

**MRD CHECKLIST**

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





**Medway Hospitals**

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr. RAMACHANDRAN R

64/Male/MHI202481643

05/01/2024/IPH2024000043

Dr.G. GNANAVELU



MHI/IPD/2022/002



Every heart beat counts

## ADMISSION SLIP

Admitting Doctor: DR GNANAVELU

Speciality: Cardiology

Advised Date & Time: 5/1/24 9:49 PM

Provisional Diagnosis:

ACS - Anterior STEMI  
RMM

Reason for Admission:

☒ Medical Management

☐ Surgical Management

☐ Others (please specify details)

Admission Type:

☐ Day Care

☐ ER

☐ Ward

☒ ICU

CW

(Specify details)

Surgery / Procedure Name (if planned):

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

Expected Duration of Stay:

3 days

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

Payer: ☒ Self ☐ Insurance ☐ Others:

Instructions to Nurse (if any):

- Investigations  
- vitals monitoring

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

Dr. Arun

91810

5/1/24

9:49



For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☒ Others CCU

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

5/1/24

9:49 PM

5/1/24

9:49 PM

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]*

Iseral B / K

MH/0273

5/1/24

9:49 PM





## ADMISSION FORM


Marital Status <b>MARRIED</b>	Full Address <b>19/4 3RD STREET POSTAL COLONY</b> <b>WEST MAMBALAM CHENNAI-33</b>	Telephone Number <b>9790765247</b>
Occupation		

Referred from <b>R. MURALIDHAR</b> <b>(FRIEND)</b>	Date of Time of Admission <b>5/1/24 9.49PM</b>	Date & Time of Discharge <b>8/1/24</b>	Total No. of Days <b>4 days</b>
UNIT <b>Cardiology</b>	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		

FINAL DIAGNOSIS	ICD Code
<b>CAD - ACS - STEMI - AAMI</b>	<b>I25.1, I24.9</b>
<b>THROMBOLYSED WITH INJ. TNK - 05.01.2024</b>	<b>I24.3</b>
<b>MODERATE LV DYSFUNCTION, EF - 40%</b>	<b>I50.1</b>
<b>ACUTE PULMONARY EDEMA - RESOLVED</b>	<b>J81.0</b>
<b>TYPE II DIABETES MELLITUS</b>	<b>E11.9</b>

DATE	OPERATION / PROCEDURES	ICPM Code
<b>6/1/24</b>	<b>CORONARY ANGIOGRAM</b>	<b>88.50</b>
<b>6/1/24</b>	<b>PTCA TO CAD</b>	<b>00.66</b>
DATE	TYPE OF ANESTHESIA	
<b>6/1/24</b>	<input checked="" type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL	

DISCHARGE STATUS		
<input checked="" type="checkbox"/> Cured	<input type="checkbox"/> Discharge at Request	<input type="checkbox"/> Expired < 48 hours
<input type="checkbox"/> Improved	<input type="checkbox"/> Against Medical Advice	<input type="checkbox"/> Expired > 48 hours
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Absconded	<input type="checkbox"/> Post-Operative Death
<input type="checkbox"/> Transferred to .....		

Signature of the Consultant 	Signature of Medical Records Officer 
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## 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. RAMACHANDRAN 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 their attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி .....-க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கான 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 மதிப்பிடக்கூடிய பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்ல 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 05/01/2024

  
எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

உறவுமுறை WIFE .

Nature of Relationship



## GENERAL CONSENT FOR ADMISSION


I, RAMACHANDRAN 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		RAMACHANDRAN	5/1/24	9:49 AM
Surrogate/Guardian (if applicable #)	R. Deepa	DEEPA (Write name and relationship with patient)	5/1/24	9:49 PM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		HARISH	5/1/24	9:49 PM
Interpreter (if applicable)				

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





**Medway Hospitals®**

The Health

Mr. RAMACHANDRAN R

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr. G. GNANAVELU



I .....  
under the

CHENNAI

: # 2/26, 1st Main Road, United India Colony, Kodambakkam,

Chennai - 600024. Tel : 044 - 2473 4455 | Mobile No : 9962 985 985

KUMBAKONAM : No. 142-B, Sri Balasubramaniam Nagar, Pilliyam Pettai,

Ammachathiram (Post), Thiruvudaimarudhur (Taluk), Kumbakonam - 612103.

(Tanjore Dist). Ph: 0435 - 2412345 | Mob : 7397720491

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

### DIL / HIGH RISK FORM

..... was informed that Mr./Mrs. Ramachandran - G.  
..... is seriously ill.

I am aware of the seriousness of his/her illness and explained in detail by the above doctor's team member.

I am giving my consent to the above Doctor and his/her team of this Hospital to proceed with the necessary treatment like continuous monitoring, oxygen therapy, ventilator management and life saving procedures (or) surgery.

I am aware that the patient is very critical, even death may occur. I will not hold the Hospital or the doctors or any employee of this hospital responsible for any consequences happening forthwith.

I also accept the prognosis of the patient.

Witness :

1. [Signature]  
2. [Signature]

Signature :

[Signature]

Relationship :

Spouse.

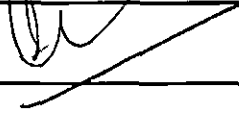


## ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE	
1	<b>Hemodynamic instability defined as</b>		
	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	<b>Cardio-vascular System.</b>		
	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		
3	<b>Miscellaneous Conditions</b>		
	Septic shock with hemodynamic instability		
	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
4	<b>Post procedure elective admission</b>		
	Post Coronary Angioplasty		
	Post Cardio-vascular Surgery		
5	<b>Following angiographic procedure</b>		
	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	<b>Pulmonary System</b>		
	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 hemoptysis		
	Respiratory failure needing imminent intubation		
7	<b>Renal failure</b>		
	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	<b>Endocrine System and Metabolism related</b>	
	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
		Dr. A. Akilan	9120	5/1/24	9:50

## 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
		Dr. A. Akilan	9120	7/1/24	12:30





## DISCHARGE SUMMARY

IP No.	IPH2024000043	D.O.A	: 05/01/2024
UHID	MHI202481642	D.O.P	: 06/01/2024
Name	Mr. RAMACHANDRAN. R	Room No.	: GN
Age / Gender	64Years / MALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 08/01/2024

### DIAGNOSIS:

CAD – ACS – STEMI-AWMI  
THROMBOLYSED WITH INJ. TNK – 05.01.2024  
MODERATE LV DYSFUNCTION, EF – 40%  
ACUTE PULMONARY EDEMA - RESOLVED  
TYPE II DIABETIS MELLITUS

### PROCEDURE:

1. CORONARY ANGIOGRAM DONE ON 06.01.2024 – SIGNIFICANT LAD DISEASE.
2. SUCCESSFUL PTCA + STENT TO LAD USING 2.75 X 28MM SYNERGY DES DONE ON 06.01.2024.

### BRIEF HISTORY:

Mr. Ramachandran. R, 64 years old male, presented with complaints of chest pain, retrosternal compressive type for 1 hour. He came to Medway Heart Institute on 05.01.2024 for evaluation and further management.

### ON EXAMINATION:

HR : 88bpm BP : 120/70mmHg SPO<sub>2</sub> : 94% in room air  
CVS : S1S2+ RS : B/L Basal crepts, ABD : Soft CNS : NFND

### INVESTIGATIONS:

**BLOOD(05.01.2024)** : Hb – 15.4gm/dl, TWBC – 11900cells / cumm, Platelet – 346000 cells/cumm, Urea – 24mg/dl, Creatinine – 0.93mg/dl, Na<sup>+</sup> -136 mmol/L, K<sup>+</sup> -4.67 mmol/l, Trop I – 15.5 ng/l, INR – 0.8 secs, CK – MB – 14.8 U/L, CPK – total – 55 u/l.

**ECG** : Sinus rhythm, HR – 63bpm, ST elevation in V1 – V6, ST depression in II, III & aVF.

**SREEENING ECHO(05.01.2024)**: Hypokinesia of basal mid & apical. Anterior wall, anterior septum, anterior lateral of LV. Moderate LV dysfunction. EF – 40%. Mild MR. No PE. Grade I LV diastolic

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

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PATIENT HELPLINE  
**94557 94557**  
**1800 572 3003**

### Medway Group of Hospitals

Kodambakkam	Mogappair	Chengalpattu	Villupuram	Kumbakonam	Kakinada
044-2473 4455	044-26530011	044-27426829	04146-242000	044-2473 4455	0884-2333367

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

### Medway Centre of Excellence (Chennai)

Heart Institute	Institute of Pulmonology
044 - 4310 8959	044-2473 4451

MHI/HOSP/2022/118



### POST PROCEDURE INVESTIGATIONS:

**BLOOD(07.01.2024)** : Urea- 38mg/dl, Creatinine- 1.12mg/dl, Na+ -134 mmol/L, K+ - 4.26sa mmol/l.

**ECG** : Sinus rhythm, HR: 97bpm , evolved AWTI changes.

**ECHO(06.01.2024)**: S/P PTCA. All chambers normal sized. RWMA (+) – septum, apex, All apical segments, mid anterior, mid anterolateral hypokinetic. Moderate LV systolic dysfunction. EF – 40%. Grade II diastolic dysfunction. Normal RV systolic function. Aortic valve sclerosis. No AS. Trivial AR. Mild MR. Trivial TR. No PAH. Echo free space noted anterior to RV. ? Epicardial fat. No clot / vegetation / effusion. IVC normal in size and collapsing.

**ECHO(08.01.2024)**: S/P PTCA. Mild concentric LVH. Chambers normal sized. RWMA – mid & apical septum, apex, mid & apical anterior hypokinetic. Mild LV systolic dysfunction. EF – 48%. Grade I diastolic dysfunction. Normal RV systolic function. Increased LV filling pressure. Aortic valve sclerosis. No AS / AR. Other valves are normal. IAS / IVS intact. Minimal pericardial effusion anterior to RV. Trace effusion postero – lateral to LV .No clot / vegetation.

### COURSE IN THE HOSPITAL:

Mr. Ramachandran. R, 64 years old male, admitted with above mentioned complaints. Basic investigations were done. ECG showed acute AWTI changes. ECHO showed Hypokinesia of basal mid & apical. Anterior wall, anterior septum, anterior lateral of LV. Moderate LV dysfunction. EF – 40%. He was diagnosed as ACS – AWTI, moderate LV dysfunction and thrombolysed with Inj. Tenecteplase 40mg IV stat on 05.01.2024. After obtaining consent, he underwent Coronary angiogram which revealed **SIGNIFICANT LAD DISEASE** followed by **SUCCESSFUL PTCA + STENT TO LAD USING 2.75 X 28MM SYNERGY DES DONE ON 06.01.2024** by right radial access approach. Post procedure period was uneventful and shifted to CCU. Post procedure ECG shown no fresh ST- T changes. He was treated with IV diuretics, dual anti-platelets, statin, betablockers and other supportive measures. Patient got shifted to ward, His RFT were within normal limits and maintained with adequate fluid balance. His medications were optimized and he is being discharged in a stable clinical condition.

### CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS - 15/15

Temp - 98.6°F

PR - 96/min

BP - 110/60mmHg

SPO2 - 95% in room air



### ADVICE MEDICATIONS:

SL. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. AX CER (TICAGRELOR)	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ATORVAS (ATORVASTATIN)	80 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	TAB. LASIX	40 MG	½	½	0	ORAL	AFTER FOOD	TO CONTINUE
8	TAB. ALDACTONE (SPIRONOLACTONE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
9	TAB. CARDACE (RAMIPRIL)	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. CARDIVAS (CARVEDILOL)	3.125MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11	TAB. IVABRADINE (IVABRADINE)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
12	SYP. CREMAFFIN	15 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
13	TAB. ANXIT (ALPRAZOLAM)	0.5 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
14	SYP. SUCRAFIL	10 MG	1	1	1	ORAL	AFTER FOOD	TO CONTINUE
15	TAB. MONTEK LC	1 TAB	0	0	1	ORAL	AFTER FOOD	X 1 WEEK
16	TAB. MAHACEF	200MG	1	0	1	ORAL	AFTER FOOD	X 5 DAYS

### DIABETIC MEDICATIONS:

SL. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. GLYCOMET - GP 2	2/500 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
2	TAB. SITAHENZ M	500 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. OXRA	10MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE



## INPATIENT INITIAL ASSESSMENT

Date: 5.1.2024

Time of arrival in ward: 9:49 PM.

Allergies (if Yes, specify details):

Drugs ☒ Yes ☐ No Allergic to Pen-D.

Blood Transfusion ☐ Yes ☐ No

Food ☐ Yes ☐ No

Others

Vital Signs: Temp: 100 (°F) | Pulse / HR: 80/5 (beats/min) | BP: 120/70 (mmHg)

Respiration: 20 (breaths/min) | SpO<sub>2</sub>: 99 (%) | Height: 170 (cms) | Weight: 85 (kgs) | BMI: 29.4 kg/m<sup>2</sup>

Pain: ☒ Yes ☐ No. If Yes, Score: 2/10

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

Duration:                      Location:                     

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

### CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

90 @ Sided Chest pain since 8:30 pm today.  
Associated sweating.  
not radiating  
no H/o SOB / palpitation

### PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☒ Yes ☐ No. If Yes, duration: 24 yr Hypertension: ☐ Yes ☒ No. If Yes, duration:                     

Others:

### Past Surgical History:

— nil —



**Present Medication (for Medication Reconciliation):**

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

**Family History:**

nil significant FH/O CD

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

Lifestyle: ☐ Sedentary ☒ Active

Occupation: Retired

Smoking: ☐ Yes ☒ No

Alcohol: ☐ Yes ☒ No

Recreational Drug Use: ☐ Yes ☒ No

Others: \_\_\_\_\_

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

NA

**General Physical Examination:**

Pallor: ☐ Yes ☒ No

Icterus: ☐ Yes ☒ No

Clubbing: ☐ Yes ☒ No

Edema: ☐ Yes ☒ No

Lymphadenopathy: ☐ Yes ☒ No



## SYSTEMIC EXAMINATION

CVS:

S/S  $\oplus$

Respiratory System:

Beats  $\oplus$  B/L. Crp  $\oplus$

Gastrointestinal System:

S/S  $\oplus$

Central Nervous System:

Normal  
res = 15/15

Urinary / Reproductive / Locomotor System:

$\uparrow$

Skin / Ophthalmic / ENT

$\oplus$

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:

ACS - & AW - STEMI - / Acute pulm. edema  
T2DM.

Plan of Care:

CCU Admission / D12 / High risk consent for  
Thrombolysis  
Thrombolysis  
CABG  $\pm$  PCI  
Drugs as per chart  
- family updated  
- H.O. chart  
- vitals hourly



**Investigations Advised:**

- Cath probe -  
- Cardiac enzymes

**Diet Advice:**

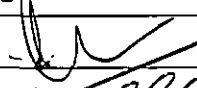
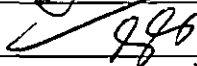
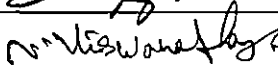
- ☐ Nil per Oral      ☐ Clear liquid diet      ☐ Normal liquid diet      ☐ Diabetic liquid diet  
☐ Semisolid diet      ☐ Soft solid diet      ☐ South Indian normal diet      ☐ North Indian normal diet  
☐ Neutropenic liquid diet      ☐ Others: \_\_\_\_\_

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

PFE: Patient Family Education

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

**Others:**

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. H. H. H. H.	94810	5/1/24	22.00
Consultant		DR. G. G. G. G.	29469	5/1/24	22.00
Patient Attendant		Relationship Soni	-	5/1/24	22-00



## CONSENT FORM FOR CRITICAL CARE (ICU)

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

☐ Read

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

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

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

### CENTRAL VENOUS CATHETER INSERTION

#### Brief description of the Procedure:

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

#### Intended benefits:

Common reasons for having a central line include:

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

#### Possible risks and complications:

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

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

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

**Alternative Forms of Treatment:** Peripheral Venous Access



## ENDOTRACHEAL INTUBATION

### Brief description of the Procedure:

Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.

The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

### Intended benefits:

The procedure might be needed for you / your patient for any of the following reasons:

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

### Possible risks and complications:

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

### Possible alternatives:

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

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful procedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.

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

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

	Signature / Thumb Impression*	Name	Date	Time
<b>Patient</b>		<i>ASA</i>		
<b>Surrogate/Guardian (if applicable #)</b>	<i>R. Deepa</i>	<i>Mrs. R. DEEPA</i> <small>(Write name and relationship with patient)</small>	<i>5/1/24</i>	<i>9:58</i>
<b>Reason for surrogate consent</b>	Patient is unable to give consent because:			
<b>Witness</b>	<i>Dr. N. Manabhai</i>		<i>5/1/24</i>	<i>9:58</i>
<b>Interpreter (if applicable)</b>				

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

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

	Signature	Name	Reg. No.	Date	Time
<b>Doctor</b>	<i>[Signature]</i>	<i>Dr. N. Manabhai</i>	<i>91810</i>	<i>5/1/24</i>	<i>9:58</i>



## உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

ப வாசித்திருக்கிறேன்

ப சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.

ப நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

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

### மைய சிரையில் கதிட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

ஒரு மைய சிரை கதிட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள ஸ்ர லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:

மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி



## மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

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

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

சாத்தியமுள்ள மற்று் வழிமுறைகள்:

உடலுக்குள் ஊடுருவாத சுவாச ஏதுவாக்கல் முறையானது, சில சூழ்நிலைகளில் உதவிகரமாக இருக்கக்கூடும். ஆனால், மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியப்படும்தோது, வேறு மாற்று சிகிச்சை முறைகள் வழங்கப்படுவதற்கு வழியில்லை.

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

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

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

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

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

மருத்துவர்	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்





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MR. RAMACHANDRAN R

64/Malc/MH1202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU



CHI/IP/2022/041



## Heart beat counts

### DOCTOR'S PROGRESS NOTES

DATE	NOTES
5/1/24	High Risk Consent for thrombolysis
10pm	<p>Story from Mr. Ramachandran, 66/M, is          consistent (Acute MI) requiring primary percutaneous          coronary intervention. High risk for bleeding          ICU and surgery, thrombolysis also carries          that risk. High risk for bleeding. Given          thrombolysis during surgery. High risk for bleeding          via surgery (Bleeding / Haemorrhage, etc)          consistent with previous history. High risk for bleeding          thrombolysis carries risk of bleeding in deep vein</p>
	R. Deen





MHI/IP/2022/041



**Medway**  
**Heart**  
Institute  
rt beat counts

### DOCTOR'S PROGRESS NOTES

[illegible]



DATE	NOTES
6/1/2024	s/b Dr. G. Charany
7.30 AM	Arrival 14:00 ENE mod w/dry/burns H2O BT Tubm 180/110 P102x few birds
	12e on 2nd line arm
	W/ last 2y W as (Pamperle) T. Cardace 2-03 1-0-7 T. Adalene 2y 1-0-0 T. Valant 2y 1-0-7 T. Clapier 2y 1-0-7 T. Euphr 1y 1-0-0 T. Arley 2y 1-0-7 T. Affarden 1-0-7 (Sauridol) T. Cardace 3-03 1-0-7 Cap Arpente 1-0-7 2:50 T. Amarg 2y 1-0-0 W/ depore by 8:00
	29469





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MHI/IP/2022/041

**Mr. RAMACHANDRAN R**

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU



edway  
**art**  
itute  
it counts

### DOCTOR'S PROGRESS NOTES

DATE	NOTES
	Sb nr color screen
6/10/26 8:00	no chest pain at present
	ok comm
	f- 109/mm
	B- 170/113
Bog	Cu/m
Vin	Romy
Mm	-ble Mammal exp
G3/mm.	v
	pam
Bog	Thy & on call to call
Endural AMP	Fab
JF	
	Mopra 8:30pm
← 1 from ne Meg hal)	red dot veribony
cpx pvs	<del>G. Valzian dom</del>
	<del>off Roudy</del>
	k
	102mm





Date : 6/1/24

Time : 9.30

Doctor's Name : Dr. Balaji

## ICU PROGRESS NOTES

ICU SCORES  
(as Appropriate)

CLIF ACLF / AD score:  
SOFA score:

MELD score:

SAPS II score:

AARC score:

APACHE II score:

ICU Day  
Background

chest pain  
+ hypot.

Issues last 24 hours

chest pain + hypot.

### Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M

Pupils

Pain score

Drains

### Cardiovascular system

HR - 71/p Rhythm -

Cardiac Output -

BP - 100/60 CVP -

Cardiac Medications:

### Respiratory system

Oxygen supplementation -

Saturation / PaO2-

Ventilator : Spontaneous / Controlled



Last C x R -  
Drains -

4 L O2

### GIT

P/A soft

Bowels - Y / N Loose stools / Melena

Drains

NG tube : Y / N

Day NGA-

USG

CT

### Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved :

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

### Microbiology

Invasive lines

1.

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

### Labs

Hb 15.4

TC 119mm

Platelets

Urea 44

Creatinine 0.9

Na 136

K 4.6

Bilirubin

AST

ALT

INR

Others

DVT prophylaxis - Y/N

Drugs :

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N

Drugs

Pressure sore Y / N

Alpha bed Y / N



Plan for the day

Yes

CAG P/ass today

6/11/24

Cath Lab → CCU.

-- o/c - G/L for Mudd  
s/p PTCA


PCI + LAD done

vital stable

B

- Plw post op ok  
- apx 10%.



Doctor	Signature	Name	Reg. No.	Date	Time
		BACOMI	12345	6/11/24	9:30





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**Mr.RAMACHANDRAN R**

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU



MHI/IP/2022/041



## Every heart beat counts

### DOCTOR'S PROGRESS NOTES

DATE	NOTES
06/01/24 12:16	<p>(RE) Radial CAG ± AdHoc PCI to LAD          BP 160/90 3.0 DBU</p> <p>CAG: (RE) Dominant significant <del>low</del> LAD disease</p> <p>LAD, LCA engaged 3.0 DBU          LAD wire 3.0 DBU          LAD predilated 2x10 SC @ Across HP.          @ 11 atm for 10 sec.          LAD stent 2.75x28 DBS Synergy.          @ 11 atm for 20 sec.          stent lesion post dilated 3x10 NC @ 12-14 atm for 10 sec          good apposition of stent          Post procedure ACR: 272</p> <p style="text-align: right;">R          @ As per dict          @ Rpt RFT tomorrow          (X) T. AXLER MD 1-01.          9320</p>

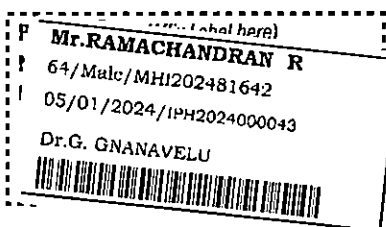


DATE	NOTES
07/01/24 1:00 PM.	S/B - Dr. C. Sui Long
	Patient reviewed from SW
	S/P: PTCA
	PCI + CAD done
Vitals stable	ops. pt conscious, oriented, afebrile
	S/B C/S - S, S, S
	Rx: B/L BAC (C)
	Rx: SFT
	Follow the drug chart.
	Monitor vitals.
Dr. C. Sui Long	
15/2005	





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MHI/ICU/2022/040



Every heart beat counts

Date : 6/1/24 **ICU PROGRESS NOTES**

Time : 6:30pm

Doctor's Name : Dr. Karthik

**ICU SCORES**  
(as Appropriate)

**CLIF ACLF / AD score:**  
**SOFA score:**

**MELD score:**  
**SAPS II score:**

**AARC score:**  
**APACHE II score:**

**ICU Day**  
**Background**

ACS  
AEW ME - STEMI  
Lysed 2 TNR.  
Act - Pul. Edema resolved.  
TLD M, MAN.

**Issues last 24 hours**

FTN.

**Central nervous system**

Conscious / oriented / sedated with

Sedation score

GCS - E V M

Pain score

15/15 Pupils

Drains

**Cardiovascular system**

HR - 90 Rhythm NS . Cardiac Output -

BP - 150/40 CVP -

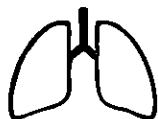
Cardiac Medications: NTG - 0.6 ml

**Respiratory system**

Oxygen supplementation - BABE

Saturation / PaO2-

Ventilator : Spontaneous / Controlled SpO2: 93%



Last C x R -

Drains -

**GIT**

P/A 3050

Bowels FTN Loose stools / Melena

Drains

NG tube : Y / N

Day NGA-

USG

CT

**Nutrition & Fluids**

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved :

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Oral feeds -  
voided unmed

**Microbiology**

Invasive lines

1.

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

periph blood

**Labs**

Hb

TC

Platelets

Urea

Creatinine

Na

K

Bilirubin

AST

ALT

INR

Others

DVT prophylaxis Y/N

Drugs :

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis Y/N

Drugs

Pressure sore Y/N

Alpha bed Y/N



Plan for the day

Adv

Drugs as charted

cont. N/A - to Librate / stop.


HO chart.

Monitor Vitals.

5 ml feeds.

F.R. 1.2 Lb / day.

1/11/24  
85851

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Lanthorn	85851	6/11/24	AM





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Definitive Details (Affiliates & Sub-centers)

Mr. RAMACHANDRAN R

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr. G. GNANAVELU



MHI/ICU/2022/040



Every heart beat counts

Date: 8/1/2024

Time: 8:10 pm

Doctor's Name: Dr. H. Aletian

## ICU PROGRESS NOTES

ICU SCORES  
(as Appropriate)

CLIF ACLF / AD score:  
SOFA score:

MELD score:

SAPS II score:

AARC score:

APACHE II score:

ICU Day D2  
Background

Aes - Aa - STEMI.  
s/p Lyric 2. Tnk  
yesterday  
Aa 5 pul - edema -> Resolved  
T2DM / 347.

Issues last 24 hours

s/p PCI to LAD done  
body  
pt stable.

### Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M 5/5

Pain score

Pupils B/L PERRL  
Drains none.

### Cardiovascular system

HR - 102/min Rhythm - Sinus Cardiac Output -

BP - 140/96 CVP - tachy.

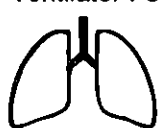
Cardiac Medications: S/S2 (+)

### Respiratory system

Oxygen supplementation -

Saturation / PaO2 - 99% T2LO2.

Ventilator: Spontaneous / Controlled



Last C x R -  
Drains -

Beside (+)

### GIT

P/A 2/5

Bowels - Y/N Loose stools / Melena

Drains

NG tube: Y / N

Day NGA-

USG

CT

### Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Adequate output.

### Microbiology

Invasive lines

1. peripheral line 2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1. -

2.

3.

### Labs

Hb

TC

Platelets

Urea

Creatinine

Na

K

Bilirubin

AST

ALT

INR

Others

DVT prophylaxis Y/N

Drugs:

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N

Drugs

Pressure sore Y / N

Alpha bed Y / N



Plan for the day

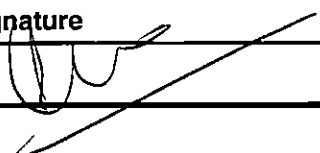
- Drug as per chart.

- SFO chart -

- vitals Monitoring -

- fluid restriction 1-2 l/day

- to do GSC / ~~Q~~ B. urea / creat / AST / ALT  
tomorrow morning

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. G. Alshar	91810	6/1/24	8:20 AM





Date : 2/1/24

Time : 8 AM

Doctor's Name : Dr. Karthi

## ICU PROGRESS NOTES

**ICU SCORES**  
(as Appropriate)

**CLIF ACLF / AD score:**  
**SOFA score:**

**MELD score:**  
**SAPS II score:**

**AARC score:**  
**APACHE II score:**

**ICU Day**  
**Background**

ACS.  
STEMI - Arteri  
Post PPCI LAD.

**Issues last 24 hours**

Tachycardia  
O<sub>2</sub> requirement @

**Central nervous system**

Conscious / oriented / sedated with  
Sedation score  
GCS - E V M 15/15 Pupils  
Pain score Drains

**Cardiovascular system**

HR - 109 Rhythm - S ~ S. Cardiac Output -  
BP - 130/80 CVP -  
Cardiac Medications:

**Respiratory system**

Oxygen supplementation -  
Saturation / PaO<sub>2</sub>-  
Ventilator : Spontaneous / Controlled



Last C x R -  
Drains -

**GIT**

P/A 5/8  
Bowels (Y) N Loose stools / Melena  
Drains  
NG tube : Y / N Day NGA-  
USG  
CT

**Nutrition & Fluids**

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved  
IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

**Microbiology**

Invasive lines

1.

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

**Labs**

Hb

TC

Platelets

Urea

Creatinine 1.2

Na

K 2.26

Bilirubin

AST

ALT

INR

Others

DVT prophylaxis - Y/N

Drugs :

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N

Drugs

Pressure sore Y/N

Alpha bed Y/N



Plan for the day

Acti

Dry as checked

HR control. - Esophageal Beta Blocker

No chest

mobility.

Monitor Wt.

oral feed - ② Diet.

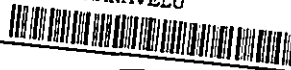
P.R. 1-5 kg

CAR.

*[Signature]*

Doctor	Signature	Name	Reg. No.	Date	Time
	<i>[Signature]</i>	Dr. Kurthor	25851.	7/1/23	9am





## DOCTOR'S PROGRESS NOTES

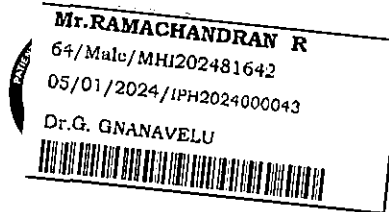
DATE	NOTES
07/1/24	SpB: Dr. Gnanavelu
9 AM	No flt symptom No chest pain No SOB No pain/swelling over (R) forearm
U/38 C/1.1	CVS: S <sub>2</sub> @ L A/CAR
BP: 120/80 HR: 96/min	R <sub>4</sub> Slight to weak
R/164/ S/2302	73225
SpB: Dr. Gnanavelu	
11/24	Care of CAH + PTCA TOLAD, TNK
6:00 PM	Posterior - no complaint
SpB: Dr. Gnanavelu	
BP: 140/80 HR: 96/min SpO <sub>2</sub> : 98% on RA	Adm - vitals monitoring - ROLLADY chart - Dfom log - upr deactivation

Rel  
123003



DATE	NOTES
7/1/24	S/S Dr. Mohamed Hythoos
10pm	R/P PZCA to AD. Patient comfortable Carries oriented Vibula
	CUS - S. S. (P) W. S. (P) P. A. - S. S. A. NT
	Stable Vibula
	Adm - Monitor vitals - To follow day chart
	(S. S. A. NT)





**Medway**  
**Heart**  
Institute  
heart beat counts

DATE	NOTES
8/1/24 - 9:30 AM	<p><u>4/B Dr. Gnanavelu team:</u></p> <p>- pt rained</p> <p>no fresh complaints</p> <p>o/e = comatose, oriented</p> <p>- PR 96/min, BP 110/60</p> <p>SpO<sub>2</sub> 95% RA</p> <p>Cm = 440</p> <p>Pl = BAC</p> <p>- Adv</p> <p>- Cont the same</p> <p>- pt seen d/c today</p> <p>Amz 9/24</p>



DATE	NOTES
08.01.2024.	Screening Echo
3:10 pm	
	S/P PTCA.
	- mild concentric LVH.
	- chambers normal sized
	- RWMA - Mid & apical septum, apex, mid & apical anterior hypokinetic.
	- mild LV systolic dysfunction
	- Grade ? diastolic dysfunction.
	- Normal RV systolic function.
	- Increased LV filling pressure.
	- Aortic valve sclerosis
	- No AS/AR.
	- Other values are normal.
	- IAS/IVS intact.
	- minimal pericardial effusion anterior to RV.
	Trace effusion postero-lateral to LV
	- No clot/vegetation/pleural effusion.
	IVS: 12 mm
	PW: 11 mm
	LVIDD: 49 mm
	LVIDS: 38 mm
	EF: 46.1.
	EDV: 90 ml
	ESV: 46 ml
	EF: 48.1.
	EIA: 0.79
	Mid E/E': 16.64
	Lat E/E': 14.49
	TRPG: 14 mmHg
	PvSp: 24 mmHg
	Done by: Revathy (CT, Res)
	MH/10098/ CARDIO



Mr. RAMACHANDRAN R

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr. G. GNANAVELU



## RE/POST OPERATIVE ECHO

Pa  
Na  
UH  
DO

Date & Time	Screening Echo Report
06/1/24	
	<ul style="list-style-type: none"> <li>- All chambers normal sized.</li> <li>- RWM present: Septum, Apex. All Apical segments, mid Anterior, mid Anterolateral hypokinetic.</li> <li>- Moderate LV systolic dysfunction.</li> <li>- Grade II Diastolic dysfunction.</li> <li>- Normal RV systolic function.</li> <li>- Aortic Valve sclerosis.</li> <li>- No AS / Aortic TRivial AR</li> <li>- Mild MR</li> <li>- Trivial TR No PAH</li> <li>- Echo free space noted anterior to RV. ?epicardial fat</li> <li>- No clot / vegetation / effusion.</li> <li>- IVC normal in size and collapsing.</li> </ul>
	HR: 105 bpm tachycardia during study
	EF By Simpson's method.
	EDV: 100ml
	ESV: 58ml
	EF: 40%
	RVDD: 44mm
	RVDS: 38mm
	EF: 39%.
	TR Gt: 24mmHg
	RUSP: 34mmHg
	RVID: 11 cm/s TAPSE: 17 mm E/A ratio 1.12 Medial E/E: 19.46 Lateral E/E: 12.5
	Done By Ms. Lokeshwari K (Cardiac tech / MHI10180) 6/1/23 / 7.48 AM





# MICROBIOLOGY SHEET

DATE	5/1/24		
COLOUR	PALE YELLOW		
REACTION			
SPECIFIC GRAVITY	1.010		
APPEARANCE	CLEAR		
ALBUMIN			
SUGAR	.		
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	2 - 3		
EPITHELIAL CELLS	1 - 2		
RBC	NIL		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL.		

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



**DIABETIC CHART****Mr. RAMACHANDRAN R**

64 / Male / MHI202481642

05/01/2024 / IPH2024000043

Dr. G. GNANAVELU

ACTUAL WEIGHT 185 kg HbA<sub>1c</sub> .....

PREVIOUS DIABETIC MEDICATIONS .....

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
5-1-24	21:00	228 mg/dl	-	AFB 08/02	DR. AKILAN
6-1-24	6:00	383 mg/dl (R.O.S)	Inj. H.A 15 units	AFB 08/02	DR. AKILAN
6-1-24	12:00	299 mg/dl	Inj. H.A 15 units	AFB 08/02	DR. Kalyani
"	18:50	239 mg/dl	Inj H.A 12 U.	AFB 08/02	DR. KARTHIK
7-1-24	6:00	219 mg/dl	Inj H.A 10 U.	AFB 08/02	DR. AKILAN
7/1/24	12:00	221 mg/dl	Inj H.A 18 U	AFB 08/02	DR. KARTHIK
	18:30	232 mg/dl	mixtal 20 units	AFB 08/02	DR. KARTHIK
8/1/24	6:30	234 mg/dl	Inj. HA 6U	AFB 08/02	DR. SALAI
	12:30	281 mg/dl	Inj HA 6U	AFB 08/02	DR. SALAI

**INSTRUCTIONS FOR INSULIN INFUSIONS**

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





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The way to better health  
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Every heart beat counts

**BLOOD GROUP**

**A +ve**

**INVESTIGATION SHEET**

**Mr. RAMACHANDRAN R**

64/Male/MHI202481642

05/01/2024/IPH2024000043

Dr.G. GNANAVELU



Date	5-1-24	7-1-24				
<b>HAEMATOLOGY</b>						
Hb	15.4					
P.C.V	45.1					
Platelets	346000					
TLC	11900 ↑					
Polymorphs	49.9					
Lymphocytes	44.4 ↑					
Eosinophils	1.3					
Mono / Basophils	4.2/0.2					
E.S.R						
<b>BIO-CHEMISTRY</b>						
Urea	24	28.				
Creatinine	0.9	1.12				
Sodium	136	134				
Potassium	4.6	2.8/4.26				
Bicarbonate	20 ↓					
Chloride	98.3					
Magnesium						
Calcium						
Phosphorus						
<b>LFT</b>						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
<b>CARDIAC ENZYMES</b>						
Troponin I	15.5					
CKNAC - CPK	55					
CK - M.B. MASS	14.8					
LDH						
Ntpro bnp						



[illegible]



T2.Drf



ALLERGY  $\Rightarrow$  TAB. PAN-D

Mr. RAMACHANDRAN R

64/Malc/MH1202481642

05/01/2024/1PH2024000043

Dr.G. GNANAVELU



## ALLERGY

## VITAL INFORMATION SHEET

BLOOD GROUP

## ON ADMISSION

Height in CM

**Weight in Kg.**

1170 m<sup>2</sup>

± 85129

**Diagnosis:**

ACS1 AG2 - STEM1

### Procedure :

[illegible]





Dr.G. GNANAVELU



Medway  
**Heart**  
Institute

## Every heart beat counts

**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  $> 5$**

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



**Medway Hospitals®**

**MR. RAMACHANDRAN R**

64/Male/MHI202481642

**Da** 05/01/2024/IPH2024000043

**24** Dr.G. GNANAVELU



●HI/IP/2022/066



## Every heart beat counts

[illegible]





MHI/IP/2022/066  
 **Medway Heart Institute**  
 Every heart beat counts

[illegible]



[illegible]



Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/PH2024000043  
Dr. G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: DM DM - AW - STDM BP - 40/1 acute PU Acute Pulmonary edema

Height: 170 cms Weight: 88 Kgs Food allergies: Yes/ No, if yes, specify: None

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

Diet Prescription: 1000 cal, 60 fat, 100 carb, 1000 ml fluid restricted, diabetic diet.

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

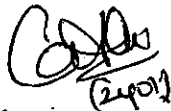
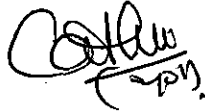
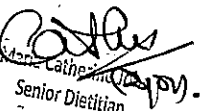

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2) Dietary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

Dietitian Signature / Name / Date / Time:

Wanda Catherine Jones  
Senior Dietitian

6/1/24, 10:00



DATE AND TIME	DIETITIAN NOTES	SIGNATURE
6/1/24, 10:00	<p>A 64 years old gentleman came to the clinic with chest pain associated to sweating was assessed to be well nourished as evidenced by SCA.</p> <p>Klebs - DM</p> <p>Patient <u>referred</u> to us. Educated the patient and family on low sodium, low fat, low salt, low fluid restricted, diabetic diet. Emphasized the small portion sizes to small portion meals.</p>	 Maria Catherine John Senior Dietitian
6/1/24, 10:00	<p>Patient <u>referred</u> to Cathleen for procedure (CATHETERIZATION) and kept on NPO. Patient <u>referred</u> to us. NPO over. Patient tolerated diabetic, lipid diet. Can tolerate on diabetic, soft solid diet.</p>	 Maria Catherine John Senior Dietitian
7/1/24, 15:00	<p>Patient <u>referred</u> to ward. Referred on the diet restriction. Motivated to eat well.</p>	 Maria Catherine John Senior Dietitian
8/1/24, 10:00	<p>Overall intake is good. Educated the patient and family on low sodium, low fat, low salt, low fluid restricted, diabetic diet on discharge. Emphasized the small portion sizes, also glucose control. Diet modification and clarification done. Diet chart given on discharge.</p>	 Maria Catherine John Senior Dietitian





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**Every heart beat counts**

### THROMBOLYSIS CHECK LIST

Name: <b>Mr. RAMACHANDRAN R</b>		Age:	Sex:	CC No.:
64/Male/MHI202481642				
05/01/2024/IPH2024000043				
Diagnosis:	<b>Dr.G. GNANAVELU</b>	Wt:	Date: <b>8-1-24</b>	
		thrombolysis - From:		To:

#### ELIGIBILITY CRITERIA

	YES	NO
<b>Clinical:</b> Chest pain for less than 12 hours	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>ECG:</b> ST elevation $\geq$ 1mm in $\geq$ 2 limb leads	<input type="checkbox"/>	<input type="checkbox"/>
ST elevation $\geq$ 2mm in $\geq$ 2 chest leads	<input checked="" type="checkbox"/>	<input type="checkbox"/>

#### CONTRAINDICATIONS - Check list

##### Absolute contraindications

	YES	NO
● Any active internal bleeding	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Known intra-cranial neoplasm	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● History of previous haemorrhagic CVA	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Suspected aortic dissection	<input type="checkbox"/>	<input checked="" type="checkbox"/>

##### Relative contraindications

	YES	NO
● Active peptic ulcer disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Recent internal bleed (< 2 - 4 weeks)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Persistent hypertension of (> 180/110 mmHg)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Previous use of streptokinase (5 days - 2 years)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Pregnancy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● History of recent embolic or ischaemic CVA	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Current anticoagulation therapy (INR > 2-3)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Major trauma or Surgery (< 2 - 4 weeks)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● Non-compressible vascular punctures	<input type="checkbox"/>	<input checked="" type="checkbox"/>
● History of chronic severe hypertension	<input type="checkbox"/>	<input checked="" type="checkbox"/>

#### Risk assessment of Intra-cerebral haemorrhage

	YES	NO
● Age more than 65 years	<input checked="" type="checkbox"/>	<input type="checkbox"/>
● Weight less than 70 Kg	<input checked="" type="checkbox"/>	<input type="checkbox"/>
● Hypertension at presentation (> 180/110 mmHg)	<input type="checkbox"/>	<input type="checkbox"/>
● Use of t-PA	<input type="checkbox"/>	<input type="checkbox"/>

#### Comments:

Thrombolytic used: **Ly. tPA**

Dose: **40 mg**

Signature of the Doctor

Date: **8/1/24** Time: **10:08 PM**



### CONSENT FOR HIV TESTING

Patient Name :	Mr. RAMACHANDRAN R 64/Male/MHI202481642 05/01/2024/IPH2024000043	Age :	Sex : M / F
Consultant :	Dr. G. GNANAVELU	UHID :	

- I, Mr. Ramachandran have been given verbal and written educational information for HIV antibody testing.
- I have been informed that a sample of my blood will be drawn and tested and tested to detect HIV antibodies I have been informed of the purpose, potential uses of the test and the consequences of not having the test done
- I hereby acknowledge that I have read or have had read to me this information regarding HIV antibody testing.
- I have been given the opportunity to ask questions and all the questions have been answered to my satisfaction.
- I acknowledge that I have given consent for performance of this blood test to detect HIV antibodies. This has been explained to me in Tamil language, which I can understand.

	Signature	Name	Date	Time
Patient				
Doctor / Nurse / Counsellor				
Interpreter				

### CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because of illness  
and I, M. Deepa (name / relationship to the patient), therefore, consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and hereby consent to this procedure.

	Signature	Name	Date	Time
Patient Representative with relationship	<u>M. Deepa</u>	<u>M. Deepa</u>	<u>5/1/24</u>	<u>9:58</u>
Doctor / Nurse / Counsellor	<u>Dr. G. Gnanavelu</u>	<u>Dr. G. Gnanavelu</u>	<u>5/1/24</u>	<u>9:58</u>
Interpreter				



## CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because \_\_\_\_\_

and I, \_\_\_\_\_ (name / relationship to the patient), therefore, consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and hereby consent to this procedure.

	Signature	Name	Date	Time
Patient Representative				
Witness				
Doctor				
Interpreter				



## PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: ACS/ AWTSTEMI/T2DM

Allergies if any: TAB. PAN-D

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
CCU	CATH LAB	6/1/24	11:30	CACI.

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

### ASSESSMENT OF PATIENT:

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

Language Barrier: ☐ Yes ☒ No ☐ If Yes, specify: \_\_\_\_\_

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO <sub>2</sub> (%)	BP (mmHg)	Pain Score
97.4	22	115	99%	179/111	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)

☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)

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

Any pre-medication given: \_\_\_\_\_

Any critical information: \_\_\_\_\_

Any specific recommendation: \_\_\_\_\_

Handover by	Signature	Name	Emp. No.	Date	Time
		S. Allwin Prangrue	0162	6/1/24	11:30
Handed over to	Signature	Name	Emp. No.	Date	Time
		V. Abinaya	0202	6/1/24	11:30

### After Procedure:

Procedure completed: ☐ Yes ☒ Yes | Any critical information: Nil

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO <sub>2</sub> (%)	BP (mmHg)	Pain Score
98.6	22 br/min	72 b/min	100%	186(101)(106)	1/0

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)

☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)

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

Handover by	Signature	Name	Emp. No.	Date	Time
		V. Abinaya	0202	6/1/24	13:5
Handed over to	Signature	Name	Emp. No.	Date	Time
		N. Anand	0253	6/1/24	13:10



**CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY****Mr. RAMACHANDRAN R**

64 / Male / MHI202481642

05/01/2024 / IPH2024000043

Dr. G. GNANAVELU



Age:

Sex: M/F

Ward &amp; Bed No:

UHID

**EDURE**

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

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

**RISKS OF THIS PROCEDURE**

The risk of coronary angiography depends on:

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

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

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

**PATIENT CONSENT:**

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

On the basis of the above statements,

**I REQUEST TO HAVE THE PROCEDURE**

	Signature	Name	Date	Time
Patient/Guardian with relationship		G. Ramachandran	6/1/24	11.10
witness		Ramya (daughter)	6/1/24	11.10
Doctor			6/1/24	11.10
Interpreter				



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

### நிலை மற்றும் செயல்முறை

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

பழைய இருமல் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவடை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டிருக்கின்ற கான்ட்ராஸ்ட் மீடியத்தினை (என்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையின் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புலான் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

### இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

- (i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டைட்) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரமாக இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(i) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவடை பகுதியில் அறுவை சிகிச்சை சரிபாடு, இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிடான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிடான சிராய்ப்பு

### நோயாளி ஒப்புதல்

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

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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



<b>Patient</b>	Mr. RAMACHANDRAN R 64/Male/MHI202481642 05/01/2024/IPH2024000043 Dr. G. GNANAVELU	<b>RY ANGIOGRAM / CORONARY ANGIOPLASTY</b>
<b>Sex:</b>	M/F	
<b>Bed No:</b>	UHID	

#### CONDITION AND PROCEDURE

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

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

#### RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

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

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

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

#### PATIENT CONSENT:

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

On the basis of the above statements,

#### I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship				
witness		Kanya (Daughter)	6/1/24	12.05
Doctor		Dr. Gnana Velu	6/1/24	12.05
Interpreter				



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

**நிலை மற்றும் செயல்முறை**

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

பழைய இருப்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்லினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு ஹோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீடர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (எக்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க கிருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்லியோபிளாஸ்டி (புலான் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

**இச்செயல்முறையிலுள்ள இடர்பாடுகள்**

இதயச்சுவர் சிறை ஆன்லியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கீவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

<b>10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)</b>	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
<b>1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)</b>	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்லியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
<b>100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)</b>	(I) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
<b>20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)</b>	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவினை சிரமப்படு அல்லது வீக்கம்
<b>வரும்பாலான மக்களுக்கு</b>	(n) சிறிய அளவினை சிரமப்படு

**நோயாளி ஒப்புதல்**

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

**செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்**

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





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## TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mr.RAMACHANDRAN R	ID:	MHI202481642
Age/Gender :	64 M	IPH:	IPH 2024000043
Cath No. :	3546	DOP:	06.01.2024
Done by	Assisted by	Technician	Physician assistant
Dr.G.Gnanavelu	Ms. Sandhiya	Mr. Pandian	Ms. Shalini

**DIAGNOSIS: AWMi; TNK LYSED; MODERATE LV DYSFUNCTION; HBP; T2DM**

Access: Right Radial artery

Hardware used: 6F sheath, 5F TIG

Contrast used: CONTRAPAQUE 40 ml

Medications given: Inj Heparin 2500 IU IA + Inj NTG 100 mcg

Hemodynamic data: Aortic pressure 167/86(104) mmHg; HR 86 bpm; SpO2 99%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx.
LAD	Type 3 vessel. Ostial LAD has plaques, Proximal LAD has 40-50% discrete stenosis, Mid LAD after major septal has 95-99% tubular stenosis, Distal LAD has non flow limiting disease, Gives 2 diagonals and many septals which have non flow limiting disease.
LCx	Nondominant. Gives 2 major OMs. Proximal & distal LCX have luminal irregularities & OMs have luminal irregularities.
RCA	Dominant. RCA appears normal. Gives PDA and PLV which appear normal.

**FINDINGS: RIGHT DOMINANT SYSTEM; SIGNIFICANT LAD DISEASE**

**ADVICE: PTCA TO LAD**

**Dr. G. GNANAVELU, MD, DM**

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

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PATIENT  
HELPLINE  
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**1800 572 3003**

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Heart Institute | Institute of Pulmonology  
044 - 4310 8959 | 044-2473 4451

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

MHI/HOSP/2022/118





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## TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

<b>Patient name</b>	<b>MR. RAMACHANDRAN.R</b>	<b>ID</b>	<b>MHI202481642</b>
<b>Age/Gender</b>	<b>64 M</b>	<b>IP No.</b>	<b>IPH2024000043</b>
<b>Cath No.</b>	<b>3547</b>	<b>D.O.P.</b>	<b>6.1.2024</b>

**Done by Dr. G.Gnanavelu**

**Technician : Mr. Prathap**

**Scrub nurse : Ms. Sharmila**

**DIAGNOSIS : AWMY LYSED WITH TNK; MODERATE LV DYSFUNCTION; T2DM; HBP  
SIGNIFICANT LAD DISEASE**

**APPROACH : Right radial artery**

**EXPOSURE TIME: 1095 sec**

**HARDWARE : 6F hemostatic sheath, 6 F EBU 3.0 guide**

**RAK: 271 mGy**

**CONTRAST : OMNIPAQUE 200 ml**

**DAP : 77 Gy.cm2**

**MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 8500 IU IA;**

**HEMODYNAMIC DATA: ABP 104/70 (81) PULSE 91 bpm SPO2 100%**

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
PROX & MID LAD	40-50% DISCRETE ECCENTRIC PROXIMAL & 95-99% TUBULAR IN MID LAD	BMW	2 X 10 SC Balloon 10 atms	SYNERGY 2.75 X 28 11 atms 15 s	3 x 10 NC 16 atms	TIMI III FLOW

**REMARKS: Uneventful procedure. Inj Nikorandil 2mg and aliquots of 50 mcg of Inj Sodium nitroprusside ACT at the end of the procedure was 303 s.**

**RESULT: SUCCESSFUL PTCA X LAD**

**Dr. G. GNANAVELU, MD, DM**

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

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### Medway Centre of Excellence (Chennai)

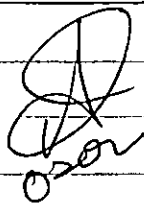
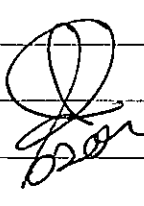
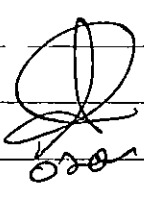

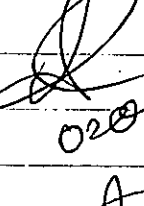
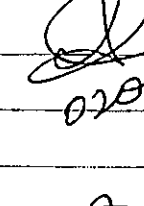
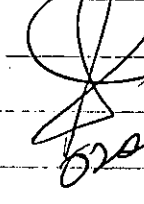
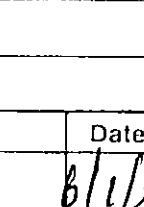

<b>Heart Institute</b> 044 - 4310 8959	<b>Institute of Pulmonology</b> 044-2473 4451
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MHI/HOSP/2022/118





## NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
11:35	⇒ patient moved ccu to cath lab ⇒ pt conscious & oriented pt vital stable pt IV line patent left 20 verflon.	 020			
11:45	⇒ sterile drapping done under the local anesthesia.	 020			
12:30	⇒ CABG procedure started Rt Radial artery approach.	 020			
12:00	⇒ O <sub>2</sub> & filters connected	 020			
12:10	⇒ INJ: NTG 200mcg + INJ: Heparin 2500 <sup>IU</sup> IV given (O/B DR-66) (SIR)	 020			
12:10	⇒ HR: 72 bt/min BP: 167/86 (104) mmHg SpO <sub>2</sub> : 100% vital stable.	 020			
12:05	⇒ CABG procedure done ⇒ PDAOC PTCA procedure started	 020			
12:10	⇒ INJ: Heparin 5000 <sup>IU</sup> IV given (O/B DR-66) (SIR)	 020			
12:20	⇒ INJ: Heparin 1000 <sup>IU</sup> IV given (O/B DR-66) (SIR)	 020			
12:35	⇒ <del>HR: 72</del> HR: 95 bt/min BP: 167/86 (104) mmHg SpO <sub>2</sub> : 100% vital stable	 020			
12:40	⇒ PTCA procedure done. ⇒ ACT = 272 secs	 020			
12:55	⇒ Rt Radial artery sheath. removed tight pressure bandage applied no occlusion no heparin to	 020			
13:05	⇒ pt shifted Cath lab to Ccu	 020			
Document endorsed by	Signature 	Name sathy	Emp. No. 0016	Date 8/1/24	Time 12:40



## NURSES PROGRESS NOTES

[illegible]



**SAFE PROCEDURE CHECKLIST**  
Adapted from WHO Safe Surgery Checklist

Mr. RAMACHANDRAN R  
64 / Male / MHI202481642  
05/01/2024 / IPH2024000043  
Dr. G. GNANAVELU

Name of the Procedure : CAG Location : cath lab Date & Time : 6/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN Before Induction of Procedural Sedation		TIME OUT After procedural Sedation and before procedure		SIGN OUT When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering 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	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <u>CAG</u> <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <u>CAG</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt Radial artery approach</u>	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input checked="" type="checkbox"/> Yes	Position <u>Supine</u>	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify : <u>Obsenation</u>	
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Antibiotic prophylaxis within last 60 minutes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
<input type="checkbox"/> Spo2 <input type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>		Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :	
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes	Corrective action :	
		For procedural sedation cases	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Intra procedure glycermic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation <u>[Signature]</u>	Doctor performing the Procedure : <u>[Signature]</u>	Nurse : <u>SN parthasarathy</u>	Technician : <u>prathap</u>	Others Please Specify : <u>[Signature]</u>
Date : Time :	Date : <u>6/1/24</u> Time : <u>9:30</u>	Date : <u>6/1/24</u> Time :	Date : <u>6/1/24</u> Time :	Date : Time :



**SAFE PROCEDURE CHECKLIST**  
Adapted from WHO Safe Surgery Checklist

Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/1PH2024000043  
Dr. G. GNANAVELU

Name of the Procedure : PTCA Location : Cath lab Date & Time : 6/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>12:00</u> Before Induction of Procedural Sedation		TIME OUT <u>12:10</u> After procedural Sedation and before procedure		SIGN OUT <u>12:40</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Identity by two identifiers	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Name of the Procedure done written down <u>PTCA</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Procedures <u>PTCA</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Name and site of all specimens / investigations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>R + Radial artery approach</u>	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Position <u>Supine</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, Pls. specify :	
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Possibility of hypothermia	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :	
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECC</u>	Name of the Antibiotic given	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Corrective action :	
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Anticipated duration briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		For procedural sedation cases	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Intra procedure glycemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation : <u>[Signature]</u>	Doctor performing the Procedure : <u>[Signature]</u>	Nurse : <u>S. N. Panchanan</u>	Technician : <u>Prathap</u>	Others Please Specify : <u>[Signature]</u>
Date : <u>6/1/24</u> Time : <u>12:40</u>	Date : <u>6/1/24</u> Time : <u>12:40</u>	Date : <u>6/1/24</u> Time : <u>12:40</u>	Date : <u>6/1/24</u> Time : <u>12:40</u>	Date : <u>6/1/24</u> Time : <u>12:40</u>



## Procedure Monitoring Sheet (Cath Lab)

Patient Name : **Mr. RAMACHANDRAN R**  
64/Male/MHI202481642  
UHID / IP : 05/01/2024/IPH2024000043  
Consultant : Dr. G. GNANA VELU

Age / Sex : 64/M  
Ward Unit : CCU  
Diagnosis : ACS/AWSTEMI/T2DM.

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 177/111 Temp: 98.2 Pulse: 115 RR: 32 SPO2: 99%			
Urine voided	✓		
Bowel preparation			✓
Pre-procedure medication administered	✓		
Procedure site marked			✓
Skin preparation done	✓		
NPO from 9 AM	✓		
Loose Tooth removed	✓		
Contact lenses / Eye glasses removed	✓		
Prosthesis present	✓		
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food) DRUG TAR. PAND	✓		
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse : <i>[Signature]</i>	Date & Time : 6/1/24 R. Ngee		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
11:55	72 bt/min	22 br/min	167/86 (104)	100 %	—	<i>[Signature]</i>
12:10	86 bt/min	22 br/min	146/89 (102)	100 %	—	<i>[Signature]</i>
12:25	105 bt/min	22 br/min	156/98 (104)	100 %	—	<i>[Signature]</i>
12:35	97 bt/min	22 br/min	186/101 (106)	100 %	—	<i>[Signature]</i>
procedure got over						



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

Time : 12:40 Route : RT Radial artery approach  
 Complication NI

BP : 186 (101) (104) mmHg, HR 94 67/min, RR : 22 16/min, SpO2 : 100%

Distal Pulse : felt, Puncture Site : no oozing no hematoma

**Advise:**

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in RT Radial artery.
- ◆ Diet : DM

◆ Inform Duty Medical Officer SOS

- a) If patient complains of any Discomfort
- b) If dressing is Loose or Socked with Blood
- c) If limbs are Cold / Absent Pulse

- ◆ Remove RT Radial Arterial dressing on 6/1/24 at 11:50 AM/PM after informing to the consultant.

- ◆ Special instruction if any:

NI

Name & Signature of Consultant

**POST PROCEDURE OBSERVATION**

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
6/1/24 12:55	186/104	85	22	100%	no oozing no hematoma	Good	-	<u>Dora</u>

**Nurses Notes :**

CABG. adhoc PTCA procedure done RT Radial artery sheath removed tight pressure bandage applied no oozing no hematoma with vit

Condition at the end of procedure : ☒ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☒ ICU ☐ Other all

Name & Signature of the Nurse

Date & Time :

Dora

6/1/24 12:55



## NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 5-1-24 Time of Arrival: 21.49 Mode of Admission: ☐ Walking ☐ Wheelchair ☒ Stretcher  
Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: Mrs. Deepa  
Relationship with Patient: Wife Contact Person's Name: Mrs. Deepa Relationship: Wife  
Contact No.: 9440465247 Primary language spoken: ☒ Tamil ☐ English ☒ Indian ☐ International  
Interpreter needed: ☒ Yes ☐ No Patient status: ☒ Conscious ☐ Unconscious ☐ Disoriented  
Menstrual History : LMP : - Menopause: - Patient Vulnerable: ☒ Yes ☐ No  
Medical History : DM / HTN / Co - Morbidity : - If Yes, specify -  
Drugs History : Antiplatelet T. Clopidogrel (Specify)

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

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than one half of the days	Nearly every day	Total
1. Little Interest or pleasure in doing things	<u>0</u>	1	2	3	
2. Feeling down, depressed, or hopeless	<u>0</u>	1	2	3	

Scoring: A PHQ-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with Columbia-suicide Severity Rating Scale (C-SSRS) tool.

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

If Yes, specify details: -

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

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 88 (beats/min) | BP: 120/70 mmHg  
Respiration: 18 (breaths/min) | SpO<sub>2</sub>: 97 (%) | CBG: 228 (mg/dl) | Height: 170 (cms) | Weight: 85 (kgs)

Allergies / Adverse Reaction: ☒ Yes ☒ No ☒ Medication ☐ Blood Transfusion ☐ Food ☐ Not known  
If Yes, specify: PAB. PAN-D.

Pain: ☐ Yes ☐ No. If Yes, Score: 0/10 Pain Scale Used: ☐ NRS (>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: DM diet  
Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: Ms. Kalpana Time: 10:00 PM

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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Hearing Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Chewing Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Walking Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		



**Daily Activity Of Living:**

Activity	Independent	Assisted	Dependent
Bathing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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



**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)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
2	Bedridden recently >3 days or major surgery within four weeks	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
5	Entire leg swollen (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
6	Localized tenderness along the deep venous system (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
9	Previously documented DVT (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

### Risk Score Interpretation (Probability of DVT):

Final Score

0

Tick the score obtained (✓)

Action Taken

Date

Time

Low Risk

-2 to 0

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	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both <input checked="" type="checkbox"/> Nil				
Hearing Aid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Nil				
Eye glasses / Contact lens	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Jewellery	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Other valuables (specify)					

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

Sign.	Name	Emp. No.	Date	Time
<i>[Signature]</i>	M. VISWANATHAN	Relationship Son	5/1/24	9:58
<i>[Signature]</i>	Authn	0282	5-1-24	9:58
<i>[Signature]</i>	JAYA DEVI	0002	5/1/24	9:58





## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 5-1-24

Shift: ☐ Morning ☐ Evening ☒ Night

**S**

### SITUATION

Diagnosis: ACS, Aa-STEMI 19 DM

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: Brachial, Anesthetic

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: P-PAN-D

On room air / oxygen: Fm with 5lit O2

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

**A**

### ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 86 (beats/min) | Respiration: 20 (breaths/min)

BP: 100/101 (mmHg) | SpO<sub>2</sub>: 95 (%) | Height: 170 (cms) | Weight: 85 (kgs) | BMI: 29.4 kg/m<sup>2</sup>

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: -



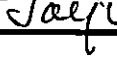
Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

- Trop - I quantitative serology to be follow

	Signature	Name	Emp. No.	Date	Time
Handover given by		S. Allwin Pranasree	0282	5-1-24	7:30
Handover taken by		S. Allwin Pranasree	0162	6/1/24	7:30
Document endorsed		S. Allwin Pranasree	0022	6/1/24	7:30



[illegible]



## PATIENT CLINICAL HANDOVER RECORD - NURSES

Date: 6/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

**S**

### SITUATION

Diagnosis: ACS, AW-STEMI/T2DM

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: Brachial Arteries

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: TAB. PAN-D

On room air / oxygen: Fm O2 5 litre

Complaints / New Symptoms in last shift:

Date of surgery: -

IV fluids on flow: -

**A**

### ASSESSMENT

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 89 (beats/min) | Respiration: 21 (breaths/min)

BP: 172/106 (mmHg) | SpO2: 96 (%) | Height: 170 (cms) | Weight: 85 (kgs) | BMI: 29.4 kg/m<sup>2</sup>

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: Dndiet.

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:

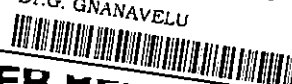
Special instructions if any: } Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by		S. Allinjannur	0162	6/1/24	11:30
Handover taken by		Mohan sap	0352	6/1/24	13:05
Document endorsed		S. Nalini	0084	6/1/24	13:05



[illegible]





## PATIENT CLINICAL HANDOVER RECORD

**NURSES**

Date: 6/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

**S**

### SITUATION

Diagnosis: ACS - AN-STEMI, T2DM

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: Anesthetic, Bronchial

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: PTCA to LAD

Allergies if any: T. PAN - D

On room air / oxygen: NPO 2 4 liters

Complaints / New Symptoms in last shift: -

Date of surgery: 6/1/24

IV fluids on flow: IVF 30 cc/hr on flow

**A**

### ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 93 (beats/min) | Respiration: 20 (breaths/min)

BP: 185/109 (mmHg) | SpO<sub>2</sub>: 98 (%) | Height: 170 (cms) | Weight: 85 (kgs) | BMI: 29.4 kg/m<sup>2</sup>

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: TO do screening ECHO, ECG, Cholesterol

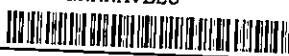
	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>Ashwini</i>	P. Nithinraj	2352	6/1/24	19:30
Handover taken by	<i>Alm</i>	Nuthin	0282	6/1/24	19:30
Document endorsed	<i>Nalini</i>	S. Nalini	0024	6/1/24	20:00



## NURSES PROGRESS NOTES

[illegible]





## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 6/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

**S**

### SITUATION

Diagnosis: ACS - AIO - STEMI / T2DM

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: Arterial, Brachial

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: PTCA T6 JAD

Allergies if any: PAN - D

On room air / oxygen: 2Ltr NP

Complaints / New Symptoms in last shift: -

Date of surgery: 6/1/24

IV fluids on flow: DVF NS - 30ml/hr.

**A**

### ASSESSMENT

Vital Signs: Temp 98.6 (°F) | Pulse / HR: 92 (beats/min) | Respiration: 24 (breaths/min)

BP: 143/62 (mmHg) | SpO<sub>2</sub>: 99 (%) | Height: 170 (cms) | Weight: 78 (kgs) | BMI: 29.4 kg/m<sup>2</sup>

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: Dmdiet

Drains: -

**R**

### RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: CBC, creat, uric, H<sup>+</sup>

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		Aruthi	0282	6-1-24	7:30
Handover taken by		S. Puerna Patha	0211	6/1/24	7:30
Document endorsed		C. Nalin	0284	6/1/24	8:30



[illegible]





## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

**S**

### SITUATION

Diagnosis: ACS - AN - STEM / T2 DM

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: Anesthetic / Bandaged

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

**B**

### BACKGROUND

Type of surgery: PTCA to LAD

Allergies if any: T. PAN - D

On room air / oxygen: 2 lit NP

Complaints / New Symptoms in last shift: -

Date of surgery: 6/1/24

IV fluids on flow: -

**A**

### ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 108 (beats/min) | Respiration: 24 (breaths/min)

BP: 153/92 (mmHg) | SpO<sub>2</sub>: 99 (%) | Height: 170 (cms) | Weight: 185 (kgs) | BMI: 29.4 kg/m<sup>2</sup>

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: 23-18 ☒ 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	S. P. Sore	S. Manalatha	0211	7/1/24	12:30
Handover taken by	S. P. Sore	S. Dhandhushini	0212	7/1/24	13:00
Document endorsed	Nag	S. Nalini	0084	7/1/24	13:00



[illegible]



## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

**S**

### SITUATION

Diagnosis: ACS - AN - STEMI

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: - Left: D2

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

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: PTCA TO LAD

Allergies if any: T. PANI-D

On room air / oxygen: on Room Air

Complaints / New Symptoms in last shift: -

Date of surgery: 6/1/24

IV fluids on flow: -

**A**

### ASSESSMENT

Vital Signs: Temp: 98.4 (°F) | Pulse / HR: 98 (beats/min) | Respiration: 22 (breaths/min)

BP: 130/70 (mmHg) | SpO<sub>2</sub>: 97 (%) | Height: 170 (cms) | Weight: 78 (kgs) | BMI: 27.4 kg/m<sup>2</sup>

Others: -

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

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

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

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

Current diet: diabetic diet

Drains: -

**R**

### RECOMMENDATION

Referral doctors: -

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	<u>[Signature]</u>	<u>A. Nandhini</u>	<u>2172</u>	<u>7/1/24</u>	<u>19.30</u>
Handover taken by	<u>[Signature]</u>	<u>M. Dase</u>	<u>0182</u>	<u>7/1/24</u>	<u>19.30</u>
Document endorsed	<u>[Signature]</u>	<u>S. Nandini</u>	<u>0024</u>	<u>7/1/24</u>	<u>20.00</u>









## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

**S**

### SITUATION

Diagnosis: CAD - SVD

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: 5/5

**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: 80 (beats/min) | Respiration: 22 (breaths/min)

BP: 120/40 (mmHg) | SpO<sub>2</sub>: 97 (%) | Height: (cms) | Weight: (kgs) | BMI: (kgs/m<sup>2</sup>)

Others: Nil

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

Fall Risk Score: 10 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: Normal diet

Drains: -

**R**

### RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0088	8/1/24	7.00
Handover taken by		M. Revathi	0225	8/1/24	7.30
Document endorsed		S. Nalini	0024	8/1/24	8.00



## NURSES PROGRESS NOTES

[illegible]



## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

**S**

### SITUATION

Diagnosis: CAD-SVD

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: -

Central line days: -

VIP Score: 0/5

**B**

### BACKGROUND

Type of surgery: -

Allergies if any: ALMDA

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: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/70 (mmHg) | SpO<sub>2</sub>: 97 (%) | Height: - (cms) | Weight: - (kgs) | BMI: -

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: -

normal 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	M. Ravi	M. Ravathy	0225	8/1/24	12.30
Handover taken by	G. Sushma	G. Sushma	0201	8/1/24	12.30
Document endorsed	A. Nalini	S. Nalini	0024	8/1/24	13.00



## NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
08/1/24	Morning duty Note.	
at		
7.30	→ Patient hand over taken to the night duty staff. → conscious & oriented. → vital signs checked & recorded. → Patient haemodynamically stable.	MD 008
8.30	→ Patient had a diabetic diet	MD 008
9.00	→ Medication given as per as drug chart.	
10.00	→ Patient had mobilized → Pt was stable & no have complaints → vital signs checked & recorded	MD 008
11.20	→ I/O chart monitoring → Patient hand over given to evening duty staff.	MD 008
8/1/24	<u>Discharge Notes</u>	
19.00	→ Pt discharge summary explain to the pt & attendant. → Pt IV line Removal. → Pt FB band Removal. → Pt old reports given.	P 008
19.30	→ Pt went to home.	P 008
Document endorsed by	Signature Nae	Name S. Nalini
		Emp. No. 0084
		Date 8/1/24
		Time 20:00



# ADULT NURSING CARE PLAN

Mr. RAMACHANDRAN R

64 / Male / MHI202481642

05/01/2024 / IPH2024000043

Dr. G. GNANAVELU



MHI/NUR/2022/044







Every heart beat counts

Initial Date: 5/1/24		Time: 10:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: ACS - STEMI / Y2DM			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M				
			E				
			N	Pt had DM diet @ 0200			
<b>OXYGENATION</b> <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input checked="" type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M				
			E				
			N	Pt on EM - 5/1/24 on flow @ 0040			
<b>FLUID &amp; ELECTROLYTES</b> <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M				
			E				
			N	Pt Encourage to Oral Intake @ 0200			



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>IMOBILITY</b> <input checked="" type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Emboloc stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M  E  N <i>Pt mobilize on bed</i>	   <i>AB</i> 0220
<b>ELIMINATION</b> <input type="checkbox"/> Catheter, bedpan, urinal <input checked="" type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenc / volume / Hemetemeses as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M  E  N <i>Pt have @ elimi- -tion pattern</i>	   <i>AB</i> 0220
<b>SKIN INTEGRITY</b> <input type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI  <b>GRADES OF PRESSURE INJURY</b> <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input checked="" type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M  E  N <i>maintain @ skin Integrity</i>	   <i>AB</i> 0220



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



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
<b>COMMUNICATION</b> <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M  E  N <i>PT good verbal communication</i>	  <i>Q 0240</i>	
<b>SPECIAL INTERVENTIONS</b> <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M  E  N <i>medicine given as per drug chart</i>	  <i>Q 0240</i>	
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>Jay</i>	<i>JAYADEN</i>	<i>6/1/24</i>	<i>5/1/24</i>	<i>10:00</i>



# ADULT NURSING CARE PLAN

Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/1PH2024000043  
Dr.G. GNANAVELU






MHI/NUR/2022/044



Every heart beat counts

Initial Date: 6/1/24 Time: 8:00		Modified Date: Time:		
Reason for Modification:		Diagnosis: ACS - STEMI, T2DM		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt had 300ml diet E patient had lunch N Pt had 200ml diet	[Signature] [Signature] 2352 [Signature]
<b>OXYGENATION</b> <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input type="checkbox"/> Mask <input type="checkbox"/> BIPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on Fm O <sub>2</sub> 5lit E patient SPO <sub>2</sub> maintained N Pt on 2lit NP O <sub>2</sub> on flow	[Signature] [Signature] 2352 [Signature]
<b>FLUID &amp; ELECTROLYTES</b> <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Patient had oral intake E patient taken oral N Pt had a oral intake	[Signature] [Signature] 2352 [Signature]



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>MOBILITY</b> <input type="checkbox"/> Mobile / Immobile <input checked="" type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt will mobilize freely E Patient mobilized in bed N Pt on bed mobilization	 Mosh 2352 d 0282
<b>ELIMINATION</b> <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenc / volume / Hemetemesi as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Pt normal elimination E Patient elimination pattern (N) N Pt (N) elimination pattern	 Mosh 2352 d 0282
<b>SKIN INTEGRITY</b> <input type="checkbox"/> Maintain normal skin integrity <input checked="" type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI <b>GRADES OF PRESSURE INJURY</b> <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Maintain Skin Integrity. E Maintained skin integrity N Pt (N) skin integrity	 Mosh 2352 d 0282



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>HYGIENE</b> <input type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M Pt will stay clean here. E patient stay cleaned N Pt clean & well groomed	[Signature] [Signature] 2352 [Signature]
<b>SAFETY</b> <input checked="" type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV <input type="checkbox"/> CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M ID band checked E Patient ID band (+) N Pt ID Band & IV line checked	[Signature] [Signature] 2352 [Signature]
<b>COMFORT AND SLEEP</b> <input type="checkbox"/> Pain Control <input checked="" type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M provided privacy E provided privacy N Pt comfortable position	[Signature] [Signature] 2352 [Signature]
<b>OBSERVATION</b> <input type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M Patient vitals stable E patient vitals stable. N Pt hourly vics monitoring	[Signature] [Signature] 2352 [Signature]
<b>PSYCHOLOGICAL / SPIRITUAL SUPPORT</b> <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M E N Pt (+) psychological support given.	[Signature] [Signature] [Signature]



-Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>COMMUNICATION</b> <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Maintained good rapport E Maintained good rapport NPT verbal communication	[Signature] Nov 23/22
<b>SPECIAL INTERVENTIONS</b> <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M patient medication given E patient medication given N pt administered medication as per chart	[Signature] Nov 23/22
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	S. Nalin	0024	6/1/24	12:00





## Every heart beat counts

Initial Date: 7-1-24		Time: 7:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: ACS, AW STENT, T2DM, Hypertension & Dry TWR			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt had DM diet  E Pt had OM diet N Pt had DM diet	  			
<b>OXYGENATION</b> <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remains within established limits <input type="checkbox"/> Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt ON ROOM AIR SpO <sub>2</sub> -99%  E patient is on Room Air  N SpO <sub>2</sub> - 97%	  			
<b>FLUID &amp; ELECTROLYTES</b> <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input checked="" type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Pt Intake well  E No chart monitored N No chart monitored	  			



Ident Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>MOBILITY</b> <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt on bed mobilized E patient mobilized well N pt well mobilized	20/02/24 20/02/24 20/02/24
<b>ELIMINATION</b> <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continnence or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Pt @ Elimination Pattern E Normal Elimination pattern N Normal Elimination Pattern	20/02/24 20/02/24 20/02/24
<b>SKIN INTEGRITY</b> <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI <b>GRADES OF PRESSURE INJURY</b> <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Pt maintain @ skin integrity E maintain normal skin integrity N skin is intact	20/02/24 20/02/24 20/02/24



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



Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>COMMUNICATION</b> <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt Communication well E Good communication N Pt on good communication	S/11 15/7 008
<b>SPECIAL INTERVENTIONS</b> <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Pt Medication given as per drug chart E Medication given as per drug chart N Due drugs are given	S/21 15/7 008
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>[Signature]</i>	S. Nalini	0024	7/11/24	13:00



# ADULT NURSING CARE PLAN

Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/1PH2024000043  
Dr.G. GNANAVELU

Initial Date: 8/1/24		Time: 7:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: ACS - STEMI			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M pt had DY diet	MD			
			E				
			N				
<b>OXYGENATION</b> <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input type="checkbox"/> Mask <input type="checkbox"/> BIPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt is on room air	MD			
			E				
			N				
<b>FLUID &amp; ELECTROLYTES</b> <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M I/O chest monitoring	MD			
			E				
			N				



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>MOBILITY</b> <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M PE 4000 mobilized E N	MCH 02/25
<b>ELIMINATION</b> <input type="checkbox"/> Catheter, bedpan, urinal <input checked="" type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as toley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemeses as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Normal Elimination pattern E N	MCH 02/25
<b>SKIN INTEGRITY</b> <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI  <b>GRADES OF PRESSURE INJURY</b> <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Maintain normal skin intact E N	MCH 02/25



Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>HYGIENE</b> <input checked="" type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M PE Good hygiene E N	MD 02/25
<b>SAFETY</b> <input type="checkbox"/> Check ID Band <input checked="" type="checkbox"/> IV care <input type="checkbox"/> EJV <b>CENTRAL LINE</b> <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M ID Band Present E N	MD 02/25
<b>COMFORT AND SLEEP</b> <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M E N	
<b>OBSERVATION</b> <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M vital signs checked, recorded E N	MD 02/25
<b>PSYCHOLOGICAL / SPIRITUAL SUPPORT</b> <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M E N	



Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>COMMUNICATION</b> <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M <i>DE Wood Communication</i> E N	<i>MD</i> <i>05/25</i>
<b>SPECIAL INTERVENTIONS</b> <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M <i>Medication given as per asaburg ch</i> E N	<i>MD</i> <i>05/25</i>
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>Due</i>	<i>S. Nalini</i>	<i>0024</i>	<i>8/1/24</i>	<i>16:10</i>





Date: 5 / 1 / 24  
Time: N

## BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

<b>SENSORY PERCEPTION</b> ability to respond meaning-fully to pressure-related discomfort	<b>1. Completely Limited</b> Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation <b>OR</b> limited ability to feel pain over most of body	<b>2. Very Limited</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness <b>OR</b> has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	<b>3. Slightly Limited</b> Responds to verbal commands, but cannot always communicate discomfort or the need to be turned <b>OR</b> had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort			4
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Rarely Moist</b> Skin is usually dry, linen only requires changing at routine intervals			3
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours			1
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance			3
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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 <b>OR</b> is NPO and / or maintained on clear liquids or IV's for more than 5 days	<b>2. Probably Inadequate</b> 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	<b>3. Adequate</b> 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 <b>OR</b> is on a tube feeding or TPN regimen which probably meets most of nutritional needs	<b>4. Excellent</b> 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			3
<b>FRICTION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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
					<b>TOTAL SCORE</b>		17
					<b>Initial &amp; Emp. No. of Staff Nurse:</b>		Amo 02/24
					<b>Initial &amp; Emp. No. of Sr. Staff Nurse:</b>		R 02/24

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

<b>SENSORY PERCEPTION</b> ability to respond meaning-fully to pressure-related discomfort	<b>1. Completely Limited</b> Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation <b>OR</b> limited ability to feel pain over most of body	<b>2. Very Limited</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness <b>OR</b> has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	<b>3. Slightly Limited</b> Responds to verbal commands, but cannot always communicate discomfort or the need to be turned <b>OR</b> had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort				
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Rarely Moist</b> Skin is usually dry, linen only requires changing at routine intervals				
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance				
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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 <b>OR</b> is NPO and / or maintained on clear liquids or IV's for more than 5 days	<b>2. Probably Inadequate</b> 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	<b>3. Adequate</b> 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 <b>OR</b> is on a tube feeding or TPN regimen which probably meets most of nutritional needs	<b>4. Excellent</b> 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				
<b>FRICTION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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					
					<b>TOTAL SCORE</b>	17	17	17
					<b>Initial &amp; Emp. No. of Staff Nurse:</b>	28	2352	28
					<b>Initial &amp; Emp. No. of Sr. Staff Nurse:</b>	100	100	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

<b>SENSORY PERCEPTION</b> ability to respond meaning-fully to pressure-related discomfort	<b>1. Completely Limited</b> 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	<b>2. Very Limited</b> 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	<b>3. Slightly Limited</b> 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	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4	
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Barely Moist</b> Skin is usually dry, linen only requires changing at routine intervals	4	4	4	
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	2	4	
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance	2	4	4	
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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	<b>2. Probably Inadequate</b> 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	<b>3. Adequate</b> 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	<b>4. Excellent</b> 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	3	4	4	
<b>FRICITION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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	
					<b>TOTAL SCORE</b>	17	23	23
					<b>Initial &amp; Emp. No. of Staff Nurse:</b>	[Signature] 225 110 106		
					<b>Initial &amp; Emp. No. of Sr. Staff Nurse:</b>	[Signature] 255 255 255		

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 ULCER RISK

<b>SENSORY PERCEPTION</b> ability to respond meaning-fully to pressure-related discomfort	<b>1. Completely Limited</b> 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	<b>2. Very Limited</b> 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	<b>3. Slightly Limited</b> 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	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Rarely Moist</b> Skin is usually dry, linen only requires changing at routine intervals	4		
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance	4		
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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	<b>2. Probably Inadequate</b> 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	<b>3. Adequate</b> 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	<b>4. Excellent</b> 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		
<b>FRICTION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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		
					<b>TOTAL SCORE</b>	23	
					<b>Initial &amp; Emp. No. of Staff Nurse:</b>	MD	
					<b>Initial &amp; Emp. No. of Sr. Staff Nurse:</b>	MD	

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





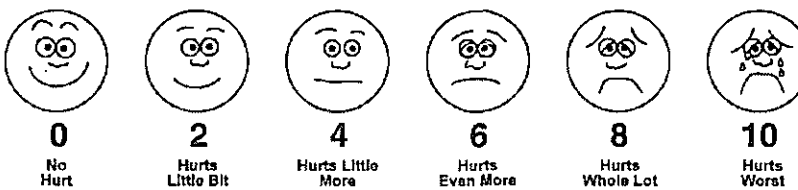
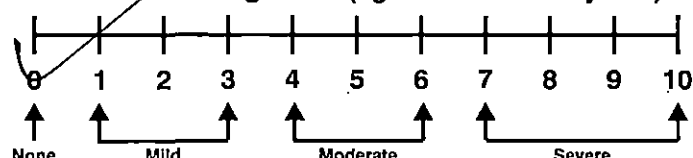
## PAIN RE-ASSESSMENT & MONITORING CHART

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.
5-1-24 21:49	2/10	dull pain	5mins	(RT) SHQ	→ pharmacological intervention as per doctor's prescription	Cora Jay	Cor Jay
21:55	2/10	dull pain	5mins	(RT) SHQ	→ pharmacological intervention as per doctor's prescription.	Cora Jay	Cor Jay
22:00	1/10	dull pain	5mins	(RT) SHQ	→ pharmacological intervention as per doctor's prescription.	Cora Jay	Cor Jay
22:05	1/10	dull pain	5mins	(RT) SHQ	→ pharmacological intervention as per doctor's prescription.	Cora Jay	Cor Jay
23:05	0/10	NO pain	-	-	-	Cora Jay	Cor Jay
6/1/24 00:05	0/10	no pain	-	-	-	Cora Jay	Cor Jay
3:05	0/10	no pain	-	-	-	Cora Jay	Cor Jay
2:05	0/10	no pain	-	-	-	Cora Jay	Cor Jay
3:05	0/10	no pain	-	-	-	Cora Jay	Cor Jay



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.
6/1/24 4.05	0/10	No pain	—	—	—	Q. Orr	Jay 500
5.05	0/10	No pain	—	—	—	Q. Orr	Jay 500
6.05	0/10	No pain	—	—	—	Q. Orr	Jay 500
7.05	0/10	No pain	—	—	—	Q. Orr	Jay 500

### PAIN SCALES

<b>PIPPS</b> (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	
<b>CRIES</b> (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.	
<b>FLACC Scale</b> (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both	
<b>Wong-Baker FACES Pain Rating Scale</b> (7 years - 12 years)		<b>Numerical Rating Scale (age more than 12 years)</b> 
<b>Critical care Pain Observation Tool (CPOT)</b> (ventilator / comatose)	<b>FACIAL EXPRESSION:</b> 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing <b>BODY MOVEMENTS:</b> 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation <b>COMPLIANCE WITH VENTILATION (intubated patients):</b> 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) <b>VOCALIZATION (non-intubated patients):</b> 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing <b>MUSCLE TENSION:</b> 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid <b>TOTAL SCORE:</b> 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain	
<b>Non-pharmacological Interventions</b>	<b>Distraction:</b> A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers <b>Cutaneous Stimulation and massage:</b> E - Positioning; F - Rubbing / Massage the skin <b>Thermal Therapies</b> (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy <b>Transcutaneous electrical nerve stimulation (TENS):</b> J - Interferential therapy   <b>Psycho-social therapy/counselling:</b> K - Individual Counseling; L - Family counseling	
Pharmacological Interventions as per doctor's prescription		



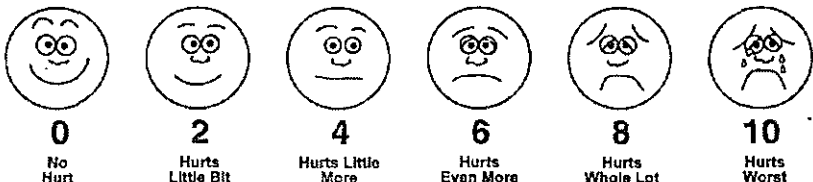
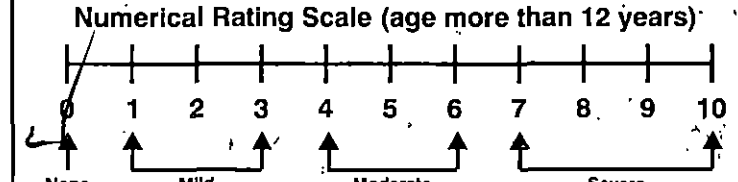
## PAIN RE-ASSESSMENT & MONITORING CHART

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.
6/1/24 8.00	0/10	No pain	—	—	—	<i>[Signature]</i> 0162	Nca 024
9.00	0/10	No pain	—	—	—	<i>[Signature]</i> 0162	Nca 024
10.00	0/10	No pain	—	—	—	<i>[Signature]</i> 0162	Nca 024
11.00	0/10	No pain ( patient shifted	—	—	to Cathlab @ 11.30	<i>[Signature]</i> 0162	Nca 024
12.30	0/10	No pain	—	—	—	Noh 2352	Nca 024
13.30	0/10	No pain	—	—	—	Noh 2352	Nca 024
14.00	0/10	No pain	—	—	—	Noh 2352	Nca 024
16.20	0/10	No pain	—	—	—	Noh 2352	Nca 024
17.20	0/10	No pain	—	—	—	Noh 2352	Nca 024



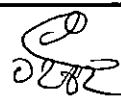
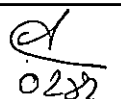
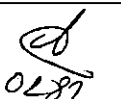

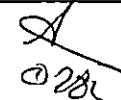

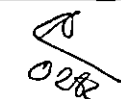


Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
18.20	0/10	No pain	—	—	—	<i>Neoh</i> 2302	<i>Nao</i> 024
19.20	0/10	No pain	—	—	—	<i>Neoh</i> 2302	<i>Nao</i> 024
20.00	0/10	No pain	Nil	Nil	Nil	<i>Neoh</i> 2302	<i>Nao</i> 024
21.00	0/10	No pain	Nil	Nil	Nil	<i>Neoh</i> 2302	<i>Nao</i> 024

### PAIN SCALES

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



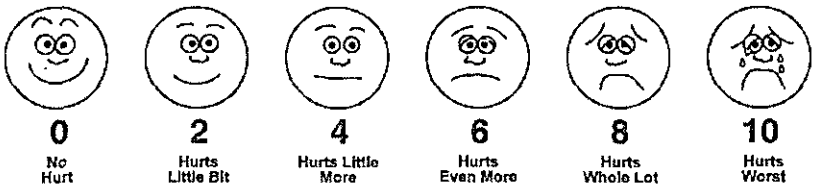
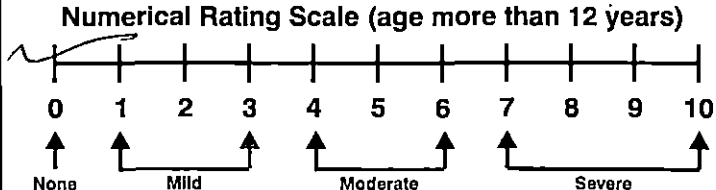
## PAIN RE-ASSESSMENT & MONITORING CHART

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.
6/1/24 22:00	0/10	no pain	—	—	—	 0282	Nae 024
23:00	0/10	no pain	—	—	—	 0282	Nae 024
7/1/24 00:00	0/10	no pain	—	—	—	 0282	Nae 024
1:00	0/10	no pain	—	—	—	 0282	Nae 024
2:00	0/10	no pain	—	—	—	 0282	Nae 024
3:00	0/10	no pain	—	—	—	 0282	Nae 024
4:00	0/10	no pain	—	—	—	 0282	Nae 024
5:00	0/10	no pain	—	—	—	 0282	Nae 024
6:00	0/10	no pain	—	—	—	 0282	Nae 024



Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7/1/24 7:00	0/10	No pain	-	-	-	<i>[Signature]</i> 028	<i>Nad</i> 024
8:00	0/10	No pain	-	-	-	<i>[Signature]</i> 041	<i>Nad</i> 027
9:00	0/10	No pain	-	-	-	<i>[Signature]</i> 021	<i>Nad</i> 024
10:00	0/10	No pain	-	-	-	<i>[Signature]</i> 041	<i>Nad</i> 024





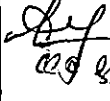

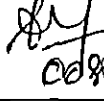
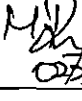
### PAIN SCALES

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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.
7/1/24 11:00	0/10	No Pain	—	—	—	 024	Nee 024
12:00	0/10	No Pain	—	—	—	 024	Nee 024
14:00	0/10	No Pain	—	—	—	 024	Nee 024
18:00	0/10	No Pain	—	—	—	 024	Nee 024
22:00	0/10	No Pain	—	—	—	 024	Nee 024
8/1/24 2:00	0/10	No Pain	—	—	—	 024	Nee 024
6:00	0/10	No Pain	—	—	—	 024	Nee 024
10:00	0/10	No Pain	—	—	—	 024	Nee 024






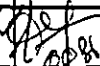
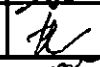









## DVT RISK ASSESSMENT

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					
		5-1-24	6-24	7-1-24	8-1-24			
		01-49	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			
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			
DVT prophylaxis started		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								





**Medway Hospitals**

*The way to better health*

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr. RAMACHANDRAN R

64/Male/MHI202431642

05/01/2024/1PH2024000043

Dr. G. GNANAVELU



MHI/NUR/2022/046



Where heart beat never stops...

## MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	5-1-24	6-1-24	6/1/24	6/1/24	7/1/24	7/1/24	7/1/24	8/1/24	
		Time	21:59	2:00	13:30	21:00	8:00	11:00	22:00	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
<b>AMBULATORY AID</b>										
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
<b>GAIT</b>										
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
<b>MENTAL STATUS</b>										
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
<b>MEDICATIONS</b> 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	15
<b>Total Score</b>		50	50	50	50	50	50	50	50	
<b>Low Risk (0 - 24)</b>										
<b>Medium Risk (25 - 44)</b>										
<b>High Risk (45 or above)</b>		✓	✓	✓	✓	✓	✓	✓	✓	
<b>Signature &amp; Emp. No. of RN</b>										
<b>Signature &amp; Emp. No. of Sr. RN</b>										

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



[illegible]



MHI/IP/2022/055

 **Medway  
Heart  
Institute**

**Every heart beat counts**

**To be filled by concerned disciplines. Use key below**

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions
Completed By : Date <u>5-1-24</u> Time <u>21-58</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
<input checked="" type="checkbox"/> Diet Instruction for patients at Nutritional risk													Maria Catherine [Signature]
<input type="checkbox"/> Diet advice for home													Senior Dietician Nurse
Discharge Planning													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													
<input type="checkbox"/> Smoking Cessation													Doctor
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> 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
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input checked="" type="checkbox"/> Written Instructions
Completed By : Date <u>08/1/24</u> Time <u>10:00</u>		Nurse Signature : <u>M. D. [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	
<b>Nutritional Guidance</b>													<b>Dietician</b>
<input type="checkbox"/> Diet Instruction for patients at Nutritional risk			P	O									Marla [Signature] Senior Dietician
<input checked="" type="checkbox"/> Diet advice for home			P	O									<b>Nurse</b>
<b>Discharge Planning</b>													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
<b>Risk Factor Reduction</b>													
<input type="checkbox"/> Smoking Cessation													<b>Doctor</b>
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> 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	<input checked="" type="checkbox"/>			Diet Advice	<input checked="" type="checkbox"/>		
ECG Report	<input checked="" type="checkbox"/>			CT Scan Report			<input checked="" type="checkbox"/>
Doppler Report			<input checked="" type="checkbox"/>	CT Scan Film			<input checked="" type="checkbox"/>
X-Ray Report	<input checked="" type="checkbox"/>			ECHO Report	<input checked="" type="checkbox"/>		
X-Ray Film	<input checked="" type="checkbox"/>			Ultrasound Report			
Compact Disk	<input checked="" type="checkbox"/>			Any Other Report			

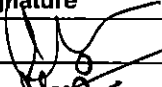
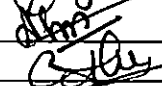
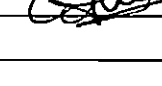
Name of Attendant / Patient : Ramya Signature : [Signature]

Name of Discharge Nurse Hannah Isaac Signature : [Signature]



## Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 5-1-24 Time: 21.58

Checklist	Yes	No	NA	Action / Remarks	
<b>MEDICAL</b>					
Daily Consultant Visit	✓				
Plan of care discussed	✓				
Discharge Planning					
Others if any					
<b>NURSING</b>					
Safety Precautions Ensured	✓				
Care of Lines and Tubes	✓				
Infection Control Measures	✓				
Skin Care	✓				
Response to assistance	✓				
Others if any					
<b>DIETICIAN</b>					
Diet Adequate	✓				
Special Request	✓				
<b>PHYSIOTHERAPIST</b>					
Available for Assistance for Activities of Daily Living					
Others if any					
<b>PATIENT CARE SERVICES</b>					
Room Cleaning satisfactory					
Room Amenities Adequate					
Billing Update available					
Non-Availability of any service					
Spiritual Needs (if yes specify)					
Others if any					
<b>Inter Disciplinary Team Members</b>					
	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		Dr. G. Gnana Velu	91810	5/1/24	21.58
Nursing Staff		Maria Catherine John	0282	5/1/24	21.58
Dietician		Senior Dietitian	0297	5/1/24	10:00
Physiotherapist					
Patient Care Service Staff					



## IN-HOUSE TRANSFER FORM

### Part A (to be filled by Nurses)

Date of Transfer: 7/1/24 Time: 12:45 Transferred from: CCU To: 3rd floor R-No

Diagnosis:

ACS / ANGIOSTEMI / T2DM / LYSOED CING-TNR.

Vital Signs: Temp: 98 (°F) | Pulse / HR: 98 (beats/min) | BP: 138/72 (mmHg) | Respiration: 28 (breaths/min)

### Part B (to be filled by Physicians)

Any Critical Investigations:

Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	<input checked="" type="checkbox"/> Clear <input type="checkbox"/> Crepitation <input type="checkbox"/> Rhonchi <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Abdomen	<input checked="" type="checkbox"/> Soft <input type="checkbox"/> Tender <input type="checkbox"/> Distended <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Heart Sound	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Feeble <input type="checkbox"/> Loud <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
CNS	<input checked="" type="checkbox"/> Conscious <input type="checkbox"/> Oriented GCS Score: <u>15</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
For Surgical Patients (if applicable)	Surgical Site: <input checked="" type="checkbox"/> Healthy <input type="checkbox"/> Soakage <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No


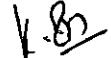
### Present Medication (for Medication Reconciliation)

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. ELOSPIRIN	75g	Pb	OD	6/1/24 @ 11:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	T. ATORVAST.	80g	Pb	OD	6/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. FLAVEDOX-TR	35g	Pb.	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. NITROCONTIN	26mg	Pb.	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. ANA IT	0.25g	Pb	OD	6/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	SYP. CLOMIPRAMINE	15ml	Pb	OD	6/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. ALDAZOLONE	0.5g	Pb	1-0-0	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	2g. CLONIDINE	0.6ml	S/L	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Amlong	5g	Pb	1-0-0	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. CLOMIPRAMINE	3-12g	Pb.	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. IVABRAD	5g	Pb	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. CARBACE	2.5g	Pb	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. ALCER	90g	Pb	1-0-1	7/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	SYP. SUCRALFATE	10ml	Pb	1-2-1	7/1/24 @ 8:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
	T. LASALIX	40g	Pb	1-0-1/2-0		<input type="checkbox"/> Yes <input type="checkbox"/> No



Additional Details (if any):

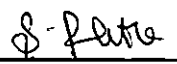

Patient Condition: ☒ Stable ☐ Sick-need urgent care ☐ Others: \_\_\_\_\_

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		Dr. Karthikeyan	85851.	2/1/24	12:45
Receiving Doctor		Dr. K. Anusuya	134559	2/1/24	12:45

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

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

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		S. Parimalatha	0211	7/1/24	12:45
Receiving Nurse		S. Subeela	2202	7/1/24	12:45



## FAMILY COUNSELLING FORM

CONSULTANT- <i>Dr. Gnanavelu.</i>			DIAGNOSIS- <i>ACS, STEMI - PDM.</i>			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
<i>8/1/24</i>	<i>Doctor</i>	<i>Wife</i>	<i>pt's critical Condition &amp; need for Thrombolysis / Risks of Thrombolysis explained to attendees in their own language.</i>		<i>N. Vignesh</i>	<i>[Signature]</i> <i>9/8/10 ~</i>
<i>6/1/24</i>	<i>Doctor.</i>	<i>WIFE</i>	<i>Clinical condition explained to family members.</i>		<i>R. Deepa</i>	<i>[Signature]</i> <i>12/2/24</i>
<i>7/1/24</i>	<i>Doctor -</i>	<i>WIFE.</i>	<i>Condition explained - wound dress</i>		<i>R. Deepa</i>	<i>[Signature]</i> <i>5/3/24</i>
			<i>I</i>			



**VIP SCALE (VISUAL INFUSION PHLEBITIS)**

PATIENT N/ **Mr. RAMACHANDRAN R**  
64/Male/MHI202481642  
05/01/2024/IPH2024000043  
AGE / SEX : **Dr. G. GNANAVELU**

IP No. / UHID No **202481642**

Ward / Bed No. **CUU**

ANY SCORE > 0 SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
5-1-24	21:00	LE Brachial Anesthetic	0/5	Inserted.	Flushed	Followed.	2024
6-1-24	8:00	② Brachial	0/5	Patent	Flushed	Followed.	2024
	13:30	② Brachial	0/5	Patent	Flushed	Followed.	2024
	21:00	② Brachial	0/5	Patent	Flushed	Followed	2024
7-1-24	8:00	② Brachial	0/5	Patent	Flushed	Followed	2024
		② Brachial		Line removed			
6/1/24	8:00	② Anesthetic	0/5	Patent	Flushed.	Followed.	2024
	13:30	② Anesthetic	0/5	Patent	Flushed.	Followed.	2024
	21:00	② Anesthetic	0/5	Patent	Flushed	Followed	2024
7-1-24	8:00	② Anesthetic	0/5	Patent	Flushed	Followed	2024
	11:00	② Anesthetic	0/5	Patent	Flushed	Followed	2024
	22:00	② Anesthetic	0/5	Patent	Flushed	Followed	2024
8/1/24	8:00	② Anesthetic	0/5	Patent	Flushed	Followed	2024
				IV line Remove			



## MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1

Height (cms): 170cm Weight (kg): 78.5kg

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

Drug Details	Description of Allergy	Doctor's Sign:
	Allergic to Aspirin	Name: Dr. G. Gnana Velu Reg. No. 91810

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

### Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
5/1/24	21:30	T. Aspirin	300mg	PO	[Signature]	91810	[Signature]	0240	21:30
5/1/24	21:30	T. Clopidogrel	300mg	PO	[Signature]	91810	[Signature]	0282	21:30
5/1/24	21:30	T. Atorvastatin	80mg	PO	[Signature]	91810	[Signature]	0282	21:30
5/1/24	21:30	T. Paracetamol	40mg	PO	[Signature]	91810	[Signature]	0282	21:30
5/1/24	21:30	T. Enoxaparin	40mg	SC	[Signature]	91810	[Signature]	0282	21:30
5/1/24	22:00	T. Cloxone	0.3ml	SC	[Signature]	91810	[Signature]	0282	22:00
5/1/24	22:30	T. Cloxone	0.6ml	SC	[Signature]	91810	[Signature]	0282	22:30
5/1/24	22:00	DNJ. LASIX	20mg	IV	[Signature]	91810	[Signature]	0282	22:00
5/1/24	22:30	DNJ. LASIX	20mg	IV	[Signature]	91810	[Signature]	0282	22:30
5/1/24	22:50	DNJ. MORPHINE	2mg	IV	[Signature]	91810	[Signature]	0282	22:50
5/1/24	22:10	Enalapril	10mg	PO	[Signature]	91810	[Signature]	0282	22:10
5/1/24	22:20	Budecort	10mg	PO	[Signature]	91810	[Signature]	0282	22:20
5/1/24	22:08	T. TNSK	40mg	IV	[Signature]	91810	[Signature]	0282	22:08
6/1/24	7:40	T. Amlong	5mg	PO	[Signature]	91810	[Signature]	0162	7:40



# REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

5-12 6-12 7-12 8-12

## DRUG NAME

T. ECOSPRIN.

Dose

75mg

Route

P.O.

Frequency

Q.T.O.

14:00

Dr. Sign & Reg. No. / Seal

*[Signature]*  
91810

Start Date & Time

5/1/24 22:30

Stop Date & Time

Additional Info:

## DRUG NAME

T. CLOPILET

Dose

75mg

Route

P.O.

Frequency

Q.T.O.

14:00

Dr. Sign & Reg. No. / Seal

*[Signature]*  
91810

Start Date & Time

5/1/24 22:30

Stop Date & Time

Additional Info:

## DRUG NAME

T. Atorva

Dose

80mg

Route

P.O.

Frequency

Q.T.O.

20:00

Dr. Sign & Reg. No. / Seal

*[Signature]*  
91810

Start Date & Time

5/1/24 22:30

Stop Date & Time

Additional Info:

## DRUG NAME

T. FLAVEDON - W

Dose

35mg

Route

P.O.

Frequency

Q.T.O.

8:00

Dr. Sign & Reg. No. / Seal

*[Signature]*  
91810

Start Date & Time

5/1/24 22:30

Stop Date & Time

Additional Info:

## DRUG NAME

T. NITROCONTIN

Dose

2-6mg

Route

P.O.

Frequency

Q.T.O.

8:00

Dr. Sign & Reg. No. / Seal

*[Signature]*  
91810

Start Date & Time

5/1/24 22:30

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

*[Signature]*  
2007/10/24

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute



**To be filled in by Doctors only**

Date →

Time ↓

**DRUG NAME**

### Dose

Route

Frequency

Dr. Sign &amp; Reg/ No. / Seal

**Start Date & Time**

**Stop Date & Time**

**Additional Info:**

**DRUG NAME**

### Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date &amp; Time

Stop Date & Time
------------------

**Additional Info:**

**DRUG NAME**

### Dose

Route

Frequency

Dr. Sign &amp; Reg. No. / Seal

### Start Date & Time

Stop Date &amp; Time

~~Additional Info:~~

**DRUG NAME**

### Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date &amp; Time

Stop Date &amp; Time

Additional Info:

**DRUG NAME**

### Dose

Route

Frequency

Dr. Sign &amp; Reg. No. / Seal

Start Date &amp; Time

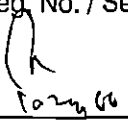
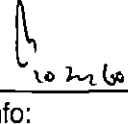
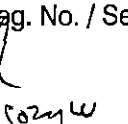
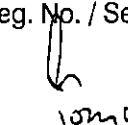
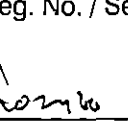
Stop Date & Time

Additional Info:

**Area In-charge**

**Nurse Signature:**



REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given				
Time ↓			6/1/24	7/1/24	8/1/24			
DRUG NAME T. Amoxyc			8.00	8.30	9.00			
Dose 500	Route PO	Frequency 1-0-0						
Dr. Sign & Reg. No. / Seal 		Start Date & Time 6/1/24 @ 10.00						
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Cefixime			8.00	8.30	9.00			
Dose 500	Route PO	Frequency 1-0-0						
Dr. Sign & Reg. No. / Seal 		Start Date & Time 6/1/24 @ 10.00						
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Ibuprofen			8.00	8.30	9.00			
Dose 500	Route PO	Frequency 1-0-0						
Dr. Sign & Reg. No. / Seal 		Start Date & Time 6/1/24 @ 10.00						
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Cefixime			8.00	8.30	9.00			
Dose 2.5m	Route PO	Frequency 1-0-0						
Dr. Sign & Reg. No. / Seal 		Start Date & Time 6/1/24 @ 10.00						
		Stop Date & Time						
Additional Info:								
DRUG NAME T. Cefixime			8.00	8.30	9.00			
Dose 500	Route PO	Frequency 1-0-0						
Dr. Sign & Reg. No. / Seal 		Start Date & Time 6/1/24 @ 10.00						
		Stop Date & Time 6/1/24 @ 12.50						
Additional Info:								
Area In-charge Nurse 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. AX CER

Dose

90mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

*[Signature]*  
9370

Start Date & Time

6/1/24 @ 11pm

Stop Date & Time

Additional Info:

DRUG NAME

Syp. SUCRALFATE

Dose

10ml

Route

P/O

Frequency

1-1-1

Dr. Sign & Reg. No. / Seal

*[Signature]*  
35851

Start Date & Time

6/1/24 @ 11pm

Stop Date & Time

Additional Info:

DRUG NAME

T. LASIX

Dose

40g

Route

P/O

Frequency

1/2 - 0 - 1/2 - 0

Dr. Sign & Reg. No. / Seal

*[Signature]*  
35851

Start Date & Time

7/1/24 @ 9:00

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:

6/1/24 7/1/24 8/1/24

8:00

8:30 9:00  
P.S. P.S.

20:00

20:00 20:30  
P.S. P.S.

8:00

8:30 9:30  
P.S. P.S.

18:00

17:30 18:00  
P.S. P.S.

19:00

18:00 19:00  
P.S. P.S.

8:00

9:00  
P.S.

16:00

16:00 16:30  
P.S. P.S.

100 100 100  
2/1 2/1 2/1

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute



[illegible][illegible]



# DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
7/1/24	9:55	Diabetic diet	[Signature]	91810					
8/1/24	8:00	Diabetic diet	[Signature]	122618					
7/1/24	8:00	Diabetic diet	[Signature]	85351					
8/1/24	8:00	Diabetic diet	[Signature]	134552					

# 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			
5-1-24	Night	Aarthi	0282	ny		Night			
6/1/24	Morning	S. Allwin Prangrao	0162	[Signature]		Morning			
6/1/24	Evening	Moharaj	0052	NOT		Evening			
6/1/24	Night	Aarthi	0282	ny		Night			
7/1/24	Morning	S. Premalatha	0211	[Signature]		Morning			
7/1/24	Evening	A. Nandhi ni	0170	[Signature]		Evening			
7/1/24	Night	Seni Priya	0284	Jes		Night			
8/1/24	Morning	E. Cathrine	0007	E.C		Morning			
8/1/24	Evening	B. Vanitha	0195	[Signature]		Evening			
	Night					Night			



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(A Unit of United Alliance Healthcare Pvt Ltd)

[illegible]Pat  
Nan  
UHI  
DOO[illegible]





**Where heart beat never stops...**

## REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex :

**Consultant Name :**

IP No. :

DOA :

UHID No. :

Room No. : ( )

[illegible]

**Nurse Name**

**Pharm Bill & Name**





**Medway Hospitals®**  
The way to better health

6/11/24  
CLV.

MR Ramachandran R.

MH 202481642.

T. Alexi going → 1 strip.  
2. Sucrafil gel → 1

0158



JwayHospitals



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in @medway-hospitals



@medwayhospitals



94457 94457  
1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam

044-2473 4455

Mogappair

044-26530011

Kumbakonam

044-2473 4455

Chengalpattu

044-27426829

Villupuram

04146-242000

Heart Institute

044 - 4310 8959

Institute of Pulmonology

044-2473 4451

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

MH/PRINT /0123/ NRS





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## REQUISITION FOR MEDICINE

IP No. \_\_\_\_\_

DOA

UHID No. :

Room No. : 220 .

Name of Patient : **Mr.RAMACHANDRAN R**

64/Malc/MH1202481642

Age / Sex : 05/01/2024/IPH2024000043

05/01/2024/IPH2024000043

**Consultant Name :** Dr.G. GNANAVELU

Dr.G. GNANAVELU

[illegible]

**Nurse Name**

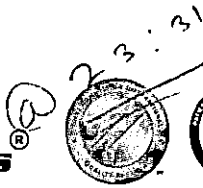
Pharm Bill &amp; Name





Pharm Bill &amp; Name





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## REQUISITION FOR MEDICINE

Name of Patient	Mr. RAMACHANDRAN R
Age / Sex	64 / Male / MH1202481642
Consultant Name	05/01/2024 / IPH2024000043
	Dr. G. GNANAVELU

7<sup>th</sup> No. :

DOA :

PHID No. :

Room No. :

S.No.	Date	Medicine Name	Qty.
1	5/1/24	T. Adalene	5
2	"	Inf. Lactin (Lump)	2
3	"	ECG Leads	10
4	"		
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

**Nurse Name**

Pharm Bill &amp; Name





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### REQUISITION FOR MEDICINE

Name of Patient : IP No. :  
Age / Sex : DOA :  
Consultant Name : UHID No. :  
Room No. : CCU

S.No.	Date	Medicine Name	Qty.
17	5/12/24	T. Clopidogrel 75mg	10
18	"	T. Enoxaparin 15mg	10
19	"	T. Atorvastatin 40mg	5
20	"	Inf. Pan 10mg	1
21	"	Inf. Enoxet 4mg	2
22	"	Dig. Glucose 10	
23	"	T. Clopidogrel (45mg)	5
24	"	T. Clopidogrel (45mg)	5
25	"	T. Atorvastatin (40mg)	5
26	"	T. Enoxaparin (10.5mg)	5
27	"	Syp. Cromoglicic acid	1

Nurse Name *2546*

Pharm Bill & Name





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### REQUISITION FOR MEDICINE

Name of Patient :  
 Age / Sex :  
 Consultant Name :

IP No. :  
 DOA :  
 UHID No. :  
 Room No. : 770

S.No.	Date	Medicine Name	Qty.
1	5/11/24	200g Verapone	2+1
2		Tab 4 + 1x	2+1
3		BD Connecta 1000	2+1
4		Posiflush	3+2
		5ml Syringe	6
6		10ml Syringe	1
7		Easy Bath	1
8		Underpad	3
9		700ml Wash	1
10		Kidney bag	1
11		Waste can	1
12		Alcohol prep	1
13		O <sub>2</sub> mask	1
14		Eccr leads	1+
15		Culture tr	1 (Air)

Nurse Name

Pharm Bill & Name











ASPS:- ACS / AN. STENT / TDM / HEPSED & INJ. TANK



INTERMEDIATE CARE FLOWCHART

B

Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/IPH2024000043  
NAME : Dr. G. GNANA VELU

UHID NO : 202481642 AGE : 64y SEX : M

BLOOD GROUP :

HEIGHT : 170 cm

WEIGHT : 85 kg

B.S.A : 1.4 m<sup>2</sup>

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8:00	109	Sim	97.1	162/105	124	hard	++	23	BLUE	97	FM O2 & dilute
9:00	96	Sim	97.1	169/106	127	hard	++	28	BLUE	95	"
10:00	111	Sim	97.1	170/113	132	hard	++	31	BLUE	97	"
11:00	115	Sim	97.1	181/114	136	hard	++	23	BLUE	97	"
PATIENT SHIFTED TO CATH LAB @ 11:30.											
12:05	85	Sim	97.8	176/104	128	hard	++	24	BLUE	97	"
14:00	82	Sim	97.8	169/90	116	hard	++	22	BLUE	97	"
15:00	84	Sim	97.2	169/90	116	hard	++	29	BLUE	97	"
16:00	98	Gas.	97.2	178/79	120	com	++	26	BLUE	100	"
17:00	103	Sim	97.1	147/78	114	com	++	28	BLUE	98	"
18:00	93	Sim	97.5	135/77	96	hard	++	24	BLUE	95	"
19:00	95	Sim	97.8	158/106	123	hard	++	22	BLUE	95	"
20:00	86	Sim	97.4	145/90	108	hard	++	18	BLUE	95	patient on NP 211-02
21:00	94	Sim	98.2	146/84	105	hard	++	20	BLUE	97	"
22:00	100	Sim	97.6	140/84	102	hard	++	22	BLUE	98	"
23:00	84	Sim	97.2	126/82	97	hard	++	25	BLUE	97	"
PREVIOUS DAY - HOURS :-											
DRAINAGE -						TOTAL INTAKE 200ml					
URINE 1950ml						TOTAL OUTPUT 1950ml					
						BALANCE 50ml					



APPS - ACS / AWC - STEROID / TDM / HYSED 2 INJ. TTK



MHI/ICU/2022/064



Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/IPH2024000043

## IMMEDIATE CARE FLOWCHART

B

NAME : Dr. G. GNANAVELU

UHID NO : 202481642 AGE : 64y SEX : M

BLOOD GROUP :

HEIGHT :  $\pm 170\text{ m}^2$

WEIGHT :  $\pm 85\text{ kg}$

B.S.A :  $1.4\text{ m}^2$

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
21.49	80	sinus	98.2	$\frac{122}{75}$	91	warm	++	20	Bx/c	95%	NP 2 lit
22.00	90	sinus	98.4	$\frac{130}{80}$	97	warm	++	18	Bx/c	96%	PI-on <del>RA</del> with 2lit O2
23.00	70	sinus	98.2	$\frac{156}{83}$	107	warm	++	14	Pr/c	96%	FM with 5lit O2
00.00	78	sinus	97.6	$\frac{156}{83}$	107	warm	++	18	Pr/c	96%	"
1.00	72	sinus	98.2	$\frac{156}{92}$	113	warm	++	26	Bx/c	96%	"
2.00	76	sinus	97.6	$\frac{112}{71}$	85	warm	++	24	Bx/c	96%	"
3.00	96	sinus	98.	$\frac{156}{82}$	112	warm	++	26	Pr/c	97%	"
4.00	94	sinus	97.6	$\frac{167}{102}$	124	warm	++	24	Bx/c	96%	"
5.00	88	sinus	98.2	$\frac{156}{100}$	118	warm	++	22	Bx/c	97%	"
6.00	94	sinus	97.4	$\frac{167}{103}$	124	warm	++	20	Bx/c	97%	"
7.00	92	sinus									

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE



**MEDICATION / DRUGS**



**MEDICATION / DRUGS**



ASPS:- ACS/AW.STEMI/ DDM/ LYSED & INJ. TNK



MHI/ICU/2022/064

NAME : Mr. RAMACHANDRAN R  
64/Male/MHI202481642  
05/01/2024/IPH2024000043  
SURGIC. Dr. G. GNANAVELU

IMMEDIATE CARE FLOWCHART

A

UHID NO : 202481642 AGE : 64y

SEX : f

POSTOP DAY : D2

FLUID REQUIREMENT : 1-2 litre / day  
6-1-24

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.		
8.00	400	400					400				200	200	200	200
9.00		400					400					200	200	200
10.00		400					400					200	200	200
11.00	300	700					700					200	200	500
	PATIENT SHIFTED TO CATH LAB @ 11.30													
13.05	400	1400					1400				150	600	600	800
14.00		1400					1400	0.6	30		100	400	730.6	669.4
15.00	200	1600					1600	0.6	30			400	761.2	838.8
16.00	-	1600					1600	0.6	30		-	700	791.8	808.2
17.00	500	2100					2100	0.6	30		50	750	841.8	1028.2
18.00	-	2100					2100	-	30		-	750	901.8	1198.2
19.00	-	2100					2100		30		100	850	1031.8	1068.2
20.00	-	2100					2100		30		100	950	1161.8	938.2
21.00	-	2100					2100		30		-	950	1191.8	908.2
22.00	-	2100					2100		30		-	950	1221.8	878.2
23.00	-	2100					2100		30		-	950	1251.8	848.2

SPECIFIC OBSERVATIONS/REMARKS

Patient Received from Cath Lab  
to CCU @ 13.05:

MEDICATION / DRUGS

—  
—



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.			
5-1-24																
21.49	-	-										-	-		-	
22.00	300	300					300					-	-		300	
23.00	400	700					700					-	-		700	
00.00	300	1000					1000					-	-		1000	
1.00	450	1450					1450					100	100	100	1350	
2.00	-	1450					1450					50	150	150	1300	
3.00	-	1450					1450					-	150	150	1300	
4.00	-	1450					1450					-	150	150	1300	
5.00	500	1950					1950					-	150	150	1800	
6.00	-	1950					1950					50	200	200	1750	
7.00	-	1950					1950					-	200	200	1750.	
SPECIFIC OBSERVATIONS/REMARKS								MEDICATION / DRUGS								