLAZIDE)	1 TABLET	60 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. METFORMIN	1 TABLET	500MG	1	1	1	ORAL	AFTER FOOD	TO CONTINUE
3	INJ. HUMAN MIXTARD ® (INSULIN ISOPHANE/ NPH (70%) + HUMAN INSULIN/ SOLUBLE INSULIN (30%))			20U	0	15U	S/C	BEFORE FOOD	TO CONTINUE
4	INJ. HUMAN INSULATARD (N) (INSULIN ISOPHANE 40IUML/ 10ML)			10U	0	8U	SC	BEFORE FOOD	TO CONTINUE

DISCHARGE ADVICE

DIET	HIGH PROTEIN, LOW SALT LOW FAT AND DIABETIC DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	NIL
REVIEW	REVIEW WITH DR. ANBARASUMOHANRAJ AFTER 23/01/2024 WITH FBS, PPBS, HB, UREA, CREATININE, SODIUM, POTASSIUM, 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

I have understood the Content of the discharge summary.

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

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MH/HOSP/2022/118



INPATIENT INITIAL ASSESSMENT

Date: 07/01/24

Time of arrival in ward: 11:00 PM.

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 93 (beats/min) | BP: 110/60 (mmHg)

Respiration: 21 (breaths/min) | SpO₂: 98 (%) | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 19.8 kg/m²

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

Pain Scale Used: ☒ Numerical Rating Scale (> 12 years) ☐ CPOT (ventilator / comatose)

Duration: Location:

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

A case of 54 years old female come in with c/o chest pain x 15 days. associated with fatigue. Chest pain was non-radiating. 15 days, the patient developed chest pain and sought consult in Rajapetthi GA and then sought consult in Private clinic where they suggested Angina and hence admitted here for further management.

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☒ Yes ☐ No. If Yes, duration: 10 years Hypertension: ☐ Yes ☒ No. If Yes, duration:

Others: K/c/o AD ~~respiratory~~ on regular medication.

Past Surgical History:

A/po LSCS 19 yrs ago & 12 yrs ago

Present Medication (for Medication Reconciliation):

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1-	Tab ATORVASTATIN (10mg)	2 Tabs	P/O	0-0-2		☒ Yes ☐ No
2	Tab. ISO SORBITRATE (5mg)	6 Tabs	P/O	2-2-2		☒ Yes ☐ No
3	Tab. CLOPILOT (75mg)	1 Tab	P/O	1-0-0	Stopped	☐ Yes ☒ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

Personal / Social History (Tick whichever is applicable)

Lifestyle: ☐ Sedentary ☒ Active Occupation: _____
 Smoking: ☐ Yes ☒ No Alcohol: ☐ Yes ☒ No Recreational Drug Use: ☐ Yes ☒ No
 Others: _____

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

Attained menopause @ 2017 → 4yrs
 Obstetric Hx
 1. + 19yrs } Delivered via LSCS.
 1. - 12yrs }

General Physical Examination:

Pallor: ☐ Yes ☒ No Icterus: ☐ Yes ☒ No Clubbing: ☐ Yes ☒ No
 Edema: ☐ Yes ☒ No Lymphadenopathy: ☐ Yes ☒ No

O/E: pt is conscious, oriented, afebrile.

SYSTEMIC EXAMINATION

CVS:

S₁S₂(+), no murmurs

Respiratory System:

B/L RVS(+), no added sounds

Gastrointestinal System:

P/A - soft, NTND.

Central Nervous System:

NTND.

Urinary / Reproductive / Locomotor System:

Skin / Ophthalmic / 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 ☒ No

Reduced dietary intake in the last week? ☐ Yes ☒ No

Is the BMI < 20.5? ☐ Yes ☒ No

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

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

Provisional Diagnosis:

CAD - DVD / ACS - unstable Angina / T2DM /
CABG / T2DM / normal LV function BP - 150 /
trivial MR / TR

Plan of Care:

Follow the drug chart
Monitor vitals
Look for decompensation
Conservative management

To do echo - ECG

Investigations Advised:*Report attached***Diet Advice:**

- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: *low salt diet*

Early Discharge Planning (fill in those which are appropriate at this stage):

PFE: Patient Family Education

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

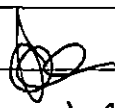
Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor	<i>[Signature]</i>	Dr. Sujith B	183573	21/12/23	14:10 PM
Consultant	<i>[Signature]</i>	Dr. R. Anu Mohanra Reg No: 55476	55476	07/01/24	15:45
Patient Attendant	<i>[Signature]</i>	Relationship HUSBAND	—	7/1/23	15:15

[illegible]

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DATE	NOTES
7/1/24	S/R. Dr. Lyndy B. (Dmo)
8:45pm	
BP-110/60	Case of C-AD-DVA. 1720m
HR-94bpm	plan - CABG
SpO2-98% on RA	pt. responsive
	• No complaints
	S/R - pt conscious,
	oriented
	Afebrile
	S/R - eu-R @
	RR - 20RR @
	<u>Adm</u>
	- vitals monitor
	- follow up chx
	- ECG monitor TPR
	- Infor sig
	- w/pt deterioration
	<u>MB</u>
	183813

DATE	NOTES
<u>7/1/24</u>	<u>S/B Dr. M. learned Hychoos</u>
19:00	
	A: CAD - DVD / T ₂ DM
	Plan: CABG & LA on Tuesday
	Patient Grooms
	Oriented
	Afebrile
Vitals	
<u>Stable.</u>	CUS → S ₁ S ₂ ⊕
	NS → BAE ⊕
	P/A → S ₄ , NT
	Adm
	- Monitor vitals
	- No follow up
	chart
	- No get Anesthes.
	Jensen
	
	USM



DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/24	S/B Dr. Mohamed hyder
10AM	Δ: CAD - DVD / T2DM. Plan: CABG & GA Tomorrow
	Patient cousin
	oriented Afebrile.
	<u>Vitals</u> PR - 87/min RR - 18/min BP - 120/80 mmHg SpO2 97% CUS → S1, S2 ⊕ RS → BA ⊕ P/A → S4, NT.
	<u>Plan</u> - Monitor vitals - To follow drug chart
	<u>Doc.</u> (16 AM)



it counts

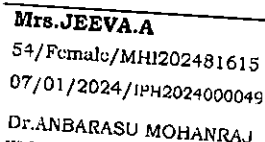
DATE	NOTES
08/11/24	S/B Dr. Anusuya
11.00	A - CAD - DVD / To DM patient reviewed. C/O: chest pain on a 0/5 O/E: patient conscious, oriented, Afebrile. S/E: - CNS - S/S 2 (+) - RS - BAE (+) - CNIS - NFND - P/A - soft, non-tender. Advice - monitor vitals - continue the drugs as per chart - plan: CABG on Tuesday wednesday - mobilise the patient
K.M (134557)	

DATE	NOTES
9/11/24	S/S Dr. Mohamed Hydrous.
10 AM	
	Δ: READ - DRY / T2 DM.
	Plan: CABG & CIA on Tomorrow
	Ⓢ. Patient comfortable
	Patient conscious
	oriented
	Afebrile
Vitals	CVS → S1 S2 ⊕
PR - 87/mm	Res BAE ⊕
RR - 20/min	Plas 87% NT
BP - 120/80 mmHg	
SpO2 87%	
	Plan
	- Monitor vitals
	- follow drug chart
	1600

DOCTOR'S PROGRESS NOTES

DATE	NOTES
9/1/24	Dr. Sijith. B. (DMD)
3:20 PM	Δ - CAD - DUA from
	Plan: CABG + mva
	PA - reviewed
	NO complaints.
	Dr. B. B. concur
	Oriented,
	Alert
	Dr. C. S. S. P.
	Dr. B. A. P.
	Adv
	- vitals monitoring
	- follow up diet
	- w/ hyperglycemia
	- Pfen 100
	RDS
	123 573

DATE	NOTES
09/1/24	S/B Dr. Anusuya
23:50	A case of CAD-DVD / T2DM
	Patient reviewed
	clp' chest pain on & off reduced now.
	OT/5' Patient conscious, oriented
Vitals stable	S/5' CMS - 5.62 ⊕
	RS - BAS ⊕
	CMS - NFM
	P/A - soft, non-tender
	Advice
	- monitor vitals
	- posted for CABG tomorrow morning 8am
	- NPO from 12 midnight
	- consent
	- post preparation
	- pre-medication
	- check pre-op CABG
	- shift to cath lab on call
K. B. B.	
134559	
10/1/24	S/B Dr. Anusuya
7:30	Patient reviewed
CABG - 286mg/dl	- posted for CABG today morning 8am
	pre-op orders followed
	pt can be shifted to OT on call
K. B. B.	
134559	



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4 heart beat counts

DATE _____

NOTES

@ 12.90

Mrs. Jeeva 54y/F underwent OPAB x 2 grafts

she was shifted to size 2 following hemodynamics.

HR - 74 BPM

Bp - 116/54 mmHg

crp - 5 mmHg

$SpO_2 = 100\%$

ventilator.

modo 1 vc

plasma 60%

Page: Twenty

Supports

Inj. noradrenaline 0.02 mg/kg/min

plan:

clean & excrete when fully awake

pos $\frac{8}{11234}$

Dr. Barbara J. J. J.
PA. Kertika (04/02/16)

DATE	NOTES
11/01/2024 @8.00	S/B : Dr Anbarasu / Dr. Rajesh / Dr. Praveen
P.O.D #1	s/p : OPCAB x 2 grafts
Hb - 11.2	. patient comfortable
U - ~~6.00~~	O/E : conscious , oriented . Afebrile
cT - 0.50	. BP - 142/50 mmHg
Na - 133	. HR - 108 bpm
K - 4.01	. SPO ₂ - 94% on room air
RBS - 210 mg/dl	. I/O - 2358 mL / 2189 mL ; Bal (+) 169.1 mL
ABG	. On weath
pH - 7.401	. Adequate urine output
plO ₂ - 38	. Tolerating oral feeds
pO ₂ - 72	. peripheries warm (+)
HCO ₃ - 23.1	Supports : Nil
BE - (-) 1.7	Total drain : 400 mL
	<u>plan</u>
	- RF - 2 L litres/day
	- Good chest physio
	- Remove drains & artery line.
	- mobilize
	- Nebulization
	- Spirometry
	- TIMETOPROLOL 25mg 1-0-1
	- Packed Dextro medication
	Gpraveen 11/22/24



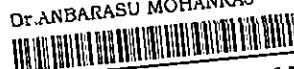
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Mrs. JEEVA.A

Mrs. JEEVA.A
54/Female/MH1202481615
07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



2022/041

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Seat counts

DOCTOR'S PROGRESS NOTES

[illegible]

NOTES

12/1/24

10:00pm

Dr. Sujith B. (Dane)

POB-2

SP-OPCAS X2grft

pt. reviewed. - no complaint

pt. concy.

oriented

Alert

BP - 150/70 mmHg
HR - 80 bpm
SpO2 - 98% LRA

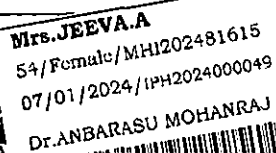
Stencils - P, S, P

Re - BAB P

Adm

- vitals monitoring
- PR 2L/ay
- chest physio
- Spironolactone, nebulizer
- w/PR diuretic
- 2 for 30s.
- follow up chart

nh
183003

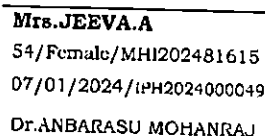


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DATE	NOTES
13/1/24	S/B Dr. Mohamed Hyman.
10pm	Post OP case of OPCAB & grafts
	POD - III,
	Patient Conscious
	Oriented
	Afebrile
	Vitals
	Stable
	CS - S/S ⊕
	MS - B/A ⊕
	PIA - soft, NI
	Adm
	- monitor vital
	- To allow di
	Chart
	- F-R - 21/20
	- Spirometry 1
	Rebule
	- Chest Physio
	(Heron)

DATE	NOTES
14/1/24	S/B Dr. Anbalagan & kam
10:40 AM	PT reviewed.
	plan d/c tomorrow
	Sugar orders to be altered - D/W with
	Dr. Praveen - change
	Continue others.
	 12/2/08.
14/1/24	S/B Dr. G. Lakshmi deega.
10:30 AM	PT reviewed.
	No new complains
	O/E. Conscious
	Oriented
	afebrile
	vitals stable.
	S/E. CuS-SiS_2+
	MC. BAET
	PA soft.
	CNS - moles all 6 limbs
	Adv
	Monitor vitals & dr
	follow drug card
	Inform SOS.
	 12/2/08



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Art beat counts

DATE _____

NOTES

14/1/24

10/17/71

S/B Dr. Mohamed Hydrous.

Post OP care of OPCAB & 2 grafts.

POD-15

Parent Cousins

oriented.

Afexile

~~vitalis~~

PR- 82 1min
1min

PR -	18/min
PR -	18

RR- 18/III
100/80mmHg

68-

8/02-971.

$$NS \rightarrow S_1 S_2 \oplus$$
$$n \rightarrow BA \in \textcircled{4}$$

$P/Q \rightarrow \text{Set}, N$

Adw

- Monitor vitals -

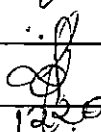
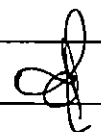
- To follow dig chart

- F.R - 2 litre/day

- chest Physio / Spirometry

- Plan: Die Form



DATE	NOTES
15/1/24.	S/B Dr. G. Lakshmi
9:30AM	P. reviewed.
	~~4/2 vomiting~~ } ↓ c/o back pain (upper)
	~~nausea~~
	O/E conscious
	Oriented vitals stable
	afebrile
	S/E. CUS-S ₁ S ₂ +
	RS - BAE +
	PA - soft
	Adv
	monitor vitals
	plan d/c today
	inform s/s.
	
	12/06/28
15/1/24.	S/B Dr. Anbalasu.
11AM.	
	D/c today -
	Review after 10 days
	
	12/06/28



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Mrs. JEEVA.A

54/Female/MHI202481615

Name : 07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ

Ward :



PRE-OPERATIVE CHECKLIST

Age : 54 Yrs Gender : F

UHID No. : 202481615

Bed No. : 202 B

B.S.

A.S.

Clinical Diagnosis :

CORONARY ARTERY DISEASE - DOUBLE
VESSEL DISEASE

Proposed Procedure :

CORONARY ARTERY BYPASS GRAFTING

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..... 150 CMS b. Weight..... 49.5 Kgs	✓	✓
5.	Allergic to drugs ? NOT KNOWN	✓	✓
6.	Surgical Preparation done ?	✓	✓
7.	Nill by Mouth From 12 MIDNIGHT	✓	✓
8.	Blood Grouping & Rh Typing 'B' POSITIVE	✓	✓
9.	Investigation ☒ X-Ray ☒ ECG ☒ LAB	✓	✓
10.	Blood Sugar..... 286 mg/dl Time..... 6.30	✓	✓
11.	TPR Chart Pulse..... 82 b/m Temp..... 97.2°F BP 140/80 mmHg RR 20 b/m	✓	✓
12.	Time Voided a. Retention ☒ Yes ☐ No	✓	✓
13.	Enema ☐ Yes ☒ No	✓	✓

14.	a. Prosthesis Removed ☐ Yes ☐ No / ☒ Not Applicable b. Plates present Removed ☐ Yes ☐ No / ☒ Not Applicable c. Contact Lenses Removed ☐ Yes ☐ No / ☒ Not Applicable d. Dentures Removed ☐ Yes ☐ No / ☒ Not Applicable	✓	
15.	Valuables and Jewellery Removed ☐ Yes ☒ No Secured ☐ Yes ☒ No	✓	✓
16.	Pre-Operative Medication Administered <u>T. RANTAC 150MG, T. ALPRAX 0.25</u> a. Time <u>21:00</u> b. Nurse <u>E. Cathrine</u>	✓	✓
17.	Blood Transfusion requisition Onchart	✓	✓
18.	X-Ray <u>1</u> No	✓	✓
	ECG / ECHO <u>3/1</u>	✓	✓
	Ultra Sound <u>-</u>		
	C.T. Scan <u>-</u>		
	MRI Scan <u>-</u>		
	TMT <u>✓</u>		
	Medication		
9/10/24	T. RANTAC 150 MG } given @ 21.00	✓	
	T. ALPRAX 0.25 mg }		
10/10/24	T. ALPRAX 0.5 mg } given @ 5.00	✓	
	Others		

E. Cathrine
0207
Nurse Signature

Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name **MRS. JEEVA** Age **49y/f** UHID

Diagnosis **CAD - DVD / ACS - unstable Angina T2DM** Plan **CABG**

Serology

EURO Score / STS Score **1.27%**

PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):

Diabetes Mellitus (HB1AC) **11.8**

Associated Illness **T2DM**

Carotid Doppler **-**

Thyroid Enzymes

T3 - 98
T4 - 10.7

TSH - 2.21

Sr. Creatinine **0.6**

Any other illness of concern

Allen's Test

Myocardial viability if needed

Varicose Veins **-**

Pulmonologist Clearance **-**

Nephro Clearance:

Neurology Clearance : **-**

Dental Clearance:

Mitral Regurgitation Assessment

Trivial MR

Nursing:

Billing Clearance:

Physiotherapy

Spirometry taught

Concerns from Surgical Team :

KAB
12/05/24
SIGNATURE:

Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/1PH2024000049
Dr. ANBARASU MOHANRAJ

CONSENT FOR SURGERY

1. Mr./Ms./Mrs. Jeeva ☒ the Patient or ☒ Representative of patient have (Please tick correct option and below):

☒ Read

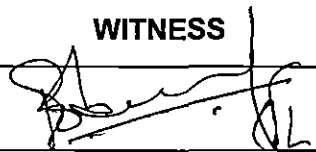
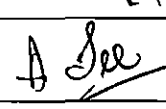
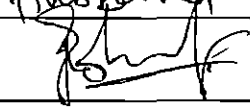
☒ I/We have been explained the current clinical condition of me/my patient

☒ Been explained this consent form in English, which I fully understand and understood the information provided about the disease Coronary artery disease - D.V.D. D.M. Adequate IV, EF - 60% and about the procedure Coronary artery Bypass Grafting (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 Re-exploration
- 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 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 need arises.
- 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.

- Possible risks & complications ①. Bleeding ②. Infection
③. Arrhythmias ④. Stroke ⑤. prolonged ICU stay /
ventilation ⑥. mild risk to life
- Benefits Relief from symptoms
- Alternatives medical management / PCA
- The likelihood of success of the surgery (Percentage / Other comments) 76%
- Possible results of non-treatment cardiac failure
myocardial Infarction
- 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.

Euroscore II: 1.27%

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	A. JEEVA	 L. ROBERT
Relationship	SELF	Husband
Signature		
Date & Time	9/1/24 at 18-30	9/1/24 at 18-30
Name & Signature of Doctor with Registration No.:  55476		

Dr. Anbarasu Mohan
Reg No: 55476

Doctor Seal

நோயாளி விவரங்கள்: (Affix Label here)

பெயர் :

UHID :

பிறந்த தேதி : யாமினம் :

அறுவை சிகிச்சை ஒப்புதல் படிவம்

1. நான் நோயாளி அல்லது நோயாளியின் பிரதிநிதி தயவுசெய்து மேலேயும் கீழேயும் பொருத்தமானதை தேர்வு செய்யவும்

☐ படியுங்கள்

☐ எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.

எந்த ஒப்புதல் படிவம் ஆங்கிலத்தில் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகிச்சையின் செயல்பாட்டின் முழுப்பெயர் அல்லது முழு பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.

- 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 சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கிறேன்.

நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில நேரங்களில் திட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்

- மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நிர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் (ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).

- இந்த அறுவை சிகிச்சை / நடைமுறையின் போது மருத்துவர் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவார் என்பதையும், தேவை ஏற்பட்டால் தொடர்புடைய நிபுணர்களிடமிருந்து மருத்துவர் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது அறிவேன்.

- சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் _____
- நன்மைகள் _____
- மாற்றுவழிகள் _____
- அறுவை சிகிச்சையின் வெற்றி வாய்ப்பு (சதவீதம் / பிற கட்டளைகள்) _____
- சிகிச்சையின்றி சாத்தியமான முடிவுகள் _____
- செயல்பாடு / நடைமுறை மற்றும் வழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்பார்க்கப்படும் போக்கையும் நான் அறிவேன். d நேரங்களில் தீவிரமான பராமரிப்பு அலகு மற்றும் / அல்லது மருத்துவமனையில் அனுமதிக்கப்படும் கால அளவு தேவைப்படலாம் மற்றும் / அல்லது கூடுதல் மருந்துகள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம். இதன் மூலம் உடல் சிகிச்சையில் அதிகரிக்கும்.
- இந்த செயல்பாடு / நடைமுறையை நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய எந்தவொரு தீசு அல்லது உடல் பகுதியை அகற்ற மருத்துவமனையை நான் அங்கீகரிக்கிறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட தகவல்களை நான் பெற்றேன் மற்றும் முழுமையாகப் புரிந்து கொண்டேன் என்று அறிவிக்கிறேன். எனது வியாதி, செயல்பாடு / நடைமுறை தொடர்பான கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அதன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும் நோக்கம் கொண்ட நன்மைகள் மற்றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும் பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நான் கையெழுத்திடும் நேரத்தில் என் முன்னிலையில் செருகல் மற்றும் நிறைவு செய்ய வேண்டிய அனைத்து துறைகளும் (இந்த வடிவத்தில் நிரப்பப்பட்டன என்று நான் மேலும் அறிவிக்கிறேன்.

விபரங்கள்	நோயாளி / உறவினர்	சாட்சியம்
பெயர்		
உறவுமுறை		
கையொப்பம்		
நாள் & நேரம்		
மருத்துவரின் பெயர் மற்றும் பதிவு எண், கையொப்பம்:		

☐ General Anaesthesia Alternatives ☐ Spinal ☐ Epidural ☐ Others	Expected Results	Total unconscious state that may involve placement of a tube into the windpipe to maintain airway
	Technique	Drug injected into the blood stream, breathed into the lungs, or given by other routes
	Risks	Sore throat, injury to vocal cords, teeth, lips, eyes; awareness during the procedure, memory dysfunction / memory loss, aspiration pneumonia, permanent organ damage, brain damage
	Benefits	- Early Recovery - Relief of Anxiety
☐ Spinal or Epidural Analgesia / Anaesthesia ☐ With Sedation / GA ☐ Without Sedation Alternatives ☐ GA ☐ Others	Expected Results	Temporary decreased or loss of feeling and / or movement in the lower half of the body
	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal
	Risks	Nerve damage, persistent back pain, headache, infection, convulsions, bleeding / hematoma, toxicity due to local anaesthetic, chronic pain, medical necessity to convert to general anaesthesia, brain damage
	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions
☐ Major / Minor Nerve Block ☐ With Sedation / GA ☐ Without Sedation Alternatives ☐ GA ☐ IV Regional Anaesthesia ☐ Spinal/Epidural Anaesthesia ☐ Others	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
	Risks	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to local anaesthetic, medical necessity to convert to general anaesthesia, brain damage
	Benefits	- Pain Free - Safer under certain conditions

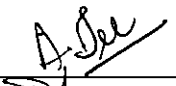
☐ Intravenous Regional Anaesthesia ☐ With Sedation / GA ☐ Without Sedation Alternatives ☐ Major/Minor Nerve Block ☐ GA ☐ Others	Expected Results	Temporary loss of feeling and / or movement of a limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risks	Infection, convulsions, persistent numbness residual pain, injury to blood vessels
	Benefits	- Pain Free - Safer under certain conditions
☐ Monitored anaesthesia care (with sedation) Alternatives ☐ General anaesthesia ☐ Spinal / Epidural ☐ Others	Expected Results	Decreased anxiety and light sedation similar to normal sleep
	Technique	Drug injected into vein of arm
	Risks	Prolonged sedation, need for airway control
	Benefits	Anxiety free; Early discharge
☐ Monitored Anaesthesia Care (without sedation) Alternatives ☐ General anaesthesia ☐ Mild Sedation ☐ Others	Expected Results	No changes in the system
	Technique	None
	Risks	Patient may have pain and anxiety
	Benefits	Early discharge

PRENATAL / EARLY CHILDHOOD ANAESTHESIA

- Potential long term negative effects on memory, behaviour and learning with prolonged or repeated exposure to general anaesthesia / moderate sedation / deep sedation during pregnancy and in early childhood
- 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

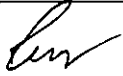
For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said operation / procedure on ☐ myself or ☐ my above named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient		A. JEEVA	9/1/24	18:00
Surrogate/Guardian (if applicable #)		L. ROBERT (Husband) (Write name and relationship with patient)	9/1/24	18:00
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		R. SUSHANA	9/1/24	18:00
Interpreter (if applicable)				

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

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned 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		Dr Jeevan M AM	8374	7/1/24	18:30

மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1. ☐ நோயாளி அல்லது ☐ நோயாளியின் பிரதிநிதி.

மேலேயும் கீழேயும் சரியான விருப்பத்தைத் தேர்ந்தெடுங்கள்! படித்தல்

என்னை / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்ட தகவல்களை நான் முழுமையாக புரிந்துகொண்டேன்.
செயல்பாடு / செயல்முறை _____

இந்த ஒப்புதல் படிவத்தின் கீழே கொடுக்கப்பட்ட செயல்பாட்டு நடைமுறையின் முழு பெயர்

- * எனது அறுவை சிகிச்சை நிபுணர் நடைமுறையின் அபாயங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி என்னிடம் கூறினார். எனது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து சேவைகள் தேவை என்பதையும் நான் புரிந்து கொள்கிறேன். இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.
- * அனைத்து வகையான மயக்க மருந்துகளும் சில அபாயங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத கடுமையான சிக்கல்கள் ஏற்படலாம். தொற்று நோய், இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு செயல்பாடு, பக்கவாதம், மூளை பாதிப்பு அல்லது மரணம் போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.
- * இந்த அபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை நான் புரிந்து கொள்கிறேன்.
- * சில நேரங்களில் உள்ளூர் மயக்க மருந்துகளைப் பயன்படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் முழுமையாகப் பெறாமல், மற்றொரு நுட்பத்தை மயக்க மருந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.

☐ பொது மயக்க மருந்து மாற்று மருந்து ☐ முதுகெலும்பு ☐ இவ்விடைவெளி ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாடையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை
	நுட்பம்	இரத்த ஓட்டத்தில் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகின்றன
	அபாயங்கள்	தொண்டைப்புண், குரல் வடங்கள், பற்கள், உதடுகள், கண்கள், செயல்முறை, நிலைவகை செயலிழப்பு, நிலைவகை இழப்பு, அபிலாஷைகள், நிரந்தர உறுப்பு சேதம், மூளை சேதம் ஆகியவற்றின் போது விழிப்புணர்வு
	நன்மைகள்	- ஆரம்ப மீட்பு - பதட்டத்தின் நிவாரணம்
☐ முதுகெலும்பு அல்லது இவ்விடைவெளி / மயக்க மருந்து ☐ மயக்க மருந்து / பொது மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல் மாற்று மருந்து ☐ பொது மயக்க மருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	உடலின் கீழ்பாதியில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு
	நுட்பம்	ஊசி / வடிகுழாய் வழியாக செலுத்தப்படும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாய்க்கு வெளியே வைக்கப்படுகிறது.
	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தப்போதல், ஹெமடோமா, உள்ளூர் மயக்க மருந்து, நாளப்பட்ட வலி, மயக்க மருந்து, மூளை சேதத்திற்கு மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை
	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிப்யூவில் பாதுகாப்பாக விடக்கூடிய எபிபிரி வடிகுழாய்களுடன் செயல்பட்டு வலி நிவாரணம்
பெரிய / சிறிய நரம்புத் தொகுதி ☐ மயக்க மருந்துடன் / பொது மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல் மாற்று மருந்து ☐ பொது மயக்க மருந்து ☐ IV பிராந்திய மயக்கமருந்து ☐ முதுகெலும்பு / இவ்விடைவெளி மயக்கமருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு அல்லது பகுதியின் தற்காலிக இழப்பு
	நுட்பம்	செயல்பாட்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகில் மருந்து செலுத்தப்படுகிறது
	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெமடோமா, உள்ளூர் மயக்க மருந்து, மருந்து, மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூளை சேதத்திற்கு மாறுதல்
	நன்மைகள்	- வலி இலவசம் - சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை

☐ நரம்பு மண்டலம் மயக்க மருந்து ☐ மயக்க மருந்து ☐ மயக்க மருந்து இல்லாமல் மாற்றுகள் ☐ பெரிய / சிறிய நரம்பு தொகுதி ☐ பொதுவான மயக்க மருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு இயக்கத்தின் தற்காலிக இழப்பு
	நுட்பம்	ஒரு டீர்னிக்கேயைப் பயன்படுத்தும் போது கை அல்லது கை நரம்புகளில் செலுத்தப்படுகிறது.
	அபாயங்கள்	தொற்று, வலிப்பு, தொடர்ச்சியான உணர்வின்மை, மீதமுள்ள வலி, இரத்த காயங்களுக்கு காயம்
	நன்மைகள்	- வலி இலவசம் - சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை
☐ கண்காணித்த மயக்க மருந்து கவனிப்பு (மயக்கத்துடன்) மாற்றுகள் ☐ பொதுவான மயக்க மருந்து ☐ மூதுகெழுப்பு / இவ்விடைவெளி மயக்க மருந்து ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	சாதாரண தூக்கத்தைப்போன்ற கவலையும் ஒளியும் குறைந்து வருகிறது
	நுட்பம்	கையின் நரம்பில் மருந்து செலுத்தப்படுகிறது
	அபாயங்கள்	நீண்ட கால மயக்கம், காற்றுப்பாதை கட்டுப்பாடு தேவை
	நன்மைகள்	கவலை இலவசம், ஆரம்ப கால வெளியேற்றம்
☐ கண்காணித்த மயக்க மருந்து கவனிப்பு (மயக்கம் இல்லாமல்) மாற்றுகள் ☐ பொதுவான மயக்க மருந்து ☐ இலேசான மயக்கம் ☐ மற்றவை	எதிர்பார்க்கப்படும் முடிவுகள்	கணினியில் மாற்றங்கள் இல்லை
	நுட்பம்	இல்லை
	அபாயங்கள்	நோயாளிக்கு வலி மற்றும் கவலை இருக்கலாம்
	நன்மைகள்	ஆரம்ப வெளியேற்றம்

கிற்புக்கு முந்தைய / ஆரம்பகால குழந்தை பருவ மயக்க மருந்து

- ★ நினைவாற்றல், நடத்தை மற்றும் கற்றலில் நீண்டகால எதிர்மறை விளைவுகள் பொது மயக்க மருந்து / மிதமான மயக்கம் / கர்ப்ப காலத்தில் மற்றும் ஆரம்ப பருவத்தில் ஆழமான மயக்கத்துடன் நீண்ட அல்லது மீண்டும் மீண்டும் மீண்டும் வெளிப்படுதல்
- ★ நான் / மேற்கூறிய நோயாளி / பெயரிடப்பட்ட நோயாளியின் பிரதிநிதி, இந்த வடிவத்தில் கையெழுத்திடப்பட்ட தேதி, மன ரீதியாக ஒலி மற்றும் எந்தவொரு பயமும் இல்லாமல் ஒப்புதல் அளிக்கிறேன் என்று நான் 18 வயதுக்கு மேற்பட்டவன் என்று இதன்மூலம் அறிவிக்கிறேன்.

மேற்கூறிய செயல்பாட்டிற்கு (எஸ்) / நடைமுறை (என்) எனக்கு தெரிந்துவிட்டது. நான் தானாக முன்வந்து எனது ஒப்புதலை வழங்குகிறேன்

டாக்டர் (டாக்டர்) டி. அல்லது டி-யில் கூறப்பட்ட செயல்பாடு / நடைமுறையை செய்வதற்கு அனுவை சிகிச்சை செயல்முறையைச் செய்வதற்கான டாக்டர் பெயர், நோயாளியிடம் முழுமையாக அறிந்திருக்கிறார். சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் மற்றும் சாத்தியமான மாற்றுகள்

நான் / மேற்கூறிய நோயாளி / பெயரிடப்பட்ட நோயாளியின் பிரதிநிதி, இந்த வடிவத்தில் கையெழுத்திடப்பட்ட தேதி, மன ரீதியாக 18 ஆண்டுகள் நிரம்பிய நான் எந்தவொரு பயமும், அச்சுறுத்தல் அல்லது தவறான அனுமதியின்றி ஒப்புதல் அளிக்கிறேன் என்று மேலும் இதன்மூலம் அறிவிக்கிறேன்.

	கையொப்பம் / கட்டை விரல் பதிவு *	பெயர்	தேதி	நேரம்
நோயாளி				
நோயாளிகளின் பிரதிநிதி / பாதுகாவலர் (பொருந்தும் என்றால்)		(நோயாளியுடன் பெயர் மற்றும் உறவை எழுதவும்)		
நோயாளிகளின் பிரதிநிதி சம்மதத்திற்கான காரணம்	நோயாளி ஒப்புதல் அளிக்க முடியவில்லை ஏனெனில்			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருந்தினால்)				

* நோயாளி ஒரு சிறியவராக இருந்தால் அல்லது சம்மதத்தை வழங்க முடியாவிட்டால் மட்டுமே ஆண்களுக்கான வலது கை மற்றும் பெண்களுக்கான இடது கை

நான் நியமிக்கப்பட்ட மருத்துவர், இயல்பு, சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள், நோக்கம் கொண்ட நன்மைகள், எதிர்பார்க்கப்பட்ட பின் நடைமுறைக்கு வரும் நடைமுறைகள் மற்றும் தீட்டமிடப்பட்ட செயல்பாடு / நடைமுறைக்கு சாத்தியமான மாற்றுகள், நோயாளி / நோயாளி பிரதிநிதிக்கு விளக்கியுள்ளார். இந்த ஆவணத்தில் விவரிக்கப்பட்டுள்ள தகவல்களை அவர் / அவள் முழுமையாகப் புரிந்து கொண்டார் என்று நான் நம்புகிறேன்.

	கையொப்பம்	பெயர்	பதிவு எண்	தேதி	நேரம்
பெற்றப்பட்ட ஒப்புதல்					



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ANAESTHESIA RECORD

MHI/OT/2022/094



Every heart beat counts

Patient Details (Affix Label here)

Name: **Mrs. JEEVA.A**
UHID: **54/Female/MHI202481615**
DOB: **07/01/2024/IPH2024000049**
DOA: **Dr. ANBARASU MOHANRAJ**
Con:

ASA Grade: ☐ I ☐ II ☒ III ☐ IV ☐ V ☐ E

Type of Surgery: ☐ Day Care ☒ Elective ☐ Emergency

Blood Group: **B⁺** Height: **150** cms Weight **49.5** Kgs

Pre-Operative Diagnosis:

CAD GIBF

Proposed Surgery:

OPCAB

Anaesthetic Plan

↓ GA

History of Present Illness:

- ☒ ANGINA
☐ DYSPNOEA
☐ SYNCOPE
☐ MI
☐ CCF
☐ OTHERS

Previous Surgery:

COMORBIDITY

- ☐ HT ☐ SMOKING
☒ DM ☐ ALCOHOL
☐ ASTHMA / COPD ☐ GERD
☐ HYPO THYROID ☐ CKD / NEPHROPATHY
☐ STROKE / TIA ☐ DRUG ALLERGY
☐ EPILEPSY ☐

Present Medication:

Anti Platelet Stopped on:

4/1/24

Physical Examination: **WNL**

- ☐ JAUNDICE ☐ PEDEL OEDEMA
☐ CYANOSIS ☐ CAROTID BRUIT
☐ CLUBBING

SYSTEMIC EXAMINATION

CVS: **S2+**

RS: **W Bst**

CNS: **ALND**

Others:

HR: **93** NIBP: **110/80** SPO2: **98%** TEMP: **36.1**

INVESTIGATION

HB: **13.2** T.BILIRUBIN: **0.7** T3: **93** SEROLOGY
PLAT: **3.7** I.D.: **—** T4: **10.7** Urine:
TC: **640** D.: **—** TSH: **2.21**
UREA: **25** T-PROTEINS: **6.7** HBA1C: **11.8**
CREAT: **0.6** S.ALBUMIN: **3.7** Others:
Na+: **144** PTT/INR: **—** RBS: **—**
K+: **4.4** APTT: **—**

ANGIO **TVD**

ECG **MR HR-75/min T4 11/24**

CXR **WNL**

ECHO **EF 50%**

GIBF NO RWNL

AIRWAY

eth **⊙**

Mallampatti class **II**

Mouth Opening **adequate**

Neck Movement **no limit**

TM Distance **10/12/14**

CAROTID DOPPLER

Pre OP Instruction:

NPO From: **12 MN**

Pre Medication:

Night Before Surgery: **PRANIL 150mg**

PRN 0.2mg

Day of Surgery

TAP 0.5mg at 8:00 am espinal

Special Instruction:

Blood Reservation

PCV: **10**

Platelet:

FFP:

CRYO:

Whole Blood:

Remarks:

Dr. JEEVANANDAM

Reg. No. 83722

Anaesthetist Name with Reg.No.: **Dr. JEEVANANDAM 83722**

Signature:

Date: 10/1/24	Anaesthetist: Dr A S Sylvester	Surgeon: Dr. Amberson, Dr. PRAVEEN	Anaesthesia Technique ☒ GA ☐ Regional ☐ Others					
PRE INDUCTION ANAESTHESIA RECORD		MONITORS AND EQUIPMENTS						
Pulse: 82/4 BP: 170/70 RR: 14/min Sensorium: WNL Sign-in Completed: ☒ Yes ☐ No Equipment Checked: ☒ Yes ☐ No Sign: [Signature] Name: Dr A S Sylvester Time: Reg. No: 43570		☐ NIBP ☐ Left ☐ Right ☐ ECG ☒ Pulse Oximeter ☒ End Tidal CO ₂ ☐ Gas Analyzer ☐ Oxygen Sensor ☒ Disconnect ☐ Temperature Probe ☐ Foley Catheter ☐ Nerve Stimulator ☐ TEE ☐ Others: ☐ CVC Type: [blank] Site: [blank] ☒ Standard Asepsis ☐ USG Guidance ☐ Complications: ☐ Yes ☒ No If Yes, details: [blank] ☒ Arterial Line - Type: 20 gauge Site: radial ☐ PVC Type: 18 gauge Site: [blank] ☐ PVC Type: [blank] Site: [blank] ☐ Others: [blank]						
PATIENT SAFETY		GENERAL ANAESTHESIA						
Position on Table: supine Pressure points checked & Padded: ☐ Yes ☒ No Eye Care: ☒ Yes ☐ No Safety Belt: ☒ Yes ☐ No Warming Blanket: ☐ Yes ☒ No Fluid Warmer: ☒ Yes ☐ No TED Stockings: ☐ Yes ☒ No Sequential Compression / Decompression: ☐ Yes ☒ No		INDUCTION: ☐ Pre O ₂ ☐ Rapid Sequence ☒ IV ☒ Inhalation - Agent used: Isoflurane Mode of Ventilation: ☐ Spontaneous ☒ Controlled AIRWAY MANAGEMENT: Intubation: Oral / Nasal ETT Size: 7.5 Type: CBTR CL Grade: I / II / III / IV Secured at: 22cm Any difficulties and accessories: Throat Pack: ☐ Yes ☒ No ☐ Removed NG / OG Tube: ☒ Yes ☐ No OTHER AIRWAY DEVICES: ☐ LMA Type & Size: ☐ Via Tracheostomy ☐ Face Mask ☐ Nasal Prongs ☐ Others: Antibiotic / Dose / Time Gy, cefuroxime 1.5g h - 9.15 am Reversal of Anaesthesia						
DRUGS	PROPOFOL							
	MIDAZOLAM	3						
	FENTANYL	125	75	50	75	50	50	75
	MORPHINE							
	VECURONIUM	6		2		1	1	1
	ETOMIDATE							
	KETAMINE							
	SUXAMETHONIUM							
	CISATRACURIUM/ATRACURIUM							
	SEVOFLURANE							
Air/O ₂								
VITAL SIGNS	Time	8:30	9:30	10:30	11:30	12:30	13:30	14:30
	Systolic V	200						
	Diastolic A	180						
	Pulse	160						
		140						
		120						
	Resp. ★	100						
	Operation ○	80						
		60						
	Temp X	40						
MONITOR	SPO ₂	100%	100%	100%	100%	100%	100%	100%
	CVP	5	7	7	8	7	8	6
	PAP							
	ETCO ₂	30	32	32	30	35	32	31
	Urine Output							
ABG	PH	7.368						7.387
	PCO ₂	49.4						34.0
	PO ₂	88.4						337.4
	Na ⁺	137						139
	K ⁺	3.75						3.53
	HCT	39						31
	RBS	236 mg/dl			138 mg/dl			127 mg/dl
	LAC							
	BE	-2.3						-0.3
	HCO ₃	27.6						23.5

		START	STOP	FLUID TRANSFUSED		BLOOD PRODUCTS	
ANAESTHESIA		8.30	12.00	CRYSTALOID	COLLOID		
PROCEDURE		9.45	12.50	Kabiglyte w " 30 " 40	Nil		
CPB							
AXC							
CUF:							
MUF:							
HEPARIN				PRESSURE MONITOR			
DOSE	TIME	ACT		PRE OP			
100 mg	10.37	350		PA	RV	PCWP	
				ABP			
PROTAMINE				POST OP			
DOSE	TIME	ACT		PA	RV	PCWP	
100	11.10	124		ABP			
INOTROPES & INFUSIONS							
DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME	DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
Nesofortine 4mg/50ml	102 - 0.5 mg/kg/min	10.20	Continued	NTG	25 mg/20ml	10.00	Stopped
Adrenaline 1mg/100ml	102 mg/kg/min	10.30	Stopped	Adrenaline	40 mg/kg		
REGIONAL ANAESTHESIA YES / NO				IABP: NIL			
DETAILS:				ECMO: NIL			
Bilateral Erector spinae - Popliteal 0.25%, PB 15+15+10+10 ml.				TEE: NIL			
Fentanyl 100 µg, 10 ml + Dexmedetomidine 50 µg							
REMARKS / CRITICAL EVENTS							
ANAESTHESIOLOGIST NAME :				SIGNATURE			
REG.NO.				Dr. A. SAMUEL SYLVESTER Reg. No: 43570			

POST OPERATIVE PLAN

Transfer to: ☒ SICU ☐ Others, specify: _____

Arrival in Recovery / ICU Time: 12:20

SpO₂: 100 % HR: 84 beats/min Rhythm: Regular RR: 14 breaths/min

ABP: 111/60 mmHg CVP: 6 mmHg PAP: - mmHg C.O.: - L/min

Conscious state: Sedated Pain score: -

VENTILATOR SETTINGS: Volume control;
RR 14/min; TV 450 ml; PEEP 5 mmHg;
FIO₂ 0.6.

IONOTROPES:

Sig. Noradrenaline 0.02 µg/kg/min

POST OP ORDERS:

- 1) Do ABC / check my / Act
- 2) Wound & antibiotic when fully awake

MODIFIED ALDRETE'S SCORE (Score against each criteria)

CRITERIA	PARAMETER	Scale
Activity, able to move, voluntarily or on command	4 extremities	2
	2 extremities	1
	No	0
Breathing	Able to breath deeply and cough freely	2
	Dyspnea, shallow or limited breathing	1
	Apnea	0
Consciousness	Fully awake	2
	Arousable on calling	1
	unresponsive	0
Circulation (Blood Pressure)	+20% of pre-anaesthesia level	2
	+20% to 49% of pre-anaesthesia level	1
	+50% of pre-anaesthesia level	0
SPO ₂	Maintains SPO ₂ >92% in ambient air	2
	Maintains SPO ₂ > 90% with O ₂	1
	Maintains SPO ₂ <90% with O ₂	0

Total Score: 10

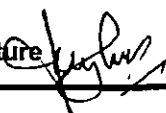
Patient fit for discharge:

☒ YES ☐ NO

Dr. A. SAMUEL SYLVESTER
Reg. No: 43570

Anaesthetist Name & Reg.No. :

Signature



OPERATION NOTES

Pre-Operative Diagnosis : CAD - DVD, Adequate LV - EF - 50%.

Post-Operative Diagnosis : -do-

Operation Procedure OPCAB x 2 grafts

LIMA → LAD

SV4 → PDA (Extensive

D.O. Operation

1	0	0	1	2	0	2	4
---	---	---	---	---	---	---	---

 Endarterectomy)

Please tick the type of procedure :

Closed ☒

Open ☐

Operation
Commenced :

9.45

Operation
Completed :

12.05

Nature of
Anaesthetic : GA

Surgeons - Dr. Anbarasu / Dr. Praveen / PA - Kartika Perfusionist -

Anaesthetist Dr. Sylvester

Nurse MS. Abitha

Incision Midline sternotomy

Cannulation

Arterial

Venous

Oxygenator

total CPB Time

Total ACC Time

Total TCA Time

Median sternotomy, pericardiectomy. LIMA & SV4 harvested. systemic heparinization. Heart stabilized with myocardial stabilizer (guidant). Distal anastomosis done with 7-0 prolene. LIMA → LAD, SV4 → PDA (extensive Endarterectomy). aorta occluded partially. one 4mm hole was made on the aorta. proximal anastomosis done with 7-0 prolene suture. protaminized. hemostasis secured. pericardium reapproximated partially. Routine chest closure done with two drain tubes inside.

Findings and Relevant Details :

good myocardial contractions

LIMA - 1.75mm, good flow, good quality

SV4 - 3.5mm, from left leg, good quality

LAD - 1.5mm, Healthy

PDA - 1.5mm, Extensive

Endarterectomy done.

POST-BY PASS HAEMODYNAMICS

RA

LA

Cardiac Output

RV

LA

CI

SVS

SYS

PA

MEAN

BP

MEAN

DIAS

DIAS

PACW

Support:

Isoprin

Adrenaline

Dopamine

I A B P

Dobutrex

Others inj. noradrenaline 0.02 µg/kg/min

POST-OPERATIVE INSTRUCTIONS :

Watch for: Bleeding, Hypotension

Blood loss: 250 mL

Blood transfusion: NIL

Drains: Chest (L1) - 1
Mediastinal - 1
Pericardial 2
Others

Sponge Count: correct



Surgeon : Dr. Anbarasu Mohanraj Date : 10/01/2024



JCI ACCREDITED



NABH ACCREDITED

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

NAME: MRS. JEEVA	AGE/GENDER: 54Years / FEMALE
UHID NO: MHI202481615	IP NO: IPH2024000049
DOA: 07/01/2024	DOS: 10/01/2024
SURGEON: DR. ANBARASU MOHANRAJ	ANESTHETIST: DR. SAMUEL SYLVESTER
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	PHYSICIAN ASSOCIATE: MS. KARTHIKA
SCRUB NURSE: MS. ABITHA	

DIAGNOSIS:**DOUBLE VESSEL CORONARY ARTERY DISEASE****NORMAL LEFT VENTRICULAR FUNCTION (EF – 50%)****UNCONTROLLED DIABETES MELLITUS****UNSTABLE ANGINA****SURGERY DONE:****OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2****LIMA TO LAD****SVG TO PDA (ENDARTERECTOMY)****FINDINGS:**

Good myocardial contractions

No significant scarring

Diffuse coronary artery disease

LIMA – 1.75mm, Good quality, good flow

SVG – 4mm, from left leg, Good quality

LAD – 1.6mm, plaques (+)

PDA – Calcified vessel, Endarterectomy done

Good distal run off in all the grafts

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1800 572 3003**Medway Group of Hospitals**

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

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118



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PROCEDURE:

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

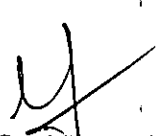
Heart positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.25mm intracoronary shunt was inserted. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD)

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and endarterectomy done. 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

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Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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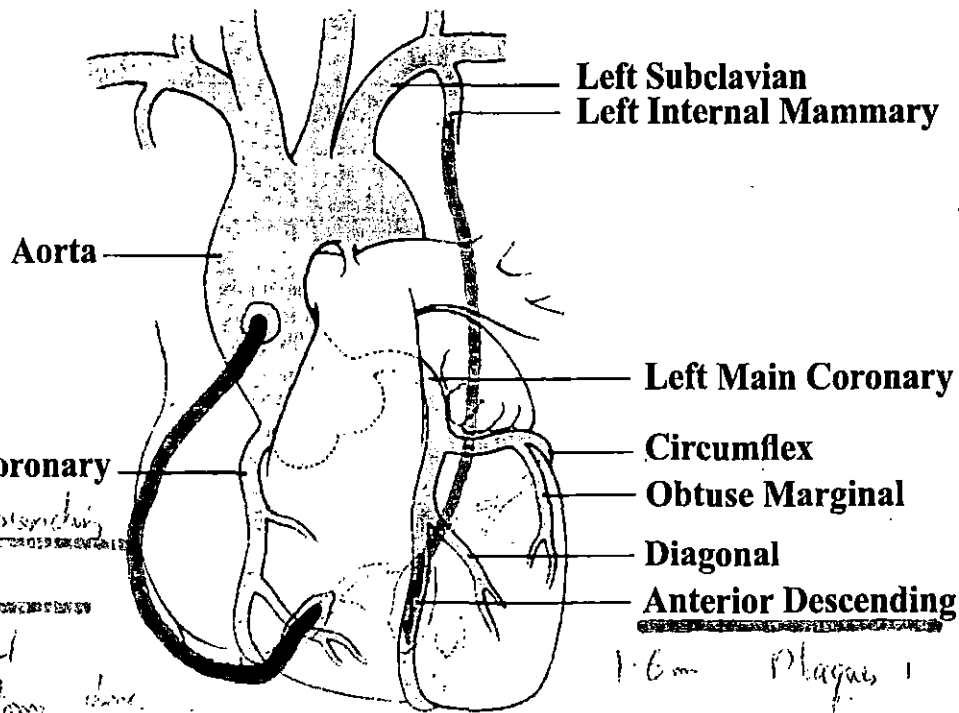
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(A Unit of United Alliance Healthcare Pvt Ltd)



Medway Heart Institute

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

Ischemic Heart Disease
Normal LV function
Unstable Angina
Hypertensive Uncontrolled Diabetes Mellitus



Good myocardial contraction

No significant stenosis
Diffuse coronary artery Disease
Left Internal Mammary Artery (LIMA) 7.1cm
Superior Vena Cava (SVC) 1.1cm

Name Mr. S. S. S. S. S4/E Date of Surgery 18/10/2024 UHID. No. 9112 20248161
Operation Performed DEB Pump Coronary Artery Bypass Grafting
(LIMA to LAD) (LIMA to LAD) (LIMA to LAD) (LIMA to LAD) (LIMA to LAD)
Per. Anubasir (Mohan) Reg No: 55476

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

NAME

Dr. ANBARASU MOHANRAJ



IT'S INFORMATION SHEET

	AGE / SEX	UHID NO
	SURGEON	ANAESTHETIST
DR. ANBARASU	DR. ANBARASU	DR. JEEVANANDAM

DIAGNOSIS (In Capital Letters)	1. CAD - DVD :
	2. ACS - UNSTABLE ANGINA
	3. NORMAL LV FUNCTION EF - 50%
	4. TRIVIAL MR / TR / PARADOXICAL SEPTUM
	5. T2DM
	6. -
	7. -
	8. -
PRESENT PROCEDURE/ SURGERY	CABG
PREVIOUS PROCEDURE/ SURGERY	H/O 2 LSCS done x. 2012, 2014 H/O CABG done on 01.01.24 showed DVD
CONTACT NO. & RELATIONSHIP	1. MR. ROBERT (HUSBAND) 2. 8454413982

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	01-01-24	T. ATORVAS	10MG	P/O	0-0-2	} continue
2	"	T. ISOSORBIDATE	5MG	P/O	2-2-2	
3	"	T. CLOPILET	75MG	P/O	1-0-0	
4		INJ. HIR		SLC	80-0-15	} continue
5		N		SLC	5-0-5	
6						
7						
8						
9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	07-1-24	T. ATORVAS	10MG	P/O	0-0-2	} continue
2	"	T. ISOSORBIDATE	5MG	P/O	2-2-2	
3						
4						
5						
6						
7						
8						
9						
10						

ANY RELEVANT INFORMATION:

Admission / OT Reveal Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer Out Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer In Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD	Year	Months	Days
	Recently Used		
	—		
	—		
4) Known Case Of Others			
Denture	☐ Yes ☒ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	☐ Yes ☒ No If you means mention about Drug / Food Name :		
Pressure Ulcer Present	☐ Yes ☒ No If you means mention about Grade : 1 / 2 / 3 / 4 & Site:		

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site:	1. Inserted Date and Time	1. Removed on :	
	2. Site:	2. Inserted Date and Time	2. Removed on :	
	3. Site:	3. Inserted Date and Time	3. Removed on :	
Neck Line : IJL / EIJ	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 : Inserted Date and Time		Removed on	
	2. Pleural Right / Left : Inserted Date and Time		Removed on	
Urinary Catheterization	Inserted Date and Time		Removed on	
Nasal / Oral Gastric Tube	Inserted Date and Time		Removed on	
Intubation Date and Time	Extubation Date And Time		Reintubation Date And Time	
Other Information	1 @ per resuscitation done confirmed with MR VENKAT			9/1/20 Sub

SAFETY FIRST

MHI/ICU/2022/092



Medway Hospitals



Every heart beat counts

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/1PH2024000049

Dr. ANBARASU MOHANRAJ



th
Ltd)

PATIENT'S INFORMATION SHEET

	AGE / SEX	UHID NO
CONSULTANT	SURGEON	ANAESTHETIST
DR. ANBARASU	DR. ANBARASU	DR. SYLVESTER
DIAGNOSIS (In Capital Letters)	1. CAD - DVD	
	2. ADEQUATE-LV SYSTOLIC FUNCTION	
	3. GRADE I DIASTOLIC DYSFUNCTION	
	4. TRIVIAL MA, TRIVIAL TR	
	5. EF - 60%.	
	6.	
	7.	
	8.	
PRESENT PROCEDURE/ SURGERY	OPCAB x 2 GRAFTS 10/1/2024. LIMA → LAD SVG → PDA (extensive endarterectomy)	
PREVIOUS PROCEDURE/ SURGERY	LPCS BEFORE 19 years & 12 years Ago	
CONTACT NO. & RELATIONSHIP	1. 8754413982 MR. ROBERT (V.C) 2. 9361469572 (MRS. MERLIN) (DAUGHTER)	

Nominal NO: 13/13

Cat: Insurance

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	7.1.24	T. ATORVASTATIN	10mg	P/O	0-0-2	Continue
2	07.1.24	T. LOSARTAN	5mg	P/O	2-2-2	
3						
4						
5						
6						
7						
8						
9						
10						

ANTIPLATELET - STOPPED on 4.1.24

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	10/1/24	SUSPENSION SUCRALFATE	10ml	P/O	1-1-1	Continue
2	10/1/24	NEB. LEVOALBUTHOL	0.62mg	INH	1-1-1	
3	11/1/24	T. FROSEMIDE	40mg	P/O	1-1-0	
4	11/1/24	T. SPARONALACTONE	25mg	P/O	1-1-0	
5	11/1/24	T. BEPLEX FORTE	1 tab	P/O	1-0-0	Continue
6	11/1/24	T. CLOPIDOGRELH + ASPIRIN	75/75 mg	P/O	0-1-0	
7	11/1/24	T. ROSUVASTATIN	20mg	P/O	0-0-1	
8	11/1/24	T. PARACETAMOL	650 mg	P/O	1-1-1	
9	11/1/24	SYP. CREMAFFIN PLUS	15ml	P/O	0-0-1	
10	11/1/24	T. METOPROLOL	20mg	P/O	1-0-1	

ANY RELEVANT INFORMATION:

Admission / OT Receival Date and Time : 10.1.24 12.20. From : OT To : SICU	Condition of the Patient : 1. Stable / Unstable ✓ 2. Oriented / Disoriented ✓ 3. Conscious / Semiconscious / Unconscious ✓ 4. Febrile / A febrile ✓ 5. Intubated / Extubated ✓		
Transfer Out 11/1/2024 AT 12:00 S1W to SDICU. Date and Time : 12/1/2024 AT 10:30 From : SDICU To : 209	Condition of the Patient : 1. Stable / Unstable ✓ 2. Oriented / Disoriented ✓ 3. Conscious / Semiconscious / Unconscious ✓ 4. Febrile / A febrile ✓ 5. Intubated / Extubated NA		
Transfer In Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD	Year 21 YEARS	Months	Days
4) Known Case Of Others			
Denture	☐ Yes ☒ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	☐ Yes ☒ No If you means mention about Drug / Food Name :		
Pressure Ulcer Present	☐ Yes ☒ No If you means mention about Grade : 1 / 2 / 3 / 4 & Site:		

ANY RELEVANT INFORMATION:

			Sign With Date
Peripheral Cannulation	1. Site: RIGHT CUBITAL 2. Site: 3. Site:	1. Inserted Date and Time 10.1.24 @ 08:20 2. Inserted Date and Time 3. Inserted Date and Time	1. Removed on : 2. Removed on : 3. Removed on :
Neck Line : IJL / EIJL	Site: RIGHT IJV	Inserted Date and Time 10.1.24 @ 08:35	Removed on 12/1/2024 AT 09:30 <i>mean 0286</i>
Arterial Line : Right/Left	Site: RADIAL	Inserted Date and Time 10/1/24 @ 08:30	Removed on 11/01/24 @ 11:00 <i>mean 0282</i>
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on
Pressure Bandage	Site: RADIAL	Inserted Date and Time 11/01/24 @ 11:10	Removed on 12/1/2024 AT 02:00 <i>mean 0286</i>
Drain Site	1. Mediastinal : Inserted Date and Time 10/1/2024 AT 12:00 2. Pleural Right / Left : Inserted Date and Time 10/1/2024 AT 12:00	Removed on 11/1/2024 @ 10:50	<i>mean 0282</i>
Urinary Catheterization	Inserted Date and Time 10.1.24 @ 08:40	Removed on 12/1/24 @ 04:30	<i>mean 0280</i>
Nasal / Oral Gastric Tube	Inserted Date and Time 10/1/24 AT 08:50	Removed on 10/1/24 @ 16:45	<i>mean 0282</i>
Intubation Date and Time 10/1/2024 AT 12:20	Extubation Date And Time 10/1/2024 AT 17:00	Reintubation Date And Time	<i>mean 0286</i>
Other Information	C/O. CHEST PAIN X 15 DAYS. CAGT DONE ON: 1/1/2024. ECMO DONE ON: 5/1/2024 CHEST XRAY DONE ON: 5/1/2024		<i>mean 0286</i>

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086

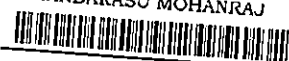


Mrs. JEEVA.A

54 / Female / MHI202481615

07/01/2024 / IPH2024000049

Dr. ANBARASU MOHANRAJ



Name of the Procedure : OP CAB (CLOSED HEART) Location : CTOT

Date & Time : 10/1/24 @ 12:15

Does the Procedure involve Procedural Sedation : ☒ Yes ☐ No

V/A

SIGN IN Before Induction of Procedural Sedation <u>8:30</u>		TIME OUT After procedural Sedation and before procedure <u>9:45</u>		SIGN OUT When Doctor indicates that the Procedure is completed <u>12:15</u>	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	☒ Yes	Identity by two identifiers	☐ Yes	Name of the Procedure done written down ☒ Yes <u>OP CAB (CLOSED HEART)</u>	
Procedure	☒ Yes	Procedures	☒ Yes	Name and site of all specimens / investigations ☐ Yes ☒ NA	
Side	☐ Rt ☒ Lt ☐ NA <u>leg</u>	Side	☐ Rt ☒ Lt ☐ NA <u>leg of chest</u>	confirms labeling and sent to lab	
Consent	☒ Yes	Position	☒ Yes	Any recovery concerns : ☐ Yes ☒ None	
Known Allergy	☐ Yes ☒ No <u>known</u> If yes, please specify	Consent	☒ Yes	If Yes, Pls. specify :	
Difficult airway / aspiration risk / dentures	☒ No ☐ Yes, equipment and assistance available	Required equipment and implants available	☒ Yes ☐ NA		
Possibility of hypothermia	☐ No ☒ Yes, warmer in place	Essential Imaging displayed	☒ Yes ☐ NA		
All concerned anesthesia equipment and medication check complete	☒ SpO2 ☐ NIBP ☐ Others pls. specify	Antibiotic prophylaxis within last 60 minutes	☒ Yes ☐ NA		
Pre OP medication taken	☒ Yes ☐ No	Name of the Antibiotic given <u>1g cefazolin</u>	☒ Yes ☐ NA	Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☒ None	
Required equipment for procedure available	☒ Yes ☐ NA	Venous Thromboembolism Prophylaxis Provided	☒ Yes ☐ NA	If Yes, Pls. specify : <u>Gauze, needle, sponges & Instruments</u>	
		Anticipated duration briefed	☒ Yes	<u>Counts or correct</u>	
		Anticipated blood loss briefed	☒ Yes ☐ NA	Corrective action :	
		Adequate fluids and blood available	☒ Yes ☐ NA		
		Team briefed on any critical or unexpected steps	☒ Yes		
		For procedural sedation cases	☐ Yes ☒ None		
		Any patient specific concerns :	☐ Yes ☒ NA		
		Intra procedure glycaemic control	☐ Yes ☒ NA		
		Any concerns about sterility	☐ Yes ☒ None		

Anaesthetist / Doctor giving
Procedural Sedation

Doctor performing the
Procedure :

Nurse : R. 238 Deelhi

Technician : SATHYA

Others Please Specify :

Dr. A. SAMUEL SYLVESTER
Date : 10/1/24
Time : 12:15
Reg. No : 43570

Dr. Anbarasu Mohanraj
Date : 10/1/24
Time : 12:15
Reg. No : 55476

Date : 10/1/24
Time : 12:15

Date : 10/1/24
Time : 12:15

Date : 10/1/24
Time : 12:15

Christina

12:15



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:

1. 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.
3. 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.....
Doctor.....
Time.....
Date.....

Patients name.....
Patient signature.....
or Guardians name.....
Guardians signature.....
Relationship to patient.....

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, improve or reverse a life-threatening/emergent medical condition.

Time: 18.30 Date: 9/1/24

Dr. P. PRAVEEN
Reg. No: 86510

Doctors signature.....

Dr. P. PRAVEEN
Reg. No: 86510

ஒப்புதல்: இரத்தம் / இரத்தத்தின் பாகங்களை செலுத்துதல்

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

சிவப்பு அணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு
தட்டணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு
குருதிநீர்	இரத்த கனஅளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு
கிரையோபிரெஸ்பேட்டேட்	சிறப்பு உறைவு அம்சங்களுக்காக

எனக்கு /நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவன் விளக்கியுள்ளார்:

1. இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானாளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அலோஹெனிக்) அல்லது சுயமாக தானாளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தத்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானாளிப்பிற்கு வாய்ப்புள்ளது.
2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்பட்டிருந்தாலும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்களான எம்எஸ், ஹெபடைடிஸ் மற்றும் இதர வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அளிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையும் நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம், இவை, காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி மற்றும் அளிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும்கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொள்கிறேன்.
3. இரத்தம் செலுத்துவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, முளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலைத் துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம், என்றாலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
4. இரத்தம் செலுத்துதல், மாற்று சிகிச்சை முறைகள், சிகிச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தப்படவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய விவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.
5. முறையான மருத்துவப் பராமரிப்பின் பொருட்டு, இரத்தம் மற்றும் /அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சோப்பின் குறிப்பிட்ட காலத்தில் முடிவடைபடும் வகையில் அல்லது இந்நோயின் முழுமையான காலகட்டத்திற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக்கொள்கிறேன்.

நோயாளியின் பெயர்.....
சாட்சி..... நோயாளியின் கையொப்பம்.....
மருத்துவன்..... அல்லது பாதுகாவலரின் பெயர்.....
நேரம்..... பாதுகாவலரின் கையொப்பம்.....
தேதி..... நோயாளியுடனான உறைவு.....

உயிருக்கு ஆபத்தான/அவசரக்கால மருத்துவ நிலை காரணமாகத் தகவலறிந்த ஒப்புதல் பெறப்படவில்லை. தகவலறிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அளவிற்கு நான் போதிய அளவு தகவலை நோயாளிக்கு வழங்கிவிட்டேன், மேலும் ஓர் உயிருக்கு ஆபத்தான/அவசரக்கால மருத்துவ நிலையை மாற்றுவதற்கு, மேம்படுத்துவதற்கு, நேர்மறாக ஆக்குவதற்கான போதிய அளவில் இரத்தப் பொருட்களை வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான் மேற்கொண்டுள்ளேன்.

நேரம்:
நோயாளியின் பெயர்..... மருத்துவரின் கையொப்பம்.....
தேதி:

CONSENT FORM - PHYSIOTHERAPY

I, Mrs. Jeeva the ☐ Patient or ☒ representative 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 TAMIL (Name of language) which I fully understand and understood the information provided about Operation / procedure

Post operative Cardiac Pulmonary Rehabilitation
 (full name of operation / procedure given below in this consent form)

Brief description of the Operation / Procedure: Dr's, Spontaneous Spine, Chest percussion to be chest wall, from to be U/L, mobilization

I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are:

To Improve Joint ROM, To Improve lung capacity & function, To Improve breathing, To clear out lung secretion

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:

Nil

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.

Signature of Patient / Patient's Relative (only if Patient is unable to sign): R. Merlin

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

R. Merlin
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 #)	<u>R. Merlin</u>	<u>R. Merlin</u> (Write name and relationship with patient)	<u>10/11/24</u>	<u>18:00</u>
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	<u>S. Meena</u>	<u>MEENA SELVAM</u>	<u>10/11/24</u>	<u>18:00</u>
Interpreter (if applicable)				

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

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned 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	<u>G. K. Arora</u>	<u>AKASH GE</u>	<u>0256</u>	<u>10/11/24</u>	<u>18:00</u>
Procedure performed by	<u>G. K. Arora</u>	<u>AKASH GE</u>	<u>0256</u>	<u>10/11/24</u>	<u>18:00</u>

IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints:

PT 'clo' chest pain x 15 days. (Associated with fatigue)

Occupation: ☐ Heavy Activity ☐ Moderate Activity ☐ Light Activity

Past Medical / Surgical History:

K/clo DM.
K/clo CAD (On Regular Medication)
S/p LSCS - (19yrs ago & 12yrs ago)

On Observation:

Built: ☐ Thin ☒ Fair ☐ Well Built ☐ Obese | Postural Deviation: ☐ Yes ☒ No | Muscles Wasting: ☐ Yes ☒ No
Deformity: ☐ Yes ☒ No | Swelling: ☐ Yes ☒ No | Gait Deviation: ☐ Yes ☒ No | External Appliances: ☐ Yes ☒ No

On Palpation:

Tenderness: ☐ Yes ☒ No | Warmth: ☐ Yes ☒ No | Muscle spasm: ☐ Yes ☒ No
Oedema: ☐ Yes ☒ No | Crepitus: ☐ Yes ☒ No | Tone: ☒ Normal ☐ Abnormal

☐ INSIGNIFICANT

FALL RISK SCREENING NIL

Fall Risk Screening for Adults: ☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem

In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.

Fall Risk Screening for Pediatrics: NIL

☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged mobility
In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.

Respiratory Status:

☐ Room Air ☐ O₂ Support ☐ Ventilatory Support ☐ BIPAP
☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask
Intubated: ☐ Yes ☒ No
Tracheostomy: ☐ Yes ☒ No

Brain Injury (if applicable): NIL

☐ Traumatic ☐ Non Traumatic
☐ Mild ☐ Moderate ☐ Severe
☐ Conscious ☐ Unconscious

GCS: E +V +M = | RLA: levels

Spine Injury: ☐ Present ☒ Absent

AIS:ISNCSCI SCALE: NIL

☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx

Associated Injuries: Speech impaired: ☐ Yes ☒ No

Voluntary Movements: ☐ Present ☒ Absent | Tone Modified: ☐ Hypotonic ☒ Normal ☐ Hypertonic

ASHWORTH SCALE: NIL

☐ 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): NIL

Dyspnoea Grading Scale:

Abnormal Breathing Sounds: ☐ Wheezing ☐ Stridor ☐ Crackles ☐ Pleural Rub ☐ Pneumothorax Click ☐ Stertor

Abnormal Breathing Pattern:

Pain Assessment: Pain: ☒ Yes ☐ No

Pain Score: 6/10

Tick whichever is applied: ☒ Numerical Rating Pain Scale ☐ Visual Analog Scale ☐ Wong-Baker Faces
☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC

Location: Chest

Duration: 15 days

Frequency: —

Character: —

☐ Acute ☒ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness

☐ Sharp ☐ Cramping ☒ Stabbing ☐ Crushing

Aggravating Factors:

Relieving Factors:

Examination (Please tick and mention abnormal findings only):

☐ Range of Motion:

Normal

☐ Muscle Strength:

Normal

☐ Reflexes:

Normal

Plantar Response: ☒ Diminished ☐ Brisk ☐ Clonus

Biceps: ☒ Diminished ☐ Brisk ☐ Clonus

Triceps: ☒ Diminished ☐ Brisk ☐ Clonus

Supinators: ☒ Diminished ☐ Brisk ☐ Clonus

Knees: ☒ Diminished ☐ Brisk ☐ Clonus

Ankle: ☒ Diminished ☐ Brisk ☐ Clonus

Sensation: Good.

☒ X-Ray

☒ ECG

☒ ECHO

☐ CAG

☒ SIP Surgery

CAD - DVD/ACS - unstable angina / T2DM / Normal LV function EF 50%
Trivial MR/TR.

Physiotherapy Management Plan:

Doc, Spirometry so, Chest percussion to BL Chest wall,
AROM to BL ULce, Mobilization

Post OP Cardiothoracic rehabilitation Phase - I

AROM to BL ULce, Mobilize outside the room,
Stair climb encouraged.

	Signature	Name	Emp. No.	Date	Time
Physiotherapist	G.B. Gopal	AKASH.G.E	0256	10/1/24	13:00

RE-ASSESSMENT FORM

Date &
Time

12/1/24

f

11:00

Fall Risk Score: —

Pain Score: Surgical site pain

Surgery / Procedure : ORAB

Respiratory status Post OP :

— In Room Air

Post intention pain score : 2/10

Treatment case & plan :

~~Post~~ — Dorsal

— grommetry su

— Chest percussion to BLK chest wall

— ARon to BLK UL fu

— Mobilization

Post Intervention Pain Score: 3/10

Treatment Care & Plan:

Post-operative Cardiac Pulmonary Rehabilitation

Signature

Name

Emp. No.

Physiotherapist

G. E. Alred

AKA SH - G. E

0256



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Mrs. JEEVA.A

54/Female/MH1202481615

07/01/2024/PH2024000049

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
10/1/24	17:00	<u>S/B Akash</u> - PT entubated - ET (oral nasal) suctioning done yielded thick white secretions - PT voice clear & audible - PT Nebulized - SPT Connected to O₂ - 6 litres - Spirometry encouraged Ins: 600cc Exp: 600cc	<i>[Signature]</i> MH10256
10/1/24	22:00	<u>S/B Ramanathan-P</u> - DBE's encouraged - Chest percussion to B/L Chest wall - AROM Ex's to B/L UL & LL - Spirometry Ex's encouraged Ins: 600cc Exp: 600cc	<i>[Signature]</i> MH10260
11/1/24	6:00	<u>S/B Ramanathan-P</u> - DBE's encouraged - Chest percussion to B/L Chest wall - AROM Ex's to B/L UL & LL - Spirometry Ex's encouraged Ins: 600cc Exp: 600cc	<i>[Signature]</i> MH10260



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
11/1/24	9:00	S/B <u>AKASH</u> - DEET encouraged - Spirometry ex encouraged Ins: 6000 Exp: 6000 - Chest percussion to BL Chest wall - AROM to BL CL & LL	G.F. <u>AKASH</u> MH10256
11/1/24	16:00	S/B <u>AKASH</u> - DEET encouraged - Spirometry ex encouraged Ins: 6000 Exp: 6000 - Chest percussion to BL Chest wall - AROM to BL CL & LL	G.F. <u>AKASH</u> MH10256
11/1/24	22:00	S/B <u>Damanathan: P</u> - DEET's encouraged - Chest percussion to BL Chest wall - AROM ex's to BL CL & LL - Spirometry ex's encouraged Ins: 6000 Exp: 6000	<u>P</u> MH10256



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Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
12/1/24	6:00	<u>S/B Ramanathan P</u> - DBE's encouraged - Chest percussion to BL Chest wall - ARom Ex's to BL UL RU - Spirometry Encouraged. - Ins: 600cc Exp: 600cc - PT Chair Mobilized	<i>[Signature]</i> MH10260
12/1/24	9:00	<u>S/B AKASH</u> - DBE's encouraged - Spirometry Encouraged - Ins: 600cc Exp: 600cc - Chest percussion to BL Chest wall - ARom to BL UL RU	<i>[Signature]</i> MH10256
12/1/24	16:00	<u>S/B AKASH</u> - DBE's encouraged - Spirometry Encouraged - Ins: 600cc Exp: 600cc - Chest percussion to BL Chest wall - ARom to BL UL RU - PT Mobilized	<i>[Signature]</i> MH10256



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Mrs. JEEVA.A

54/Female/MHJ202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
13/1/24	10:00	<u>S/B AKASH</u> - Drex encouraged - Sprometry ex encouraged - Ins: booe Exp: booe - Chest percussion to Bl chest wall - AROM to Bl u/lc - PT mobilised	G.E. Akash MH10256
13/1/24	17:00	<u>S/B AKASH</u> - Drex encouraged - Sprometry ex encouraged - Ins: booe Exp: booe - Chest percussion to Bl chest wall - AROM to Bl u/lc - PT stair climb encouraged	G.E. Akash MH10256
14/1/24	10:00	<u>S/B AKASH</u> - Drex encouraged - Sprometry ex encouraged - Ins: booe Exp: booe - Chest percussion to Bl chest wall - AROM to Bl u/lc - PT stair climb encouraged	G.E. Akash MH10256



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07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
15/1/24	10:00	STB <u>Arash</u> - DTR encouraged - Sprometry ^{also} encouraged Ins: loose Exp: loose - Chest percussion to BL Chest wall - Arm to BL side - PT Mobilised - PT home advice given	G.B. Akab MH10286



MICROBIOLOGY SHEET

MICROBIOLOGY-CULTURE REPORTS

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

Evening Report
Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ

DIABETIC CHART

ACTUAL WEIGHT 49.5 Kgs HbA_{1c} 11.8

PREVIOUS DIABETIC MEDICATIONS Inj HI R. 20 - 0-15 (BF)
N 5 - 0-5 (BF)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
11/24	11:30	337 mg/dl	Inj. HI 12U	13.25	Dr. Praveen
	18:30	117 mg/dl	Inj. HI 12U	13.35	Dr. Praveen
11/24	6:30	332 mg/dl	Inj. Regular Human Insulin 20U	13.40	Dr. Praveen
	12:30	286 mg/dl	Inj. Mixard 10U	13.45	Dr. Praveen
	18:30	245 mg/dl	Inj. HI R 18U	13.50	Dr. Praveen
11/24	6:30	444 mg/dl	R - 20 UNITS	13.55	Dr. Anusuya
	12:30	297 mg/dl	N - 15 UNITS	14.00	Dr. Anusuya
	18:30	191 mg/dl	Inj. Mixard 10U	14.05	Dr. Praveen
11/24	6:30	286 mg/dl	Inj. HI R 18U	14.10	Dr. Praveen

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
* Mix 40u short acting Insulin in 40 ml. of 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 hourly when stable) and adjust Insulin rate according to the following Algorithm.	150-200	Adjust Infusion rate to 2u / hr.
	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.

DIABETIC CHART

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



ACTUAL WEIGHT 49.5 kg. HbA_{1c} 11.8

PREVIOUS DIABETIC MEDICATIONS Inj. HUMAN INSULINATARD 20-0-15 (BF)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
10/1/24	12:20	120 mg/dl	-	meena	DR. SYLVESTER
10/1/24	16:00	224 mg/dl	Inj. H. Actrapid 6 units/hr started	meena	DR. SYLVESTER
10/1/24	18:00	150 mg/dl	Inj. H. Actrapid 10 units/hr	meena	DR. SYLVESTER
10/1/24	22:00	119 mg/dl	-	meena	DR. SYLVESTER
11/1/24	04:30	269 mg/dl	Inj. H. Actrapid 6 units/hr	meena	DR. AJEETHA
	6:38	210 mg/dl	Inj. H. Actrapid 4 units/hr	meena	DR. AJEETHA
11/1/24	8:30	162 mg/dl	Inj. HUMAN INSULINATARD @ 20 2u SLIC, Inj. HUMAN INSULINATARD N 10 2u SLIC given	meena	DR. PRAVEEN Jeyakumar
	12:30	103 mg/dl	-	meena	DR. PRAVEEN Jeyakumar
11/1/24	19:30	106 mg/dl	Inj. H. MIXTARD-15 2u SLIC Inj. H. INSULINATARD 8 units/hr	meena	DR. PRAVEEN
12/1/24	6:00	135 mg/dl	Inj. H. MIXTARD 5 units/hr Inj. H. INSULINATARD 10 units/hr	meena	DR. PRAVEEN
	12:30	265 mg/dl	Inj. HM - 14U	meena	DR. PRAVEEN
	18:30	68 mg/dl	Check after dinner	meena	DR. PRAVEEN

INSTRUCTIONS FOR INSULIN INFUSIONS

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

T. GLIZATO 6mg 1-0-1

T. METFORMIN 500mg 1-1-1

DIABETIC CHART

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ

ACTUAL WEIGHT 49.5 Kg HbA_{1c} 11.8

PREVIOUS DIABETIC MEDICATIONS

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
12/01/24	21:00	124 mg/dl	-	DC	
12/01/24	6:30	348 mg/dl	Dr. H. Mithran 20uH Dr. H. J. Mithran 15uH	DC	Dr. Praveen
	12:30	286 mg/dl	T. Glizato 6mg T. Metformin 500mg	DC	K. R. 12/01/24
	18:30	127 mg/dl	T. Glizato 6mg (B/F) T. Metformin 500mg (A/F)	DC	Dr. Praveen
14/01/24	6:30	87 mg/dl	T. Glizato 6mg T. Metformin 500mg	DC	Dr. Praveen
	9:30	122 mg/dl	-	DC	Dr. Praveen
	12:30	127 mg/dl	-	DC	Dr. Praveen
	18:30	159 mg/dl	T. Metformin 500mg T. Glizato 6mg	DC	Dr. Praveen

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
* Mix 40u short acting Insulin in 40 ml. of normal Saline (I/U - 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 hourly when stable) and adjust Insulin rate according to the following Algorithm.	150-200	Adjust Infusion rate to 2u / hr.
	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.

[illegible]

ACTUAL WEIGHT 4.9 kg HbA_{1c} 11.8 HUMAN METFORMIN 20-0-100
PREVIOUS DIABETIC MEDICATIONS T. GLI ZATO 60mg 1-0-1 (B/F) T-METFORMIN 500mg 1-1-1

INSTRUCTIONS FOR INSULIN INFUSIONS

* Mix 40u short acting Insulin in 40 ml. of normal Saline (1u - 1 ml.) * Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.). * Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm. * Target Blood Sugar 150-200 mgs. * To monitor K+ separately. - Urine Acetone	BLOOD SUGAR mg / dl	INSULIN INFUSION
	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
	150-200	Adjust Infusion rate to 2u / hr.
	201-250	Adjust Infusion rate to 4u / hr.
	251-300	Adjust Infusion rate to 6u / hr.
	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
	>400	Adjust Infusion rate to 20u / hr.

BLOOD GROUP

B' POSITIVE

INVESTIGATION SHEET

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



Date	31/12/24	2/01/24	9/1/24			
HAEMATOLOGY						
Hb		13.2	13.0			
P.C.V			39.7			
Platelets		3.16	295000			
TLC		6400	8830			
Polymorphs			66.9			
Lymphocytes			25.7			
Eosinophils			3.6			
Mono / Basophils			3.1 / 0.7			
E.S.R						
BIO-CHEMISTRY						
Urea	26	25	25			
Creatinine	1.10	0.6	0.54			
Sodium	135	144	136			
Potassium	4.8	4.4	4.64			
Bicarbonate			25			
Chloride			96.2			
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin			0.50			
D.Bilirubin			0.15			
I.Bilirubin			0.35			
S.G.O.T	17		23			
S.G.P.T	18		25			
ALP	183		198			
GGT	3.0		11			
Total Protein	6.7		7.1			
S.Albumin	3.7		4.2			
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

	05/1/24	21/12/23	21/1/24	9/1/24		
COAGULATION				10.6	12.1	
PT / INR				0.8		
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol			135			
Triglyceride		227	215			
H.D.L		50	47			
L.D.L			44			
VLDV			48			
THYROID FUNCTION						
T.S.H	2.24					
T.3	98					
T.4	10.7					
SEROLOGY						
HIV						
HBsAg						
V.D.R.L						
COVID 19						
RT- PCR						
IgM						
IgG						
HBA1C	11.8					
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						
APTT - 27.3						

BLOOD GROUP

B positive

INVESTIGATION SHEET

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



Date	9/1/24	10/1/24	11/01/24	12/01/24	14/01/24	
HAEMATOLOGY						
Hb	13.0	10.7	11.6	11.2	9.7	
P.C.V	39.7	31.7	35.1		29.9	
Platelets	295000	266000	3,40,000		377000	
TLC	8830		18,090		11980	
Polymorphs	66.9		91.9		73.7	
Lymphocytes	25.7		5.0		20.8	
Eosinophils	3.6		0.0		1.1	
Mono / Basophils	3.1/0.7		3.1/0.0		4.0/0.4	
E.S.R						
BIO-CHEMISTRY						
Urea	23		21.0	19.0	27	
Creatinine	0.54		0.44	0.50	0.67	
Sodium	136			134	135	
Potassium	4.64			4.09	4.35	
Bicarbonate	25					
Chloride	96.2					
Magnesium		2.5	2.1			
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.50		0.97			
D.Bilirubin	0.15					
I.Bilirubin	0.35					
S.G.O.T	23					
S.G.P.T	25					
ALP	128					
GGT	41					
Total Protein	7.1					
S.Albumin	4.2		3.5			
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK			325			
CK - M.B. MASS			28.5			
LDH						
Ntpro bnp						

[illegible]



Mrs. JEEVA.A

54/Female/MH1202481615

07/01/2024/IPH2024000049

Dr.ANBARASU MOHANRAJ



Every heart beat counts

BLOOD GROUP B Rh positive

ON ADMISSION

Height in CM

Weight in Kg.

158 cm

49.5 kPa

Diagnosis:

CHD-DND.

Procedure :

NO. OF DAYS	DDA	Day-1	Day-2	Day-3
DATE	07/1/24	08/1/24	09/1/24	10/01/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10
40.5°				
40°				
39.5°				
39°				
38.5°				
38°				
37.5°				
37°				
36.5°				
36°				
PULSE	93 82	88b/m 88b/m	87b/m 87	82
RESP	21 20	22b/m 22b/m	20 22	20
B.P.	110/60 110/70	120/70 125/70	120/60 110/60	140/80
SPO2	98% 95%	96% 94%	97% 96%	97%
DAILY WEIGHT	19.5kg			
24 HRS INTAKE	500ml	1500ml	1950ml	
24HRS OUTPUT	900ml	1700ml	1700ml	
BALANCE	-200ml		250ml	
MOTION				

Antiplatelet stopped on - 4/1/24.



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MH7/IP/2022/074



Every heart beat counts

VITAL INFORMATION SHEET

BLOOD GROUP	Positive.
-------------	-----------

ON ADMISSION

Height in CM

Weight in Kg.

150 cm

49.5 kg

Diagnosis: CAD-DVD.

Procedure : $0 \text{ PLA } B \times 2 \text{ STRAFT}$.

NO. OF DAYS	DOX.	I POD	II POD	POD-III	POD-IV	POD-V
DATE	10/1/24	11/1/24	12/1/24	13/01/24	14/01/24	15/1/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10
PULSE	76	60 bpm	88	90 bpm	80 bpm	88
RESP	20	21/mnt	24	22 bpm	20	20
B.P.	119/62	116/46	129/80	110/60	120/90	150/80
SPO2	100%	96% 97%	96% 96%	95%	97%	93%
DAILY WEIGHT	BED POST	BED FAST				
24 HRS INTAKE	2858 ml	2389 ml	1050 ml	1150 ml	800 ml	
24 HRS OUTPUT	2189 ml	2190 ml	1600 ml	1450 ml	1800 ml	
BALANCE	+169 ml	+199 ml	-550 ml	-300 ml	-1000 ml	
MOTION	x	x x	x	x	x	

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex: _____

Patient Id No: _____

NEWS key		DATE	TIME	DATE	TIME
0	1	7/1	11:00	7/1	17:00
1	2	7/1	21:00	8/1	1:00
2	3	8/1	5:00	8/1	9:00
NEWS key		TIME		TIME	
A+B		TIME		TIME	
Respirations		TIME		TIME	
Breath/ min		TIME		TIME	
A+B		TIME		TIME	
SpO2 Scale 1		TIME		TIME	
Oxygen Saturation (%)		TIME		TIME	
SpO2 scale 2 oxygen		TIME		TIME	
saturation (%) use scale 2		TIME		TIME	
if target range is 88-92 %		TIME		TIME	
eg: in hypercapnic		TIME		TIME	
respiratory failure only		TIME		TIME	
use scale 2 under the		TIME		TIME	
direction of qualified		TIME		TIME	
an		TIME		TIME	
Air or Oxygen ?		TIME		TIME	
A= Air		TIME		TIME	
O2litre/ min		TIME		TIME	
Device		TIME		TIME	
C		TIME		TIME	
Blood Pressure		TIME		TIME	
Diastolic BP		TIME		TIME	
C		TIME		TIME	
D		TIME		TIME	
Consciousness		TIME		TIME	
Score for New onset of		TIME		TIME	
confusion		TIME		TIME	
(no score if chronic)		TIME		TIME	
E		TIME		TIME	
Temperature		TIME		TIME	
Degree Celsius		TIME		TIME	
NEWS Total		TIME		TIME	
Monitoring Frequency		TIME		TIME	
Escalation of Care Y/N		TIME		TIME	
Initials by RN		TIME		TIME	
Initials by Sr. RN		TIME		TIME	

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

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

EARLY WARNING SCORE MONITORING CHART

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

NEWS key		DATE																	DATE
0	1	2	3	TIME														TIME	
A+B				>25														>25	
Respirations				21-24														21-24	
Breath/ min				18-20														18-20	
				15-17														15-17	
				12-14														12-14	
				9-11														9-11	
				<8														<8	
A+B				>96														>96	
Spo2 Scale 1				94-95														94-95	
Oxygen Saturation (%)				92-93														92-93	
				<91														<91	
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % eg: in hypercapnic respiratory failure only				>96 on oxygen														>96 on oxygen	
scale 2 under the action of qualified clinician				95-96 on O2														95-96 on O2	
				93-94 on O2														93-94 on O2	
				>93 on air														>93 on air	
				88-92														88-92	
				86-87														86-87	
				84-85														84-85	
				<83%														<83%	
Air or Oxygen ?				A= Air														A= Air	
				O2litre/ min														O2litre/ min	
				Device														Device	
C				>220														>220	
Blood Pressure				201-219														201-219	
				181-200														181-200	
				161-180														161-180	
				141-160														141-160	
				121-140														121-140	
				111-120														111-120	
				91-100														91-100	
				81-90														81-90	
				71-80														71-80	
				61-70														61-70	
				51-60														51-60	
				<50														<50	
Diastolic BP				mmHg														mmHg	
Pulse				>131														>131	
Beats / min				121-130														121-130	
				11															

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

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

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

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

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

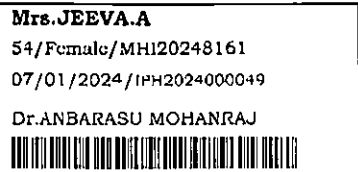


Name: _____ Age/Sex: _____ Patient Id No: _____

[illegible]

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

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



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Every heart beat counts

Date	From:	To:	Bed No:												
7/1/04	8/1/04	202-B													
24 Hrs : Started Time :		Ended Time :													
11-10		7-00													
NPO Started at :		NPO Over at :													
SHIFT	Morning	Afternoon	Night												
INTAKE			400ml												
OUTPUT			450ml												
Total Intake:	Total Output:		Difference:												
INTAKE (ml)		OUTPUT (ml)													
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
14-00	200ml					200ml	16-00	250ml					250ml		
17-00	100 ml					300ml	19-45	200ml					450ml		
21-30	150ml					450ml	22-30	250ml					700ml		
2-45	100ml					550ml	5-30	200ml					900ml	S avg	
6-00	150ml					700ml									
TOTAL INTAKE - 700ml															
TOTAL OUTPUT - 900ml															

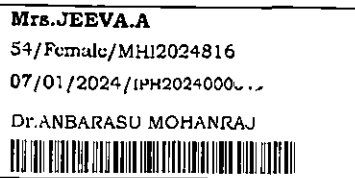
Date	From: 8/1/24	To: 9/1/24	Bed No:	INTAKE & OUTPUT CHART												
24 Hrs : Started Time :	7-00		Ended Time :												7-00	
NPO Started at :			NPO Over at :													
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)									
INTAKE	400 ml				550											
OUTPUT	500 ml.				800 ml											
Total Intake:			1500 ml		Total Output:			1700 ml		Difference:					- 200 ml	
INTAKE (ml)							OUTPUT (ml)									
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by	
			Type of Fluid	Additions	Amount											
8.30	100					100	9.00	250					250			
9.30	100					200	11.10	250					500			
11.30	200					400	14.35	200					700			
13.00	150					550	17.30	200					900			
14.30	200					750	21.00	200 ml					1100			
16.00	100					850	23.45	250 ml					1350			
17.50	100					950	2.30	200 ml					1550			
20.45	100 ml					1050	5.45	150 ml					1700 ml			
22.00	100 ml					1150										
23.30	100 ml					1250										
4.00	100 ml					1350										
6.15	150 ml					1500										
							TOTAL INTAKE - 1500 ml									
							TOTAL OUTPUT - 1700 ml									



Date	From: 9/1/24	To: 10/1/24	Bed No:	INTAKE & OUTPUT CHART											
24 Hrs : Started Time :	9.00		Ended Time :											4.00	
NPO Started at :			NPO Over at :												
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)								
INTAKE	600ml		600ml		450ml										
OUTPUT	550ml		650ml		700ml										
Total Intake: 1450			Total Output: 1700ml			Difference: 250ml									
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
8.00	200					200	8.00	150					150		
9.00	200					400	9.00	200					350		
11.30	200					600	12.00	200					550		
14.10	150					750	14.10	300					850		
16.30	100					850	16.30	150					1000		
18.00	150					1000	20.00	100					1100		
20.00	100					1100	22.00	200					1300		
22.00	150					1250	24.00	200					1500		
23.30	200					1450	6.00	200					1700		
							TOTAL INTAKE - 1450ml								
							TOTAL OUTPUT - 1700ml								
							BALANCE - 250ml								

10/05

10/07



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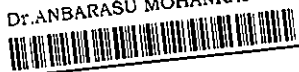
Every heart beat counts

[illegible]

王



Date	From: 13/01/24	To: 14/01/24	Bed No: 209	INTAKE & OUTPUT CHART													
24 Hrs : Started Time :	7-00		Ended Time :													7-00	
NPO Started at :			NPO Over at :														
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)										
INTAKE	800 ml		200		650 ml		2 lit/days										
OUTPUT	300 ml		800														
Total Intake: 1150 ml			Total Output: 1450 ml			Difference: 300 ml											
INTAKE (ml)							OUTPUT (ml)										
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by		
			Type of Fluid	Additions	Amount												
7-00	100					100	6-45	100					100				
8-45	100					200	10-15	200					300				
9-45	50					250	11-45	300					600				
10-15	50					300	12-45	200					800				
13-30	100					400	20-30	200					1000				
17-30	100					500	23-00	150					1150				
19-30	100					600	2-30	100					1250				
21-30	100					700	6-30	200					1450				
23-00	100					800											
2-30	100					900											
4-30	50					950											
6-30	200					1150	TOTAL INTAKE - 1150 ml										
							TOTAL OUTPUT - 1450 ml										
							BALANCE - 300 ml										



Date	From: 14/1/24	To: 15/1/24	Bed No: 209 -A	INTAKE & OUTPUT CHART											
24 Hrs : Started Time :	7.00		Ended Time :											7.00	
NPO Started at :			NPO Over at :												
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)								
INTAKE	150 ml		350 ml.				2 lts / day								
OUTPUT	200 ml		300 ml												
Total Intake:		800 ml		Total Output:		1800 ml		Difference: -1000 ml							
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
8.30	100					100	7.30	200					200		
10.00	50					150	15.00	100					300		
13.30	50					200	19.00	200					1100		
14.30	150					350	21.30	300					1400		
14.40	50					400	4.30	200					1600		
16.30	50					450	6.30	200					1800		
17.00	50					500									
20.00	100					600									
22.00	50					650									
4.30	50					700									
6.30	500					800									
							TOTAL INTAKE : 800 ml								
							TOTAL OUTPUT : 1800 ml								
							BALANCE : -1000 ml							5/1/24	

[illegible]

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



Diagnosis: CAD - DDD / DM EF - SD / CABG

Height: 150 cms Weight: 49.5 Kgs Food allergies: Yes/No; if yes, specify: None

Religious Beliefs: ☐ Vegetarian ☐ Non Vegetarian ☒ Eggetarian ☐ Jain

Diet Prescription: 1500 calories, low fat, low salt, high protein, diabetic diet

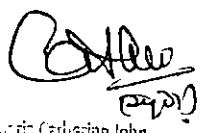
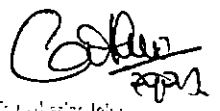
SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time:

Maria Catherine John
Senior Dietitian

27/1/24, 11:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
28/1/21, 14:00	A Syrian sed female came to do chest pain since (today) was assessed to nurse provided an incident by SUS. Wells: DM/DM. Educated the patient and family, also advised, low fat, low salt, high protein, diabetic diet. Expired a small fruit meal = low glucose intake.	 Maria Catherine John Senior Dietitian
10/1/21, 14:00	Patient shifted to OT for surgery (CPR) and kept on NBM. Patient referred to SUS. Will initiate on diabetic; liquid diet as per doctor's advice.	 Maria Catherine John Senior Dietitian
11/1/21, 14:00	Patient moved to stepdown no. room over. Patient presented diabetic; liquid diet. Can initiate on diabetic, high protein, soft solid diet.	 Maria Catherine John Senior Dietitian

Department of Dietetics

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
13/1/24, 10:00	Diet intake is better. Diet modification and clarification done. Motivated best well.	 Maria Catherine John Senior Dietitian
14/1/24, 10:00	Diet intake is good. Educated the patient and family on 1600 calories, low fat, low salt, high protein, diabetic diet on discharge - Emphid on small portion meals = low glycemic index. Diet modification and clarification done. Diet chart given on discharge.	 Maria Catherine John Senior Dietitian

INTRAOPERATIVE NURSING RECORD

Mrs. JEEVA.A

54/Female/MH1202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



Consultant : **DR. ANBARASU**

Name of Surgery **OPCAR (CLOSED HEART)**

Date of Surgery : **10/1/24**

Mode of Transfer to OR ☐ Bed ☒ Stretcher ☐ Other ☐

Anaesthesia Type : ☐ Epidural ☐ Spiral ☐ LOC ☐ MAC
☒ GEN ☐ Regional _____

Position : ☐ Lithotomy ☐ Prone ☒ Supine ☐ Right Down ☐ Left down
☐ Lateral ☐ Other ☐

Pressure Protection Pad : ☒ Headrest ☐ Sand Bag ☐ Pillow ☐ Axillary roll
☐ Shoulder roll ☒ Eye protection ☐ Chest roll ☐ Cysto/Gyn
☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
☒ L arm rest padded / Secured ☒ R Arms tucked / padded
☐ Nil ☐ R ☐ L ☐ Other (Specify) _____

Skin preparation in OT ☒ Chlorhexidine Prep ☒ Providone Iodine ☐ Lodophor scrub
☐ Alcohol Prep ☐ Others (specify) _____

Electrocautery : ☐ Monopolar ☐ Pad Location **Rt thigh** ☐ Bipolar

Tourniquet ☐ Location _____
☐ Applied Time _____ ☐ Released Time _____
☐ Applied Time _____ ☐ Released Time _____
☐ Applied Time _____ ☐ Released Time _____

Other equipment used : _____

Personal : ☐ Surgeon **DR. ANBARASU** ☐ Asst. _____
☐ Anaesthetist **DR. SYLVESTER** ☐ Asst. _____

Type of Specimen :

Lab : ☐ Pathology ☐ Permanent ☐ Frozen ☐ Time sent _____
☐ Cytology ☐ Time of report _____
☐ Microbiology } _____ ☐ Time sent _____
☐ Biochemistry }

Packing / Drains / Catheters

Type	Size	Site	Type	Size	Amount	Sign
~~Rombers~~	28 Fr	Left arm	—	—	—	~~P 228~~
~~Tomsons~~	28 Fr	Med 1st arm	—	—	—	

Urethral Catheterisation Done by Christy 14 Fr Polyjet Catheter used.
Sponge Count Record

Count	Raytex Sponges	Gauze Lined	Gauze Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	Needle	Circ. Nurse sign	Scrub Nurse Sign
Pre-op	Correct	Correct				Correct	Correct	Correct	~~P 228~~	~~AB/0104~~
Change over count	Correct	Correct				Correct	Correct	Correct	~~P 228~~	~~AB/0104~~
First closure count	~~Correct~~	~~Correct~~				~~Correct~~	~~Correct~~	~~Correct~~	~~S 0104~~	~~AB/0104~~
Final closure count	~~Correct~~	~~Correct~~				~~Correct~~	~~Correct~~	~~Correct~~	~~P 228~~	~~AB/0104~~

☒ Count Correct

Corrective action taken

[Signature]

Surgeon informed

Dressing / Cast Immobilizer ^{done} Chest Dressing with primafix & leg Dressing Done with n-net

Condition of patient at end of surgery : ☒ Stable ☐ Fair ☐ Critical

Transferred to : ☒ Patient Room ☐ CCU ☐ Recovery Room

Scrub Nurse Signature ABITHA

Name : ABITHA/0104

Date & Time : 10/1/24 @ 12.15

Circulating Nurse Signature *[Signature]*

Name : RADHICA

Date & Time 10/1/24 @ 12.15

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 07/11/24 Time of Arrival: 11.00 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher

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

Relationship with Patient: _____ Contact Person's Name: ROBERT Relationship: HUSBAND

Contact No.: 8754413982 Primary language spoken: ☒ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☐ Yes ☒ No

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

Menstrual History : LMP : - Menopause: 6 yrs

Medical History : DM / HTN / Co - Morbidity : 21 yrs Yes If yes specify

Drugs History : Antiplatelet (Specify) Clopidogrel, Aspirin stopped on 04/11/24

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: 97.3°F | Pulse / HR: 93 (beats/min) | BP: 110/60 (mmHg)

Respiration: 21 (breaths/min) | SpO₂: 98 (%) | CBG: 33 (mg/dl) | Height: 158 (cms) | Weight: 49.5 (kgs)

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

If Yes, specify: _____

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

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

Duration: _____ Location: _____

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

Nutritional Screening:

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

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

Type of Patient: ☒ Diabetic ☐ Non Diabetic Type of Diet: Diabetic diet

Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: Dr. Catherine Time: 12:00

Orient Patient if: ☐ Conscious

Orient Patient Attendant if: ☐ Unconscious ☐ Disoriented

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

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

Functional Assessment:

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

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13;

High Risk: 12 - 10; Severe Risk: 9 - 6

Total Score: 22 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)
Fall Risk Assessment (Modified Morse Scale):

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

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT):

Tick the score obtained (✓)

Final Score

0

			Action Taken	Date	Time
Low Risk	-2 to 0	0	LOW		
Moderate Risk	1 to 2				
High Risk	3 to 8				

Personal Belongings / Valuables:

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

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
		L. ROBERT	Relationship Husband	7/1/24	11:20
Nurse		Le. Lichyia	0249	7/1/24	11:20
Unit In-Charge		Pharmawan	0005	07/01/24	14:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 07/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 5/15

POD: -

Central line days: -

VIP Score: 6

B

BACKGROUND

Type of surgery: -

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.3°F | Pulse / HR: 93 (beats/min) | Respiration: 21 (breaths/min)

BP: 110/60 (mmHg) | SpO₂: 98% | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 19.8 kg/m²

Others: -

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains: -

Diabetic diet

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: Wednesday plan CABG.

	Signature	Name	Emp. No.	Date	Time
Handover given by	M.R.	M. Revathi	0225	07/1/24	12.30
Handover taken by	SA	A. Nanthini	0170	07/1/24	12.30
Document endorsed	MP	Dhananw.	0005	07/01/24	16.30

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 7/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S	SITUATION Diagnosis: CAD - JVD NEWS / PEWS Score: Ventilator day: Peripheral line day: Right: ☐ Yes ☐ No Left: ☐ Yes ☐ No Ryle's Tube: ☐ Yes ☐ No Day: Urinary Catheter: ☐ Yes ☒ No Day: Barrier nursing: ☐ Yes ☒ No MDR: ☐ Yes ☒ No. If Yes, specify organism: GCS: 15/15 POD: - Central line days: VIP Score: -
	BACKGROUND Type of surgery: - Allergies if any: NKDA On room air / oxygen: on Room Air Date of surgery: - IV fluids on flow: - Complaints / New Symptoms in last shift: -
A	ASSESSMENT Vital Signs: Temp 96 (°F) Pulse / HR: 92 (beats/min) Respiration: 22 (breaths/min) BP: 120/70 (mmHg) SpO ₂ : 97 (%) Height: 158 (cms) Weight: 49.5 (kgs) BMI: 19.8 kg/m ² Others: - Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA Current diet: Diabetic diet Drains: -
	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: - Pending follow-up orders: - Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Nanthini	0170	7/1/24	19:30
Handover taken by		Jenipriya	0284	7/1/24	19:40
Document endorsed		Dr. Anbarasu Mohanraj	005	07/01/24	08:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 7/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - DVT

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD:

Central line days: -

VIP Score: -

B

BACKGROUND

Type of surgery: -

Allergies if any: NKDA

On room air / oxygen: on Room air

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 96 (°F) | Pulse / HR: 92 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/70 (mmHg) | SpO₂: 97 (%) | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 19.8 kg/m²

Others: -

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: DM DIET.

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	Jen	Jenipriya	0224	7/1/24	7:30
Handover taken by	E. Cathi	E. Cathrine	0207	8/1/24	7:30
Document endorsed		D. Menon	0005	08/1/24	08:00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:

8/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: 0

Ventilator day: —

Peripheral line day: Right: — Left: —

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: —

Day: —

MDR: ☐ Yes ☒ No. If Yes, specify organism: —

GCS: 15/15

POD: —

Central line days: —

VIP Score: —

B

BACKGROUND

Type of surgery: —

Date of surgery: —

Allergies if any: NKDA

On room air / oxygen: —

IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 90 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 98 (%) | Height: 158 (cms) | Weight: 47.5 (kgs) | BMI: 19.8 kg/m²

Others: —

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Current diet: DM diet

Drains: —

R

RECOMMENDATION

Referral doctors: —

Pending medications: —

Pending medication indent: —

Pending lab reports / Investigations: —

Critical value alert and its corrections: —

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

Pending follow-up orders: —

Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by	E. Cat	E. Catherine	0207	8/1/24	12.30
Handover taken by	C. Sushma	R. Sushma	0207	8/1/24	12.30
Document endorsed	D. Chandra	D. Chandra	0005	08/01/24	14.00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD + VD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD:

Central line days:

VIP Score: 0/5

B

BACKGROUND

Type of surgery:

Allergies if any: NKDA

On room air / oxygen: 2L

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.1°F | Pulse / HR: 76 (beats/min) | Respiration: 22 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 99 (%) | Height: 188 (cms) | Weight: 195 (Kgs) | BMI: 19.8 kg/m²

Others:

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

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

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

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

Current diet:

Dm diet

Drains:

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0081	8/1/24	19:00
Handover taken by		A. ABINUS	0080	8/1/24	19:00
Document endorsed		Dr. Anbarasu Mohanraj	0005	08/01/24	08:30

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: - Left: -

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: -

Date of surgery: -

Allergies if any: NKDA

On room air / oxygen: ON ROOM AIR

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 22 (breaths/min)

BP: 130/70 (mmHg) | SpO₂: 97 (%) | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 23.4 kg/m²

Others: Nu

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

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: NORMAL diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

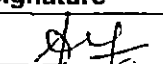
Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. A. BINU	0088	9/1/24	7:00
Handover taken by		A. A. Binu	0170	9/1/24	7:01
Document endorsed		Dharmaraj	0005	09/01/24	08:00

Date & Time	Observations / Action	Signature with Emp. No.
8/1/24	NIGHT DUTY NOTES	
19:00	Patient handover taken from the evening duty staff. Patient is stable	Jy 0080
20:00	Due medications are given to the patient	Jy 0087
22:00	Vitals/signs are checked & recorded	Jy 0088
6:00	I/O chart is maintained	Jy 0080
7:00	Patient handover given to the morning duty staff	Jy 0085
Document endorsed by	Signature 	Name Mianawano
		Emp. No. 005
		Date 09/01/24
		Time 09:00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - T2D

NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☐ Yes ☒ No Day:

Barrier nursing: ☐ Yes ☒ No

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD:

Central line days:

VIP Score: 0/5

B

BACKGROUND

Type of surgery:

Allergies if any: NKDA

On room air / oxygen: on Room Air

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.7 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/84 mmHg | SpO₂: 96 (%) | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 23.4 kg/m²

Others:

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

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet:

Drains:

Diabetic diet

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Narthini	0170	9/1/24	19:30
Handover taken by		Agasthya	0006	9/1/24	19:30
Document endorsed		Dr. Anbarasu Mohanraj	0005	09/01/24	19:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAP - TVID

NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☐ Yes ☒ No Day:

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

GCS: 15/15

POD:

Central line days:

VIP Score:

B

BACKGROUND

Type of surgery:

Allergies if any: NKDA

On room air / oxygen: On Room air

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp 98.2°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 97% | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 23

Others:

Pain Score: 4/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: DM diet

Drains:

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

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:

} Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by		RIN Bhattacharjee	0271	9/1/24	19:30
Handover taken by		F. Catharine	0207	9/1/24	19:30
Document endorsed		Dr. Anbarasu Mohanraj	0005	10/01/24	08:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: 0

Ventilator day: —

Peripheral line day: Right: — Left: —

Ryle's Tube: ☐ Yes ☒ No Day: —

Urinary Catheter: ☐ Yes ☒ No Day: —

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

GCS: 15/15

POD: —

Central line days: —

VIP Score: —

B

BACKGROUND

Type of surgery: —

Allergies if any: NKDP

On room air / oxygen: —

Complaints / New Symptoms in last shift: —

Date of surgery: —

IV fluids on flow: —

A

ASSESSMENT

Vital Signs: Temp: 98.2°F | Pulse / HR: 88 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/90 (mmHg) | SpO₂: 99 (%) | Height: 158 (cms) | Weight: 49.5 (kgs) | BMI: 23 kg/m²

Others: —

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Current diet: DM diet

Drains: —

R

RECOMMENDATION

Referral doctors: —

Pending medications: —

Pending medication indent: —

Pending lab reports / Investigations: —

Critical value alert and its corrections: —

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

Pending follow-up orders: —

Special instructions if any: Tomorrow plan CAB.G, NPO-12MN

	Signature	Name	Emp. No.	Date	Time
Handover given by	E. Caty	E. Cathrine	0207	10/01/24	7:30
Handover taken by		Shroff to OT			
Document endorsed		Shanmugam	10005	10/01/24	08:00

NURSES PROGRESS NOTES

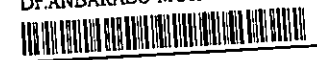
Date & Time	Observations / Action	Signature with Emp. No.
9/01/24 @ 19.30	Morn. Night duty staff ⇒ pt handed over taken by Night duty staff ⇒ pt Conscious & oriented ⇒ pt V/s checked & recorded	F. Caty 0207
20.30	⇒ pt due had diet, patient due drugs are given	F. Caty 0207
22.00	⇒ pt V/s checked & recorded ⇒ pt had no fresh complaints	F. Caty 0207
23.30	⇒ pt had bread & milk, Npo Started at 12.00	F. Caty 0207
3.00	⇒ pt slept well	F. Caty 0207
6.00	⇒ pt V/s checked & recorded ⇒ pt I/O chart maintained ⇒ pt well mobilized ⇒ pt morning care given	F. Caty 0207
7.30	⇒ pt handed over to morning duty staff	F. Caty 0207
SHIFTED NOTES		
8.00	pt Shifted to OT for CABC Preparation done, Pre medication given, Psychological Support given Auro 10 & pt all over, Black dots are there in skin.	Jeevan
Document endorsed by	Signature 	Name Dr. Jeevan
	Emp. No. 0005	Date 10/01/24
		Time 08:00

Mrs. JEEVA.A

54/Female/MH1202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp No.			
	CTOT RECEIVAL REPORT				
10/1/24	Patient Received From ~~Pnd floor~~ To CTOT With Blue Op File And Case Sheet				
10	ECG: ECHO: X-RAY: ANGIO CD:				
	CT FILE: -				
8:30	Patient Posted For Procedure: OPCAB				
	Under Anesthesia: <u>VGA</u>				
	Allergy Status: <u>not known</u>				
	Known Case Of: <u>DM</u>				
	Past Surgical History: <u>H/O & LSCS Done x 2012, 2014</u> <u>H/O CAB Done one 11.24 done</u>				
	VITAL SIGN: TEMP: 37°C HR: 88 SPO2: 100% - BP 120/80				
	CTOT SHIFTING REPORT				
10/1/24	Patient Shifted From ~~CTOT~~ To SICU With Blue Op File And Case Sheet Along With				
	*Surgery Safety Check List				
	*Intra Operative Record				
	*Nurses' Record				
	ECG: ECHO: X-RAY: ANGIO CD:				
	CT FILE: -				
	Patient Posted And Underwent For Procedure: <u>OP CAB (closed heart)</u>				
	Under Anesthesia: <u>VGA</u>				
	Procedure: <u>OP CAB</u>				
	Drain tube size and placement: <u>20Fr</u> <u>Left Pleura</u> <u>Mediastinum</u>				
	Pacing wire placement: Present/Absent Site: -				
	Implants: <u>LIMA → LAD, SV4 → RCA 2 graft</u>				
	Cautery burn/skin peeling/towel clip mark: Present/Absent				
	Site: -				
	VITAL SIGN: TEMP: HR: SPO2: BP:				
	Notes: <u>LIMA → LAD</u> <u>SV4 → RCA</u>				
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	<u>[Signature]</u>	<u>Chandrasekar</u>	<u>0026</u>	<u>10/1/24</u>	<u>12:01</u>

SAFETY FIRST



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



Mrs. JEEVA.A

54/Female/MHI202481615
07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/048



Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/2024.

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DUD.

NEWS / PEWS Score: —

Ventilator day: D1

Peripheral line day: Right: — Left: —

Ryle's Tube: ☒ Yes ☐ No Day: —

Urinary Catheter: ☒ Yes ☐ No Day: —

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

GCS: 15/15.

POD: D05.

Central line days: D1

VIP Score: 0/5.

B

BACKGROUND

Type of surgery: OPCABX 2GRAFT.

Date of surgery: 10/1/2024.

Allergies if any: NMDA.

On room air / oxygen: Ventilator.

IV fluids on flow: KABIMATE.

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 90.1 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 20 (breaths/min)

BP: 116/58 (mmHg) | SpO₂: 100 (%) | Height: 150 (cms) | Weight: 49.5 (kgs) | BMI: 22.5 kg/m²

Others: cap: 8.

Pain Score: 0/8 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 ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: NPO.

Drains: Mediastinal, Pleural

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:

NIU.

	Signature	Name	Emp. No.	Date	Time
Handover given by	S. Meena	Meena Selvam	0276.	10/1/24	19.30
Handover taken by	AB	ABUAC	0022	10/1/24	19.30
Document endorsed		ABUAC	0003	11/1/24	9.00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: COBIPAL D-① Left: -

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☒ Yes ☐ No Day: -

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

GCS: 15/15

POD: Dos

Central line days: D-①

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB x 2 GRAFTS

Allergies if any: NADA

On room air / oxygen: On O2 4Ltr

Complaints / New Symptoms in last shift: -

Date of surgery: 10/01/2024

IV fluids on flow: LABICURE

A

ASSESSMENT

Vital Signs: Temp: 96.1 (°F) | Pulse / HR: 101 (beats/min) | Respiration: 24 (breaths/min)

BP: 143/73 (mmHg) | SpO₂: 100 (%) | Height: 150 (cms) | Weight: 49.5 (kgs) | BMI: 22.5 kg/m²

Others: Cmp - 8 multy

Pain Score: 4/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale (NRS) / CPOT

Fall Risk Score: 05 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: LIQUID DIET

Drains: MEDICASTAR + CEFT PREURAL

R

RECOMMENDATION

Referral doctors: DR AJEETHA

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		ASHA C	0019	10/1/24	7:15
Handover taken by		SOWNDARYANNA	0022	11/1/24	7:30
Document endorsed		SOWNDARYANNA	0022	12/1/24	9:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/01/2024

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: ADI DND

NEWS / PEWS Score: NIL

Ventilator day: NIL

Peripheral line day: Right: CUBA Left: D2

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☒ Yes ☐ No

Barrier nursing: ☒ Yes ☐ No

Day: D2

Day: D2

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 16/15

POD: D2

Central line days: D2

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPLABX 2URART

Allergies if any: NKDA

On room air / oxygen:

Complaints / New Symptoms in last shift: NIL

Date of surgery: 10/01/2024

IV fluids on flow: NIL

A

ASSESSMENT

Vital Signs: Temp 98.7°F | Pulse / HR: 92 (beats/min) | Respiration: 22 (breaths/min)

BP: 160/100 mmHg | SpO2: 95 (%) | Height: 150 (cms) | Weight: 49.5 (kgs) | BMI: 22.5 kg/m2

Others: CVP - 7 mmHg

Pain Score: 4/10 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 ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: Soft diet

Drains: Mediastinal + 1 pleural

R

RECOMMENDATION

Referral doctors: Dr. Praveen Jayalumar

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections: NIL

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		Sandhya	002	11/1/24	12:00
Handover taken by	Meena	meena selvam	0276	11/1/24	12:00
Document endorsed		Anu	0003	11/1/24	9:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/2024

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: CUBITAL D2 Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☒ Yes ☐ No

Barrier nursing: ☒ Yes ☐ No

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: D1

Central line days: D2

VIP Score: 015

B

BACKGROUND

Type of surgery: OCLABX 26 TRAFIS

Allergies if any: +114DR

On room air / oxygen: -

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/2024

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: - (°F) | Pulse / HR: 89 (beats/min) | Respiration: 20 (breaths/min)

BP: 129/80 (mmHg) | SpO₂: 96 (%) | Height: 150 (cms) | Weight: 49.5 (kgs) | BMI: 22.5 kg/m²

Others: -

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: SOFT DIET

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

hifu.

	Signature	Name	Emp. No.	Date	Time
Handover given by	S. Meena	meena selvam	0276	11/1/24	17:30
Handover taken by	Dr. Shreya	D. Shreya	0270	11/1/24	19:40
Document endorsed	Dr. Anbarasu	Dr. Anbarasu	0273	12/1/24	9:40

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - DVP
NEWS / PEWS Score:
Ventilator day:
Peripheral line day: Right: 08m Left: D2
Ryle's Tube: ☐ Yes ☒ No Day:
Urinary Catheter: ☒ Yes ☐ No Day: D2
Barrier nursing: ☒ Yes ☐ No MDR: ☐ Yes ☒ No. If Yes, specify organism:
GCS: 15/15
POD: 1 POD
Central line days: D2
VIP Score: 0/5

B

BACKGROUND

Type of surgery: OP CAB X 2 VTRATIS
Allergies if any: NMDP
On room air / oxygen: ON RA
Complaints / New Symptoms in last shift:
Date of surgery: 10/1/24
IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 98.7°F | Pulse / HR: 100 bpm (beats/min) | Respiration: 22 bpm (breaths/min)
BP: 140/60 (mmHg) | SpO₂: 99% | Height: 150 cms | Weight: 49.5 kgs | BMI: 22.5 kg/m²
Others :
Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☒ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: Soft diet Drains:

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		D. Shoba	0270	12/1/24	7:00
Handover taken by		Manj Senthil	0276	12/1/24	07:00
Document endorsed		Manj Senthil	0276	12/1/24	9:00

Date & Time	Observations / Action	Signature with Emp. No.
11/1 by @ 09-24	Night duty Reports on 11/1 by * Taken over the pt. From evening duty staff. patient is conscious and oriented. Pt haemodynamically stable HR=108b/min, SpO ₂ =96% on Room air, BP=140/80mmHg.	ghy 0270
00-00	* patient had food @ wactor due medicine given as per chart.	
02-00	* nebulization Given, spiro given. provide comfortable position.	ghy 0270
03-00	* patient is good sleeping well.	
4-30	A morning sample was taken, send to the lab for investigations.	
5-30	* morning dressing was given to the patient; Dressing was changed.	
6-00	* CBG way checked @ Recorded. drug medicine given as per chart.	ghy 0270
7-00	* patient files and reports handed over given to morning duty staff.	ghy 0270

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	(signature)	Anwar	2002	12/11/2020	2000



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/2024

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-DVD.

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: CUBITAL D3 Left: -3

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☐ Yes ☒ No Day:

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

GCS: 15/15

POD: D2

Central line days: D3

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB x 2 GRAFTS

Allergies if any: NEDA

On room air / oxygen:

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/2024

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 98.2°F | Pulse / HR: 102 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/68 (mmHg) | SpO2: 99 (%) | Height: 150 (cms) | Weight: 49.5 (kgs) | BMI: 22.5 kg/m²

Others: -

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: SOFT DIET

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

Nil.

	Signature	Name	Emp. No.	Date	Time
Handover given by	S. Moong	Moong Selvam	0276	12/1/24	8:30
Handover taken by	[Signature]	[Signature]	0276	12/1/24	9:00
Document endorsed	[Signature]	[Signature]	0276	12/1/24	9:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24 Shift: ☒ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: COD-DVD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: - Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

MDR: ☐ Yes ☐ No. If Yes, specify organism: -

GCS: 5/5/5

POD: 2

Central line days: 3

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCABX2 GRAFTS

Date of surgery: 10 May

Allergies if any: NPOA

On room air / oxygen: ON ROOM AIR

IV fluids on flow: -

Complaints / New Symptoms in last shift: NIL

A

ASSESSMENT

Vital Signs: Temp: 98.2°F | Pulse / HR: 102b/min (beats/min) | Respiration: 20b/min (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 99 (%) | Height: 180 (cms) | Weight: 119.5 (kgs) | BMI: 22.5 kg/m²

Others: -

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

Fall Risk Score: 80 Fall Risk Protocol: ☐ Low ☐ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Soft DIET

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

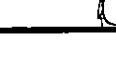
Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		M. Daiba	0102	12/1/24	19.00
Handover taken by		M. Ravalu	0225	12/1/24	19.30
Document endorsed		Amman	2005	12/1/24	9.00

NURSES PROGRESS NOTES					
Date & Time	Observations / Action				Signature with Emp. No.
12/1/24 ②	Evening duty				
12.00	→ patient hand over taken from Morning duty staff → patient Normal diet				Sgt
13.00	→ patient is stable quiet signs chest-				Sgt
14.00	→ patient medication given as per drug chart record. → patient mobilization given.				
16.00	→ patient D/P band → patient A well sleep.				
17.00	→ patient next completion → patient normal vital signs chest-				Sgt
18.00	→ patient Flt Chest				
19.00	→ patient hand over given as per night duty				Sgt
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[Signature]	Dhanu	0000	12/1/24	Fm

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - DVD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: -

Day: -

Day: -

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 15/15

POD: II

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB x 2 GRAFTS

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.6°F | Pulse / HR: 97 (beats/min) | Respiration: 20 (breaths/min)

BP: 180/70 (mmHg) | SpO₂: 97 (%) | Height: 150 (cms) | Weight: 49.2 (kgs) | BMI: 22.5 kg/m²

Others: -

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale ☒ NRS / CPOT

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: Diabetic diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>M. Royathi</i>	M. Royathi	0225	13/1/24	7.30
Handover taken by	<i>B. Vaniga</i>	B. Vaniga	0195	13/1/24	7.50
Document endorsed	<i>[Signature]</i>	<i>[Signature]</i>	2003	13/1/24	9.00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - DVT

NEWS / PEWS Score: 0

Ventilator day: —

Peripheral line day: Right: — Left: —

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: —

Day: —

Day: —

MDR: ☐ Yes ☒ No. If Yes, specify organism: —

GCS: 15/15

POD: —

Central line days: —

VIP Score: 8/5

B

BACKGROUND

Type of surgery: OPCAB X 2 GRAFTS

Allergies if any: NKA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: —

Date of surgery: —

IV fluids on flow: —

A

ASSESSMENT

Vital Signs: Temp: 97.6°F | Pulse / HR: 97 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 96 (%) | Height: 150 (cms) | Weight: 49.8 (kgs) | BMI: 22.5 kg/m²

Others: —

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Diabetic diet

Drains: —

R

RECOMMENDATION

Referral doctors: —

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: my plan ple

	Signature	Name	Emp. No.	Date	Time
Handover given by		B. Varis	0195	13/1/24	12:30
Handover taken by		R. Sushma	0201	13/1/24	12:30
Document endorsed		Dr. Anbarasu Mohanraj	005	13/1/24	14:00

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: OAD - TVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: ☒ Left: ☒

Ryle's Tube: ☐ Yes ☒ No Day: ☒

Urinary Catheter: ☐ Yes ☒ No Day: ☒

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

GCS: 15/15

POD:

Central line days:

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OP MB X 2 URAFTS

Date of surgery:

Allergies if any: NKDA

On room air / oxygen: PO

IV fluids on flow:

Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 99.1°F | Pulse / HR: 82 (beats/min) | Respiration: 24 (breaths/min)

BP: 130/80 (mmHg) | SpO₂: 99 (%) | Height: 150 (cms) | Weight: 49.8 (kgs) | BMI: 22.5 kg/m²

Others:

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

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Diabetic

Drains:

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0001	12/1/24	19.00
Handover taken by		M. Ravathi	0225	12/1/24	19.30
Document endorsed		Dr. Anbarasu	005	12/01/24	08.00

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 15/15

POD: 11

Central line days: -

VIP Score: 0/8

B

BACKGROUND

Type of surgery: OPCABX 24 Sept

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 95.1 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 21 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 97 (%) | Height: 150 (cms) | Weight: 49.8 (kgs) | BMI: 22.5 kg/m²

Others: -

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

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains: -

Diabetic diet

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: Tomorrow to do CBC, Ur, Cr, Na⁺, K⁺

	Signature	Name	Emp. No.	Date	Time
Handover given by		M.R. Ananthi	0225	14/1/24	7.30
Handover taken by		A. Manthini	0170	14/1/24	7.30
Document endorsed		Dr. Anbarasu Mohanraj	005	14/01/24	08.00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: IV

Central line days:

VIP Score: 01

B

BACKGROUND

Type of surgery: OP CABX 2 GRAFT

Date of surgery: 10/1/24

Allergies if any: N/A

On room air / oxygen: On Room Air

IV fluids on flow:

Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 97.8°F | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/70 (mmHg) | SpO₂: 98% | Height: 150 (cms) | Weight: 119.8 (kgs) | BMI: 22.5 kg/m²

Others:

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Current diet:

Drains:

Diabetic diet

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: Today plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Manthini	0170	14/1/24	12:30
Handover taken by		Parvitha	0072	14/1/24	12:30
Document endorsed		Dr. Anbarasu	005	14/01/24	14:00

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - DVD
NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right: - Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: 4th POD

Central line days:

VIP Score: 0

B

BACKGROUND

Type of surgery: OP CAB X 2 grafts

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: Nil

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 96 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/70 (mmHg) | SpO₂: 98 (%) | Height: 150 (cms) | Weight: 49.8 (kgs) | BMI: 22.5 kg/m²

Others: -

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Normal diet

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		Paviatha	0072	14/1/24	19.30
Handover taken by		M. Revathi	0025	14/1/24	19.30
Document endorsed		Dr. Anbarasu	0005	15/01/2024	08:00

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-DVD

NEWS / PEWS Score: 6

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: -

Day: -

Day: -

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 15/15

POD: IV

Central line days: -

VIP Score: 0

B

BACKGROUND

Type of surgery: OPCABX24rabb

Allergies if any: RMDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 96.2°F | Pulse / HR: 74 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/80 (mmHg) | SpO₂: 96 (%) | Height: 150 (cms) | Weight: 49.5 (kgs) | BMI: 22.5 kg/m²

Others: -

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains: -

Diabetic diet

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: Tomorrow plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by		M. Revathi	0225	15/1/24	7.36
Handover taken by		A. Nandhini	0170	15/1/24	7.30
Document endorsed		Dr. Anbarasu Mohanraj	005	15/01/24	08:00

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - DVPD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: 1

Central line days:

VIP Score:

B

BACKGROUND

Type of surgery: OPCAB X 2 GRAFT

Allergies if any:

On room air / oxygen: NKA on Room Air

Complaints / New Symptoms in last shift:

Date of surgery: 10/1/24

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.4°F | Pulse / HR: 76 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/72 (mmHg) | SpO₂: 97% | Height: 150 (cms) | Weight: 198 (kgs) | BMI: 22.5 kg/m²

Others:

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains:

Diabetic diet

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

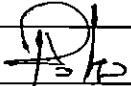
Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date:

Pending follow-up orders:

Special instructions if any: Today plan discharge

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Nanthini	0170	15/1/24	12.30
Handover taken by		Discharge			
Document endorsed		Discharge	005	15/01/24	14.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
15/1/24	Morning duty Notes				
@ 7.30	→ patient taken over from night duty staff nurse → patient conscious & oriented → patient vital signs checked & Recorded				
8.30	→ medication given as per drug chart → patient mobilized well → T/o chart monitored → Today plan discharge				
	Discharge Notes				
12.15	→ patient Today plan discharge → patient conscious & oriented → patient vital signs checked & Recorded → Patient IV line & FPO Band removed → patient all reports handing over to patient & patient attendee	 			
Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Diana...	005	15/01/24	14:00

ADULT NURSING CARE PLAN

Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ

Initial Date: 07/1/24 Time: 11:00		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 ☐ 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 Patient had PM diet N PT had PM diet	[Signature] 07/01/24
OXYGENATION ☒ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☒ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☒ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M PE is on room air E Patient is on Room Air N SpO ₂ - 95%	[Signature] [Signature] 07/01/24
FLUID & ELECTROLYTES ☒ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☒ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O chart monitored E I/O Chart Monitored N I/O chart maintained	[Signature] [Signature] 07/01/24

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☒ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☒ Encourage regular ambulation ROM exercise ☐ Apply Anti-Emboic 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 DE 4000 mobilized	MD 02/25
			E Patient Mobilized well	D 01/20
			N pt Mobilized well	dy 00/86
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☒ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continance 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 / consistenc / volume / Hemetemesi as per doctors order, and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Normal Elimination Pattern	MD 02/25
			E Normal Elimination Pattern	D 01/20
			N Normal Elimination Pattern	dy 00/86
SKIN INTEGRITY ☒ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☒ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☒ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Maintain normal Skin intact	MD 02/25
			E Maintain Normal	D 01/20
			N Skin integrity SKIN is intact	dy 00/86

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☒ Bed-Bath ☒ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☒ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M PE good hygiene E Patient well groomed N Pt well groomed	MD JH 07/5 AP JH 07/5
SAFETY ☐ Check ID Band ☒ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☒ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M ID Band wear E ID band present N ID Band @	MD JH 07/5 AP JH 07/5
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 provide comfort position E N	MD JH 07/5
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 vital signs checked & recorded E Vital Signs checked & recorded N vital signs is checked	MD JH 07/5 AP JH 07/5 JY 07/5
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☒ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping 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 provide psychological support E Psychological support to the pt N psychological support given	MD JH 07/5 AP JH 07/5 JY 07/5

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☒ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M PE good communication E Good communication N pt is on good communication	MPE E N
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☒ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M E Medication given as per drug chart N Due drugs are given	 E N
Endorsed by	Signature	Name	Emp. ID	Date	Time
		D. Chaverrero	0005	09/01/29	08:00

ADULT NURSING CARE PLAN

P: Mrs. JEEVA.A
N: 54/Female/MHI202481615
U: 07/01/2024/UPH2024000049
D: Dr. ANBARASU MOHANRAJ
C: 

Initial Date: 08/11/24 Time: 7.00		Modified Date: Time:	
Reason for Modification:		Diagnosis: CAD - DUD	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	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 R.C. 0807 E pt had sm diet P. 0807 N pt had dm diet P. 0807
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☒ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☒ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt is on room air R.C. 1807 E Pt SpO ₂ 99% P. 0807 N SpO ₂ - 98% P. 0807
FLUID & ELECTROLYTES ☒ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☒ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt I/O Chart maintained R.C. 0807 E Pt I/O Chart maintained P. 0807 N I/O Chart maintained P. 0807

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☒ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☒ Encourage regular ambulation ROM exercise ☐ Apply Anti-Emboic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M PT well mobilized E PT will mobilized N PT well mobilized	DC 0207 P 0201 JY 0205
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 normal elimination pattern E PT @ elimination pattern N elimination pattern good	DC 0207 P 0201 JY 0206
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M E N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☒ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☒ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt Well groomed E pt well groomed N pt well groomed	[Signature] [Signature] [Signature] 0080
SAFETY ☒ Check ID Band ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☒ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M Pt ID Band ⊕ E pt ID band ⊕ N ID Band ⊕	[Signature] 0207 [Signature] [Signature] 0080
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E — N —	
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M pt v/s checked E pt v/s checked N vitals is checked	[Signature] 0007 [Signature] [Signature] 0080
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E — N —	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☒ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M pt well communicated E pt well communication N pt well communication	D.C. 0207 P. 021 Ay 006
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M pt due drugs are given E pt due drugs are given N Due drugs are given	D.C. 0207 P. 021 Ay 006
Endorsed by	Signature	Name	Emp. ID	Date	Time
		Dhanendra	005	09/01/24	08:00

ADULT NURSING CARE PLAN

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 9/1/24 Time: 7.00

Modified Date: Time:

Reason for Modification:

Diagnosis: CAD - DUD

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 Patient had DM diet E Patient had DM diet N pt had DM diet	[Signature] [Signature] EC 0207
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BIPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Patient is on Room air E Patient is on Room air N pt is on room air	[Signature] [Signature] EC 0207
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 Chart Monitored E Chart Monitored N Chart maintained	[Signature] [Signature] EC 0207

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embotic 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 Patient mobilized well E Patient mobilized well N Pt well mobilized	
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 / consistenc / volume / Hemetemeses as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Normal Elimination pattern E Normal Elimination pattern was good N pt normal elimination pattern	
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Maintain Normal Skin Integrity E Maintained Skin Integrity N -	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☒ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Patient well groomed E Patient well groomed N Pt well groomed	[Signature] [Signature] EC 0207
SAFETY ☐ Check ID Band ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M ID band present E ID band present N ID Band present	[Signature] [Signature] EC 0207
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E — N —	
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M vital signs checked & recorded E vital signs (checked) N Pt v/s checked & recorded	[Signature] [Signature] EC 0207
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☒ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping 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 Psychological Support E Psychologist out the Pt Support. N —	[Signature] [Signature] EC 0207

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☒ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Good communication E Pt. in eu communication N Pt well communicated	P 147 02/21 PC 0207
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☐ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Medication given as per E Medication and drug given as per N Due drugs are given	P 147 02/21 PC 0207
Endorsed by	Signature	Name	Emp. ID	Date	Time
		Dharmendra	005	10/05/24	10:00

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 10/1/2024 Time: 014.00		Modified Date: Time: —		
Reason for Modification: —		Diagnosis: CPD - DVP		
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 chemical analgesic N pain score 4/10	meen 02/26 JH 02/26
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 spirometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M E Patient is on mechanical ventilator N On O2 4lit Rate depth normal SpO2 100%	S. meen 02/26 JH 02/26
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 — N —	— —
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-Emboloc 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 Advised for Bed Rest. N On bedrest chest tubes inserted	meen 02/26 JH 02/26

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	
			E monitored I/O chart.	meas 0226
			N Monitored intake and output	AB 0219
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 be changed by surgeons	M	
			E Aseptic technique followed.	meas 0226
			N Aseptic techniques followed	AB 0219
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	
			E Bed is low and locked position	meas 0226
			N used safety precaution	AB 0219
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	
			E Wound is Intact.	meas 0226
			N Drain tube checked for patency of lumen	AB 0219
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 parenteral 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	
			E patient is on NPO.	meas 0226
			N patient consumed a bowl of liquid diet	AB 0219

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
CARE OF CATHETERS, 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 kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M E I/O chart monitored. <i>moor 02/22</i> N Maintained adequate cleaning. <i>JS 02/22</i>		
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 E N NA		
OBSERVATION ☒ Vital Signs ☒ GCS ☒ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	M E Vitals & RBS monitored N Hemodynamically stable	 <i>moor 02/22</i> <i>JS 02/22</i>	
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 / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ 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	M E Health Education given to family N Gained knowledge on pain management	 <i>moor 02/26</i> <i>JS 02/26</i>	
ANY OTHER NEEDS			M E N		
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>[Signature]</i>	<i>[Name]</i>	<i>0003</i>	<i>13/1/24</i>	<i>9:00</i>



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 11/01/2024 Time: 8:00		Modified Date: Time:	
Reason for Modification:		Diagnosis: CAD - DVP	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation
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: Monitor proper position to the pain E: Comfortable position after. N: Provide comfortable position Sign & Initials: [Signature]
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 spirometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M: Provide SpO2 monitor E: on Room Air N: On RA. SpO2-95% Sign & Initials: [Signature]
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: - N: - Sign & Initials: [Signature]
MOBILITY ☐ Mobile / Inmobile ☐ 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-Embotic 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: Patient is lying down cannot be mobilized E: Patient is mobilized to chair. N: Safety measure followed Sign & Initials: [Signature]

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 Monitor Intake and output	J 02
			E No chart monitored.	mean 0276
			N 210 Chart was maintained.	8/0270
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 Use aseptic technique all aspect of patient care	don
			E Aseptic technique followed.	mean 0276
			N used aseptic precautions follow	8/0270
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 —	
			E Bed is lowest and locked position	mean 0276
			N kept in bed low position	8/0270
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 —	
			E —	
			N —	
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 parenteral 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 Patient has food orally food was	don
			E Patient is tolerating orally.	mean 0276
			N Soft diet	8/0270

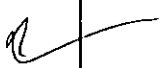
Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		☒ Patient will have patent, properly maintained catheters, drains etc	☒ Check the catheters, drains etc frequently ☐ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☒ Maintain adequate cleaning and dressing	M	Observe Plo Chart	
				E	NO cathet monitored	meas 0276
				N	Plo chart maintained	SP
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	-	
				E	-	
				N	-	
OBSERVATION ☒ Vital Signs ☒ GCS ☒ Blood Sugar ☒ Others:		☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	M	→ patient is hemodynamic stable condition	meas 0276
				E	vitals monitored	meas 0276
				N	monitored vitals	SP 0276
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 / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☒ 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	M	provided proper HLB regarding diet & skin	meas 0276
				E	Health Education given	meas 0276
				N	Explained about pt condition @ 2nd story	SP 0276
ANY OTHER NEEDS				M		
				E		
				N		
Endorsed by	Signature	Name	Emp. ID	Date	Time	
		Amman	meas	13/11/24	9.4	



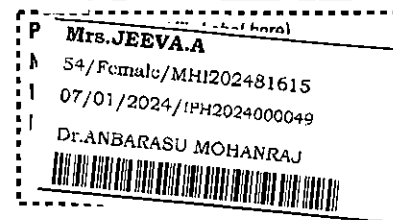
ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 12/1/24 Time: 8.00		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD -DVT		
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 comfortable position given E pt comfortable position given N provide comfortable position	meen 0276 Dr Hdy 0275
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 spirometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M on Room Air SpO2 monitoring E pt room air N Pt is room air	meen 0276 Dr Hdy 0275
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 Explained procedure before doing E pt explained procedure before N -	meen 0276 Dr
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-Emboic 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 mobilized to chair E pt mobilized to chair N Pt good mobilized	meen 0278 Dr Hdy 0275

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 D/O chart monitoring.	S. meen 0228
			E pt is on chart monitoring	S. meen 0228
			N D/O chart monitoring	S. meen
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 be changed by surgeons	M Aseptic technique followed	meen 0228
			E pt Aseptic technique followed	S. meen
			N pt Aseptic technique followed	S. meen
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 Bed is low and locked position.	meen 0228
			E pt Bed is low and locked position	S. meen
			N pt Bed is low and locked position	S. meen
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 Wound is intact	meen 0228
			E pt wound is intact	S. meen
			N pt wound is intact.	S. meen
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 parenteral 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 Patient is on soft diet	S. meen 0228
			E pt is on soft diet	S. meen
			N pt is on soft diet	S. meen

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
CARE OF CATHETERS, 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 kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M	Flt chart monitored.	new 02/26	
			E	pt Flt Chart monitored	De	
			N	210 chart monitored.	Se	
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	—	—	
			E	—		
			N	—		
OBSERVATION ☒ Vital Signs ☒ GCS ☒ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☒ Monitor GCS of patient	M	vitals monitored	new 02/26	
			E	pt vitals monitored	De	
			N	vitals monitored	Se	
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 / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ 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	M	—		
			E	—		
			N	—		
ANY OTHER NEEDS			M	—		
			E	—		
			N	—		
Endorsed by	Signature	Name	Emp. ID	Date	Time	
		Am an -	00023	14/1/24	9.00	

ADULT NURSING CARE PLAN



Initial Date: 13-1-24 Time: 8.00		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - DNP		
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 soft diet E Pt soft diet N Pt had DM diet	[Signature] [Signature] [Signature]
OXYGENATION ☒ Room Air ☐ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BIPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☒ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☒ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on room air E Pt spo 29% N Pt is on room air	[Signature] [Signature] [Signature]
FLUID & ELECTROLYTES ☐ Oral ☒ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☒ Patient will have balanced fluid and electrolytes balance	☒ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt take oral fluid E Pt I/O chart maintained N I/O chart monitored	[Signature] [Signature] [Signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☒ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☒ Apply Anti-Embotic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt mobilized well	QA / 01/05
			E pt mobilized well	P / 01/05
			N Pt good mobilized	MD / 01/05
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 / Hemetemesi as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt @ elimination Pattern	QA / 01/05
			E pt @ Pattern	P / 01/05
			N Normal Elimination Pattern	MD / 01/05
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☒ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M maintain skin integrity	QA / 01/05
			E maintain @ Integrity	P / 01/05
			N Maintain normal skin intact	MD / 01/05

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☒ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☒ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt well groomed E Pt well grooming N Pt good hygiene	[Signature] [Signature] [Signature] 05/25
SAFETY ☒ Check ID Band ☐ 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 restraint policy (if needed)	M Pt ID Band checked E Pt ID band checked N ID Band present	[Signature] [Signature] [Signature] 05/25
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E — N —	
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Pt v/s checked E Pt v/s checked N vital signs checked & recorded	[Signature] [Signature] [Signature] 05/25
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E — N —	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M P+ good communication E P+ good communication N	Ad/otas P.
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☐ To manage on time	☒ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M morning medicine given E due drugs are given N	Ad/otas P.
Endorsed by	Signature	Name	Emp. ID	Date	Time
		Dhanan	005	14/01/24	08:00

ADULT NURSING CARE PLAN

Mrs. JEEVA.A
54 / Female / MH1202481615
07/01/2024 / IPH2024000049
Dr. ANBARASU MOHANRAJ

Initial Date: 14/1/24		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 ☐ 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 patient had PM diet E takes DM diet N Pt had DM diet	[Signature] [Signature] [Signature]			
OXYGENATION ☐ Room Air ☒ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remain within established limits ☐ Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M patient is on Room Air E Patient is on room air N Pt is on room air	[Signature] [Signature] [Signature]			
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☒ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O Chart monitored E Patient takes normal fluid intake N I/O Chart monitored	[Signature] [Signature] [Signature]			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolism 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 patient mobilized well E. Patient mobilized well N PE 4000 mobilized	D 6/7/25 Polm Mdy 02/25
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☒ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continance 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 / consistenc / volume / Hemetemeses as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Normal Elimination pattern E self voiding N Normal Elimination pattern	D 6/7/25 Polm Mdy 02/25
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Maintain Normal Skin integrity E No oozing in surgical site N Maintain normal skin integrity	Polm Mdy 02/25

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M p + Self care E Pt well groomed N Pt good hygiene	Jan Polyn Maly 02/25
SAFETY ☒ Check ID Band ☐ IV care ☐ EJV ☐ CENTRAL LINE ☐ Side rails ☐ Others:	☒ Patient will have no life-threatening situations	☒ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M Pt ID Band ⊕ E ID band ⊕ N ID Band present	Jay 01/25 Polyn Maly 02/25
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 Pt not provided comfortable position E - N -	Jay 01/25 Polyn Maly 02/25
OBSERVATION ☒ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☒ Patient will have normal range of vital parameters	☒ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Pt vitals are checked E Vital Signs stable N vital signs checked & remain	Jay 01/25 Polyn Maly 02/25
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☒ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping 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 To provide the psychological support E Provided psychological support N -	Jay 01/25 Polyn Maly 02/25

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☒ Verbal ☐ Non-verbal ☐ Sign language ☐ Others:		☒ Patient will communicate effectively with positive feedback	☒ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M ~~well~~ <i>communicated</i> E <i>effective verbal communication</i> N <i>PE good communication</i>	<i>Paul</i> ~~01/24~~
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☒ To manage on time	☒ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M <i>Due medication was given</i> E <i>Medications given as per chart</i> N <i>Due drug are given</i>	<i>Paul</i> ~~01/24~~ <i>Poston</i> <i>Paul</i> ~~01/24~~
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>[Signature]</i>	<i>Dharanand</i>	<i>005</i>	<i>15/01/24</i>	<i>08:00</i>

ADULT NURSING CARE PLAN

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/UPH2024000049

Dr. ANBARASU MOHANRAJ

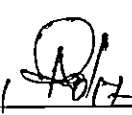
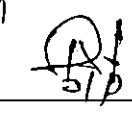
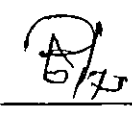


MHI/NUR/2022/044

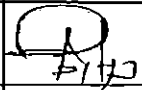
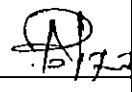


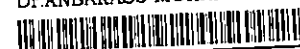
Every heart beat counts

Initial Date: 15/1/24		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 ☒ 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 patient had 1017 diet E N	[Signature] 5/7/20			
OXYGENATION ☐ Room Air ☒ Nasal Cannula / High Flow O ₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O ₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O ₂ saturation and pulse rate ☐ If any O ₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M patient is on Room Air E N	[Signature] 5/7/20			
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 Chart monitored E N	[Signature] 5/7/20			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Emboloc 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 <i>patient mobilized well</i> E N	
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continance 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 / consistent / volume / Hematemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M <i>Normal Elimination pattern</i> E N	
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M <i>Maintain Normal Skin integrity</i> E N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☒ Self-Care ☐ CBD Care (if present) ☐ Others:	☒ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M <i>patient well groomed</i> E N	
SAFETY ☐ Check ID Band ☒ 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 <i>ID band present</i> E 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	M E N	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M <i>vital signs checked & recorded</i> E N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Coping 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 <i>psychological support to the pt</i> E N	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☒ Non-verbal ☐ Sign language ☐ Others:		☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M <i>Good communication</i> E N	
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		☐ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital policies and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M <i>Medication given as per drug chart</i> E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		<i>Thomson</i>	005	16/01/24	08:00



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	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 dairy 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, dairy 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 dairy 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	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
TOTAL SCORE					23	23	23
Initial & Emp. No. of Staff Nurse:					[Signature] 17/01/24		
Initial & Emp. No. of Sr. Staff Nurse:					[Signature] 17/01/24		

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 8/1/24
Time: 11:20

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	9	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation	4	4	4
FRICITION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
					TOTAL SCORE	23	23
					Initial & Emp. No. of Staff Nurse:	22	22
					Initial & Emp. No. of Sr. Staff Nurse:	08	08
						08	08

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully 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				
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				
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance				
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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation				
FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair					
					TOTAL SCORE			
					Initial & Emp. No. of Staff Nurse:			
					Initial & Emp. No. of Sr. Staff Nurse:			

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



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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	2	2
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	1	2	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	1	1
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	1	1	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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation	1	1	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 independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		1	1	2
TOTAL SCORE					6	8	11
Initial & Emp. No. of Staff Nurse:					1234	5678	9012
Initial & Emp. No. of Sr. Staff Nurse:					1234	5678	9012

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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	2	2	2
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	2	2	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	2	2	2
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	2	2	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 IVs 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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation	2	2	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 independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		2	2	2
TOTAL SCORE					12	12	12
Initial & Emp. No. of Staff Nurse:					Mony 0224	0224	Mony 0724
Initial & Emp. No. of Sr. Staff Nurse:					0224	0224	0224

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	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 IVs 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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation	4	4		
FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3		
					TOTAL SCORE	22	23	
					Initial & Emp. No. of Staff Nurse:	88	52	
					Initial & Emp. No. of Sr. Staff Nurse:	123	100	

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



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	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 dairy 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, dairy 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 dairy 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	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3	
					TOTAL SCORE	23	23	23
					Initial & Emp. No. of Staff Nurse:	01/01/24	01/01/24	01/01/24
					Initial & Emp. No. of Sr. Staff Nurse:	01/01/24	01/01/24	01/01/24

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 14 / 1 / 24
Time: 4 / E / N

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	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 dairy 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, dairy 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 dairy 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	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3	
					TOTAL SCORE	23	23	23
					Initial & Emp. No. of Staff Nurse:			
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6					Initial & Emp. No. of Sr. Staff Nurse:			

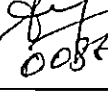
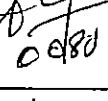
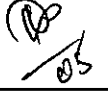
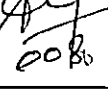
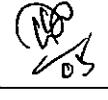
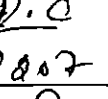
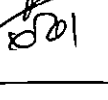
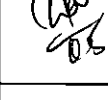
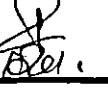
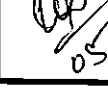


BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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				
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				
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance				
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 IVs 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 dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation				
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair					
					TOTAL SCORE	23		
					Initial & Emp. No. of Staff Nurse:			
					Initial & Emp. No. of Sr. Staff Nurse:			

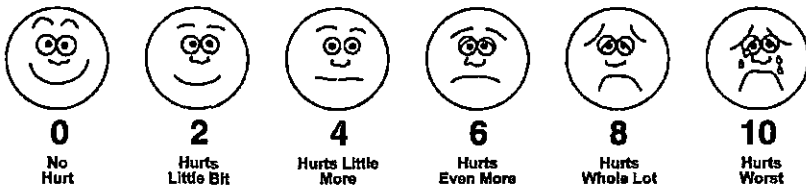
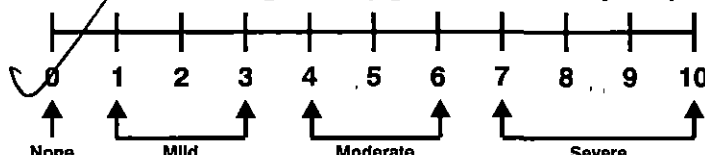
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7/1/24 11.00	0/10	No Pain	-	-	-	 0087	 0087
11.00	0/10	No pain	-	-	-	 0087	 0087
18.00	0/10	No pain	-	-	-	 0087	 0087
22.00	0/10	No Pain	-	-	-	 0087	 0087
8/1/24 2.00	0/10	No Pain	-	-	-	 0087	 0087
6.00	0/10	No Pain	-	-	-	 0087	 0087
10.00	0/10	No pain	-	-	-	 0087	 0087
14.00	0/10	No pain	-	-	-	 0087	 0087
16.00	0/10	No pain	-	-	-	 0087	 0087

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9:00	0/10	No Pain	—	—	—	dy 0080	OP 05
9/12 2:00	0/10	No Pain	—	—	—	dy 0080	OP 05
6:00	0/10	No Pain	—	—	—	dy 0080	OP 05
10:00	0/10	No pain	—	—	—	dy 0080	OP 05

PAIN SCALES

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

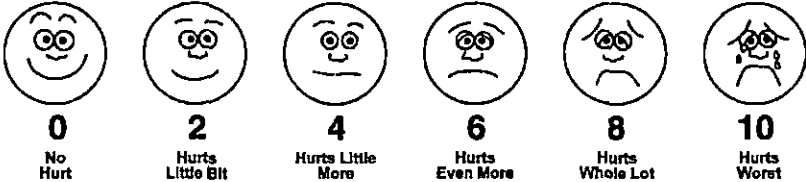
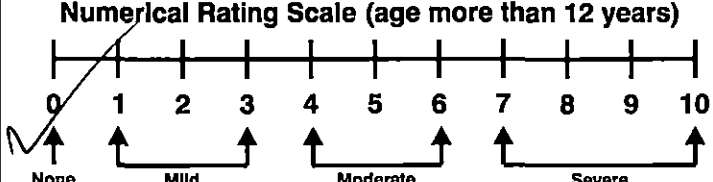
Pharmacological Interventions as per doctor's prescription

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9/1/24 14:00	0/10	No pain	-	-	-	DC 0271	DB 05
18:00	0/10	No pain	-	-	-	DC 0271	DB 05
22:00	0/10	No pain	-	-	-	DC 0271	DB 06
10/01/24 08:00		PATIENT		SLEEPING			
6:00	0/10	NO PAIN	-	-	-	DC 0271	DB 06

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

PAIN SCALES

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

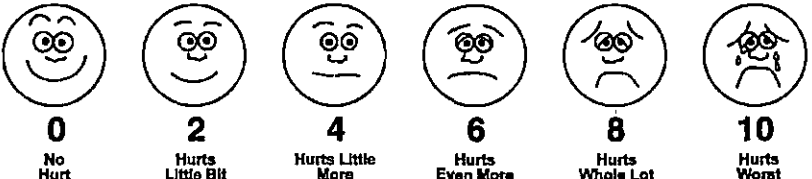
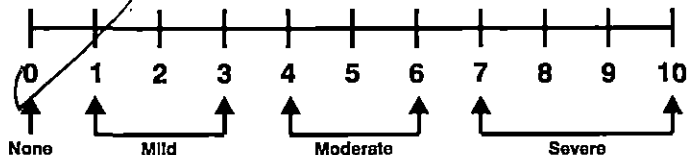
Pharmacological Interventions as per doctor's prescription

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10/12/24 12:20	4/8	CPOT	-	-	on chemical Painkillers.	man 0276	[Signature]
14:20	4/8	CPOT	-	-	on chemical Painkillers.	man 0276	[Signature]
16:20	4/8	CPOT	-	-	on chemical Painkillers.	man 0276	[Signature]
18:20	1/10	Achy pain	45 sec	Sternum	pharmacological pain management given.	man 0276	[Signature]
20:00	4/10	Achy pain	25 hr	Sternum	provided comfortable position	[Signature] 0276	[Signature]
22:00	4/10	Achy pain	10-15 hr	Sternum	pharmacological management done	[Signature] 0276	[Signature]
11/12/24 00:00	-	-	-	-	patient is sleeping	[Signature] 0276	[Signature]
02:00	-	-	-	-	patient is sleeping	[Signature] 0276	[Signature]
04:00	-	-	-	-	patient is sleeping	[Signature] 0276	[Signature]

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.
08:30	2/10	Achy pain	15 min	Stomach	pharmacological management done	AB 0019	Low
09:30	4/10	Dull pain	10 min	Stomach	Reassured the level of pain, felt reduced level of pain. She is comfortable	AB 0019	Low
01:30	4/10	Dull pain	10 sec	① Scapula region	Non-pharmacological Management done	AB 0022	Low
10:30	2/10	Achy pain	10 sec	② Scapula region	pharmacological Management done	AB 0022	Low

PAIN SCALES

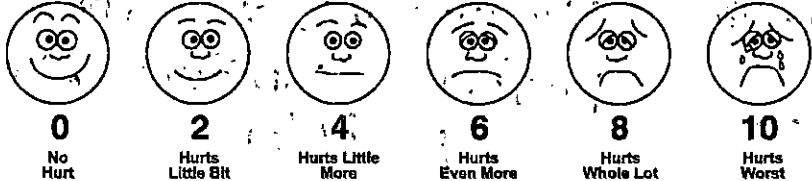
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FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst
	Numerical Rating Scale (age more than 12 years)  0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
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Pharmacological Interventions as per doctor's prescription	

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
11/11/24 12:30	1/10	Achy pain	<15 sec.	Sternum.	Non pharmacological pain management given.	meem 0276.	A 0005
14:30	1/10	Achy pain	<10 sec	Sternum	Non Pharmacological Pain management given.	meem 0276	A 0005
16:30	1/10	Achy pain	<15 sec	Back	Non pharmacological Pain management given	meem 0276	A 0005
18:30	1/10	Achy pain	<5 sec	Sternum.	Non Pharmacological Pain management given.	meem 0276.	A 0005
20:30	1/10	Dull pain	<10 sec	Sternum	non-pharmacological Intervention done	sh 0276	A 0005
22:30	1/10	Dull pain	<15 sec	Back	provide comfortable position	sh 0276	A 0005
12/1/24 00:30		patient	Is	Slept well		sh 0276	A 0005
02:30		patient	Is	Slept well		sh 0276	A 0005
04:30		patient	Is	Slept well		sh 0276.	A 0005

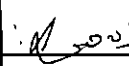
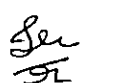
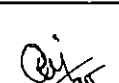
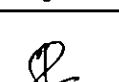
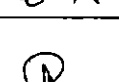
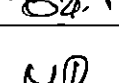
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
6:30	1/10	dull pain	< 10 sec	sternum	non-pharmacological intervention done	Sh 0256	✓ 3027
8:30	1/10	dull pain	< 15 sec	sternum	non-pharmacological pain management given.	Sh 0256	✓ 3027
10:30	1/10	dull pain	< 10 15 sec	sternum	non-pharmacological pain management given	Sh 0256	✓ 3027
12:30	1/10	dull pain	< 10 15 sec	sternum	non-pharmacological pain management given	Sh 0256	✓ 3027

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Pharmacological interventions as per doctor's prescription	

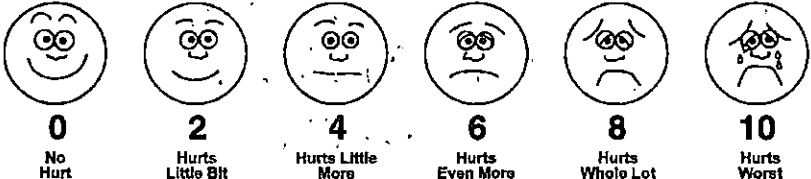
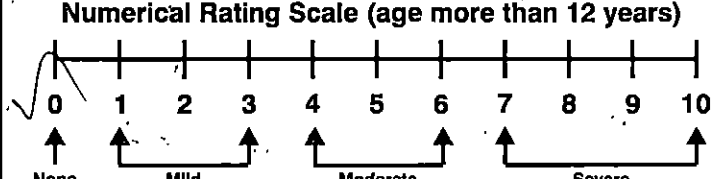


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
18:30	4/10	dull pain	4 to 15 sec	Sternum	non-pharmatological Relementon given		
20:00	4/10	" Dull pain	4 to 15 sec	sternum	Non-pharmatological Relementon given		
13/1/24 6:00	4/10	dull pain	on & off	sternum	provide comfortable position		
10:00	4/10	Dull pain	on & off	Sternum	Provide comfortable position		
14:00	4/10	Dull pain	on & off	sternum	provide comfortable position		
18:00	4/10	Dull pain	on & off	Sternum	provide comfortable position		
22:00	0/10	NO Pain	-	-	-		
14/1/24 2:00				Patient sleeping good			
6:00	0/10	NO Pain	-	-	-		

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10.00	0/10	no pain	-	-	-	Qui 0145	AD 05
14.00	0/10	No pain	-	-	-	Qui 0145	AD 05
18.00	0/10	No pain	-	-	-	Qui 0145	AD 05
22.00	0/10	NO pain	-	-	-	Qui 0145	AD 05

PAIN SCALES

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FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst Numerical Rating Scale (age more than 12 years)  0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counseling: K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs. JEEVA, A

54/Female/MH1202481615

07/01/2024/IPH2024000049

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052



Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

[illegible]



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	Time				
		7/1/24	11:00	8/1/24	7:00	9/1/24	6:00
S. No.	PARAMETERS						
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0		
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	0		
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0		
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0		
5	Entire leg swollen (Assess for both legs)	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0	0		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0		
9	Previously documented DVT (Assess for both legs)	0	0	0	0		
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESKD / 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	0	0		
FINAL SCORE		0	0	0	0		
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		Low	Low	Low	Low		
DVT prophylaxis started		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Signature & Emp. No. of RN		 10/01/24	 10/01/24	 10/01/24	 10/01/24		
Signature & Emp. No. of Sr. RN		 05	 05	 05	 05		



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	10/1/24	11/1/24	12/1/24	13/1/24	14/1/24	15/1/24
		Time	12:20	06:00	6:00	6:00	6:00	6:00
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0	0	0
2	Bedridden recently >3 days or major surgery within four weeks	+1	+1	+1	+1	+1	+1	+1
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0	0	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0	0	0
5	Entire leg swollen (Assess for both legs)	0	0	0	0	0	0	0
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0	0	0	0	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0	0	0	0
9	Previously documented DVT (Assess for both legs)	0	0	0	0	0	0	0
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0	0	0	0	0
FINAL SCORE		+1	+1	+1	+1	+1	+1	+1
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		MOD	MOD	MOD	MOD	MOD	MOD	MOD
DVT prophylaxis started		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
Signature & Emp. No. of RN		MRS JEEVA.A 2026	MRS JEEVA.A 2026	MRS JEEVA.A 2026	MRS JEEVA.A 2026	MRS JEEVA.A 2026	MRS JEEVA.A 2026	MRS JEEVA.A 2026
Signature & Emp. No. of Sr. RN								

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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	7/1/24	7/1/24	7/1/24	8/1/24	8/1	8/1	9/1/24	9/1/24	9/1/24
	Time	11:00	11:00	22:00	8:00	14:00	22:00	8:00	14:00	20:00
History of falling (immediate or within 6 months)	No	☒	☒	☒	☒	☒	☒	☒	☒	☒
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	☒	☒	☒	☒	☒	☒	☒	☒	☒
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		☒	☒	☒	☒	☒	☒	☒	☒	☒
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		☒	☒	☒	☒	☒	☒	☒	☒	☒
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		☒	☒	☒	☒	☒	☒	☒	☒	☒
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	30	30	30	30	30	30	30	30
Low Risk (0 - 24)										
Medium Risk (25 - 44)		☒	☒	☒	☒	☒	☒	☒	☒	☒
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	10/1/24	10/1/24	11/1/24	11/1/24	12/1/24	12/1/24	12/1/24	12/1/24	12/1/24
	Time	12:20	20:00	2:10	12:00	22:00	07:00	14:00	20:00	8:00
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		65	65	65	50	56	50	80	50	80
Low Risk (0 - 24)		-	-	-	-	-	-	-	-	-
Medium Risk (25 - 44)		-	-	-	-	-	-	-	-	-
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN		mon 22	16/01/24	don 02/24	mon 02/24	16/01/24	mon 02/24	16/01/24	16/01/24	16/01/24
Signature & Emp. No. of Sr. RN		16/01/24	16/01/24	16/01/24	16/01/24	16/01/24	16/01/24	16/01/24	16/01/24	16/01/24

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

INTERVENTIONS Tick as per the Risk Score	Date	10/1/24	10/1/24	11/1/24	11/1/24	11/1/24	12/1/24	12/1/24	12/1/24	12/1/24
	Time	07:20	08:00	8:40	10:00	09:00	07:00	14:00	20:00	8:00
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		/	/	/	/		/	/	/	/
Remind the patient to use call bell before getting out of bed		/	/	/	/		/	/	/	/
Keep the two side rails in the raised position at all times for all patients regardless of age		/	/	/	/		/	/	/	/
Keep the call bell, bedside table, water, glasses within the patient's easy reach		/	/	/	/		/	/	/	/
Remove excess equipment or furniture to make a clear path		/	/	/	/		/	/	/	/
Keep the patient's bed in the low position at all times except during procedure		/	/	/	/		/	/	/	/
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		/	/	/	/		/	/	/	/
Bed wheels should be locked		/	/	/	/		/	/	/	/
Encourage family participation in the patient's care		/	/	/	/		/	/	/	/
Ensure that floor of the bathroom is dry and not slippery		/	/	/	/		/	/	/	/
Review medications for potential side effects that can promote falls		/	/	/	/		/	/	/	/
Use safety belts during movement in wheelchair		/	/	/	/		/	/	/	/
The patients are not ambulated by themselves. They are to be ambulated only with assistance		/	/	/	/		/	/	/	/
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		/	/	/	/	/	/	/	/	/
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		/	/	/	/	/	/	/	/	/
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		/	/	/	/	/	/	/	/	/
Use restraints and bed monitors as ordered by the doctor		/	/	/	/	/	/	/	/	/
Allow the patient to ambulate only with assistance		/	/	/	/	/	/	/	/	/
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		/	/	/	/	/	/	/	/	/
Do not leave patients unattended in diagnostic or treatment areas		/	/	/	/	/	/	/	/	/
Accompany the patient while going to bathroom		/	/	/	/	/	/	/	/	/
Advise 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		NA	NA	NA	NA		NA	/	/	/
Answer these patients call bells as quickly as possible		NA	NA	NA	NA		NA	/	/	/
Provide a commode at bedside (if appropriate)		NA	NA	NA	NA		NA	/	/	/
Urinal/bedpan should be within easy reach (if appropriate)		NA	NA	NA	NA		NA	/	/	/
Encourage family members or other visitors to stay with them		NA	NA	NA	NA		NA	/	/	/
If appropriate, consider using protection devices: safety belts		/	/	/	/	/	/	/	/	/
Signature & Emp. No. of RN		Mary 0226	11/1/24	11/1/24	Mary 0226	11/1/24	Mary 0226	11/1/24	11/1/24	11/1/24
Signature & Emp. No. of Sr. RN		11/1/24	11/1/24	11/1/24	11/1/24	11/1/24	11/1/24	11/1/24	11/1/24	11/1/24

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(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	13/1	13/124	14/124	14/124	14/124	14/124	15/124		
	Time	14:00	20:00	8:00	14:00	20:00	8:00			
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		50	50	50	50	30	30			
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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



Mrs. JEEVA.A

54/Female/MH1202481615

07/01/2024/IPH2024000049

Dr.ANBARASU MOHANRAJ



MHI/IP/2022/055



Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☒ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☒ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>7/1/24</u> Time <u>11-30</u>		Nurse Signature : <u>[Signature]</u>

Learning Record

[illegible]

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☒ Diet Instruction for patients at Nutritional risk													<i>Marlene John</i> Senior Dietician
☐ Diet advice for home													Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☒ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>1/11/24</u> Time <u>10:02</u>		Nurse Signature : <u>[Signature]</u>

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Disease	10/01/21											Doctor	
☒ Information on Disease / Diagnostics		P	OD	✓								~~Wm~~ 134579	
☒ Treatment Medications		P	OD	N								Doctor / Nurse	
☒ Information on Safe and Effective use of medicines		P	OD	✓									
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions												Nurse	
☒ Pre - Operative Instructions		P	OD	✓								~~Nce~~ 024	
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management												Nurse	
☒ Reporting of pain		P	OD	✓								~~Nce~~ 024	
☒ Pain Management		P	OD	✓									
Safe and effective use of medical Equipment (if required)												Doctor / Nurse	
Name of Equipment Rehabilitation Techniques												~~Wm~~ 134579	

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☒ Diet Instruction for patients at Nutritional risk													<i>[Signature]</i>
☐ Diet advice for home													Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)



Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☒ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☒ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☒ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>10/01/24</u> Time <u>12:30</u>		Nurse Signature : <u>[Signature]</u>

Learning Record

Need	Date <u>10/1/24</u>	Visit 1			Date <u>11/1/24</u>	Visit 2			Date <u>12/1/24</u>	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Disease													Doctor
☐ Information on Disease / Diagnostics													
☐ Treatment Medications													Doctor / Nurse
☐ Information on Safe and Effective use of medicines													
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse <u>[Signature]</u>
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)		S	OD	V	S	OD	V	S	OD	V	P	OD	V
Pain Management		S	OD	V	S	OD	V	S	OD	V	P	OD	V
☐ Reporting of pain		S	OD	V	S	OD	V	S	OD	V	P	OD	V
☐ Pain Management		S	OD	V	S	OD	V	S	OD	V	P	OD	V
Safe and effective use of medical Equipment (if required)		S	OD	V	C	OD	V	S	OD	V	P	OD	V
Name of Equipment		S	OD	V	C	OD	V	S	OD	V	P	OD	V
Rehabilitation Techniques		S	OD	V	C	OD	V	S	OD	V	P	OD	V

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance	10/11				11/11				12/11				Dietician
☐ Diet Instruction for patients at Nutritional risk			S	aw			S	aw					Marie [Signature] Senior Dietician
☐ Diet advice for home			/				/				/		Nurse
Discharge Planning													
☐ Self care													
☐ Follow up			/				/				/		
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others			/				/				/		
Risk Factor Reduction													
☐ Smoking Cessation			/				/				/		Doctor
☐ Weight Control			/				/				/		
☐ Exercise			/				/				/		
☐ Hypertension			/				/				/		
☐ Other Risks			/				/				/		

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

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

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

Written Material given and explained (if any)

NIL

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____



Mrs. JEEVA/A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



MHI/IP/2022/055



Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☒ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Cognitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instructions
Completed By : Date <u>11/1/24</u> Time <u>7:30</u> Nurse Signature : <u>[Signature]</u>		

Learning Record

[illegible]

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☒ Diet Instruction for patients at Nutritional risk			P	NO			P	NO					Maria C. John Senior Dietician
☒ Diet advice for home			P	NO			P	NO					Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)

NUC /

Reports Given :

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

Name of Attendant / Patient :

L. Robert

Signature :

[Signature]

Name of Discharge Nurse

A. Nardhini

Signature :

[Signature]

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 7/1/24 Time: 11.00

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		Dr. Smith	183573	7/1/24	14:30
Nursing Staff		A. Nandhini Maria Catherine John	0150	7/1/24	14:30
Dietician		Akash G.B.	2407	7/1/24	14:30
Physiotherapist		Akash G.B.	0256	10/1/24	14:30
Patient Care Service Staff					

MHI/IP/2022/054

 **Medway
Heart
Institute**

Every heart beat counts

Additional Details (if any):

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

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	<i>[Signature]</i>	DR. PRAVEEN J. JAYAWARDHANA	112236	12/1/24	10:15
Receiving Doctor	<i>[Signature]</i>	Dr. K. Anurag	134559	12/1/24	10:30

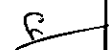
Part C (to be filled by Nurses)

Check for	Transferring Nurse	Receiving Nurse
Drains	☐ Chest ☐ Abdominal ☐ Others: <u>None</u>	☒ Yes ☐ No
Respiratory	Air Way Type: ☒ Patent ☐ Tracheostomy ☐ Others: _____ Oxygen Therapy: ☒ No ☐ Yes via: _____ Rate: _____ li/min	☒ Yes ☐ No
NG Tube / Oral	☐ Yes ☒ No ☐ For Feeding ☐ Gastric Suction ☐ Fluid Restriction	☒ Yes ☐ No
Foley's Catheter	☐ Yes ☒ No	☒ Yes ☐ No
Intravenous Access	☒ Peripheral Line ☐ Central Venous Line ☐ Others: _____	☒ Yes ☐ No
Pressure Injury	☐ Yes ☒ No If Yes, give details: _____	☒ Yes ☐ No
Score	Fall Risk: <u>50</u> WELLS: _____ NEWS / PEWS: _____	☒ Yes ☐ No
Patient Belongings	☒ Yes ☐ No If Yes, give details: <u>Flask</u>	☒ Yes ☐ No
Handover Details	Medication Administration Record explained: ☒ Yes ☐ No Lab & Diagnostic Reports handed over: ☒ Yes ☐ No	☒ Yes ☐ No
Patient Attendant Informed	☒ Yes ☐ No If No, give details: _____	☒ Yes ☐ No

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	<i>[Signature]</i>	Manoj Selwan	0276	12/1/24	10:30
Receiving Nurse	<i>[Signature]</i>	Agas Jayin	0276	12/1/24	10:30

FAMILY COUNSELLING FORM

CONSULTANT- DR. ANBARASU .			DIAGNOSIS- CAD-DVD			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
10/1/24	RIN . S. Meena		Explained General condition of the patient . Explained . present need of stay in ICU . Explained visitors policy .	—		 112236
11/1/24	RIN S. meena.		Explained general condition of the patient Explained present need of stay in ICU. Explained visitors policy .	—		 112236

MHI/CP/2022/193



HOME MEDICATION USAGE FORM

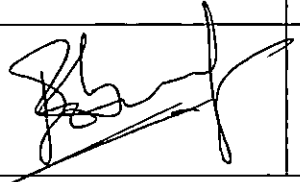
Mrs. JEEVA.A
54/Female/MH1202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ

Allergies: NKDA

Diagnosis: CAD - DVD / T2DM

[illegible]

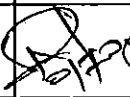
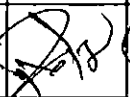
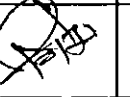
This is to certify that, I take full responsibility of the quality and potency of the medications that I have brought to the hospital. Medications that I have got are stored with proper medication storage recommendation given by the manufacturer (Room temperature (below 25°C) or Fridge temperature (2°-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

	Signature/ Thumb impression	Name	Date	Time
Patient				
Guardian		(Name and Relationship with the Patient)	7/1/24	19.55

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff		A. Nandhini	7/1/24	19.50

WOUND ASSESSMENT CHART

EXUDATE AMOUNT								
none	☐	☐	☐	☐	☐	☐	☐	☐
evidence of some moisture	☐	☐	☐	☐	☐	☐	☐	☐
evidence of significant flow	☐	☐	☐	☐	☐	☐	☐	☐
EXUDATE								
serous	☐	☐	☐	☐	☐	☐	☐	☒
sero - sanguinous	☐	☐	☐	☐	☐	☐	☐	☐
Purulent	☐	☐	☐	☐	☐	☐	☐	☐
ODOUR								
none	☐	☐	☐	☐	☐	☐	☐	☐
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							
INFECTION SUSPECTED*	☐	☐	☐	☐	☐	☐	☐	☐
SWAB SENT	☐	☐	☐	☐	☐	☐	☐	☐
ANTIBIOTIC THERAPY	☐	☐	☐	☐	☐	☐	☐	☐
BLOOD GLUCOSE / URINE ANALYSIS	☐	☐	☐	☐	☐	☐	☐	☐
PATIENT / CARER TO DO DRESSING	☒	☒	☒	☐	☐	☐	☐	☐
SIGNATURE								

***SIGNS & SYMPTOMS OF WOUND INFECTION :**

- Pyrexia
- localised pain
- erythema
- localoedema
- excess exudate
- pus
- offensive odour

***SUSPECT WOUND INFECTION IF :**

- granulation tissue bleeds easily
- fragile bridge of epithelium occurs
- odour increases
- healing is slower than anticipated
- wound breakdown



PATIENT NAME :

Mrs.JEEVA.A

54/Female/MH1202481615

07/01/2024/IPH2024000049

AGE / SEX :

Dr.ANBARASU MOHANRAJ

IP No. / UHID No

Ward / Bed No. 31W - 03

ANY SCORE>0 SHOULD BE MONITORED IN EVERY SHIFT

[illegible]



Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug Chart: _____ of _____

Height (cms): 158 cms Weight (kg): 49.5 kg

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

Drug Details NKDA	Description of Allergy —	Doctor's Sign:  Name: Dr. Mohamed Alyoun Reg. No. 6572
---------------------------------	--	---

DOCTOR INSTRUCTIONS

1. Use generic name when prescribing drug
2. Write in BLOCK LETTERS, clearly and legibly
3. Sign and enter MCI registration no. or apply seal
4. No prescription should be altered / overwritten
5. Use 24-hour format when writing time

NURSING STAFF INSTRUCTIONS

1. Check entries in every section to avoid omissions
2. Nurse in-charge should verify drug chart on daily basis
3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings
4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

11/1 8/1 9/1 10/01

DRUG NAME

TAB. ATORVASTATIN 10mg

Dose

(10mg)

Route

PO

Frequency

0-0-2

Dr. Sign & Reg. No. / Seal

Dr. A/
19/205

Start Date & Time

08/01/24

Stop Date & Time

20.00

8/1 8/1 20.00
20.00 20.00 8/1

Additional Info:

DRUG NAME

TAB. ISOSORBIDATE (5mg)

Dose

(5mg)

Route

PO

Frequency

2-2-2

Dr. Sign & Reg. No. / Seal

Dr. A/
19/205

Start Date & Time

08/01/24

Stop Date & Time

20.00

8.30 8.45 Npo
14.30 14.30
20.00 20.00 8/1

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

05/05 05/05 05/05 05/05

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

ANTIMICROBIALS <i>To be filled in by Doctors only</i>			Date →		To be filled by Nursing Staff only. Sign and time given							
			Time ↓									
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
DRUG NAME												
Dose	Route	Frequency										
Dr. Sign & Reg. No. / Seal		Start Date & Time										
		Stop Date & Time										
Additional Info:												
Area In-charge Nurse Signature:												

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
11/1/24	3:00pm	Low salt, Low fat	<i>[Signature]</i>	134559					
11/1/24	8AM	Low salt, Low fat	<i>[Signature]</i>	134559					
11/1/24	8AM	Low salt, Low fat	<i>[Signature]</i>	134559					
11/1/24	8AM	NPO	<i>[Signature]</i>	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
7/1/24	Night	A. ALBINUS	0088	A		Night			
8/1/24	Morning	E. Catherine	0207	E.C		Morning			
8/1/24	Evening	Hannah Grace	0105	H.G		Evening			
8/1/24	Night	Albinus	0022	A		Night			
9/1/24	Morning	A. Pandhini	0172	A		Morning			
9/1/24	Evening	Agasthya	0146	A		Evening			
9/1/24	Night	U. Dileya	0249	U		Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			



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



Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IRH2024000049

Dr. ANBARASU MOHANRAJ



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug Chart: _____ of _____

Height (cms): 150

Weight (kg): 49.5 kg

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

Drug Details NKDA	Description of Allergy NKDA	Doctor's Sign: <i>S. Praveen</i> Name: DR. PRAVEEN JEYAKUMAR Reg. No. 112231
--	--	---

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

Stat / Once Only / Premedication Drugs[illegible]

REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given				
			Time ↓	11/12/24	12/12/24	13/12/24	14/12/24	15/12/24
DRUG NAME TAB. BBPlex forte			08:00	8:00	10:30	9:00	9:00	8:30
Dose 1 tab	Route PO	Frequency 1-0-0						
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236		Start Date & Time 11/12/24 at 8:00						
		Stop Date & Time						
Additional Info:								
DRUG NAME TAB. CLOPIDYREL & ASPIRIN			14:00	14:00	14:00	14:00	14:00	
Dose 75/15mg	Route PO	Frequency 0-1-0						
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236		Start Date & Time 11/12/24 at 14:00						
		Stop Date & Time						
Additional Info:								
DRUG NAME TAB. ROSUVASTATIN			20:00	20:00	21:00	21:00	20:20	
Dose 20mg	Route PO	Frequency 0-0-1						
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236		Start Date & Time 11/12/24 at 21:00						
		Stop Date & Time						
Additional Info:								
DRUG NAME TAB. PARACETAMOL			08:00	08:30	9:00	9:30	9:30	
Dose 650mg	Route PO	Frequency 1-1-1						
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236		Start Date & Time 11/12/24 at 14:00						
		Stop Date & Time						
Additional Info:								
DRUG NAME Syr. CREMAPPIN plus			21:00	21:00	21:00	21:00	20:20	
Dose 15mL	Route PO	Frequency 0-0-1						
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236		Start Date & Time 11/12/24 at 21:00						
		Stop Date & Time						
Additional Info:								
Nurse in-charge Signature:								

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

T. METOPROLOL (BETALOC)

Dose

25mg

Route

PO

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 8-00

Stop Date & Time

Additional Info:

DRUG NAME

T. PREGALIN

Dose

75mg

Route

PO

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

DR. PRAVEEN JEYAKUMAR.

Reg No: 112236

Start Date & Time

12/1/24 8-00

Stop Date & Time

Additional Info:

DRUG NAME

T. LOPRAMIDE

Dose

100mg

Route

PO

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

K. M. (131059)

Start Date & Time

13/1/24 @ 9.30

Stop Date & Time

15/1/24 @ 10.00

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

11/1/24

12/1/24

13/01

14/01

15/1/24

8:00

08:30

9:00

9:30

20:00

20:30

21:00

20:00

20:30

20:00

20:30

20:00

20:30

8:00

08:30

9:00

9:30

8:00

08:30

9:00

9:30

8:00

Clinical Pharmacist
Medway Heart Institute

ANTIMICROBIALS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given					
			Time ↓	10/11/24	11/11/24	13/11/24	14/11/24		
DRUG NAME			09:15						
INJ. CEFURXIME SODIUM									
Dose	Route	Frequency							
1.5gm	IV	Q 12 hourly							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
Dr. PRAVEEN JYAKUMAR		10/11/2024 AT 09:15							
8 Reg. No: 112236		Stop Date & Time							
		11/11/2024 AT 18:00							
Additional Info:									
DRUG NAME									
F. CIPLOX TZ									
Dose	Route	Frequency							
500mg	P/O	1-0-1	8:00						
Dr. Sign & Reg. No. / Seal		Start Date & Time							
Dr. PRAVEEN JYAKUMAR		13/11/2024 AT 08:00							
11/11/2024 AT 18:00		Stop Date & Time							
		15/11/2024 AT 18:00							
Additional Info:									
DRUG NAME									
Dose	Route	Frequency							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
		Stop Date & Time							
Additional Info:									
DRUG NAME									
Dose	Route	Frequency							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
		Stop Date & Time							
Additional Info:									
DRUG NAME									
Dose	Route	Frequency							
Dr. Sign & Reg. No. / Seal		Start Date & Time							
		Stop Date & Time							
Additional Info:									
Area In-charge Nurse Signature:									

Dr. PRAVEEN JYAKUMAR
11/11/2024 AT 18:00

ANTIMICROBIALS <i>To be filled in by Doctors only</i>			Date →	To be filled by Nursing Staff only. Sign and time given							
			Time ↓								
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. No. / Seal		Start Date & Time									
		Stop Date & Time									
Additional Info:											
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. No. / Seal		Start Date & Time									
		Stop Date & Time									
Additional Info:											
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. No. / Seal		Start Date & Time									
		Stop Date & Time									
Additional Info:											
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. No. / Seal		Start Date & Time									
		Stop Date & Time									
Additional Info:											
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. No. / Seal		Start Date & Time									
		Stop Date & Time									
Additional Info:											
DRUG NAME											
Dose	Route	Frequency									
Dr. Sign & Reg. No. / Seal		Start Date & Time									
		Stop Date & Time									
Additional Info:											
Area In-charge Nurse Signature:											

[illegible][illegible]

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
10/1/24	12:20	NS 0.9%	50 mL	0.02 mL/hr	IV	INJ. NORADRENALINE	ACC to BP.	-	P	112236	12:20 PM	14:30	mev 0276
10/1/24	12:30	NS 0.9%	50 mL	25 mL/hr	IV	INJ. POTASSIUM CHLORIDE	20 meq	-	S	112236	12:30 PM	14:30 PM	mev 0276
10/1/24	16:30	NS 0.9%	40 mL	6 mL/hr	IV	INJ. ACTRAPID.	40 IU	Acc to CBG	S	112236	16:30	22:30	mev 0276
10/1/24	18:00	NS 0.9%	20 mL	1 mL/hr	IV	INJ. FENTANYL	25 mcg/hr	-	S	112236	18:00	4:30	mev 0276
10/1/24	18:30	NS 0.9%	25 mL	2 mL/hr	IV	INJ. NTG. NITROGLYCERIN.	ACC to BP.	-	S	112236	18:30	01:30	mev 0276
10/1/24	4:30	NS 0.9%	40 mL	6 mL/hr	IV	INJ. H- ATRAPID	40 IU	Acc to CBG	S	112236	4:30	8:30	mev 0276

[Handwritten signatures and initials on the right margin]
 0019
 0020

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
17/1/24	12:20	lipo.	E	112236					
11/1/24	8:00	Liquid Diet	E	112236					
12/1/24	9:00	Soft diet	L.B.	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
10/1/24	Morning				14/1/24	Morning	B. Vanitha	0195	AB
10/1/24	Evening	MEENA SELVAM	0276	meen	14/1/24	Evening	Janipiya	0284	Jan
10/1/24	Night	Ashac	0019	AB	14/1/24	Night	M. Roshni	0225	Rosh
11/1/24	Morning	Soundaryam	0022	✓	15/1/24	Morning	A. Nandhini	0170	A
11/1/24	Evening	MEENA SELVAM	0276	meen		Evening			
11/1/24	Night	Shreya D	0250	Sh		Night			
12/1/24	Morning	MEENA SELVAM	0276	meen		Morning			
12/1/24	Evening	A. ALBINUS	0088	AB		Evening			
12/1/24	Night	Janipiya	0284	Jan		Night			
13/1/24	Morning	Shreya	1100	Sh		Morning			
13/1/24	Evening	A. ALBINUS	0088	AB		Evening			
13/1/24	Night	F. Catherine	1207	F.C		Night			

Sx: OP CAB X 2 GRAFTS.
LIMA → LAD
SVG → PDA (EXTENSIVE
ENDARTECTOMY)



Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ

MHI/ICU/2022/076

Sheet No.

①

Age

Sex

Blood Group

B+ve

Height

150cm

Weight

49.5 kg

BSA

1.4 m²

A

SURGICAL PROCEDURE:

DATE OF SURGERY:

POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FIO ₂		pH	PCO ₂	PO ₂	HCO ₃	SAT%	BE
10.1.24	12.20	VC	14			5.0			410		60%	12.20	7.460	31.3	315.9	23.3	97.8	-2.1
	14.00	SIMV PRVC	12	20	23	5.0	10	5.5	441	446	60%							
	14.30	SIMV PRVC	10	16	22	5.0	9	4.6	445	490	60%							
	15.30	SIMV PRVC	8	12	24	5.0	9	4.0	485	586	60%							
	16.00	PS CPAP			29	5.0	10	8.2	421	454	60%	16.30	7.38	42.9	346.8	24.5	99.8	0.1
	17.00	Extubated.										18.00	7.29	50.3	229.0	22.1	99.4	-2.9
	17.10	Oxygen mask.									5L/min.							
	18.00	Nasal cannula.									2L/min.							

CRITICAL CARE FLOWCHART

PATIENT RECEIVED FROM OT: 12.20
OT URINE OUTPUT: 650ml

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

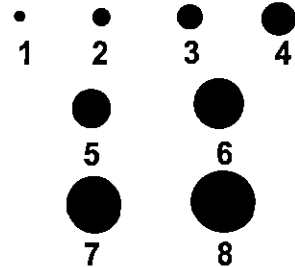
MOTOR

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

MOTOR ARMS/LEGS

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

PUPILS SCALE (mm)



PUPILS REACTION

Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL

Br-Brisk
Sl-Sluggish
O-Absent

EDEMA

D-Dependent
G-Generalised
O-Absent

HEART SOUNDS

S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS

JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced /
Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING

Ab-Abdominal
TA-Thoraco-abdomial
L-Laboured

SUCTION

ET-Endotracheal
N-Nasal
Or-Oral

BREATH SOUNDS

CL-Clear
Ro-Ronchi
Wh-Wheezes
CR-Crackles
BECL-Bilat
equal & clear

SECRETIONS

COLOUR
CL-Clear
Y-Yellow
W-White
Pk-Pink

CHARACTER

M-Moderate
Sc-Scanty
Th-Thin
Tk-Thick
Cs-Copious
R-Red

GASTROINTESTINAL

BOWEL SOUNDS

+Present
O-Absent

NGT POSITION

Air injected
+Heard in Abd
O-Absent
GA-Gastric contents aspirated
Dr-Dependent Drainage

ABDOMINAL TONE

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

GASTRIC RESIDUAL

G-Green B-Bleeding
Y-Yellow C-Coffee ground

LIVERSIZE

N-Normal
E-Enlarged

Sx: OPCAB x 2 GRAFTS.
LIMA → LAD
SVG → PDA (EXTENSIVE
-ENDARTECTOMY)



Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ

MHI/ICU/2022/076

Sheet No.		
(2)		
Age	Sex	
Blood Group	Height	Weight
B3ve	190cm	49.5kg
	BSA	
	1.4m ²	
A		

SURGICAL PROCEDURE:

DATE OF SURGERY: 10/1/24

POST-OP DAY: 003

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FIO ₂		pH	PCO ₂	PO ₂	HCO ₃	SAT%	BE
10/1/24	22:30	ON	NASAL PRONGS								44%	22.14	7.378	42.2	243.6	23.8	99.5	7.5
	22:45	ON	NASAL PRONGS								24%							
11/1/24	05:00	ON	ROOM AIR									6.38	7.401	38.0	72.0	23.1	94.6	1.4

CRITICAL CARE FLOWCHART

NEURO

EYES

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

VERBAL

Oriented-5
Confused/Disoriented-4
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Sounds-2
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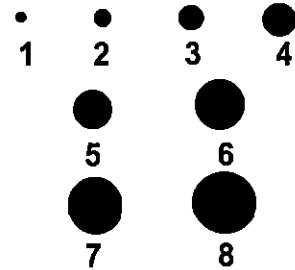
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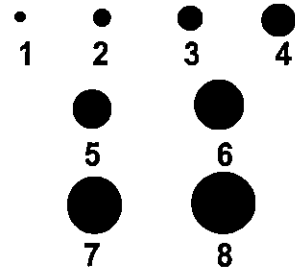
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E-Enlarged

Sheet No. ①	Mrs. JEEVA.A 54/Female/MHI202481615 07/01/2024/IPH2024000049 Dr. ANBARASU MOHANRAJ 			
	Age	Sex		
B	Blood Group B+ve	Height 150cm	Weight 49.5kg	BSA 1.4m ²



MHI/ICU/2022/076



DATE	TIME	BIOCHEMISTRY						VITAL PARAMETERS							CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd™G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
	12.20	10.0	139	3.22	0.96 120		12.20		cl	100%	18/mt		90.4F						
							13.30		cl	100%	12								
							14.30		cl	100%	11								
							15.30		cl	100%	12								
							16.30		cl	100%	10		95.4F						
	16.30	10.7	137	3.72	1.00 223		17.30		cl	100%	28								
	18.00	12.1	138	3.40	1.00 150		18.30		cl	100%	21								
							19.30		cl	100%	20								
							20.30		cl	100%	29/mt		96.1F						
							21.30		cl	100%	25/mt								

CRITICAL CARE FLOWCHART

PATIENT NOT FULLY AWARE AT: 14:00.

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME			12:20 ^{PM}	16:20	20:00	
	EYES			CP	4	4	
	VERBAL			CP	5	5	
	MOTOR			CP	6	6	
	ARMS R/L			CP	5/5	5/5	
	LEGS R/L			CP	5/5	5/5	
PUPILS	R.SIZE/REACTION			3/BR	3/BR	3/Br	
	L.SIZE/REACTION			3/BR	3/BR	3/Br	
CARDIO-VASCULAR	HEART SOUNDS			S, S2	S, S2	S, S2	
	VALVE CLICK			-	-	-	
	CAPILLARY REFILL			+	+	+	
	EDEMA			-	-	-	
	NECK VEINS			N	N	N	
PULMONARY	WORK OF BREATHING			TA	TA	TA	
	SUCTION			+	-	-	
	SECREATIONS			+	-	-	
GASTRO INTESTINAL	BOWEL SOUNDS			ST	ST	ST	
	ABDOMINAL TONE			SOFT	SOFT	SOFT	
	N/G POSITION			-	-	-	
	GASTRIC RESIDUAL			-	-	-	
	LIVER			N	N	N	

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE			CL	CL	CL	
	PD - FUNCTION			-	-	-	
	DRAINAGE			-	-	-	
	PD - SITE			-	-	-	
	COLOUR			-	-	-	
SKN	Sx WOUND-CHEST			CL	CL	CL	
	LEG			CL	CL	CL	
	DRESSING			-	-	-	
	PRESSURE SORE-SITE			-	-	-	
	AREA			-	-	-	
	DRESSING CONDITION			CL	CL	CL	
MISCELL	POSITION CHANGE			-	-	-	
	CHEST-PHYSIO			HEB Suction	HEB SPIRO	HEB SPM	
	ACTIVITY			PE	PE	PE	
	S/N NAME			MEEN	MEEN	MEEN	
	TIME			12:20	16:36	20:00	
	SIGNATURE			MEEN 0276	MEEN 0276	MEEN 0276	

Mrs. JEEVA.A
 54/Female/MHI202481615
 07/01/2024/IPH2024000049
 Dr. ANBARASU MOHANRAJ


Sheet No. ②

Blood Group	Btve	Height	50cm	Weight	49.5	BSA	1.4m ²
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MHI/ICU/2022/076



DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd ^{cm} G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
10/1/24	22.14	11.6	138	4.10	$\frac{1.01}{119}$		22.30		cl	100%	21/mt								
							23.30		cl	100%	16/mt								
							00.30		cl	100%	18/mt		97.5°F						
							01.30		cl	100%	21/mt								
							02.30		cl	100%	16/mt								
							3.30		cl	100%	23/mt								
11/1/24	4.30				$\frac{269}{210}$		04.30		cl	100%	24/mt								
	6.38	11.5	133	4.01	$\frac{1.08}{210}$		05.30		cl	96%	21/mt								
							06.30		cl	96%	18/mt								

CRITICAL CARE FLOWCHART 2/18

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME					00.00	04.00
	EYES					4	4
	VERBAL					5	5
	MOTOR					6	6
	ARMS R/L					5/5	5/5
	LEGS R/L					5/5	5/5
PUPILS	R.SIZE/REACTION					3Bx	3Bx
	L.SIZE/REACTION					3Bx	3Bx
CARDIO-VASCULAR	HEART SOUNDS					S1S2	S1S2
	VALVE CLICK					-	-
	CAPILLARY REFILL					8s	8s
	EDEMA					0	0
	NECK VEINS					N	N
PULMONARY	WORK OF BREATHING					7A	7A
	SUCTION					-	-
	SECREATIONS					-	-
GASTRO INTESTINAL	BOWEL SOUNDS					+	+
	ABDOMINAL TONE					S	S
	N/G POSITION					-	-
	GASTRIC RESIDUAL					-	-
	LIVER					N	N

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE					C	C
	PD - FUNCTION					-	-
	DRAINAGE					-	-
	PD - SITE					-	-
SKN	COLOUR					-	-
	Sx WOUND-CHEST					C	C
	LEG					C	C
	DRESSING					OT	OT
	PRESSURE SORE-SITE					NIL	NIL
	AREA					-	-
	DRESSING CONDITION					-	-
MISCELL	POSITION CHANGE					Q2H	Q2H
	CHEST-PHYSIO					Nel spiro	Nel spiro
	ACTIVITY					PE	PE
						HBP CVP	ABP CVP
	S/N NAME					ASHAC	ASHAC
	TIME					00.00	04.00
	SIGNATURE					DR 2011	DA 2011

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/1PH2024000049

Dr. ANBARASU MOHANRAJ

Name

Sheet No.

3

UHID N:



Age

Sex

B

Blood Group

Bte -

Height

150cm

Weight

49.5kg

BSA

1.4m²**Medway Hospitals®**

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



JCI ACCREDITED



NABH ACCREDITED

MHI/ICU/2022/076



Every heart beat counts

DATE	TIME	BIOCHEMISTRY						VITAL PARAMETERS							CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd ^{cm} G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
11/1/24							1:30		cl	96%	24/mt		98.7°						
	8:30				162		2:30		cl	97%	26/mt								
							9:30		cl	100%	23/mt								
							10:30		cl	100%	24/mt								
							11:30		cl	96%	24/mt		98.4°						
							12:30		cl	96%	26/mt	128/70 (80)							
							13:30		cl	99%	22/mt								
							14:30		cl	99%	25/mt								
							15:30		cl	98%	22/mt								
							16:30		cl	98%	22/mt								

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	2:00		12PM	16PM		
	EYES	4		4	4		
	VERBAL	5		5	5		
	MOTOR	6		6	6		
	ARMS R/L	5+		5+	5+		
	LEGS R/L	5+		5+	5+		
PUPILS	R.SIZE/REACTION	3/4r		3/BR	3/BR		
	L.SIZE/REACTION	3/4r		3/BR	3/BR		
CARDIO-VASCULAR	HEART SOUNDS	S1S2		S1S2	S1S2		
	VALVE CLICK	-		-	-		
	CAPILLARY REFILL	2r		+	+		
	EDEMA	0		0	0		
	NECK VEINS	2		N	N		
PULMONARY	WORK OF BREATHING	1A		1A	1A		
	SUCTION	-		-	-		
	SECREATIONS	-		-	-		
GASTRO INTESTINAL	BOWEL SOUNDS	+		+	+		
	ABDOMINAL TONE	SOFT		SOFT	SOFT		
	N/G POSITION	-		-	-		
	GASTRIC RESIDUAL	-		-	-		
	LIVER	2		(2)	(2)		

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE	U		CL	CL		
	PD - FUNCTION	-		-	-		
	DRAINAGE	-		-	-		
	PD - SITE	-		-	-		
SKN	COLOUR	-		-	-		
	Sx WOUND-CHEST	U		CL	CL		
	LEG	U		CL	CL		
	DRESSING	OT		OT	OT		
	PRESSURE SORE-SITE	NIL		NIL	NIL		
	AREA	-		-	-		
	DRESSING CONDITION	-		-	-		
MISCELL	POSITION CHANGE	Q2H		Q2H	Q2H		
	CHEST-PHYSIO	NBR SPINO		NBR PPIRO	NBR OP.R.		
	ACTIVITY	PE		PE	PE		
		ABP SUP		-	-		
	S/N NAME	CHEN		CHEN	CHEN		
	TIME	8:00		12:00	16:00		
	SIGNATURE	CHEN		CHEN	CHEN		

Mrs. JEE
54/Female/MHI202481615
07/01/2024/1PH2024000049

MHI/ICU/2022/076

Name	Dr. ANBARASU MOHANRAJ			Sheet No.	1
UHID N	Age	Sex			
Blood Group	Height	Weight	BSA	C	
Btve	150 cm	49.5 kg	1.4 m ²		

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOTAL	ADP	KCL	NTG	
10.1.24	12:20														200	200	4.5	1.0		
	13:30	100	100			40		40	40			6.0	6.0	146	100	300	0.5	25		
	14:30	90	190			20		20	60				6.0	256	100	400	0.1	25		
	5:30	80	270			40		40	100				6.0	376	100	500			4.0	40
	16:30	75	345			20		20	120				6.0	471	100	600			6.0	
	17:30	60	405			30		30	150				6.0	561	100	700			6.0	NTG 25/25
	18:30	40	445			30		30	180			2.0	8.0	633	100	800		25	1.0	2.0
	19:30	250	695			10		10	190				8.0	893	100	900		25	1.0	2.5
	20:30	120	815			20		20	210				8.0	1033	100	1000			1.0	2.0
	21:30	100	915			20		20	230				8.0	1153	100	1100			1.0	2.0

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

ACT - 129 Sec.

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

C-Clean
R-Redness
BD-Block discoloration

DRAINAGE

CL-Clear
BS-Blood

MISCELLANEOUS

POSITION CHANGE

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

V-Vibrator
CP-Chest percussion
DC-Deep breath & cough
N-Nebulizer

TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

SKIN

COLOUR

Pk-Pink
F-Flushed
P-Pale
Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air
R-Redness at site
Sw-Swelling at site
Dr-Draining
D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

PRESSURE SORE

AREA

R-Redness
BD-Black discoloration
BL-Blister
SP-Skin Peeling
D-Deep

DRESSING

B-Betadine
AI-Antibiotic
Irrigation

DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049
Dr. ANBARASU MOHANRAJ
Blood Group **B+**

MHI/ICU/2022/076

Sheet No. **(2)**

Age Sex

Height **150cm** Weight **49.5kg** BSA **1.4m²** **C**

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS				
		AMT	TOTAL	RT.PL.	LT.PL. ⁺	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	Flow	MTG	H-Act	PENTA
10/1/24	22.30	100	1015			30		30	260			1.0	9.0	1284	100	1200	2.0	1.0	0.5
	23.30	80	1095			20		20	280				9.0	1384	100	1300	2.0	+	0.5
11/1/24	00.30	100	1195			20		20	300				9.0	1504	100	1400	2.0		1.0
	01.30	100	1295						300				9.0	1604	100	1500	1.0		1.0
	02.30	80	1375			30		30	330				9.0	1714	100	1600	1		1.0
	3.30	80	1455			30		30	360			4.0	13.00	1828	100	1700			1.0
	4.30	100	1555			20		20	380				13.00	1944	100	1800			1.0
	5.30	75	1630			20		20	400				13.00	2039	100	1900		6.0	-
	6.30	150	1780						400				13.00	2189		1900		6.0	

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

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DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

Mrs. JEEVA.A 54/Female/MHI202481615		MHI/ICU/2022/076	
Name	07/01/2024/IPH2024000049	Sheet No. (2)	
UHID No.	Dr. ANBARASU MOHANRAJ	Age	Sex
Blood Group	B+ve	Height	Weight
	150	49.5	BSA
			1.4 m ²
			C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOT	ACT/PP	NO/NO
11/01/24	7:30	100	100											100			6.0	
	8:30	90	190			20		20	20					210			-	
	9:30	50	240						20					250				
	10:30	50	290						20					310				
	11:30	75	365						20					385				
	12:30	50	415						20					435				
	13:30	80	495						20					515				
	14:30	100	595						20					615				
	15:30	100	695						20					715				
	16:30	150	845						20					865				

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME	OBSERVATIONS/PROBLEMS
	10:50	① pleural + Mediastinal Drain Removed
	11:00	② RADIAL Arterial line removed

CRITICAL CARE FLOWCHART

GENITOURINARY (GU)

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Stained
HC-High Coloured

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DRAINAGE

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HL-Heparin Lock
B-Blocked

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Name

Dr. ANBARASU MOHANRAJ

Sheet No.

UHID No.

Sex

Blood Group

B+ve

Height

150cm

Weight

49.5kg

BSA

1.4m²

D



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MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: B +ve

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						ml/sv		AMT.	TOTAL														
10.1.24	12.20					2.0	3.0			203	+203	78	sinus	0.00	136/80	96	6		Wau	F/R			
	13.30					2.0	27.5			330.5	+184.5	78	SINUS	0.00	122/66	84	10		Wau	++			
	14.30					2.0	27.1			457.6	+201.6	82	Sinus	0.00	135/71	91	13		Wau	++			
	15.30					2.0	2.0			559.6	+183.6	78	Sinus	0.00	127/64	85	13		Wau	++			
	16.30					2.0	2.0			661.6	+190.6	81	Sinus	0.00	128/56	79	8		Wau	++			
	17.30	PENTH 200/20				2.0	8.0			769.6	+298.6	99	Sinus	0.00	153/59	92	6		Wau	++			
	18.30	1.0				2.0	28.0			899.6	+266.6	101	Sinus Tachy	0.00	160/68	98	9		Wau	++			
	19.30	0.5				2.0	30.5			1030.1	+137.1	102	Sinus Tachy	0.01	154/68	98	7		Wau	++			
	20.30	0.5				2.0	5.5	100	100	1235.6	+202.6	106	Sinus	0.01	149/78	93	8		Wau	++			
	21.30	0.5				2.0	5.5	75	175	1416.1	+263.1	104	Sinus	0.01	154/72	100	8		Wau	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME

PREVIOUS DAY HRS

DRAINAGE:

TOTAL INTAKE:

URINE :

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ

Name

UHID No.

Blood Group

B+ve

Height
150^{cm}Weight
49.5^{kg}BSA
1.4^{m²}

Sheet No.

Age

Sex

2

D



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MHI/ICU/2022/076

Medway Heart Institute

Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: B+ve

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						U/L		AMT.	TOTAL														
10/1/24	22:30					2.0	5.5		175	1521.6	237.6	101	Sinus	0.01	132/62	85	12		Warm	++			
	23:30					2.0	4.5		175	1626.1	242.1	99	Sinus	0.01	132/59	83	10		Warm	++			
11/1/24	00:30					2.0	5.0		175	1731.1	227.1	99	Sinus	0.01	136/59	84	11		Warm	++			
	01:30					2.0	4.0	50	225	1885.1	281.1	95	Sinus	0.01	120/63	82	10		Warm	++			
	02:30					2.0	3.0		225	1988.1	274.1	96	Sinus	0.01	104/52	65	10		Warm	++			
	3:30					2.0	3.0		225	2091.1	263.1	100	Sinus	0.01	128/53	83	8		Warm	++			
	4:30					2.0	3.0		225	2194.1	250.1	101	Sinus	0.00	137/52	80	7		Warm	++			
	5:30					2.0	6.0		225	2300.1	261.1	101	Sinus	0.01	123/58	78	8		Warm	++			
	6:30					2.0	8.0	50	275	2358.1	169.1	100	Sinus	0.01	128/45	71	6		Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME 22:30

T. EUSPIRIN 75mg po STAT Given B/O DR ANBARASU

PREVIOUS DAY HRS

DRAINAGE:

TOTAL INTAKE:

URINE :

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

Mrs. JEEVA.A

54/Female/MHI202481615

07/01/2024/1PH2024000049

Dr. ANBARASU MOHANRAJ



Sheet No.

Sex

3

Name

UHID No.

Blood Group

RTE

Height

150cm

Weight

49.5kg

BSA

1.4m²

D

**Medway Hospitals**

The way to better health

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JCI ACCREDITED



NABH ACCREDITED

MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: B+

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						MIS		AMT.	TOTAL														
11/12/24	7:30					2.0	8.0	100	100	108	↑ 8	106	Sinus	0.02	144/61	84	7		Warm	++			
	8:30					2.0	2.0		100	110	↑ 100	102	Sinus	0.02	132/62	80	6		Warm	++			
	9:30					2.0	2.0	100	200	212	↑ 38	101	Sinus	0.01	154/60	93	5		Warm	++			
	10:30					2.0	2.0		200	214	↑ 96	98	Sinus	0.01	124/65	80	8		Warm	++			
	11:30					-		100	300	314	↑ 7	94	Sinus	0.02	-				Warm	++			
	12:30								300	314	↑ 121	90	Sinus	0.00	-				Warm	++			
	13:30							200	500	514	↑ 1	90	Sinus	0.04					Warm	++			
	14:30							100	600	614	↑ 1	90	Sinus	0.02					Warm	++			
	15:30							100	700	714	↑ 1	98	Sinus	0.03					Warm	++			
	16:30							100	800	814	↑ 51	96	Sinus	0.02					Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME

PREVIOUS DAY 18.12.2024 HRS

DRAINAGE: 400 ml TOTAL INTAKE: 2358.1 ml

URINE: 1780 ml TOTAL OUTPUT: 2189 ml

TOTAL BALANCE: +169.1 ml

P.T.O.



BALANCE 499 ml

Mrs. JEEVA.A
54/Female/MHI202481615
07/01/2024/IPH2024000049

Dr. ANBARASU MOHANRAJ



INTERMEDIATE CARE FLOWCHART

B

UHID NO :

AGE :

SEX :

①

BLOOD GROUP : 'B' POSITIVE

HEIGHT : 150 cms

WEIGHT : 49.5 kgs

B.S.A : 1.4 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
98.1	99	Sinus	0.01	136/64	(86)	norm	++	26	BL CL	98%	} Room Air .
	98	Sinus	0.01	136/64	(86)	norm	++	24	CL	96%	
	96	Sinus	0.00	150/81	106	norm	++	26	CL	98%	
	100	sinus	0.04	149/79	99	norm	++	27	CL	97%	
	99	sinus	0.01	150/81	106	norm	++	24	CL	95%	
	98	sinus	0.00	151/78	102	norm	++	26	CL	96%	
	97	sinus	0.00	140/67	81	norm	++	28	CL	96%	
	95	sinus	0.00	127/75	92	norm	++	24	CL	96%	
	96	sinus	0.01	142/89	93	norm	++	26	CL	96%	
	95	sinus	0.01	116/66	79	norm	++	27	CL	97%	
	94	sinus	0.00	126/66	81	norm	++	24	CL	98%	
	90	sinus	0.01	110/71	65	norm	++	22	CL	97%	
97.7	98	sinus	0.01	122/67	81	norm	++	20	CL	97%	
	96	sinus	0.01	130/66	79	norm	++	18	CL	96%	

PREVIOUS DAY - HOURS

DRAINAGE

URINE

I

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

I



DATE & TIME	URINE		CHEST DRAINAGE			TOTAL OUTPUT	I.V. FLUIDS			ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE			
	H.T.	G.T.		AIR LEAK	H.T.		G.T.				H.T.			H.T.	G.T.	
11/1/85 17:30	150	995				20	1015					200	1000	1014	-1	
18:30	250	1245				20	1265					50	1050	1064	-201	
19:30	150	1395				20	1415					100	1150	1164	251	
20:30	100	1495				20	1515					150	1300	1314	201	
21:30	75	1570				20	1590						1300	1314	276	
22:30	100	1670				20	1690					100	1400	1414	276	
23:30 12/1/85	75	1745				20	1765			carbolyte		100	1500	1514	251	
00:30	100	1845				20	1865	100				100	1500	1614	251	
01:30	75	1920				20	1940	100				200	75	1575	1789	151
02:30	100	2020				20	2040	100				200		1575	1889	151
03:30	75	2095				20	2115	100				400	100	1675	2009	26
04:30	75	2170				20	2190	100				500	100	1775	2289	99
05:30 (12)		2170				20	2190					-		1775	2289	99
06:30		2170				20	2190					-	100	1875	2389	199

MEDICATION / DRUGS