

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	5	
- Name, Age & Sex of Patient	5	
- General Admission Consent		
- Initial Assessment of Patient / Diagnosis	\sim	
- Nutritional Assessment by Consultant	5	
- Plan of care counter signed by the Consultant	\sim	
- Treatment Orders - Date, Time, Name & Sign.	9	
- 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	N	



MIS.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035





weaway Hospitais , Millian Millian Control of the C
The way to better health (A Unit of United Alliance Healthcare Pvt Ltd) ADMISSION SLIP
Admitting Doctor: a Shark Speciality: Cardio Cozit.
Advised Date & Time: DY 12 V P 3 426 m.
Provisional Diagnosis:
PSVT - AT -PAVNET.
Reason for Admission: Medical Management Surgical Management
Others (please specify details)
Admission Type: Day Care ER Ward
Cu (Specify details)
Surgery / Procedure Name (if planned):
Blood Product Requirement: Yes (Kindly specify details of components required in space below)
Expected Duration of Stay: 2 -3 clays
Expected Cost of Treatment (as per Financial Counseling Form):
Payer: Self Insurance Others:
Instructions to Nurse (if any): De do Call park (nichtigelei)
Any other Instructions (if any):
Cari Lauko.
Doctor's Signature Name Reg. No. 49448 Date 2 Time

For admission desk	staff only:		
Room Category:	☐ General-Ward		
	Single Room		-
•	Twin Sharing		
-	Deluxe Room		
	☐ Suite Room		
	Others		
<u> </u>			
Admission intir	nation Receipt Details	Admission Ti	me in HIS
Date	Time	Date	Time
4/1/24	g-43p~	4/01/2024	3.46pm
Source:	☐ OPD ☐ ER ☐ Direct		·
_	Blood requirement specified by th on and Blood Bank clearance com	•	No
Front office Staff Sigr	nature Name	Emp. No.	Date Time
DAR	Absh	01692	4/1/23 3-46p
·			
. •			
•		,	
•		·	
-	•		



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



Patient Batalla (Aug. 1 J. 1 J. 1 JAIN

31/Female/MHI202381578 04/01/2024/iPH2024000035

D Dr.K.JAISHANKAR





MHI/HOSP/2022/129

ADMISSION FORM

Marital Statu Occupation OF Referred from	North town, Binny Mills Perumber - 6000	tal No. of Days
	Oly X 1	~ ~
UNIT Condial	MLC Yes No If Yes AR No.:	
	FINAL DIAGNOSIS	ICD Code
	PSVT - AVNRT GOOD W FUNCTION	47.1
	GOOD W FUNCTION	5501
	· · · · · · · · · · · · · · · · · · ·	
·		
DATE	OPERATION / PROCEDURES	ICPM Code
5/11214	ELECTROPHY SIOLOGY STUDY + RADIOFRED. ABLATION.	ENCY 04.3
DATE	TYPE OF ANESTHESIA	
5/1/24	☐ GENERAL ☐ SPINAL ☐ LOCAL ☐ REGIONAL	, 🗌 ÉPIDURAL
	DISCHARGE STATUS	
Cured		Expired < 48 hours
☐ Improve	☐ Against Medical Advice ☐ Absconded ☐ ☐	Expired > 48 hours
☐ Unchan	· · · · · · · · · · · · · · · · · · ·	Post-Operative Death
11:00	Lyand Miles	Reis
Signature	of the Consultant Signature of Med	ರ್ಷನ್ dical Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be who is my/fa.......... (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 . சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நீர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளிக்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகீச்சை செய்யவும் அதிகாரம் வழங்குகீறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

Signature of Admitting Nurse

4/02/2024 GBB 3-46PM-

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

Janian Gethung







GENERAL CONSENT FOR ADMISSION

	Shorts Jaly the D. Rationt or D. Raprocontative of nations have
1, . (p	the Patient or Representative of patient have lease tick the correct option above and below)
	Read 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	- fais	SHWETA JAW	4/1/24	3.46	
Surrogate/Guardian (if applicable #)	Trinay Tething	SANTAY SETHIYA (Write name and relationship with patient)	4/1/24	3.466	
Reason for surrogate consent	Patient is unable to give consent to	pecause:			
Witness	· Saujan Gething	SANJAY SETHIYA	4/1/24	3.46	
Interpreter (if applicable)	,				

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









DISCHARGE SUMMARY

IP No.

IPH2024000035

D.O.A

: 04/01/2024

UHID

MHI202381578

D.O.P

: 05/01/2024

Name

Mrs. SHWETA JAIN

Room No. : 109

Age / Gender

31 Years / FEMALE

Consultant

: Dr. JAISHANKAR.K MD., DM., FIAMS

D.O.D

: 06/01/2024

Director and Clinical Lead

Cardiology and Electrophysiology

DIAGNOSIS:

PSVT -AVNRT

GOOD LV FUNCTION

PROCEDURE:

SUCCESSFUL ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE FOR TYPICAL AVNRT - SLOW PATHWAY DONE ON 05.01.2024.

BRIEF HISTORY:

Mrs. Shweta Jain, 31 years/Female, Presented with complaints of palpitation associated with choking sensation and giddiness since 2 months. She initially went to Muthu hospital and treated conservatively. Then she came to medway heart insitute on 30.12.2023 evaluated in OPD, diagnosed as PSVT - AVNRT and advised for Electrophysiology study + radiofrequency ablation using 3D ensite for which she has been admitted.

No H/O Syncope or pre syncope, fever, cough, vomiting, diarrhea.

N/K/C/O DM, SHT, RHD / CKD, BA, seizure disorder or Hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

HR

81bpm

BP

130/80mmHg

SPO2

97% in room air

CVS

S1S2 (+)

RS

BAE (+)

Abdomen

Kodambakkam

CNS

Soft, NT **NFND**

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

Villupuram

¶ @MedwayHospitals

Mogappair

(C) @medwayhospitals

Chengalpattu

M @medway-hospitals

Kumbakonam

@medwayhospitals

Kakinada

94557 94557 1800 572 3003

Medway Centre of Excellence (Chennai)

Medway Group of Hospitals

Heart Institute 044 - 4310 8959

Institute of Pulmonology 044-2473 4451

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



UHID: MHI202381578



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INVESTIGATIONS:

BLOOD(04.01.2024): Hb - 12.2gm/dl, TC- 5140 cells/cumm, PLT - 324000 laks/cumm, Urea - 25mg/dl, Creatinine- 0.46 mg/dl, Sodium – 139 mmol/L, Potassium – 4.75mmol/L.

TACHYCARDIA ECG: SVT @ 158BPM, narrow qrs complex. short RP tachycardia, S/O AVNRT.

BASAL ECG: NSR, HR – 78BPM.

SCRENNING ECHO(04.01.2024): All chambers normal sized, No RWMA, Normal LV function, Normal RV function, IAS / IVS intact, All valves are structurally normal, Trivial MR, Trivial TR, No PAH, IVC normal in size and collapsing, No clot / vegetation / effusion, RVOT normal sized, measures – 28mm.

POST RFA INVESTIGATIONS:

ECG: sinus rhythm, HR – 71 bpm, Within Normal Limits.

- SCRENNING ECHO(04.01.2024): All chambers normal sized, No RWMA, Normal LV function, Normal RV function, IAS / IVS intact, All valves are structurally normal, Trivial MR, Trivial TR, No PAH, IVC normal in size and collapsing, No clot / vegetation / pericardial / pleural effusion, RVOT normal sized, measures - 28mm.

COURSE IN THE HOSPITAL:

Mrs. Shweta jain, 31 years/Female, was admitted with above mentioned complaints. Basic investigation was done. She underwent SUCCESSFUL ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE FOR TYPICAL AVNRT - SLOW PATHWAY ABLATION DONE ON 05.01.2024. Her post procedure period was uneventful and shifted to CCU. Right femoral access site normal, peripheral pulses well felt, no hematoma/soakage. Post RFA ECG showed normal sinus rhythm and ECHO showed no pericardial effusion. She was observed in ICU and shifted to ward. She had complaints of burning micturation, ? Hematuria and urine routine / culture were sent & reports are awaited. Her medications are optimized and she is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile General condition Stable

GCS

15/15

Temp

98.6°F

Mogappair

BP

110/70mmHg

PR

90/min

SPO2

98% in room air

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

Villupuram

₹@MedwayHospitals

Kodambakkam

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Chengalpattu

[@medway-hospitals

Kumbakonam

@medwayhospitals

Kakinada

94557 94557 1800 572 3003

Medway Centre of Excellence (Chennai)

Medway Group of Hospitals

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



UHID: MHI202381578



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ADVICE MEDICATIONS:

Sl.	NAME OF THE DRUGS	DOSAGE FREQUENCY		,	ROUTE	RELATION	DURATION	
NO	WITH GENERIC NAME		M	A	N	}	SHIP WITH MEAL	
1.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	X 3 DAYS
2.	TAB. DOLO (PARACETAMOL)	650 MG	1	1	Ī	ORAL	AFTER FOOD	X 3 DAYS

	DISCHARGE ADVICE
DIET	LOW FAT DIET.
PHYSICAL ACTIVITIES	DAILY WALKING FOR 30 MINS.
REVIEW	REVIEW WITH DR. JAISHANKAR. K AFTER 1 MONTH WITH ECG.

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

CONSULTANT SIGNATURE

2005 SLAW

Dr. Jaishankar. K MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology

Typed by: Sandhiya J

Mogappair

Kodambakkam

Dr. K. JAISHANKAR Reg. No: 49448

Kakinada

ு#9, 1st Main Road, Un	ited India Colony, Kodan	nbakkam, Chennai - 6000	024. Tel : 044	- 4310 8959	
₽ @MedwayHospitals	@medwayhospitals	in @medway-hospitals	9 @medwa	ayhospitals	
Medway Group of Hospitals Medway Centr					

Villupuram

Kumbakonam



Institute of Pulmonology

044-2473 4451

Medway Centre of Excellence (Chennai)

Heart Institute

044 - 4310 8959

Chengalpattu

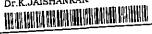




Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035







INPATIENT INITIAL ASSESSMENT

Date: 4/1/24	Time of arrival in ward: 16 20.
Allergies (if Yes, spec	ify details):
Drugs [] Yes ☑ No
Blood Transfusion] Yes 🗹 No
Food] Yes 🗹 No
Others	
Vital Signs: Temp: 9	8 (°F) Pulse / HR: 81 (beats/min) BP: 130 80 (mmHg) eaths/min) SpO₂: 97(%) Height: 156(cms) Weight: 62: (kgs) BMI: 25.6 kg/m²
Duration:	Yes, Score:/ID
clo Payi?	18 HISTORY OF PRESENT ILLNESS 31 yrs old female Came with Complaints of tation - troops associated with Choking Sensations -no 4/6 fever, vomiting, bossi stools
	- no 1/2 d'unie output, constration.
	- no 4/0 Obistipadin.
	ORY (with duration of illness):
Diabetes Mellitus: Y	es ☑No. If Yes, duration:Hypertension: ☐ Yes ☑No. If Yes, duration:
Others:	NINICIO Bronchial Asthma/GPD/CKD/PTB/CopD. Epilepny
Past Surgical History	NIL

Investigations Ad	vised:				
	To do Cath	Pack inve	ntryation		
Diet Advice:					
☐ Nil per Oral	Clear liquid diet [☐ Normal liquid	d diet Diabetic liquid diet		
Semisolid diet	Soft solid diet		n normal diet 🔲 North Indian norma	l diet	
□ Neutropenic liquid	diet Others:	w dalt.	low fact		
Early Discharge Plan	ning (fill in those which are a	appropriate at thi	is stage): PFE: Patient Famil	y Education	
Special support need	led at home	□ Yes ☑ No	If Yes, PFE done		
Home equipment anti	icipated	☐Yes☑No	If Yes, PFE done and equipment ad	vised	
Physiotherapy at hom	ne anticipated	□Yes☑No	If Yes, educated on physical limitation	ons, if any	
Wound care needs anticipated at home		□Yes☑No	If Yes, educated on signs on infection	on	
Pain Management		☐ Yes ☐ No	If Yes, PFE done and medication ac	lvised	
Special Dietary needs	3	□ Yes □ No	If Yes, educated on dietary restrictions, food drug interactions and allergies		
Continuous / ongoing	g care anticipated	☐ Yes ☐ No	If Yes, educated on various aspects care required	of ongoing	
Other special educati	on need, i.e.:	□Yes ☑No	If Yes, PFE done		
Nature of post hospiti infection control, fall r	al needs like patient safety, risk, etc, addressed	☐ Yes ☐ No	If Yes, specific education given		
Others:	7 *		11 0 × 1 × 2	- -	
		· . · · · · . ·			
	Signature	Name	Reg. No. Date	Time	
Resident Doctor	000		medlyhon 165300 4/11		
Consultant	1 Kderign	_	aishanian 49442 51112	(10.0)	
Patient Attendant	Farjan Yethin	Relationship	~ - All 29	16/20	







MHI/IP/2022/041

Medway

Heart

Every heart beat counts

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

Dr.K.Jaishankar

	_ TO HE DOLL BY STORE HER BUILDING HER
	DOCTOR'S PROGRESS NOTES
PATE	NOTES
DA/1/24	5/B DO-FRUKLING
1000	4
10.00pm	do palpitation on 8/ 156
	0/8' Partient conscious, oriented,
Vital Stable	SE'. W -5152P
VHayson	RS - BASP
	CNS-NEAD
	Advia
	- posted for CAG1+ EPS+RFA
	+omotion wing.
	- NPO From 6-30 Am to morrow
	- Convent
	parts preparation
	- Doe-modication
	- check Poe-op CBOY
	- se cure IV Line.
1000	shift to coth Lab on call.
BURKT	Shift to coth Lab on call 'before shifting, to give Zoy. sulphardyl lym
	M. 0 0 1

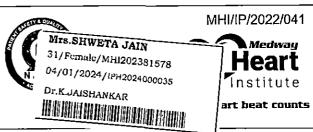
DATE	NOTES -
05/01/2024	CIDIB Dr. K. Jankankay.
25/01/20pm.	CIDIB D. K. J. Wychardrog.
8,	and the state of t
٠,٩٠٠	Procedure: Electrophy Bology study t
05th WO. 3539.	Radio frequency ablation living 30 thate
6756 S	
335	I SAP, wing 2-1. Kyloraine ar total anestresa.
	<u> </u>
	Appeach: RFV 1 RFA
	Sheath: 6 fr.
	Carthetes: RV, His, Cs, R& ablation cathetes.
_	Elechophysology study:
	A regular naurow ares tuchyrandia was induced
	with Programmed elimidation Protocul.
	Tachycardea cycle Dength - 380ms.
	AH jump & tcho noted before quitation of tachyears
-	+Gs. Rynchow PVC would not pulling Ahral Rignals.
	voo, would entrain the tachycardia with PPI-TEL
	= Long, V-A-H-V Keepanke.
	
	Thus the Tachycardia defined as typical AVNRT.
	OCA William Ca william
	RFA Wing 30 thút:
	Uxing 30 naix enit, RA geometry was created
	2 Porteroxeptal region was mapped. Sit was tougetted.
	(50°, 60m, 60-120 seconds) energies were delinered kultid
-	En Slow guettonal chythm. Lew more concelidation
	was done at the lame adjoining region.

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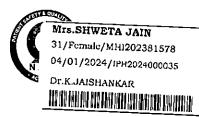


	DOCTOR'S PROGRESS NOTES
DATE	NOTES
	Port RFA:
	No Teichy coudia was Evoluted with or without Iro.
<u>-</u>	Part RFA baral Intervals au normal.
	Alleran Bragoninon: Port Cath Orda:
	· 2mobilize (R) Lower limb
	· natch hemaloma/Bluding.
	· monther Vitali.
	· To do! Eccy
	· TAB. DOLD bsomg TDS
	· TAB. PAN 40mg OD
	· Discharge tomorrow.
	· RIA I month & Ecq.,
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	Dr. Janes Typical - AVNRT Dr. Janes Succeeful ablation dans for slow pathway lignals.
	Slow pathway lignals.
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08/01/24	SB Dr. Ozi Lama (DHD).
	SB Dr. Szi Lanja (DHD). BD-0.
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<u> </u>	SIP- RPS F KFA
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Heart Institute

MHI/IP/2022/041

art beat counts

	DOCTOR'S PROGRESS NOTES				
DATE	DATE NOTES				
6/1/24	8/18. De. Sijith, B. (Dno).				
8:35 pm.					
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Every heart beat counts

Mis.SHWETA JAIN

31/Female/MHl202381578 04/01/2024/teH2024000035

Dr.K.JAISHANKAR

URINE ROUTINE ANALYSIS MICROBIOLOGY SHEET

-	 -		

DATE	4 1 24	
COLOUR	YELLOW	
REACTION		
SPECIFIC GRAVITY	1.015	
APPEARANCE	CLEAR	
ALBUMIN		
SUGAR	NIL	
ACETONE		
BILE SALT		
BILE PIGMENT		
UROBILINOGEN	NORMAL.	
PUS CELLS	2-3	
EPITHELIAL CELLS	1-2	
RBC	NIL	
CASTS .	NIL	
CRYSTALS	NIL	
OTHERS	NIL	

MICROBIOLOGY-CULTURE REPORTS

GROWTH- 24h, 48h, ORGANISM	SENSITIVITY
	•



ACTUAL WEIGHT 6.8:4 Kgs HbA,c HbA,c





Every heart beat counts

DIABETIC CHART

Mrs.SHWETA JAIN 31/Fernalc/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR	
DI. IC.O. Harman and the state of the state	Ш
Dr.K.JAISHANDIN	110
PAN ANI ANIA ANIA MANIA	

PREVIOUS I	DIABETIC I	<i>U</i> MEDICATIONS		•••••	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
Philas	17.00	12-8 mg/ell	(Bound	DR. ANISIYA
(((00				-	,
5/124	11.30	gg myldl	NIPO	Polly	DR-ANUSIYA
` 1		, , 0			

INSTRUCTIONS FOR INSULIN INFUSIONS

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







BLOOD GROUP

O'POSITIVE

INVESTIGATION SHEET

Mrs.SHWETA JAIN 31/Female/MHI202381578 04/01/2024/IPH2024000035

					<u> </u>		
Date	4/1/24						
HAEMATOLOGY							
Hb	12.2						
P.C.V	35.3						
Platelets	324000						
TLC	5140			,			
Polymorphs	62.0						
Lymphocytes	23.1				<u> </u>		
Eosinophils	9.5						
Mono / Basophils	47107						
E.S.R	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				1		
BIO-CHEMISTRY							
Urea	25						
Creatinine	0.46						
Sodium	139						
Potassium	4.75						
Bicarbonate	23						
Chloride	102.5						
Magnesium							
Calcium					-		
Phosphorus							
LFT							
T.Bilirubin	•						
D.Bilirubin							
I.Bilirubin			-				
S.G.O.T							
S.G.P.T							
ALP							
GGT		,	_				
Total Protien							
S.Albumin							
CARDIAC ENZYMES							
Troponin I							
CKNAC - CPK							
CK - M.B. MASS							
LDH							
Ntpro bnp							

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Date	4/1/24					, , ,
COAGULATION	,					
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D Dimer						
<u>LIPID PROFILE</u>				_		<u>.</u>
Total Cholesterol			İ			
Triglyceride				-		_
H.D.L						
L.D.L						,
VLDV					_	
THYROID FUNCTION				, ,		
T.S.H						
T.3						
T.4				·		
SEROLORY						
HIV 7						
HBsAg U	Negative				-	
V.D.R.L	0					
COVID 19		i				
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Mrs.SHWETA JAIN 31/Fcmulc/MHI202381578 04/01/2024/IPH2024000035 Dr.K.JAISHANKAR





118 AN 1811 DE FERREN BER 1811 BER 181 Every heart beat counts To: 6 From: 4/1/24 Bed No: 100 - A Date **INTAKE & OUTPUT** 24 Hrs: Started Time: / Ended Time: ゴルの CHART NPO Over at: NPO Started at: **Night** Restricted Fluid (RF) SHIFT Morning **Afternoon** 021 INTAKE bsom OUTPUT HOON 200 FOOM 1050M Difference: 350M **Total Output:** Total Intake: **INTAKE (ml) OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Oral Total Total Time R/N Sign Feeding Type of Fluid Time Urine Vomitus Others Aspirate Tube by **Additions Amount** 1230 100 100 Soom 18.00 50 600 800 100 dso 22:00 650 300 19:30 150 A50 1050 6230 20:40 150 \$00° 550 22:30 100 400 6:00 dso Total Intake- Foom! Total outbut losom 250W Baldne -Hoy





Mrs.SHWET IN 31/Female/M____2381578 04/01/2024/IPH2024000035





To: 6/1/24 Bed No: 105A From: 5/1/24 Date **INTAKE & OUTPUT** 24 Hrs: Started Time: 并:如 Ended Time: ₹ : 00 **CHART** NPO Started at: NPO Over at: **SHIFT** Morning Night Restricted Fluid (RF) Afternoon INTAKE 400 **OUTPUT** 800 **Total Output:** Difference: **Total Intake: INTAKE** (ml) OUTPUT (ml) Intravenous Infusion Tube N/G **Endorsed** Drain Time Oral Total Time Total R/N Sign Urine Vomitus **Others** Feeding Aspirate Tube Type of Fluid **Additions Amount** by 1130 400m 少久 D CATH LAR TOTAL han m 7/50 Bos OUBINT Portake 20% ध ८ 250 to<u>s 0</u> 220 22:00 300 1350 100 020 1:00 1600 250 150 2039 1100 100 200



MIS.SHWETA JAIN
31/Female/MH12023815
04/01/2024/1PH2024000035
Dr.K.JAISHANKAR





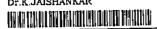


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Mrs.SHWETA JAIN 31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR







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NPO	Start	ed at :			NP	O Over	at :						CHA	KKI	į
SHIF	T	N	Morning		Aftern	oon			Nigh	t		Rest	ricted F	luid (R	F)
INTAI	KE		300												
OUTF	TUS		780							·					
Total I	ntake	:			otal Outpu	ıt:	_			Differen	ce:				
			INTAKE	(ml)						OUT	TPUT	(ml)			
Time	Oral	Tube		nous Infusio			Time	Urine	Vomitus	N/G	Drain	Othoro	Techi V	D/M Class	Endorsed
	O.G.	Feeding	Type of Fluid	Additions	Amount	िल्हा	Tille	Offine	Vomitus	Aspirate	Tube	Others	ILOUGIL 7	KON SIGII	by
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'MHI/IP/2022/074

Every heart beat counts

Medway Hospitals
The way to better health

(A Mrs.SHWETA JAIN

31/Female/Augusta

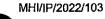
31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR

VITAL INFORMATION SHEET

BLOOD GROUP ON ADMISSION Height in CM Weight in Kg.

Diagnosis:	ps	. ัน	†	-? AT ? AUDRT Procedure:																				1	5	6	(מנ	חר				6	2	, t	<u>f</u>																						
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Medway Hospital:

The every to better health
(A unit of United Alliance Healthcare Pyr Ltd)

Mrs. SHWETA JAIN

Mrs. SHWETA JAIN

31/Fcmulu/MHI20238

04/01/2024/IPH20240 31/Female/MHI202381578 04/01/2024/IPH2024000035 Dr.K.JAISHANKAR



Every heart beat counts

EARLY W. KE MONITORING CHART

Name: _				•	·	Age	/Ṣex:		<u> </u>	P	atient	Id No	:		_
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Po2 Scale 1	94-95					 _	<u> </u>	1				\bot			94-95
xygen Saturation (%)	92-93		į			بلا		2				<u> </u>	<u> </u>		92-93
po2 scale 2 oxygen aturation (%) use scale 2 target range is 88-92 % o: In hypercaphic	<91														>96 on oxygen
ratory failure only cale 2 under the	95-96 on a2					d		2					\top		95-96 on o2
irection of qualified	93-94 on O2	1						1							93-94 on O2
linician	>93 on air	1.	I	9	-0			-				T	1	\vdash	>93 on air
1	88-92													1	88-92
!	86-87					0		1				<u> </u>			86-87
ì	84-85							2							84-85
	<83%														<83%
ir or Oxygen ?	A= Air														A= Air
	O2litre/ mln	\top		$\overline{}$				2		\Box			1	1	O2 tre/min
	Device	\top		\Box										1	Device
<u></u>						દ									
ood Pressure	>220														>220
	201-219	↓		 	$ldsymbol{\sqcup}$					 	<u> </u>	└	↓		201-219
	181-200		ļ	<u></u>		~	_	2							181-200
	161-180	╄—	igsquare	 _	igsquare					<u> </u>	└	↓		↓	161-180
	141-160	 		<u> </u>	igsquare	þ				 -	<u> </u>	↓	↓		141-160
	121-140	<u> </u>		<u> </u>	oxdot					<u> </u>		└		ļ	121-140
	111-120									 _			<u> </u>	L	111-120
	91-100		igsquare			10		1				<u> </u>			91-100
	81-90		<u> </u>			-53		2			<u> </u>				81-90
	71-80					7.0					4 3.m				71-80
	61-70	_										بسبتي	_		61-70
	51-60										4-4				51-60
	<50						<u> </u>			73 3					<50
tolic BP	mmHg	164	70	_ % o	া বুফ			80	70	86					mmHg
	>131							. <u>.</u>			_		and the same		>131
Tse .	121-130		<u> </u>			4.		2							121-130
ats / min	111-120		[]			\angle		2							111-120
	101-110							1							101-110
4	91-100	T			\Box	$\neg \neg$		1							91-100
	81-90				\Box										81-90
	71-80				- 2		Ę								71-80
	61-70	1													61-70
	51-60														51-60
	41-50						l	1			i		T		41-50
	31-40		السي		نجير										31-40
	<30					نجي				تتابع					<30
	Alert	-													Alert
nsclousness	Confusion		أويهم		نهيري							المراية	الكسب		Confusion
ore for New onset of	· -									نسيا	لجنس	السناعا			V
nfusion	Р					لوي				أحجاته					P
o score if chronic)	Ŋ			أكري						السري					_U_
	>39.1 degree					$\neg \neg$		2		7					>39.1 degree Celsius
	Celsius	ļ			i							<u></u>		Ll	
mperature	38.1-39.0	\bot						1							_38.1-39.0
gree Celsius	37.1-38.0				\Box										37.1-38.0
:	36.1-37.0		oxdot				7	0		_					36.1-37.0
	35.1-36.0							1							35.1-36.0
	< 35.0												الكي	<i>;</i>	< 35.0
WS Total			0	Q,	0.		0	0	0	0					
onltoring Frequency		UM	A^{μ}	46	1 00		M	44	414	\ ১১৭	/				
calation of Care Y/N		1 820	שנא	_47.7	7		S	NO	20						
Itlals by RN		1	HPY	_XXX	MY		Ø.	they	Hay	201					
			- 1.37	No	2010		te	1	. 00			1			
Initials by Sr. RN		1 5 -	100	100			700	1		نفو) ـ	- 1	1	1		

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







Every heart beat counts

Mrs.SHWETA JAIN
31/Female/MHi202381578

04/01/2024/IPH2024000035

Dr.K.JAISHANKAR



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

ignosis: PS	υτ- ?	PAT 1 ? AUN	nor FDs + (LEA.	£-00.	1.		•	ľ
ight:K	cms	Weight: Kgs Vegetarian	Food allergies:	Yes/No; if y	es, specify		*********		
ligious Beliefs:		Vegetarian	☐ Non Veget	arian		To	Eggetarian	☐ Jaii	n
et Prescription:.	- 1500	caloui, l	es lat, es	Kalt	الله الله	- 			
BJECTIVE	GLOB	AL ASSESSMENT	(ADVLTS)						
	(A) -	Patient's related Medical Hist	tory	- Fu.		.	+ 100		
1	1)	Weight Change (overall chang	ge In past 6 months)	;					
	<u> </u>		D2		_		□4		
(4.1)	,	No weight change/	<5%	5 - 10%		10)- 15%		>15%
2)	Dietary Intake	Duration:		<u> </u>					
1 "			□ 2 - 1,5 A	3 '		·- , T	14 1		
	Oral .	No change	Sub - optimal	Full liquid die	,	1	typo'- caloric		Starvation
			solid diet	moderate overall decre			quid diet		
	Enteral / Parenteral	Adequate / Excessive	Sub-optimal	Inadequate			ypo - caloric eeds		Staryation
1	Nutrition	'/· _ ' .	to the co	· { :	S 2 10	· - - - - - - - -		Į.	•
3)	Gastvalatasii	nal Symptopys Duration:	1		_ .			 	
	000.021.02	121	D2 .	3		TE	34 , .		
1	/	 	Nausea	Vomiting/	,u		larrhoea .		severe anorexia
		No symptoms	rausea	moderate GI symptoms	·		ea (rajea		PEASIG WINNESS
4)	Functional C	apacity (Nutrition related functional im	pairment) Duration:		1.4.	. 1	,,		
17 1		121	9,	□ 3		1	O 4		□ 5
		Nane /Improved	Difficulty with ambulation	Difficulty normal a		ı	Light activity		Bed / chair - ridden with no or little activity
5)	Co - morbidity	(Disease and its relationship to nutrition	on requirements)						
	1 44 - 1144 544		2	الما		γ			5
		Healthy	Mild co -	Mod	rate co -		severe co -		Very severe
	_	,	morbidity	mor	oldity/age years		morbidity		multiple co - morbidity
B)	Physical exa	mination							
1)	Decreased fa	t stores or loss of subcutaneous fat							
	1 -	P 1	D 2	□ 3			G 4		□.5
	 	Normal -	Mild	Moderate		_			Severe
	Sign of muscle			1.			·		
ļ— <u>-</u> -,	aign of muscle		103				D4.		To,
	╅	Normal	Med	Moderate			 -		Severa
 	ــــــــــــــــــــــــــــــــــــــ	1					L		
Total Score = 5	um fabove 7 com	ponents					-		
							-		
Nutritional Sta	tus : Based on this				_				
	Well Nourished			7 (7 to 14)		?			
	Moderately Ma] (15 to 18)			'		
	Severely Mains	purished] [19 to 35]			<u>-</u>		
Nutrition Inter	vention:								
	9-01-1			Enteral		☐ Parente	ral		
Diet counseliln	g provided:	ZV6		□ No		<u> </u>			
Frequency of r	e-assessment:	Weekly			Fort - night		☐ Monthly		
Enteral / Paren	iteral	□ Dally			Calorie count:	☐ Yes	ET NO		
į		ļ				1			

Dietitian Signature / Name / Date / Time: April Cathering Cathering Company (1975)

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
4/1/24,	A 21 years ded feman came à do parpitation (on 10 of) since (morte) was assured to be used nounded as eviden by 54A. No consoloidate	- A
	Reducated the patriot and family on these calories, too fat, to not dut. Empfid on more font mad.	Maria Catherine John Senior Dietitian
6/12e1,	Patriit skiped to Cathlan for procedure ETS + RPA) and legge or HOM. Patriot mind to coord. Hom over. Patriot brusted light diet. Com initialit on soft wind duit.	Maria Sterine Senior Dietitian
6/1/2m, ca:01	Deal intern à good. Educated les pateint and family on 1600 calonis, books, to some dist en discharge. Empfor en small fact meals. Bit modificates and claif cation deus. Di chart gien en discharge.	Maria Catherine John Senior Dietitian

The control of the second second

e)



Mis.SHWETA JAIN

31/Female/MH1202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR

PSYCHOLOGICAL WELLBEING REPORT

Date: 06/01/24

Time: 1,00 pm.

Unit: 105 A

Clinical diagnosis:

EPS+ RFA

Surgery/ Procedure:

Impression:

Junctioning well

- calm affect, oriented. Verprovive.

- vleep ? appelite (b), called self ex "deposite"!

- nimulaistanding ? conflicts in givin

i gradue ? extended family regardly

parriar Ceaseer.

- suppositive enumeling provided &

propero education on depersion.

Employee ID: MH10275954

Signature of the Psychologist:



Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis:	Psv	<u> </u>		A	llergies	if any:	NKDA							
From (Area)	To (Area))	Date	Time	Reaso	n for Transfer / Na	ame of Pro	cedure					
ISEFLOOR	IDAB)	CATHI	AB	5/1/24	11.30	E	254RFA							
Method of Trai	nsfer: [☐ On Bed ☐ On	Wheelc	hair 🗌 On :	Stretche	er								
ASSESSMENT General condi		TIENT: Patient: Cons	cious 🗆	☐ Semi-cons	scious [☐ Un-consc	zious							
Language Bar	rier: 🗌	Yes 🗷 No 🗆 If Y	'es, spe	cify:										
Fall Risk Cate	gory; 🗹	Low Risk Med	lium Ris	k 🗌 High F	Risk	<u></u> _								
Vital Signs (to b	e docun	nented at the time	of shift	ing):										
Temp (°F)	RR (t	oreaths/min)	Puls	e (beats/mi	n)	SpO ₂ (%)	BP (mmHg)	Pain	Score					
96.4		کے	ı	88		98	110/80	0/10						
Any pre-medic	ation giv	ale (>12 years) ☐ ven: n: ndation:		(ventilator /	comato	se) 								
	Signa	ature	Nan	ne			Emp. No.	Date	Time					
Handover by		Polla		Paulle	Y~~			Sliber	1					
Handed over to				VO	bProu	ya 📗	0202	5/164	11.20					
	oleted: [Yes Xes			(ion:	<i>)</i> 	Ni/							
Temp (°F)		reaths/min)		::::9). e (beats/mir	n)	SpO₂ (%)	BP (mmHg)	Pain	Score					
C186'	<u>.</u> دو	holmin		`	h	100%	115/86/9	5/ 1/	10					
☐ FLACC Scale	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)													
	Signa	ature	Nan	ne	17.		Emp. No.	Date	Time					
Handover by Handed over to			- /			rys	0202	5/1/24	150					
Tallueu over to	1	<u> </u>	<u> </u>	X. MET	ren	1/4	235	25/1/24	17.00V					





CONSENT FOR ELECTROPHYSIOLOGY & ABLATION PROCEDURE

Mrs.SHWETA JAIN 31/Female/MH1202381578

04/01/2024/iPH2024000035

Consultan

Patient Na

Dr.K.JAISHANKAR

No:

UHID

Sex: M/F

CONDITION AND PROCEDURE

Dr JAISHANKan has explained that I have the following condition:

Each and every heartbeat is preceded by an electrical wave that travels from the right-upper corner of the heart called the sinus node (the natural pacemaker in the heart) to spread to the upper chambers (atria) and then through the junction of the top and bottom portions of the heart, called the AV Node and Bundle of HIS to the lower chambers (ventricle). This electrical wave then dies out and a fresh wave starts again from the sinus node for the next beat.

Diseases of the Sinus node can seriously delay the origin of heart beats resulting in a slow heart rate (Bradycardia) that can cause giddiness or loss of consciousness. In some disorders the rate of the heart is higher (Tachycardia) than the normal. This may be because an abnormal area in the heart either the atria (Supraventricular - SVT) or the ventricles (Ventricular - VT) starts behaving like the sinus node, but at a very fast rate. This can pause palpitations, chest discomfort, giddiness or breeathlessness. In some other conditions an abnormal link of connection between the atria and the ventricle (Accessory Pathway) can cause the electrical wave to return back to the atria from the ventricle and then again back to the ventricle to cause a circus like movement of the electrical wave that causes the heart to gallop at rates over 200 per minute.

The abnormal sites of impulse creation or the abnormal links of communication can be accurately pin pointed by mapping with electrical wires that are kept in various key locations of the heart and mapping the progress of the electrical wave as it excites the heart.

After an injection of local anesthetic, a fine wire about 2mm in thickness (Catheter) is put into the vein in the groin / neck through a sheath that has a bleeding, preventing valve. The catheter is carefully passed into and maneuvered in to a particular region in the heart. In this fashion three to five catheters are inserted into various region of the heart and the other end of the catheter is connected by a junction box to a sophisticated computer called an Electrophysiology Laboratory.

The study of the electrical wave from the different regions of the heart that are displayed simultaneously on a multichannel monitor with electronic cursors help in accurately identifying the location of any abnormal focus that is discharging or abnormal connections that are conducting electrical waves and to diagnose the illness (Electrophysiology Study) and further on treat it by Radiofrequency Ablation.

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
	(I) Perforation of the heart and blood vessels by the catheter that may require a surgery or reparative procedure
1 in 100 people (0.01%)	(j)the heart may not beat in a proper rhythm which will need urgent treatment.(k) Surgical repair of the groin puncture site. This may need a longer stay in hospital.(l) Minor reaction to contrast medium such as hives.
	(m) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(n) Major bruising or swelling at the groin punture site
Most People	(o) Minor bruising

PATIENT CONSENT:

On the basis of the above statements,

I AGREE TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	tais	Shweter Join	04-01-2024	17230
witness	Janoy Pething	Sanger Sething	04.01.2024	(7130
Doctor	(fromk)	Or siva	·	
Interpreter				





மின்உடலியங்கியல் & உறுப்புநீக்கல் மருத்துவ செயல்முறைக்கான ஒப்புதல்

நோயாளியின் டெயர்	வயது:	பாலினம்: ஆண்/பெண்
மருத்துவர்: [வார்டு & படுக்கை எண்:	UHID

நோய் நிலைமை மற்றும் மருத்துவ செயல்முறை எனக்கு கீழ்க்கண்ட நோய் / பாதிப்பு நிலைகள் இருப்பதாக மருத்துவர்....... விளக்கியிருக்கிறார்:

ஒவ்வொரு இதயத்துடிப்பிற்கும் முன்னதாக ஒரு மின்சார அலை, சைனஸ் முனை (இதயத்தின் இயற்கையான பேஸ்மேக்கர்) என அழைக்கப்படும் இதயத்தின் வலது மேற்புற மூலையிலிருந்து பயணித்து இதயத்தின் மேற்புற அறைகளுக்கு (அட்ரியா) பரவுகிறது; அதன்பிறகு AV முனை மற்றும் HIS -ன் தொகுப்பு என அழைக்கப்படும் இதயத்தின் மேல் மற்றும் கீழ்ப்பகுதிகளில் உள்ள சந்திப்புகள் வழியாக இதய கீழறைகளுக்கு (வெண்ட்ரிக்கிள்) அந்த மின்சார அலை பயணிக்கிறது. இந்த மின்சார அலை அதன்பிறகு முடிவுக்கு வருகிறது மற்றும் அடுத்த இதயத்துடிப்பிற்காக சைனஸ் முனையிலிருந்து ஒரு புதிய அலை மீண்டும் பயணிக்கத் தொடங்குகிறது.

சைனஸ் முனையில் ஏற்படும் நோய்கள், இதயத்துடிப்புகளின் தோற்றத்தை கடுமையாக தாமதிக்கச் செய்யும்; இதனால், உணர்விழப்பு நிலை அல்லது மயக்கத்தை விளைவிக்கின்ற மெதுவான இதயத்துடிப்பு (குறை இதயத்துடிப்பு) ஏற்படுகிறது. சில சீர்கேடுகளில் இதயத்துடிப்பு வேகம் இயல்பானதை விட அதிகமாக (மிகை இதயத்துடிப்பு) இருக்கும். இதய மேலறை (சுப்ராவெண்ட்ரிக்குலர் - SVT) அல்லது இதய கீழறையில் (வெண்ட்ரிகுலர்-VT) ஒரு இயல்புக்கு மாறான பகுதி, சைனஸ் முனையைப்போல, ஆனால் மிக வேகமான விகிதத்தில் செயல்படுவதால் இது நிகழக்கூடும். இது, படபடப்புகளையும், மார்பு அசௌகரியத்தையும் மயக்கம் அல்லது கவாசசிரமத்தையும் விளைவிக்கக்கூடும். வேறுசில பாதிப்பு நிலைகளில் இதய மேலறைக்கும், இதய கீழறைக்கும் இடையிலான ஒரு இயல்புக்கு மாறான இணைப்பு, இதய கீழறையிலிருந்து, மேலறைக்கு மின்சார அலையை திரும்பப்போகுமாறு விளைவிக்கும் மற்றும் அதன்பிறகு, கீழறைக்குத் திரும்ப வருமாறு செய்வதால், மின்சார அலை சுழற்சி போன்ற இயக்கத்தை அது உருவாக்கும். இதனால் ஒரு நிமிடத்திற்கு 200-க்கும் அதிகமான இதயத்துடிப்புகளோடு இதயம் வேகமாக விரைவதை இது விளைவிக்கும்.

இந்த உந்துவிசை உருவாக்கத்தின் இயல்புக்கு மாறான அமைவிடங்கள் அல்லது தகவல் பரிமாற்றத்தின் இயல்புக்கு மாறான இணைப்புகளை இதயத்தின் பல்வேறு முக்கிய அமைவிடங்களில் வைக்கப்படும் மின்சார வயர்களின் மூலம் வரைபடமாக்குவதன் வழியாக துல்லியமாக கண்டறிய முடியும். இதயத்தை மின்சார அலை கிளர்ச்சியூட்டுகிறபோது அதன் முன்னேற்றத்தை இதன்மூலம் மேப்பிங் செய்ய முடியும்.

குறிப்பிட்ட அமைவிடத்தில் தரப்படும் மயக்க மருந்து உட்செலுத்திய பிறகு சுமார் 2 மி.மீ. அடர்த்தி கொண்ட ஒரு மெல்லிய கம்பி (கதீட்டர்), இரத்தக்கசிவை தடுக்கின்ற ஒரு வால்வைக் கொண்டிருக்கும் ஒரு உறை வழியாக, இடுப்புக்கவட்டை / கழுத்திலுள்ள சிரை நரம்பு வழியாக உட்செலுத்தப்படுகிறது. இதயத்தில் ஒரு குறிப்பிட்ட பகுதிக்குள் செல்லுமாறு இந்த கதீட்டர் மிக கவனத்தோடு அனுப்பப்படுகிறது. இந்த வழிமுறையின் மூலம் இதயத்தின் பல்வேறு பகுதிகளுக்குள் 3 முதல் ஐந்து கதீட்ரல்கள் வரை உட்செலுத்தப்படுகின்றன. கதீட்டரின் மற்றொரு முனையானது, ஒரு மின்உடலியங்கியல் பரிசோதனையகம் என அழைக்கப்படும் ஒரு நவீன கணினியுடன் ஒரு ஐங்ஷன் பாக்ஸ் முலம் இணைக்கப்பட்டிருக்கும்.

இதயத்தின் பல்வேறு பகுதிகளிலிருந்து, மின்சார அலையின் மீது செய்யப்படும் ஆய்வு எலக்ட்ரானிக் கர்சர்கள் உடன் கூடிய ஒரு மல்ட்டிசேனல் மானிட்டரில் அதேநேரத்தில் காட்சிப்படுத்தப்படுகின்றன. மின்சார அலைகளை வெளியேற்றுகின்ற அல்லது இயல்புக்கு மாநான கர்நோக்க அமைவிடத்தை அல்லது இவைகளை கடத்துகின்ற இயல்புக்கு மாநான பிணைப்புகளை துல்லியமாக அடையாளம் காண இது உதவுகிறது. அத்துடன் நோயை துல்லியமாக அடையாளம் கண்டு உறுதிசெய்யவும் மற்றும் (மின்உடலியங்கியல் ஆய்வு) அதன்பிறகு கதிரியக்க அதிர்வெண் நீக்கத்தின் வழியாக அதற்கு சிகிச்சையளிக்கவும் இது உதவுகிறது.

இம்மருத்துவ செயல்முறையின் இடர்கள்

கரோனரி ஆஞ்சியோகிரா. பியில் ஏற்படும் இடர்கள் கீழ்க்கண்டவற்றை சார்ந்திருக்கிறது:

- (i) கரோனரி தமனி நோயின் தன்மை
- (ii) இதயத்தின் இரத்தத்தை உடலின் பிற உறுப்புகளுக்கு பம்ப் செய்யும் திறன்நிலை.
- (iii) உங்களது வயது மற்றும் பொதுவான உடல்நலம்

நிகழக்கூடிய மிகத் தீவிரமான இடர்களுள் இவைகள் சில; ஆனால், இவைகள் மட்டும் முழுமையான பட்டியல் அல்ல:

10,000 நபர்களில் 1 நபருக்கும்	(a) கதிர்வீச்சு சிகிச்சையினால் ஏற்படக்கூடிய சரும காயம்; இதன் விளைவாக சருமத்தின்
குறைவாக (0.0001%)	மேற்பரப்பு சிவந்துவிடும்
1000 நபர்களில் 1 நபருக்கும்	(b) பக்கவாதத்தையும் மற்றும் நீண்டகால திறனிழப்பையும் (c) மாரடைப்பையும்
குறைவாக (0.001%)	விளைவிக்கக்கூடும்.

1 in 100 people (0.01%)	(d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டை / சாயம்) ஒரு ஆபத்தான எதிர்வினை. இது நிகழுமானால், ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்புத்தாக்கங்கள் போன்ற கடுமையான எதிர்வினைகள் உங்களுக்கு வரக்கூடும். 2,50,000 முதல் 4,00,000 வரையிலான ஊசி மருந்து செலுத்தலில் ஒரு நபருக்கு உயிரிழப்பு — மிக மிக அரிதான நேர்வுகளில். (e) காலில் துளையிட்ட இடத்தில் பெரிய அறுவைசிகிச்சைக்கான அவசியம். (f) அவசர நிலை நிகழ்வாக இதய அறுவைசிகிச்சை அல்லது ஆஞ்சியோபினாஸ்டிக்கான அவசியம். (g) எக்ஸ்-ரே / ஊடுகதிருக்கு வெளிப்படுவதால் உயர்ந்திருக்கும் ஆயுட்கால இடர்வாய்ப்பு (h) உயிரிழப்பு (l) அறுவைசிகிச்சை அல்லது பழுதுநீக்கும் மருத்துவ செயல்முறை அவசியப்படுகிறவாறு கதீட்டரால் இதயம் மற்றும் இரத்தநாளங்களில் துளை விழுதல்.
1 in 100 people (0.01%)	 (j) முறையான லயத்துடன் இதயத்துடிப்பு இருக்காது; இதற்கு அவசரசிகிச்சை தேவைப்படும். (k) இடுப்பு கவட்டையில் துளையிட்ட அமைவிடத்தில் அறுவைசிகிச்சை சார்ந்த பழுதுநீக்கல; மருத்துவமனையில் நீண்டகாலம் தங்கி சிகிச்சைப்பெறுவது இதற்கு அவசியமாக இருக்கலாம். (l) கான்ட்ராஸ்ட் மீடியத்திற்கு தோலரிப்பு போன்ற சிறிய எதிர்வினை. (m) கான்ட்ராஸ்ட் மீடியத்தின் காரணமாக சிறுநீரக செயல்திறன் இழப்பு / பாதிப்பு
1 in 20 people (0.05%)	(n) இடுப்புக் கவட்டையில் துளையிட்ட அமைவிடத்தில் பெரிய அளவிலான சிராய்ப்பு காயம் அல்லது வீக்கம்
Most People	(o) சிறிய அளவிலான சிராய்ப்பு காயம்

நோயாளியின்	வப்ப	கல்
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சிகிச்சையளிக்கும் மருத்துவர் எனது மருத்துவ நிலை குறித்தும் மற்றும் செய்ய திட்டமிடப்பட்டிருக்கும் மருத்துவ செயல்முறை குறித்தும் டாக்டர்

_______ விளக்கியிருக்கிறார் என நான் உறுதி செய்கிறேன். எனக்கு குறிப்பாக பொருந்துகின்ற இடர்கள் உட்பட, இந்த மருத்துவ செயல்முறை, உணர்விழப்பிற்கான மருந்து ஆகியவற்றில் உள்ள இடர்கள் / சிக்கல்கள் எழுமானால், அதனால் நிகழ சாத்தியமுள்ள விளைவுகள் உட்பட இச்செயல்முறையின் இடர்களை நான் புரிந்து கொண்டுள்ளேன். தொடர்புடைய பிற சிகிச்சை விருப்பத்தேர்வுகள், அவைகளின் இடர்கள் மற்றும் இச்சிகிச்சையை ஏற்க மறுப்பதற்கு எனக்கு இருக்கும் உரிமை ஆகியவை பற்றியும் மருத்துவர் விளக்கிக் கூறியிருக்கிறார். எனது மருத்துவ / நோய் நிலை குறித்தும் மற்றும் இச்சிகிச்சை செயல்முறையை மேற்கொள்ளாததால் ஏற்பட வாய்ப்புள்ள இடர்கள் பற்றியும் அவர் விளக்கியிருக்கிறார். எனது தற்போதைய உடல்நிலை பாதிப்பு, செய்யப்படவுள்ள மருத்துவ செயல்முறை, அதன் இடர்வாய்ப்புகள் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் பற்றி கேள்விகள் கேட்கவும், கவலைகளை வெளிப்பகுத்தவும் எனக்கு வாய்ப்பளிக்கப்பட்டது என்றும் மற்றும் நான் முழு திருதியடையும் வன்னவடில் என்னுடைய அனைத்து கேள்விகளும், கவலைகளை வெளிப்பகுத்தவும் எனக்கு வாய்ப்பளிக்கப்பட்டன நிகழ்வுகற்கு கூறிறும் நேர்வில் இரத்தமேற்றல், ஒரு சுடுதல் மருத்துவ செயல்முறை அல்லது அறுவைசிகிச்சை எனக்குத் தேவைப்படலாம் என்று நான் புரிந்து கொள்கிறேன். சிகிச்சை செயல்முறையின்போது உயியுருக்கிறார். இந்த சிகிச்சை செயல்முறையானது எனது நேரிய நிலையை குணமாக்கி மேம்படுத்தும் என்றும் மருத்துவர் என்னிடம் விளங்கிக் கூறியிருக்கிறார். இந்த சிகிச்சை செயல்முறையானது எனது நோய் நிலையை குணமாக்கி மேம்படுத்தும் என்று மருத்துவர் என்கிடும் விளங்கிக் கூறியிருக்கிறார். இந்த சிகிச்சை செயல்முறையானது எனது நோய் நிலையை குணமாக்கி மேம்படுத்துன் என்பதுற்கு உத்தரவாதம் செயல்ப்பட்டனிறேன்.

மேற்கூறப்பட்ட அறிக்கைகளின் அடிப்படையில்,

இந்த மருத்துவ செயல்முறை எனக்கு செய்யப்படுவதற்கு நூன் சம்மதிக்கிறேன்.

	கையெரப்பம்	பெயர்	தேதி	நேரம்
நோயாளி/பாதுகாவலருடனான]	
உறவுமுறை				
சாட்சி	_			
மருத்துவர்				
மொழிபெயர்ப்பாளர்				







ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABEA FIGNILISM PAR PVt Ltd)

ENSITE REPORT

PATIENT NAME: Mrs.SHWETA JAIN

UHID IP NO : MHI202381578

AGE/GENDER

:31 YEARS / FEMALE

: IPH2024000035

CONSULTANT

: Dr. Jaishankar. K MD., DM., FIAMS

D.O.A

: 04.01.2024

Director and Clinical Lead

D.O.P

: 05.01.2024

Cardiology and Electrophysiology

CATH DATE	05.01.2024	DONE BY	DR. K. JAISHANKAR
CATH NO	3538/3539	ASSISTED BY	MS. PUNCHAVARANAM
CATH DURATION	1.5 HOURS	TECHNICIAN	MR. RAM
FLUORO TIME	1282 SECONDS	PHYSICIAN ASSISTANT	MS. SHALINI
HEIGHT	156CMS	. WEIGHT	62.4 KGS

ACCESS : RIGHT FEMORAL VEIN (2 X 6 FR SHEATH) (1 X 8 FR)

SITE	CATHETERS
HIS	6F QUADRIPOLAR
RV	6F QUADRIPOLAR
CS	6F DECAPOLAR
MAPPING & ABLATION	7F THERAPY CURVE

INDICATION: PSVT – AVNRT

TACHYCARDIA ECG: SVT @ 158BPM, NARROW QRS COMPLEX. SHORT RP TACHYCARDIA

, S/O AVNRT.

BASAL ECG

: NSR, HR - 78BPM.

ECHO

: GOOD BIVENTRICULAR FUNCTION

ELECTROPHYSIOLOGY STUDY:

BASELINE INTERVALS ARE NORMAL.

AH	70 ms
HV	40 ms
P-P	680 ms
R-R	770 ms
P-R	152 ms
QRS	78 ms
QT	382 ms
QTc	439 ms

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

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Medway Centre of Excellence (Chennai)

Kodambakkam Mogappair 044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367

Chengalpattu

Villupuram

Kumbakonam

Kakinada

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

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





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VAWB 320 ms

NO ANTEGRADE PRE-EXCITATION PATTERN NOTED

VA CONDUCTION WAS CONCENTRIC AND DECRMENTAL

A REGULAR NARROW QRS TACHYCARDIA WAS INDUCED WITH PROGRAMMED ATRIAL STIMULATION PROTOCOLS.

AH JUMP AND ECHO WAS NOTED BEFORE INITIATION OF TACHYCARDIA

TACHYCARDIA CYCLE LENGTH - 380MSEC.

HIS SYNCHRONOUS PVC COULD NOT PULL SUBSEQUENT 'ATRIAL' SIGNAL.

VOD PACING COULD ENTRAIN THE TACHYCARDIA WITH POST PACING INTERVAL PPI – TCL (540 – 380) = >115MS AND V-A-H-V RESPONSE.

THUS, TACHYCARDIA DEFINED AS TYPICAL AVNRT.

RADIO FREQUENCY ABLATION:

USING "NAVX" ENSITE 3D MAPPING - ACTIVATION, RA GEOMETRY WAS CREATED AND HIS CLOUDING DONE, POSTEROSEPTAL REGION WAS TAGGED FOR SLOW PATHWAY SIGNALS.

THE POSTEROSEPTAL REGION OF RA AND CORONARY SINUS OS WAS MAPPED FOR SLOW PATHWAY SIGNALS. GOOD SLOW PATHWAY SIGNALS NOTED

RF ENERGY DELIVERED USING 7FR ST JUDE THERAPY ABLATION CATHETER IN THE REGION OF SLOW PATHWAY IN KOCH'S TRIANGLE (TEMPERATURE 50°, 60 W, 60-120 SECONDS), RESULTED IN SLOW JUNCTIONAL RHYTHM.

FEW MORE CONSOLIDATION ENERGIES WERE DELIVERED IN THE SAME AND ADJOINING REGION.

POST RADIO FREQUENCY ABLATION:

	 _
A 3 733 7	l ago
AVW	38UMS
227 77	

ON ISOPRENALINE:

AVNERP	S1 400/S2 300/S3 180ms	

NO TACHYCARDIA COULD BE INDUCED DESPITE VIGOROUS STIMULATION PROTOCOLS WITH AND WITHOUT ISOPRENALINE.

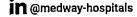
POST RFA INTERVALS ARE NORMAL.

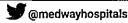
PROCEDURE WAS UNEVENTFUL.

·			
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Medway Centre of Excellence (Chennai)





IMPRESSION:

TYPICAL AVNRT SUCCESSFUL RFA - SLOW PATHWAY ABLATION DONE

ADVICE:

REVIEW AFTER 1 MONTH WITH ECG.

CONSULTANT SIGNATURE

pai shaw

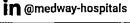
Dr. Jaishankar. K MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology

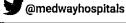
Dr. K. JAISHANKAR Reg. No: 49448

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

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

MHI/HOSP/2022/118

Mrs.SHWETA JAIN 31/Female/MHl202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR

٠, ه	NURSES PROGRESS NOTES		
Date & Time	Observations / Action		Signature with Emp. No.
12:40	=> patient revised 1st floor to Couth lab pt consions 9 oncented	<i>k</i> : /	
12:50	pt vital stable pt Iv line pa =7 sterile drapping done under		030
12.58	Jeal aheashess	ted	1
3.5	Pt formoral artery and vonous ay	proech _	1)
13.2		m/tg	000
1320	Spor: 100%, vital stable.	Heres	Og .
13.50	DESSISITION EMESEI HMJ DU JUNOS	O/B	
13.20	Et Or & letters connectado	. 110	620
12 10	=> HR: 85 SHM10 Bp: 107/72(85) n Sport00/ Vifal Stable.	0m/77 — L	
13.40	DR. JS)(S) Y)		000
L4:00	RI- femoral arteer and renows		2
	sheath removed light pressure.	lo	0000 An
15.00.	speamlome - =7 pt shifted cath lost its co	<u></u>	
			0200
	Signature Name	Emp. No	Date Time
Document endorsed by	Sarting	001	6 5/1/24 1600

	N	URSES PROGRESS NOT	ES	•	
Date & Time		Observations / Action		Signature with En	np. No.
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<u> </u>	'Signature	Name	Emp. No.	Date	Time
Document endorsed by					





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086 Medway Heart Institute

Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Name of the Procedure:	EDS+RFA+31	Location: Cath Lab	Date & Time :	04/01/2024/IPH2024000035 Dr.K.JAISHANKAR
Does the Procedure involve	1	4		Dr.K.JASHANAAR
SIGN IN 13 2 50 Before Induction of Procedural Sc	edation	TIME OUT 12:55 After procedural Sedation and before procedure		SIGN OUT LICENSON When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural ctor performing the procedure)	(Anaesthetist or Qualified Physician	administering Procedura performing the Proced	al Sedation + Nurse + Technician + Doctor lure
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	☐Yes ☐	Identity by two identifiers	☑Yes	Name of the Procedure done written down FOSHPER +30
Procedure	□Xes	Procedures PDS + RFA +>1)	₽ Yes _	Name and site of all specimens / investigations ☐ Yes ☐ NA
Side	GRY OLI ONA	Side R. Johnsval whey would expected Blood loss MA approa	ØRI □LI □NA U,	confirms labeling and sent to lab
Consent	☑Yes	Position SUDING	□ Yes	Any recovery concerns:
Known Allergy	☐ Yes ☐ No	Consent	☐Yes	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants available	□Yes □NA	If Yes, Pls. specify:
Difficult airway / aspiration risk	☐ Yes, equipment		Yes NA	Up.
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	│	
Possibility of hypothermia	☑No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☐ None
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☑ NA	If Yes, Pls. specify:
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	☐ Yes,	,
Spo2 - NIBP - Other		Anticipated blood loss briefed	É Yes □NA	
Pre OP medication taken	□Yes □Ne	Adequate fluids and blood available	☐Yes ☐NA	
Danied and and a		Team briefed on any critical or unexpected steps For procedural sedation cases	☑ X es	Corrective action :
Required equipment for procedure available	□Yes □WA	Any patient specific concerns :	☐Yes ☐None	
procedure available		Intra procedure glycernic control	TYes TINK	
		Any concerns about sterility	☐ Yes ☐ Kone	
Anaesthetiet / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse: Sh parchavan Te	echnician: Ramo	Others Please Specify:
Troopardia occasion	1.100000010.	(h) 30020	, , &	
Date :	Date: 5 124	Date: n 1/24 Da	ate: 5 124	Date: \
Time:	Time:		me:	Time :

NΑ



Heart Institute

Every heart beat counts

NO

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

Procedure Monitoring Sheet (Cath Lab)

Patient	Nama	•
	LACILIES.	-

MIS.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

UHID / IP:

Consultant:

Dr.K.JAISHANKAR

PARAMETERS

al signs : BP: lou to temp: Att-6. Pulse: .. to RR: . d. O. SPO2: 98-

Age / Sex : 314/F

Ward Unit: 13+ floor.

Diagnosis: \$SVT.

YES

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

							 	
Urine v	Urine voided							
Bowel	preparation					_	~	
Pre-pro	ocedure medicat	ion administered	j			_		
Proced	lure site marked		٠	1.	,	,		
Skin pr	eparation done		√					
NPO	ĺ	. 23 0						
Loose	Tooth removed	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
Contac	Contact lenses / Eye glasses removed						<u></u>	
Prosth	esis present							
Jewelle	ery/Nail polish re	emoved	V.	'		, ,	•	
Checke	ed for Allergies (Drug / food)	KOA		<u> </u>	1.1	~	
- Iv line/	In-situ				· · ·	;	:	
Conse	nt taken		,		~		,	
Investi	gation reports / [Documents recei	ived		~			
Signate	ure of Nurse :	4.200			Date & Time: 05/1/24 at			
		· •	ocedural Record (1	To be filled by the				
Time	HR / min	RR / min	BP mmHg	SpO ₂ %	Medication	/ Remarks	Sign. of Nurse	
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1220	85 bHMin	solor losio	107/21 (P5)	1001.		- (On a	
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Compli	cation :	Ni				ve	inaeg
вр:⊥	18/82	(95)	mmHg, HR	1: 85 b+/m/n, RR:	22 68/min sp02	:_ 100;	· .
Distal F Advise	Pulse:			, Puncture Site: <u>NØ <i>b</i>0</u>			
♦ Shi ♦ Bea ♦ Ob	ift To: Wai d rest up t serve pun itch for Pu	to icture sit ilse in	b e for bleedir	hours ng <i>Monal</i> artery.			
a) b) c) ♦ Re	If patient	complaing is Loo re Cold	[/] Absent <i>∤</i> Pul	scomfort d with Bloog	at &, 	<u>∂</u> AM /PM⁴	after informing
♦ Spe	ecial instri		any:			Many	
	•	,	~ `		Na	ame & Signature	of Consultant
•				POST PROCEDURE OB	SERVATION		
Date & Time	BP	HR RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign, of Nurse
5 124 4:15	18/6	8622	100%	ho overy no	Topol		Down
11, 20	120/7e	85 2	100%	11	(/		Dow
14:50	118 54	8222	100/	· <u> </u>	11		Donne
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	'		,				
Nurses	Notes:				,		1
CB1	ley :	Epst Shaeb 90 ze	RFA H over	30 procedure nocied tight for	done RA wessue bo - cesti el	femora nSage	L ggslå 3
						<u>.</u>	-
Condition	on at the e	end of pr	ocedure :	Stable	ical	· ·	
Patient	shift to :		Recovery F	Room	CCU Othe	erCLL	
Name 8	l Signatur	e of the	Nurse:		Date & Time :	1 104	
			Sir .		F	5/1/24/55	
•			-			Jan	





Mrs.SHWETA JAIN

31/Female/MH1202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





Date of Admission: Time of Arrival: Mode of Admission: Walking Wheelchair Stretcher Accompanied by Relative: Yes No _ If Yes, Name of the Relative: Relationship with Patient: Contact Person's Name: Relationship: Contact No.: Primary language spoken: Tainil English Indian International Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No Menstrual History: LMP: Menopause:
Accompanied by Relative: Yes No If Yes, Name of the Relative: MY - School And Relationship with Patient: Contact Person's Name: Relationship: Contact No.: Primary language spoken: Tamil English Indian International Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No
Relationship with Patient:Contact Person's Name:Relationship: Contact No.: Primary language spoken:TamilEnglishIndian International Interpreter needed:Yes No Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No
Contact No.: Primary language spoken: English Indian International Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No
Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No
L
Monostruol History : I MD : Monospause:
· · · · · · · · · · · · · · · · · · ·
Medical History: DM / HTN / Co - Morbility: ————————————————————————————————————
Drugs History : Antiplatelet (Specify)
Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty
Do you have any special religious, spiritual or cultural needs to be considered? Yes No
If Yes, specify details:
Socio Economic Status: Employed Retired Own Business Home-Maker Others:
Vital Signs: Temp: 986(°F) Pulse / HR: 76 (beats/min) BP: 100/80 (mmHg)
Respiration: (breaths/min) SpO ₂ : 96 (%) CBG: (23 (mg/dl) Height: (cms) Weight: 62.4 (kgs)
Allergies / Adverse Reaction: Yes Averse Medication Blood Transfusion Food Not known
If Yes, specify:
Pain: Yes No. If Yes, Score: Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years)
Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)
Duration: Location:
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain
Nutritional Screening:
Last 3 months Appetite: Increased Decreased No Change
Last 3 months Weight: Increased Decreased No Change
Type of Patient: Diabetic Non Diabetic Type of Diet: NOT west client
Type of Patient: Diabetic Non Diabetic Type of Diet: NOT west client
Type of Patient: Diabetic Non Diabetic Type of Diet: Non View Ciex Dietician Informed: Yes No. If Yes, mention the Name: My-cethnice Time: (8)
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Type of Patient: Diabetic Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Dietician Informed: Yes No. If Yes, mention the Name: Non Catherine Time:
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Type of Patient: Diabetic Non Diabetic Type of Diet: Non Dieter Type of
Type of Patient: Diabetic Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diabetic Type of Diet: Non Diet Diet Diet Diet Diet Diet Diet Diet
Type of Patient: Diabetic Non Diabetic Type of Diet: Dornal Clear Dietician Informed: Yes No. If Yes, mention the Name: Who cather Itime: Color Time:

Assisted Dependent Bathing	Daily Activity Of L	.iving:	• -							
Dressing	Activity		Independe	ent		Assisted	Į	De	pende	nt =====
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As per the score, tick the following appropriate	hove	e.						
	DOXC.	J.						
Low Risk Interventions (0 - 24)								
Familiarize the patient with the immediate surrounding								
Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all times		natio	ente regardless of age					
Keep the call bell, bedside table, water, glasses within t								
Remove excess equipment or furniture to make a clear			5 day 1 day 1					
Keep the patient's bed in the low position at all times ex	•	uring	gprocedure					
Jeach fall-prevention techniques, such as sitting up for	r a mon	nent	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								
Heview medications for potential side effects that can promote falls Use safety belts during movement in wheelchair								
☐ Apply all the low risk interventions								
☐ Tie yellow fall risk tag in the bed and Wheel chair / Stret	cher							
\square Make sure that proper transfer precautions are institu	uted for	r hea	avy or debilitated patients in a					
bed or wheel chair or on a toilet seat								
Use restraints and bed monitors as ordered by the doc	ctor							
☐ Allow the patient to ambulate only with assistance	faata le	av cal	of conneiguences, gait and					
 Consider peak effects of the medications that effection elimination when planning patient's care 	iecis it	evei	or consciousness, gait and					
☐ Do not leave patients unattended in diagnostic or treat	menta	reas	 					
Accompany the patient while going to bathroom								
Advice the patient to use grab bars near the toilet, bath	tub, an	dsh	iower					
Make sure the family and other visitors understand the	restric	tions	s 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		tion						
 □ Locate the high-risk patients in a room close to the nurs □ Answer these patients call bells as quickly as possible 	562 516	uon						
☐ Provide a commode at bedside (if appropriate)								
☐ Urinal/bedpan should be within easy reach (if appropri	riate)							
☐ Encourage family members or other visitors to stay with								
☐ If appropriate, consider using protection devices: safe	ty belts							
			•					
Initial Assessment to Special Needs and Vulnera	ability	of	Patient:					
	Yes	No	Remarks (please specify)					
Terminally ill patients		4						
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	[',}	•					

	Assign a d	coro	of 1 if (VE	:C) in 1	nars				SSMENT	re of -2 if (YES) in p	aram	otor no. 1	<i>-</i>	د ،
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1	Active cancer	(on-c					d within 6	months	or palliative ca	re)	\vdash		No	00016
2	Bedridden red										片		No	
3		>3 cı	m compare						red at 10 cm i	pelow tibial tubercle			No	
4	Collateral (no			rficial v	eins	orese	nt (Asses	ss for hoth	· leas)	·	\vdash	Yes 🗍	No	
	Entire leg swo							30101 2011			H		No	
5											片			
6	Localized tend						· ·				片		No.	
7	Pitting edema	, grea	ater in the s	ymptor	nati	cleg (/	Assess fo	or both leg	js)		Yes No		No	
8	Paralysis, par	esis, d	or recent pl	aster in	nmo	bilizat	ion of the	lower ex	tremity (Asses	s for both legs)		Yes 🗍	No	
9	Previously do	cume	ented DVT (Assess	for	both le	egs)					Yes 🔲 I	Ņο	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.							Yes 🗍	No					
	Score Inter			babil	ity	of DV	T):		-		F	Final Sco	re	
lick	the score ob	taine	ed (√)	√	/				Action Take	en.		Date	T	Time
Low	Risk		-2 to 0	レ	/	_							1	
Mod	lerate Risk		1 to 2										1	_
Higl	n Risk		3 to 8					_	-				1	
Pers	sonal Belong	jings	s / Valuab	les:										
Valua	ables	[Description	n		Vith itient		atient's ndant		Signature of the atient's Attendant		Rema	rks	-
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	glasses / act lens	₽	res diN	lo										
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Othe (spec	r valuables cify)													
Rep	ort (List of X-	ray,	ECG, lab	report	s re	etained	d with th	ne nurse)	:					
Dati	ent /		Sign.			Na	me			Emp. No.		Date	T	ime
	ent's Attend	ant	Jana	- J	14	<u>.</u>	SAT	797	SETTING.	Relationship 1 fest back	H	11/24	<u>l</u>	6230
Nur	se		7	áz			A-W	dna	Leo	@/h/		deper	16	130
Unit	In-Charge		N	00-			s.	Malin	`	0024		1/24	(उण्ट्र







Mrs.SHWETA JAIN 31/Female/MH1202381578 04/01/2024/IPH2024000035 Dr.K.JAISHANKAR



	PATIE	NT CLINICAL H	IANDOVER RECOR	D FOR NUR	ISES	
Date:	11/28	Shift: Morn	ing Evening Night	•		
S	NEWS / F Ventilator Periphera Ryle's Tul	SEWS Score: day: I line day: Right: Left be: Yes No Day atheter:	POD: Central line VIP Score:	ols.		
В	On room		Date of surg IV fluids on f	· .		
A	BP: 10 Others: Pain Sco Fall Risk Braden S	re: Oldo Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	HR:(beats/min) Respira (%) Height:(cms) Weight: PIPPS / GRIES / FLACC / Wong-Ballotocol:Low Medium	らり (kgs) BMI: ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	<u> 25-6kg</u> l g Scale / NRS 12-10⊟Severe	SYCPOT
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	And If Yes, modified care plan date	ə: <u> </u>		
		Signature	Name	Emp. No.	Date	Time
Handover g	-	CPOUL	K. Suffma	0201	4/134	17.00
Handover to	aken by	Hay	Hannah Grace	Olos	A/1/24	197:30
Document of	endorsed	No	Sillalin	<i>0</i> 0)4	5/1/29	9.00

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
4/1/23.	ADMISSION NO TES	-
/' (a)		
17.00	=> patient got admitted in . 1987	A Something the second
·	Floop.	70 - 7
17.00	spt Consider & Oriented	
		1
4.30	=> pt here Q diet	6201
	Det don dwax am giver.	
1800	=) of mall mobilized.	
	271 Well 19001 4 24	6000
1850	2pt To chart Monitaries	P
19.00	Dr VIS showed & Gordes	5/0(1
19 90	Spt pengling only given by	
	Night duty Staft.	\$21.
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endorsed by	Noe s'Malin	De 2/1/24 9-20



Document endorsed





Pr Mrs.SHWETA JAIN N: 31/Fernale/MHI202381578 U 04/01/2024/IPH2024000035 Dr.K.JAISHANKAR

MHI/NUR/2022/048

Heart
Institute

PATIENT CLINICAL HANDOVER RECORD FUH NURSES

Date: A	124	Shift: Morn	ing Evening Night		1	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: P3 V1 PEWS Score: O day: Il line day: Right: Left be:	VIP Score: _	days:		
В	On room	,			,	
A	BP: \2 Others : . Pain Sco Fall Risk Braden S Pressure	ns: Temp: 98.6 (°F) Pulse	/ HR:(beats/min) Respira (%) Height: \(\sum_{56} \) (cms) Weight: \(\sum_{56} \) (cms) Wong-Baker (cms) Woderate Rises (cms) Woderate Rises (cms) Woderate Rises (cms) Wound Description Weight: \(\sum_{56} \) (weight: \(\sum_{56} \) (weigh: \(\sum	ker FACES Pain Rating sk: 14-13 ☐ High Risk: 1 Pressing done: ☐ Yes	95.6 kglr g Scale / NRS 12-10∐Severe	
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent; lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	Nº 1 No. If Yes, modified care plan date on Eps + RFA, N		5120	
Nonders:		Signature	Name	Emp. No.	Date	Time
Handover to		Hay loss	Hannah Crase	01/05 0072	5/1/24	7130

(CD)

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
4/1/24	Night duty notes	
19:30	Patient handing over taken	
	Grom Evening duty Stay	- Hair
	Patient handing over taken I from Evening duty Staff in a hemoslynamically Stable Londition	Hay
	l andition.	1
do:00	Vital Signs Checked & Recorded	-fhy 0105
	<u> </u>	6405
21:00	Due deugs all given as per dug chalt	
	dug chalt	flayour
22.00	Patient us Steeping	fhyolo5
2;∞	Patient is Steeping well had no complaints	
,	"had no complaints	Hayous
	· · · · · · · · · · · · · · · · · · ·	
6:00	patient Vital Signs Checkeds Recorded	
_	'Kelorded	Hay
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. , .	Signature Name Emp.	No. Date Time
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endorsed by	3. Marin	Oly 5/1620 9,00







MIS.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





Date: 5 1	124	Shift: Morr	ing Evening Night		ę	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: PSV7 PEWS Score: 6 day:	POD Centi :: VIP \$	ral line days;	¢°	f
В	Onvoem		IV flui	of surgery: • ids on flow: _		ز
A	Others: Pain Sco Fall Risk Braden S Pressure Current of	re: O(O) Pain Scale used Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PU	/ HR:(beats/min) (%) Height: 15 (cms) : PIPPS / CRIES / FLACC / Wo otocol: Low Medium _ At Risk-Mild Risk: 18-15 Mod SH):Yes No NA V	Weight: () - 4 (kgs) BMI: 8 ong-Baker FACES Pain Ratin High	<i>IȘ. Gleg</i> l. M ng Scale / NB 12-10□Sever	97 CPOT
R	Referral of Pending Pending Pending Critical vo Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care p		,	
		Signature	Name	Emp. No.	Date	Time
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	NU	JRSES PROGRESS NOTES	S	_	*.
Date & Time		Observations / Action	-	Signature with E	mp. No.
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Mis.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





Date: 5-1	يد ا	} Shift: ☐ Morr	ning Evening Night		.020	
S	entilator eripheral yle's Tub rinary Ca	:	y: — VIP Score: (days: — "	•	•
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A P	P: 10' Others:_ ain Scol ail Risk braden S	re: O/rO Pain Scale used Score: Fall Risk Procere: Minimal Risk: 23-19	/ HR:(beats/min) Respire [(%) Height: // (cms) Weight: PIPPS / CRIES / FLACC / Wong-Bate Cotocok	ker FACES Pain Ratinsk: 14-13 High Risk:	ØS 6 kg (g Scale / NR 12-10 ⊟Sever	S / CPOT e Risk: 9-6
R	deferral deferral deferral defending referral defending leferral values defending fending f	medications: medication indent: ab reports / Investigations: lue alert and its corrections in nursing care plan: Yes ollow-up orders:	NI L DNo. If Yes, modified care plan date	: :	÷	•
		Signature	Name	Emp. No.	Date	Time
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Handover take	en by	Hay	Hannah Grace	0105	5/1/24	19:00
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Mis.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





Date: 6	ાં ઢિય	Shift: ☐Mo	rning Evening Night		, ,	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: P3VT PEWS Score: 0 day: al line day: Right: Le be:	GCS:\6\15\ POD: — Central line ay: VIP Score:			ı (ø
В	Allergies	ROUND WOOD Wrgery: Eps+RPA if any: NKDA air / oxygen: oh beome nts / New Symptoms in last	ال الا الا الا الا الا الا الا الا الا	gery: 511 by		. • . •
A	Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: 98 b F) Pulse Pulse Pul	e / HR: 80 (beats/mln) Respi 17 (%) Height: 156 (cms) Weigh d: PIPPS / CRIES / FLACC. / Wong-Barotocol: 10 Low Medium 24 figh At Risk-Mild Risk: 18-15 Moderate F JSH): Yes No No NA Wound	t: 6&4 (kgs) BMI: 6 aker FACES Pain Ratin Risk: 14-13 ∐High Risk:	26-5 Kg/r ng Scale / NR 12-10 □ Sever	e Risk: 9-6
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its correction in nursing care plan: Ye	(Nº1	-	3310	
		Signature	Name	Emp. No.	Date	Time
				Ī		
Handover g	jiven by	Hort	Hannah Grace	0105	6/1/24	7:30
Handover g		Host Post	Hannah Grace	0105 0072	6/1/24	7:30 7:3

	NL	JRSES PROGRESS NOTES				
Date & Time		Observations / Action		Signa	ture with E	mp. No.
5/1/24	Night	duty notes		-		
19:30	Patient hand Evening duty hemodynamical	ing over taken g Staff un a ly Stable Conditi	som oh-	;	Hay:	
20:00	Vi'tal Signs Cl	hocked & Revooded	1	4	Hay	
21 200	Due deugs deug chaet	nce given as per		41	ay Glos	·
22:00	patient Sleen	•	,	+	ley our	
2:00		Beeping well, whac		•	Hay	
6:00	Patient Vital Recorded Ilo Chaet 1	Signs Checked an	d		-thy olos	
7:00	pressure Landa and hemotom Healthy site	<i>(</i>)	zing	-4	ay subs	
+ <i>i</i> yo	frestient chara Mosning duty	Staff.	ło	-	stos Stos	
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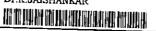




Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/iPH2024000035

Dr.K.JAISHANKAR





Date: 06	عوانا	Shift: ☑Morn	ing □Evening □Night			
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: PCV7 PEWS Score: D day: - Il line day: Right: Left be: □ Yes □ No Day atheter: □ Yes □ No Däy	: VIP Score:	days: -,		
В	Allergies i	ROUND Jegery: EPS+RFA if any: UKDA air / oxygen: RA ts / New Symptoms in last sl	iV fluids on fl	00 05 li 124		() - 4
A	BP: 130 Others: Pain Sco Fall Risk Braden S Pressure Current of	re: OLD Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	/ HR:(beats/min) Respira (%) Height/	ker FACES Pain Ratinsk: 14-13 High Risk:	<u>6.CKg</u> /n g Scale NR 12-10∐Severe	
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date			,
Uandans -	uliyan ker	Signature	Name	Emp. No.	Date	Time
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	NU	JRSES PROGRESS NOTES	,	ydi.	•
Date & Time		Observations / Action		Signature with E	mp. No.
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9.30	-> Pation	+ was stables	NO	OXL	
	Complainty	<u> </u>	í		
10.00	, , , , ,	y plan discharge			
11.30	l '	mont monitores		 -	
• •		signs Chockeds }	- , /		
12.30	- Dations	hard ovoy giv	ion to	MD	
	the evening	ng duty staff	•	0/24	
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	Discharge	e roors			
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ADULT NURSING CARE PLAN

Mrs.SHWETA JAIN

31/Fernale/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





	·					
Initial Date: 山ん	Time: 19:00	Modified Date: Time:				
Reason for Modification:	<u> </u>	Diagnosis: PSVT - AT - 9 AVNRT				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M EPT had N diest N Patient had lint	Dig Day		
OXYGENATION Hoom Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	M hosmal cult	Jell 102al		
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M E Pt sto chart Mantaneof N Sho chart	065 9801.		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment	М	
☐ Others:	P_tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	 ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) 	E pt well	I della
		· · · · · · · · · · · · · · · · · · ·	N Patient Mobilized well	fort pro
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	м	
Urination Others:	control of bowel incontinence, and regulár elimination patterns :	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E Pt Mormal pattern	Jeg Jora
		and follow proper protocol Check for malena / constipation / urinary retention	N Pt had normal elimination patteen	Hout
SKIN INTEGRITY Maintain normal skin integrity of the pressure points site assessment HAPI OPI	Patient will maintain normal healing status Patient will discharge with intact skin integrity		М	
GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4			Dt Sign	1
☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased		 ☐ Monitor the healing status ☐ Educate patient and family members about further skin care 	E Integrity	Orol
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

Patlent Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Epecurage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	M Ept Well groomed well	· House
SAFETV Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	M E Pt ID bonof Chelkeol N ID band present	fay Out
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	M E N	
OBSERVATION ☐ Vital Sighs ☐ GCS ☐ Blood Sugar ☐ Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M E P7 V S thereod N Patient vital 8 19ns are stable	Guy) Hay
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Bellefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	☐ Patient will achieve spiritual needs☐ Patient will be able to control his feeling toward his illness☐ Patient will maintain normal psychological pattern	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	M E	

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Patient Specifi Problems / Ne		Measurable Goals	-	Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT	TION	Patient will communic with positive feedbac		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed	_	М	•	
☐ Sigh language ☐ Others:	language		No negative speaking about the patient's or prognosis in the patient's presence	condition	E D+ WG	Municition	0%1.	
, * *	· ,					N pot Con	municated	Hay
SPECIAL/INTE Medication Wound care Isolation Ostomy Care	RVENTIONS	To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family	•	M		
☐ Storny Care ☐ Blood / Blood r fransfusion ☐ Fluid tapping ☐ DVT Managem ☐ Others:	,			Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing belood products and fluids Monitor DVT score and continue treatment as per doctors order	lood or	E Due Al ace	given	Foi.
	Signature		Name	l	Emp. ID		Date	Time
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ADULT NURSING CARE PLAN

MIS.DIWETA JAIN
31/Female/MHI202381578
04/01/2024/IPH2024000035
Dr.K.JAISHANKAR

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease P-tient will use safety measures to minimize potential for injury	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse)	MPE 4000d mobilized	My Costs
	Patient will demonstrate the use of adaptive devices to increase mobility	Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E Problème	2300
			N Patient Mobilized Slightly	Hay Dub!
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	pattern pattern Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's /	M Normal Elimination Pattoun	14
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E PLD alingnation pattern	Net 230
		and follow proper protocol Check for malena / constipation / urinary retention	Patient had noomal elimination patteen	Hay
SKIN INTEGRITY Maintain normal skin integri Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal ty healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	Maentaen Normal M Skin intact	14 took
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	E Scin Integrity	wh 23 or
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:) · v- · · · · · · · · · · · · · · · · ·		Patient had N normal skin Integrity	Hoy Sto

Patient Specif. Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:		Patient will communic with positive feedback	cate effectively \	Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patient's or prognosis in the patient's presence	s condition	- 101-Cond	nunication	Horse Hart
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood y transfusion Fluid tapping DVT Managem Others:	oroducts	☐ To manage on time		Double check for high alert medication Doserve and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing be blood products and fluids Monitor DVT score and continue treatments as per doctors order	solation ensure blood or	N Due de	hon-	Hay our
	Signature		Name		Emp. ID		Date	Time
Endorsed by,		Roce		s. Malini	ď	002 ₇	5/1/24	9- 00
							·	





Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





Every heart beat counts

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR'	Y RISK Time:	-1) -	1	/-
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	LP
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Molst Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skiń is usually dry, linen only requires changing at routine intervals	,	/ 	7
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4 Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		4	W
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	A-No Limitation Makes major and frequent changes in position without assistance	1	4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		4	CN/
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,				7	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	chair, restraints or other devices.	- Cr Gridin	TOTAL SCORE	Y	-	യ
	agitation leads to almost constant friction	slides down		Initial & Emp. No. of Staff Nurse:	S.	RI SO	tlay
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	ligh Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	9	الوسلا	Nug





ADULT NURSING CARE PLAN

Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





Every heart beat counts

Initial Date: もんしるy	Time: 8100	Modified Date: Time:				
Reason for Modification:		Diagnosis: Eps + REA				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
☐ Keep NPO	Patient will have adequate nutrition with no nausea and vomiting	Provide Prescribed diet on time Encourage patient to consume the served meal	MPE had @ diet	Make		
Regular Diet Others:	 Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs 	Record amount of food consumed	E .	- 6428		
	·		N			
OXYGENATION Hoom Air Nasal Cannula / High Flow O ₂ Mask BIPAP / CPAP	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate	MPt is on	Month		
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Destromy Patient will indicates, either verbally or through behavior, feeling comfortable when breathing comfortable when breathing Destroin within established limits If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	E				
		Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N			
☐ Oral ☐ Intravenous ☐ Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	☐ Enfrance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output	M 210 Chart monitorg	May		
☐ Parenteral Nutrition ☐ Others:		 Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes 	E			
			N			

ı	D 11 34 D 37				
	Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
-	Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	MPt 4000/ MOBILIZOS	M
				E	
				N	
	Catheter, bedpan, urinal	Patient will have normal elimination 'pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	□ Encourage fluid intake □ Encourage fibre diet intake □ Encourage early ambulation □ Report any abnormalities to physician □ Observe voiding accessories as foley's / silicone catheter □ Check placement before feeding □ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol □ Check for malena / constipation / urinary retention	M Normal Elimination Pattour	MOST
				E	
				N	
	SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	healing status points site points site pent port Port Port Port Port Port Port Port P	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	Maintain normal	My Shar
	INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased			E ,	
	☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	.v		N	

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	Patient Specific Problems / Needs	Measurable Goals.	Nursing Interventions	Evaluation	Sign & Initials
	HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	MPt 4000 in hygiene	Marie Jan
1	SAFETY Check ID Hand IV care	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	M ±D Band Present E N	4 R
1	COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ -Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M F	
	OBSERVATION □ Vital Signs □ GCS □ Blood Sugar □ Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	m vital signs Ehana roccodo E	E YD
	PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others;	☐ Patient will achieve spiritual needs☐ Patient will be able to control his feeling toward his illness☐ Patient will maintain normal psychological pattern	 □ Pray or encourage the patient to pray □ Use inspirational words □ Respond to spiritual needs as they arise □ Evaluate spiritual needs □ Encourage verbalization of feelings / therapeutic touch □ Provide empathy and reassurance 	M E N	

COMMUNICATION Patient will communicate effectively with positive feedback Infroduce the care giver Encourage the use of call bell CORDINAL Callion Provide presence Infroduce the care giver Encourage the use of call bell CORDINAL Callion Provide presence Infroduce the care giver Infroduce the care giver Encourage the use of call bell CORDINAL Callion Provide presence Infroduce the care giver Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions		Evaluation		Sign & Initials	
Sigh language Others: No negative speaking about the patient's condition or prognosis in the patient's presence No	☐ Verbal	Patient will communicate effectively with positive feedback	☐ Encourage the use of call bell	<u> </u>	MPE 4000 com	MA CON	
SPECIAL INTERVENTIONS To manage on time Double check for high alert medication Observe and report any medication reaction Solution Observe and report any medication reaction Provide proper measures of wound care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation Isolation Ostomy Care Isolation Isolation Isolation Isolation Ostomy Care Isolation ☐ Sigh language		☐ No negative speaking about the patient's	s condition				
Ostomy Care Blood / Blood products transfusion Check for cross matching and typing, to ensure compatibility Practice strict assepsis while transfusing blood or blood products and fluids Others: N Signature Name Emp. ID Date Time Endorsed by Care And explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict assepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment N Emp. ID Date Time Colored Date Time Date Da							
Ostomy Care Blood / Blcod products transfusion Pluid tapping Practice strict assepsis while transfusing blood or blood products and fluids Practice strict assepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment as per doctors order N Signature Name Emp. ID Date Time	Medication Wound care	To manage on time	Observe and report any medication react Provide proper measures of wound care		MHODICAL as Porc	ion given us abugan	业
Others: Monitor DVT score and continue treatment as per doctors order N	 □ Blood / Blood products transfusion □ Fluid tapping 		and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b	ensure			
Endorsed by No. 2. Nalin. 0024 611124 13:0			☐ Monitor DVT score and continue treatment	nt	N		
Endorsed by	Signature	Name		Emp. ID		Date	Time
	Endorsed by	Nasa g.	Nalin	००८५		6/1/84	13.00
		 					

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Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/iPH2024000035

Dr.K.JAISHANKAR





Date: Counts

_	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISKTime:	5		211
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3/Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Barely Molst Skin is usually dry, linen only requires changing at routine intervals	4	4	3
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-/ existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	Malks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4: Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		4	N
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	eats only about 2 of any food offered, Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary		4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	7	9	3
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	slides to some extent against sheets, chair, restraints or other devices.	3-No Apparent Problem Moves in bed and in chair independently and has sufficient muscl strength to lift up completely during move. Maintains good position in be or chair TOTAL SCOR			25	20 Ha
Score	Interpretation: Minimal Risk: 23 - 19; At Risk i	,	High Risk: 12 - 10; Severe Risk: 9 - 6	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	No	100	€r





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

Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





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

Initial & Emp. No.

of Sr. Staff Nurse:







MIS.SHWETA JAIN 31/Female/MHI202381578 04/01/2024/IPH2024000035 Dr.K.JAISHANKAR

MHI/NUR/2022/052

15



Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Time	/Pain Score	(dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial: & Emp. No.	Senior Staff Initial & / Emp. No.
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22.0	o lu	· · · · · · · · · · · · · · · · · · ·	-	_		Hay	Non
				Patie	nt is Skeping		
5/1/28	0/6	Mopain	_	-		Hay Blos	Noe
10.00	0][0	NO pain	•		~	MA	Non
1900	,	At preined	Don	Jath less	MC7.00		
B.00	10	No pain		-		William .	Nus
18,0°C	W/W	duel pain	640 6 Us	Aerwood	phohmological Interventy	Ju.	NUR 024
83500	Yw	Pull Pain	on &	Jenosal 8°te	Enterention given	Hory Otto	Hary

Date & Time	Paln Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site	In	terventions			Staff Initial & Emp. No.	Senior Staf Initial & Emp. No.
•	*		-		Patient		ilng				
P:00	1/100	Q	allpuin	St. Je	Bagger Jemoalsite	Mon-phasina	cological Given)		Hay.	Dos
<u></u>	Nio	1 00	pain	-	· -	·				Hely	New
	,						,				
			· · · · · · · · · · · · · · · · · · ·	; ;	PA	IN SCALES					
(28 week		weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to seve	pain de comfort me		п					
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score esic administration is indicated				4,	1
	ACC Sca onths - 7 y		0: Relaxed & comfortab	le, 1-3: Mild di	scomfort, 4-6: Mode	rate discomfort, 7-10: Severe d	iscomfort / pain /	both			
_	-Baker F/						Numerical	Rating	Scale (age r	nore than 12	years) ′
	Rating Sars - 12 ye		0 2 No Hurts Hurt Little Bit	4 Hurts Little More	6 Hurts Even More W	8 10 Hurts Thole Lot Worst	0 1 2 ↑	3 	4 5 Moderate	5 7 8	9 10 ere
Observa	ical care f ation Tool ator / com	(CPOT)	COMPLIANCE WITH VE	- Absence of m INTILATION (in tubated patler Relaxed, 1 - Te	ovements or normal p ntubated patients): 0 nts): 0 - Talking on nor nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restles - Tolerating Ventilator or Moveme mal tone or no sound, 1 - Sighin nse, Rigid	ent , 1 - Coughing			y ventilator (or)	1
	-		Distance A Dala etta		nuironment: P. T/: C	- Music; D - Physical and mental	avaraisass.	<u> </u>			

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Patient De Mrs.SHWETA JAIN

Name: 31/Female/MHI202381578 UHID: 04/01/2024/IPH2024000035

DOB: Dr.

Consultant

Dr.K.JAISHANKAR



eart beat counts

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	1 101 1	5/1/24	6/1/24	Ü			1
	Time		06:00	6700				
S. No.	PARAMETERS	1.1.1.	0.0	070				•
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	Ø	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	10	0	O				
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	Ø	0	0	•			
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	Q	Ю	D				
5	Entire leg swollen (Assess for both legs)	Ø	0	0		_		
6	Localized tenderness along the deep venous system (Assess for both legs)	b	0	O				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	60	10	O				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	Ø	0.	0				
9	Previously documented DVT (Assess for both legs)	8	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	Ą	0	0				
	FINAL SCORE		0	0				
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	<i>(</i> 0)	Low	Low				
_	DVT prophylaxis started	□ Yes	∏Yes ∐No	□ Yes □ No	□ Yes □ No	☐ Yes ☐ No	□ Yes □ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	(1)	Horal	tay sub				
	Signature & Emp. No. of Sr. RN	Nue	Nog	Miss 1				



The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)





Mrs.SHWETA JAIN

31/Femule/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	41	HIPA	5/1/23		511124	6/112 0			
variables	Time	1400	70,00	gam	15.00	20:00	8.00		<u> </u>	
History of falling	No	10	9	0	0	Þ	\O_	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	_87	0	(O)	(b)	28/	\B\	0	0	0
(≥ 2 medical diagnosis)	Yes	15	⁷ 15	15	15	15	15	15	15	15
Intravenous Therapy /	No	8	7 0	6	0	0/	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	1/20	120	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	/0	(0/2	0	A	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT					A	1/	_			
Normal / Bed Rest / Wheel Chair		107	_8	(6)	©	0	V	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS	<u> </u>			h_					1	
Oriented to own stability		0	/8 (C ₀	6	No.	0	0	o	0
Overestimated or forgets limitations	_	15	໌ 15	15	15	15	15	15	15	15
MEDICATIONS						_				
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	10	0	(6)	6	p	0	0	0	0
immunosuppresent, anticonvulsants,	Yes	15	15	15	15	15	15	15	15	15
anti-hypertensives, hypoglycemics and psychotropics						•				
Total Score		80	0	\sim	0	مړ	35			
Low Risk (0 - 24)		_/	7							
Medium Risk (25 - 44)	<u> </u>								·	
High Risk (45 or above)					<u> </u>					
Signature & Emp. No. of RN		AG.	pay 6	W	12/1	Hestor	Will K			
Signature & Emp. No. of Sr. RN		Joe	Noon	New	Nas		مديق			
	L	<u>۱۰۰۶۳۸</u> ۱ - ۱۱	24· I ow	Risk: 2	ا م يحر 5 - 44: N	ledium	Risk 45	or aho	ve- Hich	Riek

	_								ži i
INTERVENTIONS	Date	eyll	Milso	5/10	7/1/2	SIM	6/124		
Tick as per the Risk Score	Time	40	D. 20	g.00	1500	20°.00	8.00		• `
Low Risk Interventions (0 - 24)									
Familiarize the patient with the immediate surround		(•						
Remind the patient to use call bell before getting ou				<u> </u>					
Keep the two side rails in the raised position at all t	imes for			l					
all patients regardiess of age									
Keep the call bell, bedside table, water, glasses w	ithin the	_	/		_	~			
patient's easy reach			_/_						
Remove excess equipment or furniture to make	a clear	l . :	/	[: _	_	/		1	
path		-						_	-
Keep the patient's bed in the low position at all times	s except		-, /	·/					l
during procedure	4			<u> </u>	<u> </u>	/			_ }-
Teach fall-prevention techniques, such as sitting	up tor a		· /	トッ		1			į
moment before rising from the bed				-		 			
Bed wheels should be locked		\vdash	-				-/-		+
Encourage family participation in the patient's care		 	-/-	 			/-		+
Ensure that floor of the bathroom is dry and not slipp		 	-	 	<u> </u>		-/-		
Review medications for potential side effects the	nat can			/	/				Ì
promote falls			-/						-
Use safety belts during movement in wheelchair The patients are not ambulated by themselves. The	ov oro to	-	1		<u> </u>				- -
be ambulated only with assistance	ay aie to	_							-
Medium risk interventions (25 - 44)				<u> </u>					
Apply all the low risk interventions			_		<u>-</u>				
Tie yellow fall risk tag in the bed and Wheel chair / St	trotohor	 -		 					-
Make sure that proper transfer precautions are in		 			<u> </u>	-		 -	
for heavy or debilitated patients in a bed or wheel								j	
on a toilet seat	CHAII OI	i							
Use restraints and bed monitors as ordered by the	doctor			<u> </u>		 			
Allow the patient to ambulate only with assistance		 					-		
Consider peak effects of the medications that effects	cts level	<u> </u>	-						
of consciousness, gait and elimination when p		1		1					
patient's care]					
Do not leave patients unattended in diagno	ostic or	•							
treatment areas		l)		
Accompany the patient while going to bathroom							5		1
Advice the patient to use grab bars near the toilet, t	oathtub,								
and shower		<u> </u>		<u> </u>	<u> </u>	<u> </u>	/		
Make sure the family and other visitors understa	and the								
restrictions mentioned above					1				1
High-risk interventions (45 or above)				ļ		-		-	1
Apply all the low and medium risk interventions		ļ		ļ <u>.</u>					
Tie red fall risk tag in the bed, wheel chair and stretc				 	ļ				
Locate the high-risk patients in a room close to the	nurses'		Ì	ŀ					
station		ļ		ļ	ļ	<u> </u>			
Answer these patients call bells as quickly as possit	ble				<u> </u>	<u> </u>		<u> </u>	
Provide a commode at bedside (if appropriate)									
Urinal/bedpan should be within easy reach (if appro					<u> </u>	.	<u> </u>		
Encourage family members or other visitors to s	tay with			1					
them		-		<u> </u>	_	 		_	-
If appropriate, consider using protection devices	s. sarety	xn			}				
belts			There	_ &~	777	11/20	\ <u>.</u>		
Signature & Emp. No.	of RN	Ma	-1808	On the	12/2	80	7		
Signature & Emp. No. of S	Sr. RN	Nos	Nor	10/8	1900	مق	المقو		







Patient Details (Affix Label here)

Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR



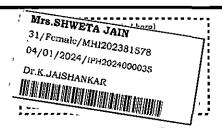


PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below																
Barriers to	Le	arning								Plan t	o A	ddr	es	s Factors		
Nane		Vision	/ He	arin	g lin	nitations	;			Use	of I	nterp	rete	er		
Limited Reading Abilities		Physic	al b	arrie	rs				딫	Edu	cate	fam	ily			
Religious / Cultural Factors		Langu	age	barri	ers				Simple Language							
Congnitive Limitations - unable to	Low motivation / desire to learn									☐ Written Instuctions						
understand and follow directions									Γ	<u></u>	,		-			
Completed By : Date Ph 1 2 Tim	e	77-0	900	N	lurs	e Signa	ture	:_			W					
										70.11	1					
Learning Record			.							_	_			·		
Need		Date	\	/isit	1	Date	<u>_</u>	/isit	2	Date	<u> </u>	/isit	3	Signature		
		4112	P	Р	0	St.	L	Р	0	6/1/24	L	Р	0			
Disease		, .												Doctor		
Information on														. 0~		
Disease / Diagnostics			1	60	ν		$ \mathcal{T} $	40	y		P	OP	V	\\-\\-\\'-\\		
☐ Treatment										Į				134		
Medications			Ð	8	ν			Ja.) y		P	00	y	Doctor / Nurse		
☐ Information on Safe and)				$ \setminus $						7			
Effective use of medicines										_	P	OP	V	\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\		
Information on drug / drug and						,								STY I		
drug / food interactions			0 (P	ا		E	9)	y i		2	OP	V			
Discharge Medications		•					1							WAY.		
Surgical Instructions				_			_							Nurse (CXX)		
Pre - Operative Instructions			b	nO.	1		pa	P	v	•	Ω	OF	V			
Post - Operative Instructions			U									_				
(Wound / Dressing Care)											7	D	4			
Pain Management													Ш	Nurse		
Reporting of pain			2	OD	\vee		7	60	V					Near		
Pain Management			2	5 0	V		P	DO	\checkmark		2	ď	V	027		
Safe and effective use of medical	,		'				۷							Doctor / Nurse		
Equipment (if required)				_	Ц							_	$oxed{oxed}$			
Name of Equipment																
Rehabilitation Techniques			l	l				l			l		l	[

leed	Date	١,	/isit	1	Date	\	/isit	2	Date	١,	√isit	3	Signature
		ī	Р	0		L	Р	0		┌	Р	o	
Nutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk		b	عد	၁		b	ğ	S		Ų	مىد	٦	Senior Dietition
Diet advice for home		_								V	S.	Ď	Nurse
Pischarge Planning													
Self care													
Follow up													4),
Reporting Concerns Immunizations													
Parenting education					_				_				
Others													
isk Factor Reduction													
Smoking Cessation					•	Ç		,		. '			Doctor
Weight Control													
Exercise													
Hypertension													
Other Risks		y74			,-								
ROCESS (P)- OD - Oral Discussion, UTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(;	Stat	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(;	Stat	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(;	Staf	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(;	Staf	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten						Staf	te Relationship)
EARNER (L) - PrPatient, M - Mother PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten						Stat	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(;	Stat	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(\$	Stat	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	on,	W- Wri	itten					(\$	Stat	te Relationship)
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Iritten Material given and explained	D- Demo	ons	trati	on,	W- Wri	itten				n	(s		
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Iritten Material given and explained	D- Demo	V - \	trati	on,	W- Wri	ders				n			
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Iritten Material given and explained Reports Given : Given Pendi	D- Demo	V - \	trati	on, paliz	W- Wri	ders	tane			n			
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Iritten Material given and explained Reports Given : Given Pendi Discharge Summary	D- Demo	V - \	/erb	on, paliz	W- Writed Unc	ders	tane			n			
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Iritten Material given and explained Reports Given : Given Pendi Discharge Summary ECG Report Doppler Report	D- Demo	V - \	trati	On, paliz	W- Writed Und	eport	tane			n			
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Iritten Material given and explained Reports Given : Given Pendi Discharge Summary ECG Report Doppler Report X-Ray Report	D- Demo	V - \	derbi	On, aliz	M- Writed Und	eport	tane			n			
ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained Reports Given : Given Pendi Discharge Summary ECG Report Doppler Report	D- Demo	V - \	/erb	On, aliz	W- Writed Und	eport m Rep	tane			n			







Inter Disciplinary Team Rounds (IDTR) Checklist

inter Dis	scipii	IIIai	y 16	ani nounus (ib	in) Check	IIƏL	
Date: 4 1 83.	Time:	(3.	30				
Checklist	Yes	No	NA		ction / Remarks		
MEDICAL							
Daily Consultant Visit							
Plan of care discussed							
Discharge Planning							
Others if any							
NURSING							
Safety Precautions Ensured	T/						
Care of Lines and Tubes					,		
Infection Control Measures							
Skin Care					<u></u>		
Response to assistance							
Others if any	$\top \omega$						
DIÉTICIAN							
Diet Adequate	T_{\checkmark}						
Special Request							
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living							
Others if any	1						-
PATIENT CARE SERVICES							
Room Cleaning satisfactory							
Room Amenities Adequate	1 -						
Billing Update available							
Non-Availability of any service	1						,
Spiritual Needs (if yes specify)				·			
Others if any							
		lr	iter Dis	sciplinary Team Members			
	Signatur	e		Name	Reg. / Emp. No.	Date	Time
Doctor	1011			Dr-Anusuya	134559	04/1/2	Niot
Nursing Staff	- Co	4		K. Sustano	021	4/1/24	Miro
Dietician	_&	<u> 11/14</u>		Senior Dietitian	2401	ylik	12100
Physiotherapist					V	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
Patient Care Service Staff			,				



Mrs.SHWETA JAIN

31/Female/MH1202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





IN-HOUSE TRANSFER FORM

<u> </u>	A (to be filled by Nu					,	. St
Date	of Transfer:	Time:	<u>6.</u>	ansferred 	from: <u>C</u>	<i>w</i> , To:	1 Floor 105
Diag	gnosis:						·
Vital	Signs: Temp: 00.1 (°F	=) Pulse / HR:	74	(beats/n	nin) BP: 109-	169 (mmHg) Resp	piration. (breaths/min)
Part	B (to be filled by Phy	ysicians) /	Any Critic	al Investig	jations:		
	Check for				nsferring Docto		Receiving Doctor
	oiratory (Breath sounds)	 	Crepitat		Rhonchi -01		Yes No
Abdo	<u> </u>	80ft [Tender		Distended Ot		Yes No
Heart	t Sound	Normál [Feeble		d Others:_		Yes No
CNS		Cemsciou	us UOr	riented 	GCS Scor	re:	YesNo
	Surgical Patients plicable)	<u> </u>	<u> </u>	_ <u></u> _	Soakage		Yes No
		Prese	nt Medic	ation (for	Medication Re	econciliation)	
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
r	T. Oslo		6509	plo	1-1-1		Yes □ No
2	J. Polo		Long	1810.	1-1-1		☑Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
						_	☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
	·						☐ Yes ☐ No
	·						☐ Yes ☐ No
		!	{ '	1	}		☐ Yes ☐ No

Additional De	tails (if any):			-	<u>-</u>
					•
		·			
٠					
Patient Condi	tion: Stable	Sick-need urgent care Oth	ers:		
	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	le.	BALATI	123615	5/1/24	16.30.
Receiving Doctor	000/	Dr. Molane Llypm	Kora	5/1/24	17.00
Part C (to be	filled by Nurses)	<u> </u>			,
Check for		Transferring Nurse		Receiv	/ing Nurse
Drains	Chest .	Abdominal Others:			es 🗌 No
Respiratory	Air Way Type: Oxygen Therap	:	s:li/m	nin Ye	es 🗌 No
NG Tube / Oral	Yes V	For Feeding Gastric Suction	Fluid Restriction	 ✓ Ye	es 🗌 No
Foley's Cathete	Yes Ne			✓ Ye	es No
Intravenous Acc	ess Peripheral L	ine Central Venous Line Others			es 🗌 No
Pressure Injury	Yes Dudo	If Yes, give details:		Y	s No
Score	Fall Risk: Vov	WELLS: NEWS / PEWS:		Ye	s No
Patient Belongir	ngs Yes UNO	If Yes, give details:		7¢	es 🗌 No
Handover Detail		ninistration Record explained: Yes ic Reports handed over: Yes N		∠ Ye	es 🗌 No
Patient Attendar Informed	nt Yes No	If No, give details:			es 🗌 No
Additional De	tails (if any):				
			-		
		T.,	Te N	Гъ	
Transferring	Sign.	Name	Emp. No.	Date	Time
Nurse	& mon j	Quohamrag.	2352	5/1/24	1.6.60
Receiving Nurse	A.	Agasting.	016	5/1/24	17,00
		0 8			



MHI/IP/2022/116

Every heart beat counts

The way to better health (A Unit of United Alliance Healthcare Pyr Ltd) Mrs. SHWETA JAIN IP No. / UHID No.

PATIENT NAME:

04/01/2024/IPH2024000035

Dr.K.JAISHANKAR

AGE / SEX:

IP No. / UHID No

Ward / Bed No. los

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

		ANY	SCORE>	O SHOULD BE MONI	TORED IN E	VERY SHIFT	
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.
- \ \	8:00	Et Beade	05	Patent	Sheshed		gosn
5/1/24	15.00	Loly Branchol	015	Patent pateni-	Aughal	Followed	Dien 2300
	20\20	\$ bracking	015	Patent Patent Une Per	Hushod Hushod	-	10/0001
1,,	200	RT Broucha	,015	patent	Mushog	_	Mana
6/1/24			I	, line Pen	rovel		
		-					
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			-				
		•					
		_				<u>.</u> .	
						•	







Where heart heat never stops...

REQUISITION FOR MEDICINE

(A Unit of United Alliance Healthcare Pvt Ltd)

IP No.

Name of Patient

DOA

Age / Sex

UHID No. :

Room No + CCA

Consu	Itant Name	: Room No. : CC	J.
S.No.	Date	Medicine Name	Qty.
	27,130	Trub. riols bering.	5
	6 15-13	Trub. Molo box ing. 1 rd. Pan bomg Under pad Bed pour	
3.		under pad	
1		sect pour	1
7.		,	
		/	
	100		





Mrs.SHWETA JAIN

31/Female/MHI202381578 04/01/2024/IPH2024000035

Dr.K.JAISHANKAR





MEDICATION ADMINISTRATION RECORD

Drug Chart	:	_of	<u> </u>		Heig	ht (cms):	15 6cms	Weigh	t (kg): 52.	4Kg					
	KNOW	N MEDICINE A	LLERGIE	S (if NO	ONE is c	onfirmed,	write NKDA in	1 box 1)		ľ					
Drug Details			Descrip	otion of	Allergy			Doct	or's Sign:	111611					
	~			И	OTK	NOW	2		יע	ANUS 1887					
DOCTO	R INSTRUC	TIONS	+		NU	RSING ST	TAFF INSTRUC	 CTIONS		\dashv					
1. Check entries in every section to avoid omissions 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 the 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, 18:00hrs, 22:00hrs, Q4hrly: 02:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, Q25:00hrs, Q4hrly: 02:00hrs, Q6:00hrs, 10:00hrs, Q6hrly: 05:00hrs, Q6h															
			Once O	niy/P	remea				Administeres	,					
Date Time	DOCTOR INSTRUCTIONS Use generic name when prescribing drug Write in BLOCK LETTERS, clearly and legibly Sign and enter MCI registration no. or apply seal No prescription should be altered / overwritten Use 24-hour format when writing time Name: TR. ANUM Reg. No. L2UM 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, 10:00hrs, 10:00hrs, 18:00hrs, 22:00hrs Stat / Once Only / Premedication Drugs														
15 112411-15	INT-	SULPHAG	13417	Sof	00 %	101									
holy 113	INT	_SULPHE	LIRADI	₹	1 —	rm	_134667	Rob	0072	1(24					
5 24 13.5	INJ. !	HEPARIN	=	1000	ZŪ	6	no2411	Du.	020000	13.5					
5/12/13:20	ZNJ.	EMESET	/	HM	IV	<i>b</i>			020	13.20					
15/12/13.20	ENJ:	FENTAN	YL #	20 Fal.	ZV_)	O Si	0202	BO					
5 124 B40	JN) !	parta		Hone	BU	N_	North	0	000	1340					
		· 													
						- · ·			-						
	_		_												
				_	,										
								<u> </u>							
										<u> </u>					

Clinical Phamacist Medway Heart Institute

Clinical Pharmacist CAS

PEGUI	LAR PRESCRIP	TIONS I	Date →	To be	filled b	y Nurs	ing Sta	ff only.	Sign ar	nd time	given
	filled in by Doctor		Time ↓	E 11/2	L/c/2	-					~ 4
DRUG NAME			-70	, _	Qage	<u>-</u>					
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61124	8:40	Low sout, Low Fat diet	K.B.	134559					
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5/1/24	Evening	Agas-Rija	004	Si		Evening			
Stilay	Night	Hannah Cirace	DUN	Hay		Night			
61121	Morning	y. Devathi	0225	MK		Morning			
	Evening			,,,,	•	Evening			
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Night

Night

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Mrs.SHWETA JAIN 31/Female/MH1202381578 04/01/2024/IPH2024000035 Dr.K.JAISHANKAR



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INTERMEDIATE CARE FLOWCHART

NAME: Kyss. Showeya Jain

UHID NO:

AGE:

SEX:

BLOOD GROUP:

N1+1202381578

HEIGHT: 156.cm

WEIGHT: 62.4

B.S.A: 1.6 m2

HAEMODYNAMICS .								RESI	P. PARAMET	ERS	INVESTIGATIONS /		
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PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

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Mrs.SHWETA JAIN 31/Female/MHI202381578 04/01/2024/IPH2024000035

04/01/2024/IPH202400000 Dr.K.Jaishankar



eart beat counts

INTERMEDIATE CARE FLOWCHART

A

NAME: KMI, Sheveta Jain

UHID NO:

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SURGICAL PROCEDURE:

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POSTOP DAY:

FLUID REQUIREMENT: ~

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