

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



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

Mrs. SHWETA JAIN
31/Female/MHI202381578
04/01/2024/UPH2024000035
Dr. K. JAISHANKAR

MHI/IPD/2022/002
Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

Admitting Doctor:

Speciality:

Advised Date & Time:

Provisional Diagnosis:

Reason for Admission:

☐ Medical Management

☐ Surgical Management

☒ Others (please specify details)

Admission Type:

☐ Day Care

☐ ER

☒ Ward

☐ ICU

(Specify details)

Surgery / Procedure Name (if planned):

Blood Product Requirement:

☒ No

☐ Yes

(Kindly specify details of components required in space below)

Expected Duration of Stay:

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

Payer: ☐ Self ☒ Insurance ☐ Others:

Instructions to Nurse (if any):

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

For admission desk staff only:

Room Category: ☐ General Ward
☒ Single Room
☐ Twin Sharing
☐ Deluxe Room
☐ Suite Room
☐ Others _____

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

4/1/24

3:43 PM

4/01/2024

3.46 PM

Source:

☒ OPD

☐ ER

☐ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time



Ash

01692

4/1/23

3.46 PM

INSURANCE



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Patient Name	Mrs. SHWETA JAIN
Age	31 / Female / MHI202381578
Date	04/01/2024 / IPH2024000035
Dr.	Dr. K. JAISHANKAR

MHI/HOSP/2022/129



ADMISSION FORM

Marital Status M	Full Address Tower # 1, Flat # 802, Stephens Road		Telephone Number 9940525831
Occupation IT	North town, Binny Mills, Perumbur - 600012		8610429580
Referred from Mr. Pillai / Dr. Prabakaran	Date of Time of Admission 4/01/2024 - 3-46	Date & Time of Discharge 6/1/24	Total No. of Days 3 days
UNIT Cardiology	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
PSVT - AVNRT			I47.1
Good W FUNCTION			I50.1
DATE	OPERATION / PROCEDURES		ICPM Code
5/1/24	ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION.		04.3
DATE	TYPE OF ANESTHESIA		
5/1/24	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL		
DISCHARGE STATUS			
<input checked="" type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Signature of the Consultant K. Jaishankar		Signature of Medical Records Officer [Signature]	

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.


செவிலியர் கையொப்பம்

Signature of Admitting Nurse

4/02/2024

தேதி

3.46pm -

Date




எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

உறவுமுறை

Nature of Relationship

Patient Details (Affix Label here)	
N	Mrs. SHWETA JAIN
U	31/Female/MHI202381578
D	04/01/2024/IPH2024000035
D	Dr. K. JAISHANKAR
C	

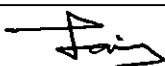
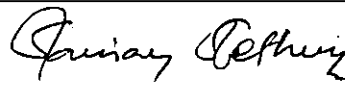
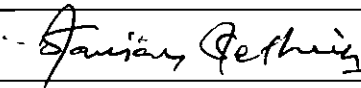
GENERAL CONSENT FOR ADMISSION

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient		SHWETA JAIN	4/1/24	3.46 PM -
Surrogate/Guardian (if applicable #)		SANTAY SETHIYA (Write name and relationship with patient)	4/1/24	3.46 PM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		SANTAY SETHIYA	4/1/24	3.46 PM
Interpreter (if applicable)				

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



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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 Director and Clinical Lead Cardiology and Electrophysiology	D.O.D	: 06/01/2024

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
SPO ₂	-	97% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft, NT
CNS	-	NFND

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

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94557 94557
1800 572 3003

Medway Group of Hospitals

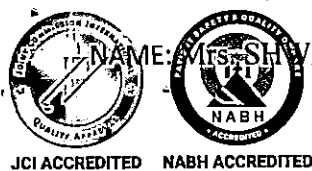
Kodambakkam 044-2473 4455	Mogappair 044-26530011	Chengalpattu 044-27426829	Villupuram 04146-242000	Kumbakonam 044-2473 4455	Kakinada 0884-2333367
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)

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



NAME: Mrs. SHWETA JAIN

UHID: MHI202381578

IP.NO: IPH2024000085

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

BLOOD(04.01.2024): Hb – 12.2gm/dl, TC- 5140 cells/cumm, PLT – 324000 lacs/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.

SCREENING 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 – 71bpm, Within Normal Limits.

SCREENING 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	BP	- 110/70mmHg
PR	-	90/min	SPO2	- 98% in room air

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**PATIENT
HELPLINE**
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Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED

NAME: Mrs. SHIVETA JAIN

UHID: MHI202381578

IP.NO: IPH2024000005



Every heart beat counts
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ADVICE MEDICATIONS:

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

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

Typed by: Sandhiya J

Dr. K. JAISHANKAR
Reg. No: 49448

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Medway Centre of Excellence (Chennai)

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

MHI/HOSP/2022/118

INPATIENT INITIAL ASSESSMENT

Date: 4/1/24

Time of arrival in ward: 16:20.

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98 (°F) | Pulse / HR: 81 (beats/min) | BP: 130/80 (mmHg)

Respiration: 18 (breaths/min) | SpO₂: 97 (%) | Height: 156 (cms) | Weight: 62.8 (kgs) | BMI: 25.6 kg/m²

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

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

Duration: Location:

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

31yrs old female came with complaints of
c/o Palpitation - 1 month associated with Choking Sensation.
- no 4/6 fever, vomiting, loose stools
- no 4/6 urine output, constipation.
- no 4/6 obstipation.

PAST MEDICAL HISTORY (with duration of illness):

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

Others:

NH/c/o Bronchial Asthma / COPD / CKD / PTB / COPD.
epilepsy

Past Surgical History:

NFL

Investigations Advised:

To do Cath Pack investigation

Diet Advice:

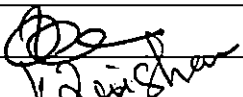
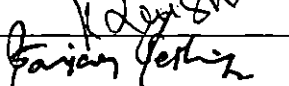
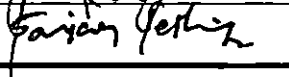
- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: low salt, low fat

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

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. M. Mohamedhyder	165307	4/1/24	16:00
Consultant		DR. K. Jaishankar	49448	5/1/24	10:00
Patient Attendant		Relationship <u>husband</u>	—	4/1/24	16:00



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

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

Dr. K. JAISHANKAR



MHI/IP/2022/041

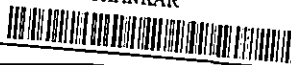


Every heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
04/1/24	S/B Dr. Anusuya
10:50 PM	ch' palpitation on 8 ECG
	O/S: Patient conscious, oriented,
Vitals stable	S/B: CUS - S1S2 ⊕ RS - BAS ⊕ CNS - NFNID
	7 Advice
	- posted for CABG + ERS + RFA
	tomorrow morning
	- NPO from 6:30 AM tomorrow
	- Consent
	- parts preparation
	- pre-medication
	- check Pre-op CBO
	- secure IV line
124557	Shift to Cath Lab on call
	before shifting, to give 2gm Sulphadyl 1gm

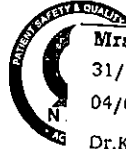
DATE	NOTES
05/01/2024 2:00pm.	CIDB Dr. K. Jaisankar.
Cath no: 3558 3558/3539.	<p>Procedure: Electrophysiology study + Radio frequency ablation using 3D cath.</p> <p>↓ SAP, using 2-1. xylocaine as local anesthesia.</p> <p>Approach : RAV & RFA</p> <p>Sheath : 6Fr.</p> <p>Catheter : RV, HX, CS, RA ablation catheter.</p> <p><u>Electrophysiology study:</u></p> <p>A regular narrow QRS tachycardia was induced with Programmed stimulation protocol.</p> <p>Tachycardia cycle length - 380ms.</p> <p>AH jump & echo noted before initiation of tachycardia.</p> <p>HX. synchronous PVC could not pulling Atrial signals.</p> <p>VOD, could entrain the tachycardia with PPI - TCL = Long, V-A-H-V response.</p> <p>Thus the Tachycardia defined as typical AVNRT.</p> <p><u>RFA using 3D cath:</u></p> <p>Using 3D naviX cath, RA geometry was created & posteroseptal region was mapped. Site was targeted. (50°, 60w, 60-120 seconds) energy was delivered resulted in slow junctional rhythm. few more consolidation was done at the same adjoining region.</p>



DOCTOR'S PROGRESS NOTES

DATE	NOTES
	<p><u>Post RFA:</u></p> <p>No Tachycardia was induced with or without IxO.</p> <p>Post RFA basal intervals are normal.</p>
	<p><u>Final Impression:</u> Post Cath Order:</p> <ul style="list-style-type: none"> • Immobilize (R) Lower Limb • watch hematoma / bleeding. • monitor vitals. • To do: ECG • TAB. Dolo 650mg TDS • TAB. PAN 40mg OD • Discharge tomorrow. • RIA 1 month E ECG. • shift to CCU E IV fluids. / ward shift by evening. after voiding.
	<p><u>Post RFA : Screening Echo:</u></p> <p>No pericardial / pleural effusion.</p>
	<p><u>Final Impression:</u></p> <ul style="list-style-type: none"> • Typical - AVNRT • Successful ablation done for slow pathway signal.

Dr. Jaishankar
49/01/24



Mrs. SHWETA JAIN

31/Female/MHI202381578

04/01/2024/IPH2024000035

Dr. K. JAISHANKAR



DOCTOR'S PROGRESS NOTES

DATE	NOTES
6/1/24	S/B. Dr. Sujith B. (Dmo)
8:35 AM	S/P - Eps + RFA.
	pt. reviewed
	- c/o. pain over chest
	S/R - pt. conscious, oriented, Afebrile
	S/R - c/o - S/Sx RR - BAB PA - soft.
	Ach
	- vitals monitoring.
	- w/f desaturation / bleeding
	- Follow dysrhythmia
	- Inferior SOS
	B.S.
	183573

~~Input 1500
Output 1600 L.
(neg. bal - 500 L.)
BP 110/70 mmHg
HR 90 bpm
SpO2 98% JRA~~

DATE	NOTES
6/1/24	Shirley Jones
9:30	clothes machine
	allowing
	2) in
	no rub
	from
	very
	11/10/20
	paper
	plan
	new MB, new
	9.10.20 from my
	3 day
	F. per day
	3 day
	Mohile
	d/c today
	Review on Tuesday
	with report
	1
	10/20



MICROBIOLOGY SHEET

MICROBIOLOGY-CULTURE REPORTS



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

DIABETIC CHART

Mrs. SHWETA JAIN
31/Female/MH1202381578
04/01/2024/1PH2024000035
Dr. K. JAISHANKAR

ACTUAL WEIGHT 62.4 Kgs HbA_{1c} —

PREVIOUS DIABETIC MEDICATIONS —

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
4/1/24	15:00	128 mg/dl	—		DR. ANUSUYA
5/1/24	11:30	99 mg/dl	ins		DR. ANUSUYA

INSTRUCTIONS FOR INSULIN INFUSIONS

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

BLOOD GROUP

Mrs. SHWETA JAIN

31/Female/MHI202381578

04/01/2024/IPH2024000035

Dr. K. JAISHANKAR



INVESTIGATION SHEET

Date	4/1/24					
HAEMATOLOGY						
Hb	12.2					
P.C.V	35.3					
Platelets	324000					
TLC	5140					
Polymorphs	62.0					
Lymphocytes	23.1					
Eosinophils	9.5					
Mono / Basophils	4.7 / 0.7					
E.S.R						
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 Protein						
S.Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]



Medway Hospital
The way to better heal
(A Unit of United Alliance Healthcare Pvt.)

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

Dr. K. JAISHANKAR



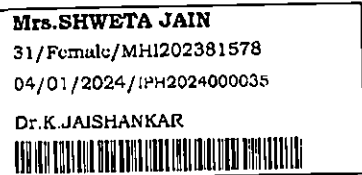
MHI/IP/2022/066



Every heart beat counts

Date	From: 11/1/24	To: 11/1/24	Bed No: 100 - A	INTAKE & OUTPUT CHART												
24 Hrs : Started Time : 16:00		Ended Time : 17:00														
NPO Started at :		NPO Over at :														
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)									
INTAKE			150		650ml											
OUTPUT			300		450ml											
Total Intake: 700ml			Total Output: 1050ml			Difference: 350ml										
INTAKE (ml)							OUTPUT (ml)									
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by	
			Type of Fluid	Additions	Amount											
17:30	100					100										
18:00	50					150	18:00	300				300ml				
19:30	150					300	22:00	250				650				
20:40	150					450	6:30	400				1050				
22:30	100					550										
6:00	250					700										
										Total Intake - 700ml						
										Total Output - 1050ml						
										Balance - 350ml						
															Hay	
															0105	
															11/1/24	

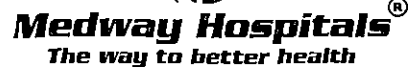
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Medway
Heart
Institute

Every heart beat counts

[illegible]



(A ~~United Alliance Healthcare Pvt Ltd~~)

(A) Indian Alliance He
Mrs. SHWETA JAIN

31/Female/MH1202381578

04/01/2024/IPH2024000035

Dr.K.JAISHANKAR



'MHI/IP/2022/074



Every heart beat counts

VITAL INFORMATION SHEET

BLOOD GROUP

ON ADMISSION

Height in CM

Weight in Kg.

156 Cmm

62.4

Diagnosis: psut -? AT /? ADORT

Procedure :

[illegible]

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

Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex: _____

Patient Id No: _____

NEWS key		DATE	TIME	DATE	TIME
0	1 2 3				
A+B	Respirations Breath/ min				
	>25				
	21-24				
	18-20				
	15-17				
	12-14				
	9-11				
	<8				
A+B	SpO2 Scale 1 Oxygen Saturation (%)				
	>96				
	94-95				
	92-93				
	<91				
	SpO2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 %				
	>96 on oxygen				
	85-96 on O2				
	93-94 on O2				
	>93 on air				
	88-92				
	86-87				
	84-85				
	<83%				
Air or Oxygen ?	A= Air O2litre/ min Device				
C	Blood Pressure				
	>220				
	201-219				
	181-200				
	161-180				
	141-160				
	121-140				
	111-120				
	91-100				
	81-90				
	71-80				
	61-70				
	51-60				
	<50				
Diastolic BP	mmHg				
	>131				
Pulse	Beats / min				
	121-130				
	111-120				
	101-110				
	91-100				
	81-90				
	71-80				
	61-70				
	51-60				
	41-50				
	31-40				
	<30				
D	Consciousness Score for New onset of confusion (no score if chronic)				
	Alert				
	Confusion				
	V				
	P				
	U				
E	Temperature Degree Celsius				
	>39.1 degree Celsius				
	38.1-39.0				
	37.1-38.0				
	36.1-37.0				
	35.1-36.0				
	< 35.0				
NEWS Total					
Monitoring Frequency					
Escalation of Care Y/N					
Initials by RN					
Initials by Sr. RN					

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

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

Mrs. SHWETA JAIN

31/Female/MHI/202381578

04/01/2024/IPH2024000035

Dr. K. JAISHANKAR



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: PSOT-2AT | 2AUNRE | EDS+RFA | EF-55%

Height: 156 cms Weight: 62.4 Kgs Food allergies: Yes/No; if yes, specify.....

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

Diet Prescription: 1000 cal diet, low fat, low salt diet

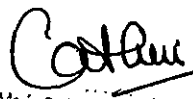
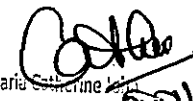
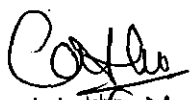
SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time:

Signature
Maria Catherine
Senior Dietitian

4/1/24, 12:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
4/1/24, 17:00	<p>A 31 year old female came to do palpitation (on & off) since 1 month) was around to be well nourished as evident by SGA.</p> <p>No comorbidity.</p> <p>Educated the patient and family on 1600 calories, low fat, low salt diet. Emphasized on small frequent meals.</p>	 Maria Catherine John Senior Dietitian
5/1/24, 18:00	<p>Patient shifted to Cathlam for procedure (ERS + RFA) and kept on NPO. Patient <u>unable</u> to swallow. NPO over. Patient <u>unable</u> to eat. Can initiate on soft solid diet.</p>	 Maria Catherine John Senior Dietitian
6/1/24, 10:00	<p>Oral intake is good. Educated the patient and family on 1600 calories, low fat, low salt diet <u>on discharge</u>. Emphasized on small frequent meals. Diet modification and clarification done. <u>Diet</u> chart given on discharge.</p>	 Maria Catherine John Senior Dietitian



Mrs. SHWETA JAIN

31/Female/MHI202381578

04/01/2024/IPH2024000035

Dr. K. JAISHANKAR



e)

PSYCHOLOGICAL WELLBEING REPORT

Date: 06/01/24

Time: 1.00 pm.

Unit: 105A

Clinical diagnosis: EPS + RFA

Surgery/ Procedure:

Impression: Functioning well

- calm affect, oriented, responsive.
- sleep & appetite (N), called self as "depression".
- misunderstanding & conflicts in given
environment of extended family regarding
personal career.
- supportive counseling provided &
psycho education on depression.

Employee ID: MH10278PS4

Signature of the Psychologist:

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: PSVT Allergies if any: NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
1 st Floor (WAB)	CATH LAB	5/1/24	11:30	EPS + RFA

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

ASSESSMENT OF PATIENT:

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

Language Barrier: ☐ Yes ☒ No ☐ If Yes, specify: _____

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

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

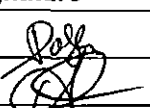
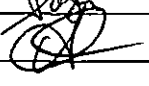
Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.4	20	88	98	110/80	0/10

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

Any pre-medication given: yes

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
Handed over to		Dr. K. Jaishankar	0072	5/1/24	11:30
		V. Abinaya	0202	5/1/24	11:30

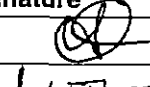
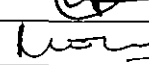
After Procedure:

Procedure completed: ☐ Yes ☒ No | Any critical information: Nil


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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.6	22 br/min	85 bt/min	100%	115/86 (95)	1/10

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

Handover by	Signature	Name	Emp. No.	Date	Time
Handed over to		V. Abinaya	0202	5/1/24	15:00
		Dr. K. Jaishankar	235	5/1/24	15:00

CONSENT FOR ELECTROPHYSIOLOGY & ABLATION PROCEDURE

Patient Na	Mrs.SHWETA JAIN 31/Female/MHI202381578 04/01/2024/IPH2024000035	Sex: M/F
Consultan	Dr.K.JAISHANKAR 	No: UHID

CONDITION AND PROCEDURE

Dr. ~~JAISHANKAR~~ 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 cause palpitations, chest discomfort, giddiness or breathlessness. 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.

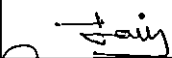
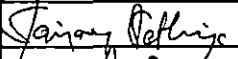
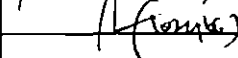
	(d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency 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 puncture site
Most People	(o) Minor bruising

PATIENT CONSENT:

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

On the basis of the above statements,

I AGREE TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		Shweta Jain	04-01-2024	17:30
witness		Sangeet Sethi	04.01.2024	17:30
Doctor		Dr. Gupta		
Interpreter				

மின்உடலியங்கியல் & உறுப்புநீக்கல் மருத்துவ செயல்முறைக்கான ஒப்புதல்

நோயாளியின் பெயர்	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 முனையிலிருந்து பயணித்து இதயத்தின் மேற்புற அறைகளுக்கு (அட்ரியா) பரவுகிறது; அதன்பிறகு AV முனை மற்றும் HIS-ன் தொகுப்பு என அழைக்கப்படும் இதயத்தின் மேல் மற்றும் கீழ்ப்பகுதிகளில் உள்ள சந்திப்புகள் வழியாக இதய கீழறைகளுக்கு (வெண்ட்ரிக்ளின்) 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 (சுப்ராவெண்ட்ரிக்ளூல் - SVT) அல்லது இதய கீழறையில் (வெண்ட்ரிக்ளூல்-VT) ஒரு இயல்புக்கு மாறான பகுதி, சைனஸ் முனையைப்போல, ஆனால் மிக வேகமான விகிதத்தில் செயல்படுவதால் இது நிகழக்கூடும். இது, பட்டப்புகளையும், மார்பு அசௌகரியத்தையும் மயக்கம் அல்லது சுவாசசிரமத்தையும் விளைவிக்கக்கூடும். வேறுசில பாதிப்பு நிலைகளில் இதய மேலறைக்கும், இதய கீழறைக்கும் இடையிலான ஒரு இயல்புக்கு மாறான இணைப்பு, இதய கீழறையிலிருந்து, மேலறைக்கு மின்சார அலையை திரும்பப்போகாமாறு 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 (கதிட்டர்), இரத்தக்கசிவை தடுக்கின்ற ஒரு வால்வைக் கொண்டிருக்கும் ஒரு உறை வழியாக, இடுப்புக்கவட்டை / கழுத்திலுள்ள சிறை நரம்பு வழியாக உட்செலுத்தப்படுகிறது. இதயத்தில் ஒரு குறிப்பிட்ட பகுதிக்குள் செல்லுமாறு இந்த கதிட்டர் மிக கவனத்தோடு அனுப்பப்படுகிறது. இந்த வழிமுறையின் மூலம் இதயத்தின் பல்வேறு பகுதிகளுக்குள் 3 முதல் ஐந்து கதிட்டர்கள் வரை உட்செலுத்தப்படுகின்றன. கதிட்டரின் மற்றொரு முனையானது, ஒரு மின்உடலியங்கியல் பரிசோதனையாக என அழைக்கப்படும் ஒரு நவீன கணினியுடன் ஒரு ஐங்ஷன் பாக்ஸ் மூலம் இணைக்கப்பட்டிருக்கும்.

இதயத்தின் பல்வேறு பகுதிகளிலிருந்து, மின்சார அலையின் மீது செய்யப்படும் ஆய்வு எலக்ட்ரானிக் கர்சர்கள் உடன் கூடிய ஒரு மல்டிசேனல் மானிட்டரில் அதேநேரத்தில் காட்சிப்படுத்தப்படுகின்றன. மின்சார அலைகளை வெளியேற்றுகின்ற அல்லது இயல்புக்கு மாறான கூர்நோக்க அமைவிடத்தை அல்லது இவைகளை கடத்துகின்ற இயல்புக்கு மாறான 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 ஆஞ்சியோகிராஃபியில் ஏற்படும் இடர்கள் கீழ்க்கண்டவற்றை சார்ந்திருக்கிறது:

- கரோனரி தமனி நோயின் தன்மை
- இதயத்தின் இரத்தத்தை உடலின் பிற உறுப்புகளுக்கு பம்ப் செய்யும் திறன்நிலை.
- உங்களது வயது மற்றும் பொதுவான உடல்நலம்

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

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

	<p>(d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டை / சாயம்) ஒரு ஆயத்தான 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.</p> <p>(e) காலில் துளையிட்ட இடத்தில் பெரிய அறுவைசிகிச்சைக்கான அவசியம்.</p> <p>(f) அவசர நிலை நிகழ்வாக இதய அறுவைசிகிச்சை அல்லது ஆஞ்சியோபிளாஸ்டிக்கான அவசியம்.</p> <p>(g) எக்ஸ்-ரே / ஊடுகதிருக்கு வெளிப்படுவதால் உயர்ந்திருக்கும் ஆயுட்கால இடர்வாய்ப்பு</p> <p>(h) உயிரிழப்பு</p> <p>(i) அறுவைசிகிச்சை அல்லது பழுதுநீக்கும் மருத்துவ செயல்முறை அவசியப்படுகிறவாறு கத்திரால் இதயம் மற்றும் இரத்தநாளங்களில் துளை விழுதல்.</p>
1 in 100 people (0.01%)	<p>(j) முறையான லயத்துடன் இதயத்தாடிப்பு இருக்காது; இதற்கு அவசரசிகிச்சை தேவைப்படும்.</p> <p>(k) இடுப்பு கவட்டையில் துளையிட்ட அமைவிடத்தில் அறுவைசிகிச்சை சார்ந்த பழுதுநீக்கல்; மருத்துவமனையில் நீண்டகாலம் தங்கி சிகிச்சைப்பெறுவது இதற்கு அவசியமாக இருக்கலாம்.</p> <p>(l) கான்ட்ராஸ்ட் மீடியத்திற்கு தோலரிப்பு போன்ற சிறிய எதிர்வினை.</p> <p>(m) கான்ட்ராஸ்ட் மீடியத்தின் காரணமாக சிறுநீரக செயல்திறன் இழப்பு / பாதிப்பு</p>
1 in 20 people (0.05%)	<p>(n) இடுப்புக் கவட்டையில் துளையிட்ட அமைவிடத்தில் பெரிய அளவிலான சிராய்ப்பு காயம் அல்லது வீக்கம்</p>
Most People	<p>(o) சிறிய அளவிலான சிராய்ப்பு காயம்</p>

நோயாளியின் ஒப்புதல்:

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 வெளிப்படுத்தவும் எனக்கு வாய்ப்பளிக்கப்பட்டது என்றும் மற்றும் நான் முழு திருப்தியடையும் வகையில் என்னுடைய அனைத்து கேள்விகளும், கவலைகளும் விவாதிக்கப்பட்டன மற்றும் பதிலளிக்கப்பட்டன நிகழ்வதற்கு அரிதான சிக்கல்கள் ஏற்படும் நேர்வில் இரத்தமேற்றல், ஒரு கூடுதல் மருத்துவ செயல்முறை அல்லது அறுவைசிகிச்சை எனக்குத் தேவைப்படலாம் என்று நான் புரிந்து கொள்கிறேன். சிகிச்சை செயல்முறையின்போது உயிருக்கு ஆபத்தான நிகழ்வுகள் நிகழுமானால், அவைகளுக்கு உரியவாறு சிகிச்சையளிக்கப்படும் என்று மருத்துவர் என்னிடம் விளங்கிக் கூறியிருக்கிறார். இந்த சிகிச்சை செயல்முறையானது எனது நோய் நிலையை குணமாக்கி மேம்படுத்தும் என்பதற்கு உத்தரவாதம் ஏதும் செய்யப்படவில்லை என்றும் நான் புரிந்துகொள்கிறேன்.

மேற்கூறப்பட்ட அறிக்கைகளின் அடிப்படையில்,

இந்த மருத்துவ செயல்முறை எனக்கு செய்யப்படுவதற்கு நான் சம்மதிக்கிறேன்.

	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி/பாதுகாவலருடனான உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				



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Every heart beat counts

ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D**ENSITE REPORT**

PATIENT NAME : Mrs.SHWETA JAIN **UHD** : MHI202381578
AGE/GENDER : 31 YEARS / FEMALE **IP NO** : 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

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VAWB	320 ms
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NO ANTEGRADE PRE-EXCITATION PATTERN NOTED

VA CONDUCTION WAS CONCENTRIC AND DECREMENTAL

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:

AVW	380ms
-----	-------

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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IMPRESSION:

TYPICAL AVNRT
SUCCESSFUL RFA - SLOW PATHWAY ABLATION DONE

ADVICE:

REVIEW AFTER 1 MONTH WITH ECG.

CONSULTANT SIGNATURE

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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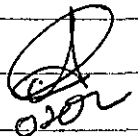

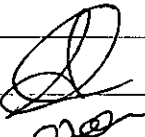
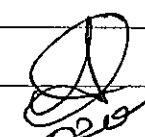
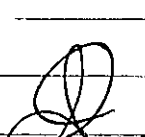
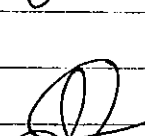
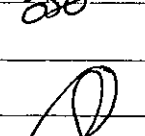
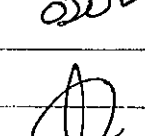
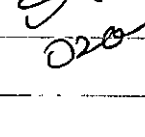
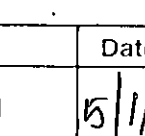

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NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12:40	⇒ patient arrived 1st floor to Cath lab pt conscious & oriented pt vital stable pt IV line patent	 020
12:50	⇒ Sterile Drapping done under the local anaesthesia.	 020
12:55	⇒ EPST RFA 3D procedure started Rt femoral artery and venous approach	 020
13:05	⇒ AM: Heparin 10000 IV gives (O/B DR. JS) (SIR)	 020
13:15	⇒ HR: 94 b/min Bp: 114/64(81) mm/Hg SpO2: 100% vital stable.	 020
13:20	⇒ AM: Fentanyl 20 mcg IV gives (O/B DR. JS) (SIR)	 020
13:30	⇒ AM: EMESEI 4 mg IV gives O/B (DR. JS) (SIR)	 020
13:35	⇒ O2 4 liters connected	 020
13:40	⇒ HR: 85 b/min Bp: 107/72(85) mm/Hg SpO2: 100% vital stable.	 020
13:40	⇒ AM: pantie hang IV gives O/B (DR. JS) (SIR)	 020
14:00	⇒ EPST RFA 3D procedure done Rt femoral artery and venous sheath removed tight pressure bandage applied no oozing no haematoma	 020
15:00	⇒ pt shifted cath lab to cell.	 020

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Jaishankar	0016	15/1/24	16:00

NURSES PROGRESS NOTES

[illegible]

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086



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

Dr. K. JAISHANKAR



Name of the Procedure : EPS + RFA T3D Location : Cath Lab Date & Time : 5/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>12:50</u> Before Induction of Procedural Sedation		TIME OUT <u>12:55</u> After procedural Sedation and before procedure		SIGN OUT <u>14:00</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>EPS + RFA T3D</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input type="checkbox"/> Yes <input type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt femoral artery removal</u>	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input checked="" type="checkbox"/> Yes	Position <u>supine</u>	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify : <u>Observation</u>	
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
All concerned anaesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify <u>ECG</u>	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify : <u>P</u>	
		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes	Corrective action :	
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes		
		For procedural sedation cases			
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycaemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : <u>Spr panehawan</u>	Technician : <u>Panna</u>	Others Please Specify :
Date : <u>5/1/24</u>	Date : <u>5/1/24</u>	Date : <u>5/1/24</u>	Date : <u>5/1/24</u>	Date : <u>5/1/24</u>
Time : <u>14:15</u>	Time : <u>14:15</u>	Time : <u>14:15</u>	Time : <u>14:15</u>	Time : <u>14:15</u>

Procedure Monitoring Sheet (Cath Lab)

Patient Name : **Mrs. SHWETA JAIN**
31/Female/MHI202381578
UHID / IP : 04/01/2024/IPH2024000035
Consultant : Dr. K. JAISHANKAR

Age / Sex : 31Y/F
Ward Unit : 1st floor
Diagnosis : PSVT

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

PARAMETERS	YES	NO	NA
al signs : BP: 104/118 Temp: 37.6 Pulse: 78 RR: 20 SPO2: 98	✓		
Urine voided	✓		
Bowel preparation			✓
Pre-procedure medication administered	✓		
Procedure site marked			✓
Skin preparation done	✓		
NPO 6:30			
Loose Tooth removed			✓
Contact lenses / Eye glasses removed			✓
Prosthesis present			✓
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food) NKDA	✓		✓
iv line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓	✓	
Signature of Nurse : M. R. 2025	Date & Time : 05/11/24 at		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
13:5	94 bt/min	22 br/min	114/64 (81)	100 %	-	Dona
13:20	85 bt/min	20 br/min	107/73 (85)	100 %	-	Dona
13:40	84 bt/min	22 br/min	114/86 (95)	100 %	-	Dona
14:00	82 bt/min	22 br/min	112/82 (96)	100 %	-	Dona
procedure got over						

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

Time : 12:00 Route : RT femoral artery

Complication : Nil venous

BP : 118/82(95) mmHg, HR : 85 b/min, RR : 22 b/min SpO2 : 100%

Distal Pulse : well Puncture Site : no oozing no haematoma

Advise:

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

◆ Inform Duty Medical Officer SOS

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

- ◆ Remove RT femoral dressing on 6/1/24 at 12.00 AM / PM after informing to the consultant.

- ◆ Special instruction if any:

Nil

[Signature]

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
5/1/24 14:15	118/56	86	22	100%	no oozing no haematoma	Good	—	<u>[Signature]</u>
14:30	120/70	85	22	100%	"	"	—	<u>[Signature]</u>
14:50	118/54	82	22	100%	"	"	—	<u>[Signature]</u>

Nurses Notes :

EPST RFA 3D procedure done RT femoral artery sheath removed tight pressure bandage applied no oozing no haematoma seen

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

[Signature]

Date & Time :

5/1/24
14:55

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 11/04 Time of Arrival: 16:30 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher
Accompanied by Relative: ☐ Yes ☐ No If Yes, Name of the Relative: Mr - Sankar
Relationship with Patient: husband 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
Menstrual History : LMP : _____ Menopause: _____
Medical History : DM / HTN / Co - Morbidity : _____ Yes If yes specify
Drugs History : Antiplatelet _____ (Specify)

Psychological Status: ☒ Calm ☐ Anxious ☐ Withdrawn ☐ Agitated ☐ Depressed ☐ Sleeping Difficulty
Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☒ No
If Yes, specify details: _____

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

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 76 (beats/min) | BP: 120/80 (mmHg)
Respiration: 20 (breaths/min) | SpO₂: 96 (%) | CBG: 128 (mg/dl) | Height: 56 (cms) | Weight: 62.4 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☒ No ☐ Medication ☐ Blood Transfusion ☐ Food ☒ Not known
If Yes, specify: _____

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10 Pain Scale Used: ☐ Wong-Baker FACES Pain Rating Scale (7-12 years)
☒ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)
Duration: _____ Location: _____
Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:
Last 3 months Appetite: ☐ Increased ☐ Decreased ☒ No Change
Last 3 months Weight: ☐ Increased ☐ Decreased ☒ No Change
Type of Patient: ☐ Diabetic ☒ Non Diabetic Type of Diet: normal diet
Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: ms- carthine Time: 10:30

Orient Patient if: ☒ Conscious Orient Patient Attendant if: ☐ Unconscious ☐ Disoriented
☐ Room ☐ Side Rails ☐ Toilet Bell ☐ Patient Information Board ☐ Bathroom ☐ Bed Controls
☐ Use of Footstool ☐ Grab Bars ☐ Nurses Call Bell ☐ Television ☐ Light Controls ☐ Telephone

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Hearing Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Chewing Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Walking Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

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

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

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

Witnessed by: _____ Signature: _____ Relationship: _____

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

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

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT):

Tick the score obtained (✓)

Final Score

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

Personal Belongings / Valuables:

Valuables	Description	With Patient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant	Remarks
Dentures	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both <input checked="" type="checkbox"/> Nil				
Hearing Aid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Nil				
Eye glasses / Contact lens	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Jewellery	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Other valuables (specify)					

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
	<i>[Signature]</i>	SARJAY SETHI	Relationship Husband	11/1/24	16:30
Nurse	<i>[Signature]</i>	A-MONISHA	0141	11/1/24	16:30
Unit In-Charge	<i>[Signature]</i>	S. Nalin	0024	11/1/24	9:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 4/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: POST ? ABORT

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: - Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day: -

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: -

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 18 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 99 (%) | Height: 156 (cms) | Weight: 62.4 (kgs) | BMI: 25.6 kg/m²

Others: -

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

Fall Risk Score: 59 Fall Risk Protocol: ☒ Low ☐ Medium ☐ High

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: Normal diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>[Signature]</u>	<u>P. Sushma</u>	<u>0801</u>	<u>4/1/24</u>	<u>17:00</u>
Handover taken by	<u>[Signature]</u>	<u>Hannah Croare</u>	<u>0100</u>	<u>4/1/24</u>	<u>19:30</u>
Document endorsed	<u>[Signature]</u>	<u>S. Nalin</u>	<u>0024</u>	<u>5/1/24</u>	<u>9:00</u>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 4/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: P3VT

NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right: ☒ Left: ☐

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

Day:

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

GCS: 15/15

POD: —

Central line days: —

VIP Score: —

B

BACKGROUND

Type of surgery: —

Date of surgery: —

Allergies if any: NKDA

On room air / oxygen: on room air

IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 97 (%) | Height: 156 (cms) | Weight: 62.4 (kgs) | BMI: 25.6 kg/m²

Others: —

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

Fall Risk Score: 0 Fall Risk Protocol: ☒ Low ☐ Medium ☐ High

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Normal diet

Drains: —

R

RECOMMENDATION

Referral doctors: —

Pending medications: —

Pending medication indent: —

Pending lab reports / Investigations: —

Critical value alert and its corrections: —

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

Pending follow-up orders: —

Special instructions if any: Plan Eps + RFA, NPO from 6:30

	Signature	Name	Emp. No.	Date	Time
Handover given by	Hay	Hannah Cruise	0105	5/1/24	7:30
Handover taken by	Rag	Ravisha	0072	5/1/24	7:30
Document endorsed	Nae	S. Nalin	0024	5/1/24	9:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
11/24	Night duty notes	
19:30	Patient handover taken from Evening duty staff in a hemodynamically stable condition.	Hay 0105
20:00	Vital Signs checked & Recorded	Hay 0105
21:00	Due drugs are given as per drug chart	Hay 0105
22:00	Patient is sleeping	Hay 0105
23:00	Patient is sleeping well had no complaints	Hay 0105
6:00	patient Vital Signs checked & Recorded Ilo chart Maintained	Hay 0105
Document endorsed by	Signature S. Nalin	Name S. Nalin
		Emp. No. 0024
		Date Sept 9, 2022
		Time 9:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 5/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: PSVT

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: -

Day: -

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: +

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 96.7 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 97 (%) | Height: 156 (cms) | Weight: 62.4 (kgs) | BMI: 25.6 kg/m²

Others: -

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

Fall Risk Score: 20 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Current diet: Normal diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: mi

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: Today EPS + RFA Plan.

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>[Signature]</u>	<u>M. Ravi</u>	<u>0225</u>	<u>5/1/24</u>	<u>11.40</u>
Handover taken by	<u>[Signature]</u>	<u>Dr. Reshamraj</u>	<u>232</u>	<u>5/1/24</u>	<u>11.40</u>
Document endorsed	<u>[Signature]</u>	<u>S. Alalini</u>	<u>0024</u>	<u>5/1/24</u>	<u>11.40</u>

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 5/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: PSVT

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: Bronchial

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: Bronchial

Day: -

Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 01

B

BACKGROUND

Type of surgery: Tumor

Allergies if any: -

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: D15 NS 80ml/hr.

A

ASSESSMENT

Vital Signs: Temp: 37.3 (°F) | Pulse / HR: 75 (beats/min) | Respiration: 22 (breaths/min)

BP: 107/68 (mmHg) | SpO₂: 99 (%) | Height: 156 (cms) | Weight: 62.4 (kgs) | BMI: 25.6 kg/m²

Others: -

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

Fall Risk Score: 0 Fall Risk Protocol: ☒ Low ☐ Medium ☐ High

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

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

Current diet: Normal diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: Bronchoscopy D/S

	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>[Signature]</i>	R. Ananthanaray	2832	5/1/24	16:00
Handover taken by	<i>[Signature]</i>	Hannah Grace	0105	5/1/24	19:00
Document endorsed	<i>[Signature]</i>	S. Nalini	0094	5/1/24	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
11/24		
15.00	pt G pt Records taken over from cathlab staff. pt conscious & oriented. pt vitals are stable. pt (R) (L) peripheral line present & patent. (R) Femoral procedure site no oozing & Haematoma.	<u>not</u> 23a
16.00	pt Abdomen soft. pt ECG taken, CRG checked	<u>not</u> 23a
16.50	pt Had a Juice pt Shifted to ward Hand over to the Ward Staff.	<u>not</u> 23a
	Receiving Notes.	
17.00	pt received From A&C at 17.00 pt conscious & oriented pt had on wound dress	<u>not</u> 23a
17.30	Right femoral approach. Anastomosis to be removed	
18.00	vital signs checked & monitored PvO ₂ chart monitored	
19.00	pt handover over to the Night duty staff	<u>not</u> 23a
Document endorsed by	Signature <u>Not</u>	Name S. Nalini
		Emp. No. 0024
		Date 5/11/24
		Time 22:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 6/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: PSVT

NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

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

GCS: 15/15

POD: —

Central line days: —

VIP Score: 0/5

B

BACKGROUND

Type of surgery: Proced EpstRFA

Allergies if any: NKDA

On room air / oxygen: on room air

Complaints / New Symptoms in last shift: —

Date of surgery: 5/1/24

IV fluids on flow: —

A

ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 97 (%) | Height: 156 (cms) | Weight: 62.4 (kgs) | BMI: 26.5 Kg/m²

Others: —

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

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

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

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

Current diet: Normal diet

Drains: —

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders: —

Special instructions if any: Removal approach, Plan dls tomorrow

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>Hoy</u>	<u>Hannah Grace</u>	<u>0105</u>	<u>6/1/24</u>	<u>7:30</u>
Handover taken by	<u>Pat</u>	<u>David</u>	<u>0072</u>	<u>6/1/24</u>	<u>7:30</u>
Document endorsed	<u>Nas</u>	<u>S. Naeini</u>	<u>0084</u>	<u>6/1/24</u>	<u>8:00</u>

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 06/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: PSVT

NEWS / PEWS Score: 0

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: EPST RFA

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift:

Date of surgery: 05/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.6°F | Pulse / HR: 74 (beats/min) | Respiration: 26 (breaths/min)

BP: 130/70 (mmHg) | SpO₂: 98 (%) | Height: 156 (cms) | Weight: 62.4 (kgs) | BMI: 26.5 kg/m²

Others: -

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

Fall Risk Score: 35 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Current diet:

Drains:

Normal diet

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

Today plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by	M. R.	M. R. Ravathi	0225	06/1/24	12:30
Handover taken by					
Document endorsed	N. S.	S. Nalin	0084	6/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
6/1/24 at	Morning duty note.	
7.30	→ Patient hand over taken to the night duty staff. → conscious & oriented.	M.D. dy 05/25
8.50	→ vital signs checked & recorded. → Patient had a normal diet → medication given as per as drug chart.	M.D. dy 05/25
9.30	→ patient was stable & NO complaints	
10.00	→ Today plan discharge.	
11.30	→ I/O chart monitored → vital signs checked & recorded	
12.30	→ patient hand over given to the evening duty staff.	M.D. dy 05/25
	Discharge Notes	
14.00	Pt discharge summary explained.	
	vital signs checked & monitored	
	Willing cleared	
	IV line removed	
15.40	Pt discharged at 15.40	
Document endorsed by	Signature S. Nalini	Name S. Nalini
		Emp. No. 0084
		Date 6/1/24
		Time 16:00

ADULT NURSING CARE PLAN

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



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 4/1/24. Time: 19:00

Modified Date: Time:

Reason for Modification:

Diagnosis: PSVT - AT - I AVNRT

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input checked="" type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Encourage regular ambulation ROM exercise <input checked="" type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M	
			E pt well Mobilized	Jeff 02/01
			N Patient Mobilized well	Hay 02/01
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input checked="" type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continnence or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input checked="" type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemesi as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M	
			E pt Normal pattern	Jeff 02/01
			N Pt had normal elimination patteen	Hay 02/01
SKIN INTEGRITY <input type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input checked="" type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M	
			E pt skin Integrity	Jeff 02/01
			N	

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M E pt well communication N pt communicated well	 P H S
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input checked="" type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M E Due drops clear given N —	 P
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>No</i>	S. Nalin	0024	5/1/24	9:00

ADULT NURSING CARE PLAN

Mrs. **SWETA JAIN**
31/Female/MHI202331578
04/01/2024/IPH2024000035
Dr. K. JAISHANKAR



Consultant

MHI/NUR/2022/044




Every heart beat counts

Initial Date: <u>05/12/23</u> Time: <u>8:00</u>		Modified Date: _____ Time: _____		
Reason for Modification: _____		Diagnosis: <u>non-ST ECG pST</u>		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input checked="" type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt had <u>(N) diet</u> E <u>Pt Had a (N) diet</u> N Patient had normal diet	<u>MD</u> <u>23/12</u> <u>Hay</u> <u>over</u>
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BIPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input checked="" type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt is on room air E Pt on room air N Patient was stable on room air	<u>MD</u> <u>23/12</u> <u>Hay</u> <u>over</u>
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M I/O chart monitored E Pt R/F NS 60ml/hr going to flow N I/O chart maintained	<u>MD</u> <u>23/12</u> <u>Hay</u> <u>over</u>

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input checked="" type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input checked="" type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt Good mobilized	MD 23/5
			E Pt Bed mobilize	MD 23/5
			N Patient mobilized slightly	Hay 23/5
ELIMINATION <input checked="" type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input checked="" type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenc / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Normal Elimination Pattern	MD 23/5
			E Pt @ Elimination pattern	MD 23/5
			N Patient had normal elimination pattern	Hay 23/5
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Maintain normal skin intact	MD 23/5
			E Pt maintain (N) skin integrity	MD 23/5
			N Patient had normal skin integrity	Hay 23/5

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input checked="" type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M pt good hygiene E pt clean & Hygienic N pt groomed well	MD 07/23 23rd Hay 01/05
SAFETY <input checked="" type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	MID Band Present E pt ID band present N ID band present	MD 07/23 23rd Hay 01/05
COMFORT AND SLEEP <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M — E pt comfortable position N —	23rd Hay 01/05
OBSERVATION <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M vital signs checked & recorded E pt vitals record it N Patient Vital Signs are stable	MD 07/23 23rd Hay 01/05
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M — E pt good psychological support N —	MD 07/23 23rd Hay 01/05

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input checked="" type="checkbox"/> Encourage the use of call bell <input checked="" type="checkbox"/> Obtain interpreter if needed <input checked="" type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M PE 4000 - communication E Pt Good verbal communication N Pt Communicated well	NP 2/28 Hay 01/05
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M — E administered the medication as per physician N Due drugs are Given	not 2/28 Hay 01/05
Endorsed by,	Signature	Name	Emp. ID	Date	Time
		S. Nalini	0024	2/1/24	9-20

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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

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

ADULT NURSING CARE PLAN

Mrs. SHWETA JAIN
31/Female/MHI202381578
04/01/2024/UPH2024000035
Dr. K. JAISHANKAR

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

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M <i>pt 4000 communication</i> E N	<i>MB</i> MB
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M <i>Medication given as per as doctors</i> E N	<i>MB</i> MB
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>Nes</i>	<i>S. Nalin</i>	<i>0024</i>	<i>6/1/24</i>	<i>13:00</i>



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	3	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	3	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4	4	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IVs for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4	3	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3	
					TOTAL SCORE	23	23	20
					Initial & Emp. No. of Staff Nurse:	MD 1001	MD 1001	MD 1001
					Initial & Emp. No. of Sr. Staff Nurse:	MD 1001	MD 1001	MD 1001

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
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 Moist Skin is usually dry, linen only requires changing at routine intervals	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4		
FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3		
					TOTAL SCORE	23	
					Initial & Emp. No. of Staff Nurse:	108	
					Initial & Emp. No. of Sr. Staff Nurse:	102	

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

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
4/1/24 17:00	0/10	No pain	-	-	-	Hay 024	Nee 24
22:00	0/10	No pain	-	-	-	Hay 024	Nee 24
		Patient is sleeping					
5/1/24 6:00	0/10	No pain	-	-	-	Hay 024	Nee 24
10:00	0/10	NO PAIN	-	-	-	Nee 024	Nee 24
14:00		Referred from		Left leg	15:00		
18:00	0/10	No pain	-	-	-	Nee 024	Nee 24
18:00	0/10	dull pain	01:00	Femoral site	Pharmacological Intervention given	Nee 024	Nee 24
22:00	4/10	Dull pain	01:00	Femoral site	Non-pharmacological intervention given	Hay 024	Nee 24

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
				Patient is sleeping			
6/1/23 6:00	1/10	Dull pain	one 88	Referred femoral site	Non-pharmacological Intervention given	Hay 010	Don 024
10:00	0/10	NO Pain	-	-	-	Hay 010	Don 024







PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures > 12 = Moderate to severe pain - Pharmacological intervention
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	<p>0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst</p> <p>Numerical Rating Scale (age more than 12 years)</p> <p>0 1 2 3 4 5 6 7 8 9 10 None Mild Moderate Severe</p>
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling

Pharmacological interventions as per doctor's prescription

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



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

Dr. K. JAISHANKAR



MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	4/1	4/12/24	5/1/24	5/1/24	5/1/24	6/1/24			
	Time	14:00	20:00	8:00	15:00	20:00	8:00			
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		0	0	0	0	20	35			
Low Risk (0 - 24)		✓	✓	✓	✓	✓				
Medium Risk (25 - 44)							✓			
High Risk (45 or above)										
Signature & Emp. No. of RN		Dr. Jay	Dr. Jay	Dr. Jay	Dr. Jay	Dr. Jay	Dr. Jay			
Signature & Emp. No. of Sr. RN		N/A	N/A	N/A	N/A	N/A	N/A			

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

INTERVENTIONS <i>Tick as per the Risk Score</i>	Date	4/11	11/24	5/1/24	5/1/24	5/1/24	6/1/24			
	Time	17:00	20:00	8:00	15:00	20:00	8:00			
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓			
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓			
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓			
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓			
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓			
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓			
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓			
Bed wheels should be locked		✓	✓	✓	✓	✓	✓			
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓			
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓	✓	✓	✓			
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓	✓			
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓			
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓			
Medium risk interventions (25 - 44)										
Apply all the low risk interventions							✓			
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher							✓			
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat							✓			
Use restraints and bed monitors as ordered by the doctor							✓			
Allow the patient to ambulate only with assistance							✓			
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care							✓			
Do not leave patients unattended in diagnostic or treatment areas							✓			
Accompany the patient while going to bathroom							✓			
Advice the patient to use grab bars near the toilet, bathtub, and shower							✓			
Make sure the family and other visitors understand the restrictions mentioned above							✓			
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions										
Tie red fall risk tag in the bed, wheel chair and stretcher										
Locate the high-risk patients in a room close to the nurses' station										
Answer these patients call bells as quickly as possible										
Provide a commode at bedside (if appropriate)										
Urinal/bedpan should be within easy reach (if appropriate)										
Encourage family members or other visitors to stay with them										
If appropriate, consider using protection devices: safety belts										
Signature & Emp. No. of RN		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			
Signature & Emp. No. of Sr. RN		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			



Patient Details *(Affix Label here)*

Mrs.SHWETA JAIN

31/Female/MH1202381578

04/01/2024/IPH2024000035

Dr.K.JAISHANKAR



MHI/IP/2022/055



Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input checked="" type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions
Completed By : Date <u>11/1/24</u> Time <u>12:00</u>		Nurse Signature : <u>[Signature]</u>

Learning Record

[illegible]

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
<input checked="" type="checkbox"/> Diet Instruction for patients at Nutritional risk			P	W			P	W			P	W	Senior Dietitian
<input checked="" type="checkbox"/> Diet advice for home			P	W			P	W			P	W	Nurse
Discharge Planning													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													
<input type="checkbox"/> Smoking Cessation													Doctor
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> Other Risks													

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

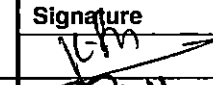
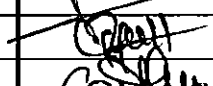
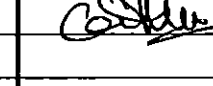
Name of Discharge Nurse : _____ Signature : _____

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 4/1/23. Time: 13.30

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



Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		Dr. Anusuya	130559	04/1/23	12:00
Nursing Staff		R. Sathyan	0201	4/1/24	14:00
Dietician		Senior Dietitian	2401	4/1/24	15:00
Physiotherapist					
Patient Care Service Staff					

[illegible]

Additional Details (if any):

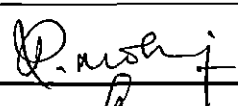

Patient Condition: ☒ Stable ☐ Sick-need urgent care ☐ Others: _____

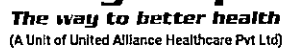
	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		BALAZI	123615	5/1/24	16.30
Receiving Doctor		Dr. Mohamed Elghayour	16002	5/1/24	17.00

Part C (to be filled by Nurses)

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

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		P. Ashamraj	2352	5/1/24	16.40
Receiving Nurse		Agasthya	0116	5/1/24	17.00



Every heart beat counts

[illegible]



REQUISITION FOR MEDICINE

Room No. : 000

[illegible]

Pharm Bill & Name

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

I-Dolo P (3) Day

Dose

650mg

Route

PO

Frequency

TDS

Dr. Sign & Reg. No. / Seal

49442

Start Date & Time

5/1/24 @ 15:48

Stop Date & Time

Additional Info:

2.00

14.00

20.00

7.00

5/1/24 6/1/24

18:30

18:30

7:00

DRUG NAME

T-PAN X (3) Day

Dose

40mg

Route

PO

Frequency

BD

Dr. Sign & Reg. No. / Seal

49442

Start Date & Time

5/1/24 @ 15:48

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

11:00 24 11:00 024

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

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

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

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

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

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

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

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

[illegible][illegible]

[illegible][illegible]

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
04/1/24	15:00	Low salt, Low Fat	<i>[Signature]</i>	134559					
05/1/24	8:00	NPO	<i>[Signature]</i>	134559					
06/1/24	8:00	Low salt, Low Fat diet	<i>[Signature]</i>	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
5/1/24	Morning	<i>[Signature]</i>	0072	<i>[Initials]</i>		Morning			
5/1/24	Evening	<i>[Signature]</i>	006	<i>[Initials]</i>		Evening			
5/1/24	Night	<i>[Signature]</i>	0105	<i>[Initials]</i>		Night			
6/1/24	Morning	<i>[Signature]</i>	0225	<i>[Initials]</i>		Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

[illegible]

[illegible]