Medway Hospitals®
The way to better health

MH/ PRINT / 0075 / MRD

MRD CHECKLIST

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

INSURANCE

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

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/IPD/2022/002

Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Anbarasu. **Speciality:** CTVS.

Advised Date & Time: 4/1/23 @ 12.0pm.

Provisional Diagnosis:
CAD - Triple vessel disease.

Reason for Admission: ☐ Medical Management ☑ Surgical Management
☐ Others (please specify details) _____

Admission Type: ☐ Day Care ☐ ER ☑ Ward
☐ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):
CABG.

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

Expected Duration of Stay: 5-6 days.

Expected Cost of Treatment *(as per Financial Counselling Form)*:

Payer: ☐ Self ☑ Insurance ☐ Others: _____ INSURANCE

Instructions to Nurse (if any):
→ Admit in private ward.
→

Any other Instructions (if any):

Dr. Anbarasu Mohanraj
Reg No: 55476

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr. Anbarasu	55476.	4/1/23	12.00pm

For admission desk staff only:

Room Category:

- [ ] General Ward
- [x] Single Room
- [ ] Twin Sharing
- [ ] Deluxe Room
- [ ] Suite Room
- [ ] Others _____

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
4/1/23	12.06pm	04/12/2023	12:17 PM

Source:

- [x] OPD
- [ ] ER
- [ ] Direct

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

Is Blood Reservation and Blood Bank clearance completed as advised: [x] Yes [ ] No

Front office Staff Signature	Name	Emp. No.	Date	Time
	[illegible]	169	04/1/24	12.17

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
Married	No.6/15B "John Mary Illam" Murugu Nagar Extension, Velachery Chennai-600 042.	9176099130 9776710730 9884297592
Occupation: Pensioner		

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
Dr. Anbarasu	04/01/2024 - 12.17	11/1/24	8 days.

UNIT	MLC		
[illegible]	☐ Yes	☑ No	If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
TRIPLE VESSEL CORONARY ARTERY	I25.1
DISEASE CALCIFIC CORONARIES, ACS - NSTEMI	I24.9
HEART FAILURE WITH REDUCED EJECTION	I21.4
FRACTION GOOD LV SYSTOLIC FUNCTION - EF 54%.	I50.0
CHRONIC UNCONTROLLED TYPE II DIABETES	I50.1
SYSTEMIC HYPERTENSION PERIPHERAL	E11.6, I10
VASCULAR DISEASE, RIGHT DIABETIC FOOT ULCER	I73.8, E10.6

DATE	OPERATION / PROCEDURES	ICPM Code
5/1/24	OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCABG) X 4 GRAFT LIMA TO LAD (EXTENSIVE ENDARTERECTOMY) SVG TO OM, SVG TO RAMUS INTERMEDIUS, SVG TO DISTAL RCA. DONE 5/1/24	36.14 99.00

DATE	TYPE OF ANESTHESIA				
5/1/24	☐ GENERAL	☑ SPINAL	☐ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

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

12/01 Dr. Anbarasu Mohanraj
Reg No: 55476
Signature of the Consultant

S. Alexander 2738
Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்
Signature of Admitting Nurse

தேதி 04/01/2024
Date 12:17

எனது/உறவினர்/காப்பாளர் கையொப்பம்
(J. IMMANUEL)
Signature of the Patient / Relative / Gurdian

y Husband.

உறவுமுறை
Nature of Relationship

Medway Hospitals®
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(A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/008
Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

I, Mrs. Cecilia Subashini.H 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	H. Cecilia Subashini	H. CECILIA SUBASHINI	04/1/2024	12.17
Surrogate/Guardian (if applicable #)		J. IMMANUEL Husband *(Write name and relationship with patient)*	04/1/2024	12.17
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		J. IMMANUEL	04/1/24	12.17
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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Mrs.CECILIA SUBASHINI.H
Consultant.

MHI/ICU/2022/114

Medway Heart Institute
Every heart beat counts

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

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

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
8	**Endocrine System and Metabolism related** Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis	
	Thyroid storm or myxedema coma with hemodynamic instability	
	Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl	
	Other endocrine problems such as adrenal crises with hemodynamic instability	
	Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring	
	Hypo or hypernatremia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered mental status	
	Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias	
	Hypo or hyperkalemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or muscular weakness	
	Hypophosphatemia with muscular weakness	

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Praveen	112236	5/1/24	13:[illegible]

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
1	Stable hemodynamic parameters	
2	Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent	
3	Minimal oxygen requirement (not more than 3 L by nasal prongs)	
4	Intravenous / Inotropic / Vasopressor support and vasodilators are no longer necessary	
5	Cardiac dysrhythmias are controlled	
6	Presence of distal pulses	
7	No signs of bleeding and hematoma at puncture site	
8	End of life care pathway chosen	

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Praveen	112236	7/1/24	13:[illegible]

MRD

DISCHARGE SUMMARY

IP No.	: IPH2024000033	**D.O.A**	: 04/01/2024
UHID	: MHI202381349	**D.O.D**	: 11/01/2024
Name	: Mrs. CECILIA SUBASHINI. H	**Room No.**	: 103
Age / Gender	: 60Years / FEMALE		
Consultant	: **Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)** **Director and Clinical lead – Cardio Vascular and Thoracic Surgery**		

D.O.S: 05.01.2024

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE
CALCIFIC CORONARIES
ACS - NSTEMI
HEART FAILURE WITH REDUCED EJECTION FRACTION
GOOD LV SYSTOLIC FUNCTION – EF : 54%
CHRONIC UNCONTROLLED TYPE II DIABETES MELLITUS
SYSTEMIC HYPERTENSION
PERIPHERAL VASCULAR DISEASE
RIGTH DIABETIC FOOT ULCER
RECENT EPISODE OF SEPSIS – TREATED
ANEMIA

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD (EXTENSIVE ENDARTERECTOMY) SVG TO OM, SVG TO RAMUS INTERMEDIUS, SVG TO DISTAL RCA DONE ON 05.01.2024

BRIEF HISTORY:

Mrs. Cecilia Subashini.H, 60 years old female, a known case of Chronic Uncontrolled Type II diabetes mellitus, Systemic hypertension, Anemia, Peripheral vascular disease, Right diabetic foot ulcer, Heart failure with reduced ejection fraction, Recent episode of Sepsis - treated, ACS – NSTEMI, Calcific Triple vessel disease, Good LV systolic function, has come for CABG. Patient was doing well with medications till one month ago when she developed breathlessness on exertion, NYHA class II – III. H/o cough and vomiting (+). H/o giddiness and generalized tiredness (+). She was taken to Prashanth Hospital where her Troponin T and Pro BNP levels were elevated.

She was managed conservatively. Her blood and pus culture report showed position for micro – organism growth. She was started on broad spectrum sensitive antibiotics. After medical stabilization, she underwent coronary angiogram on 15.12.2023 which showed Triple vessel disease. She then came to Medway Heart Institute on 18.12.2023 and was advised early CABG. Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, she is getting admitted for the same. No H/O Palpitations, Syncope or Swelling of Legs. No H/O CVA, CKD, BA or Hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP	-	98.2° F
HR	-	74bpm
BP	-	130/90mmHg
SPO_2	-	96% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft, BS (+)
CNS	-	NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	11.7	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	35.8	39-52	%
TWBC	11660	4000 - 10000	Cells/Cumm
NEUTROPHILS		40-70	%
LYMPHOCYTES	19.7	20 - 40	%
EOSINOPHILS	2.6	0 - 6	%
MONOCYTES	3.8	0 - 6	%
BASOPHILS	0.3	0 - 2	%
PLATELET	499000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Cells/Cumm
Urea	31	14 - 40	mgs/dl
Creatinine	0.80	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na+)	136	135 - 145	mmol/l
Potassium (K+)	4.32	3.4 - 5.5	mmol/l
T. Bilirubin	0.35	0.2-1.0	mg/dl
D. Bilirubin	0.13	0.00 – 0.4	mg/dl
I. Bilirubin	0.22	0.4-0.6	mg/dl
S.G.O.T	35	<38	U/L
S.G.P.T	31	<41	U/L
ALP	85	Adult: 42 - 141	U/L

NAME : MRS. CECILIA SUBASHINI.H UHID: MHI202381349 IPNO: IPH2024000033

GGT	24	Male : 10 - 45 Female : 5 - 32	U/L
Total Protein	7.9	6.0 - 8.0	gm/dl
S. Albumin	3.7	3.5 - 5.0	gm/dl

PROTHROMBIN TIME	12.5	Normal : 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction : 2.0 - 3.0 Deep Vein Thrombosis : 2.0 - 3.0 Pulmonary Embolism : 2.0 - 3.0 Artificial Cardiac Value : 3.0 -4.5 Recur.Systmic Embolism: 3.0 - 4.5 INR	
INR	1.0		
HBA1C	10.3	Normal: Below 6.0 Good control: 6.1-7.0 Fair Control : 7.1-8.0 Unsatisfactory: 8.1-10.0 Above 10 : poor control (GHB is an index of your blood Sugar control for the past (3 months)	%
T.S.H	5.12	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	ulU/ml
T3	119	"Adult : 60 - 152 New born - 4 days : 96 - 730 1 - 11 Months : 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	11.0	"Adult : 4.6 - 9.3 New born - 4 days : 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs : 6.3 - 13.16	ug/dl

ECG: HR – 76bpm, sinus rhythm, no significant ST – T changes.

ECHO: CONCENTRIC LVH, ALL CHAMBERS NORMAL SIZED, NO REGIONAL WALL MOTION ABNORMALITY, ADEQUATE LV SYSTOLIC FUNCTION, GRADE I DIASTOLIC DYSFUNCTION, INCREASED LV FILLING PRESSURE, NORMAL RV SYSTOLIC FUNCTION, IAS / IVS INTACT, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, PML ANNULAR CALCIUM PRESENT, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, IVC NORMAL IN SIZE AND COLLAPSING, ECHO FREE SPACE NOTED ANTERIOR TO RV (? EPICARDIAL FAT), NO CLOT / VEGETATION / EFFUSION.

CAROTID DOPPER : CALCIFIC PLAQUE NOTED IN LEFT CCA AND RIGHT CAROTID BULB, CHUNK OF CALCIUM PRESENT N LEFT CAROTID BULB, NO FLOW LIMITING DISEASE, NORMAL BILATERAL VERTEBRAL DOPPLER STUDY.

CXR: PA film, lung fields clear.

NAME : MRS. CECILIA SUBASHINI.H UHID: MHI202381349 IPNO: IPH2024000033

COURSE IN THE HOSPITAL:

Mrs. Cecilia Subashini.H, 60 years old female, was admitted with above mentioned complaints. She underwent **OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD (EXTENSIVE ENDARTERECTOMY) SVG TO OM, SVG TO RAMUS INTERMEDIUS, SVG TO DISTAL RCA ON 05.01.2024.** She was shifted to SICU with stable hemodynamics and Inj. Nor adrenaline 0.05µg/kg/min supports. She was extubated on the same day (05/01/2024) at 16.45 pm. Drains were removed on POD1 (06/01/2024). She was shifted to ward on POD 2 (07/01/2024). Suture removal was done on POD4 (09/01/2024). Patient course in the hospital was uneventful. Her medications are optimized and she is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR - 100/min BP - 120/80 mmHg
SPO2 - 88% in room air

POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	8.1	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	25.0	39-52	%
TWBC	10730	4000 - 10000	Cells/Cumm
NEUTROPHILS	76.1	40-70	%
LYMPHOCYTES	13.8	20 - 40	%
EOSINOPHILS	5.6	0 - 6	%
MONOCYTES	4.2	0 - 6	%
BASOPHILS	0.3	0 - 2	%
PLATELET	290000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Lakhs/cumm
Urea	55	14 - 40	mgs/dl
Creatinine	0.80	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na+)	132	135 - 145	mmol/l
Potassium (K+)	4.42	3.4 - 5.5	mmol/l

ECG: 78bpm, sinus rhythm, T wave inversion in V1 – V5 leads.

ECHO : S/P CABG, ALL CHAMBERS NORMAL IN SIZED, PARADOXICAL SEPTUM, ADEQUATE LV SYSTOLIC FUNCTION – EF : 54%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 9CM/S, TAPSE : 17MM, AORTIC VALVE SCLEROSIS, PML ANNULAR CALCIUM PRESENT, OTHER VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 8 MM HG, MEAN GRADIENT – 5 MM HG, PARADOXICAL SEPTUM, GRADE I DIASTOLIC DYSFUNCTION, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, TRIVIAL MR, TRIVIAL TR, NO PAH, MILD BILATERAL PLEURAL EFFUSION, NO CLOT / VEGETATION / PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, lung fields clear, mild bilateral pleural effusion.

NAME : MRS. CECILIA SUBASHINI.H UHID: MHI202381349 IPNO: IPH2024000033

ADVICE MEDICATIONS:

Sl.. NO.	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. ASPIRIN	1 TABLET	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. TICABID (TICAGRELOR)	1 TABLET	90MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ROSUVAS (ROSUVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2WEEKS
6	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
7	TAB. PREGALIN (PREGABALIN)	1 TABLET	75MG	0	0	1	ORAL	AFTER FOOD	X 1 MONTH
8	TAB. LIVOGEN (FOLIC ACID + FERROUS FUMARATE)	1 TABLET	1500MCG + 152MG	1	0	0	ORAL	AFTER FOOD	X 30 DAYS
9	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATION)
10	TAB. GLIAREN – D (METHYLCOBALAMIN + ALPHA LIPOIC ACID + VITAMIN B6 (PYRIDOXINE) + FOLIC ACID + VITAMIN D3)	1 TABLET		0	1	0	ORAL	AFTER FOOD	X 1 MONTH
11	SYP ALEX PLUS (DEXTROMETHORPHAN HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
12	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

NAME : MRS. CECILIA SUBASHINI.H UHID: MHI202381349 IPNO: IPH2024000033

DIABETIC MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. AMARYL (M2) (GLIMEPIRIDE + METFORMIN)	1 TABLET	2MG/ 500MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	INJ. HUMAN MIXTARD (INSULIN ISOPHANE/ NPH (70%) + HUMAN INSULIN/ SOLUBLE INSULIN (30%)			15U	0	6U	S/C	BEFORE FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	HIGH PROTEIN, LOW SALT LOW FAT AND DIABETIC DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	NIL
REVIEW	REVIEW WITH **DR. ANBARASUMOHANRAJ** AFTER 19/01/2024 WITH FBS, PPBS, HB, UREA, CREATININE, SODIUM, POTASSIUM, CHEST X RAY

To report: If fever> 101 'F / Difficulty in breathing / Headache / Giddiness/chest pain/ Groin swelling/ bleeding / discharge at operated site/ Any other significant symptoms.
In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai/S.Hari

"I understood the Content of the discharge summary."

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

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

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NABH ACCREDITED

Pa Mrs.CECILIA SUBASHINI.H
Ni 60/Female/MHI202381349
UI 04/01/2024/IPH2024000033
Dr Dr.ANBARASU MOHANRAJ
D
C

MHI/IP/2022/107

Medway Heart Institute
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INPATIENT INITIAL ASSESSMENT

Date: 4/1/24 **Time of arrival in ward:** 13.00

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 74 (beats/min) | BP: 130/90 (mmHg)
Respiration: 20 (breaths/min) | SpO_2: 96 (%) | Height: 152 (cms) | Weight: 65 (kgs) | BMI: 28.1 kg/m²

Pain: ☑ Yes ☐ No. If Yes, Score:
Pain Scale Used: ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)
Duration: Location:
Pain Character: ☑ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

pt. presented to OPD for CABG plan.
pt had c/o SOB x 1 month.
pain radiation over lt side of arm x 1 month.
Dyspnea on exertion x 1 month.
H/o Diabetic wound. x R foot x 6 month.
c/o cough & cold. x 4 days

PAST MEDICAL HISTORY (with duration of illness):
Diabetes Mellitus: ☑ Yes ☐ No. If Yes, duration: 30yrs Hypertension: ☑ Yes ☐ No. If Yes, duration: 6 month.

Others:
N/K/c/o BA/thyroid disorder.
CAG x 18/12/23 - TVD

Past Surgical History: H/o LSCS x 1995
B/L Cataract Surgery x 2013 & 2018.

Present Medication *(for Medication Reconciliation)*:

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	T. DYTOR	10mg	oral	1-0-0	4/1/23	☑ Yes ☐ No
2.	T. BPTUS	25mg	oral.	0-1-0	4/1/23	☑ Yes ☐ No
3.	T-ATORVA	40mg	oral	0-0-1	"	☑ Yes ☐ No
4.	T. CONCOR	2.5mg	oral	1-0-1	"	☑ Yes ☐ No
5.	T. FLAVEDON MR	35mg	oral	1-0-1	"	☑ Yes ☐ No
6.	T AMARYL M	2mg	oral	1-0-1	"	☑ Yes ☐ No
7.	CAP. CLOPILET A	75/75	o.d.	0-1-0	31/12/23.	☐ Yes ☑ No
7.	T. Amaryl M2	1tab	PO	1-0-1	4/1/24	☑ Yes ☐ No
8.	T. Chiar and	1tab	PO	0-0-1	"	☐ Yes ☐ No
9.	Inj. Human mixtard		S/C	20-0-8	"	☑ Yes ☐ No

Family History:

—

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

Lifestyle: ☑ Sedentary ☐ Active **Occupation:** Homemaker

Smoking: ☐ Yes ☑ No **Alcohol:** ☐ Yes ☐ No **Recreational Drug Use:** ☐ Yes ☑ No

Others: _____

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

Menopaused 10yrs back

General Physical Examination:

Pallor: ☐ Yes ☑ No **Icterus:** ☐ Yes ☑ No **Clubbing:** ☐ Yes ☑ No

Edema: ☐ Yes ☐ No **Lymphadenopathy:** ☐ Yes ☑ No

SYSTEMIC EXAMINATION

CVS:

S1 S2 (+), NAD

Respiratory System:

BAE (+), NAD

Gastrointestinal System:

Soft, NTND

Central Nervous System:

NFND, Able to move all (4) limbs

Urinary / Reproductive / Locomotor System:

—

Skin / Opthalmic / ENT

Suspected of contagious disease: ☐ Yes ☑ No   Immuno compromised status: ☐ Yes ☒ No

Isolation required: ☐ Yes ☑ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☑ Normal ☐ Anxious ☐ Depressed ☐ Others: ______________________

Nutritional Screening *(ESPEN Guidelines for Nutritional Screening - NRS 2002)*:

Weight loss within the last 3 months? ☐ Yes ☐ No   Is the patient severely ill? *(e.g. in Intensive Therapy)* ☐ Yes ☐ No

Reduced dietary intake in the last week? ☐ Yes ☐ No   Is the BMI < 20.5? ☐ Yes ☐ No

Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk
No: If the answer is "NO" to all questions, the patient is at Normal and not at risk

Provisional Diagnosis: CAD -TVD / T2DM / SHTN / EF - 55% / Good LV.

Plan of Care:

- CABG plan
- Follow drug chart.
- vitals monitoring
- Inform SOS.
- w/E destination ..

Investigations Advised:

Blue - BG
TWBC - 11660
Hb - 11.7
Plt - 499000
APTT - 29.2
PT - 12.5 / 12.1
INR - 1.0

Na^+ - 136
K^+ - 4.3
Cl - 95.4
Urea (3.1)
Creat - 0.8
SGOT - 35
SGPT - 31
GGT - 24.

HIV 1&2 / HBsAg / Anti HCV) Neg.

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor	Dr. Anbarasu Mohanraj Reg No: 55476	Dr. SUJETH. B	183573	4/1/23	8:45PM
Consultant		Dr Anbarasu V	55476	5/1/23	9:00
Patient Attendant		Relationship Husband.	—	9/1/23.	13:00

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

DOCTOR'S PROGRESS NOTES

DATE	NOTES
4/1/24	S/B Dr. Mohamed Hydroos
5pm	
	Δ : CAD – TVD / T2DM (HTN)
	EF – 55%
	Plan : CABG ↓ GA Tomorrow.
	Patient Conscious
	Oriented
	Vitals Afebrile
	Stable
	CVS → S1S2 (+)
	RS → BAE (+)
	P/A → soft, NT
	Adv
	- Monitor vitals.
	- To follow drug chart
	- To get Anaesthetic fitness
	- Consent / Parts / Prepared
	(signature)
	(Kotai)

DATE	NOTES
04/1/24	S/B Dr. Anusuya
11.00PM	
	patient reviewed.
	c/o: chestpain on & off
	O/E: patient conscious, oriented
Vitals stable	S/E: CVS - S1S2 (+)
	RS - BAE (+)
	L/E: (R) diabetic foot
	wound healthy & healing
	Advice
	- monitor vitals
	- posted for CABG tomorrow
	- NPO from 12 midnight
	- consent
	- parts preparation
	- pre-medication
	- shift to OT on call.
(signature) 134575	
05/1/24	S/B Dr. Anusuya
7.20AM	
	patient reviewed.
CBG at 5 AM - 60 mg/dl	c/o: giddness
25% dextrose	O/E: patient conscious, oriented
IV given	S/E:
Rechecked CBG 180mg/dl	Posted for CABG today
	Pre-OP orders followed.
	Pt can be shifted to OT
	(signature) 134575

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
05/01/2024 @13.15	Mrs. cecilia Subashini 60y/F underwent OPCAB x 4 grafts.
	She was shifted to SICU & following hemodynamics HR – 76 Bpm BP – 104/58 mmHg CVP – 11 mmHg SpO_2 – 100% on ventilator
	Ventilator: mode: VC FiO_2 50% peep 5 mmHg
	Supports: inj. noradrenaline 0.05 µg/kg/min
	plan: Wean & extubate when fully awake
	For Dr. Anbarasu PA. Karthika (MHI0216)

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

DOCTOR'S PROGRESS NOTES

DATE	NOTES
06/01/2024 @8.35	S/B/Dr. Anbarasu / Dr. Rajesh / Dr. praveen
	S/P: OPCABX4 grafts.
POD#1	. patient comfortable
Hb - 9.7	O/E: conscious, oriented, Afebrile
u - 27	. BP - 124/52 mmHg
cr - 0.84	. HR - 88 BPM
na - 132	. SpO_2 - 100% on nasal prongs (2 litres of O_2)
k - 4.69	. I/O - 3017.2ml / 2150ml ; Bal +867.2ml
	. on ucath
RBS - 158 mg/dl	. Adequate urine output
ABG	. peripheries warm (+)
pH - 7.41	. Tolerating feeds.
pCO_2 - 35.5	supports: inj. noradrenaline 0.5ml/hr
pO_2 - 57	Total drain: 340ml
HCO_3 - 22.5	Plan
BE - +2.2	. RF - 2.2 litres/day
	. good chest physio
	. mobilize
	. Remove drains by 11am
	. inj. nor adrenaline start tapering & Stop
	. nebulization
	. Spirometry
	. T. METOPROLOL 25mg 1-0-1
	. T. Forxiga 10mg 1-0-0
	. Restrict Diuretic medications
	. T. PRECHIN 75mg 1-0-1

Praveen 122236

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04/01/2024/IPH2024000033
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MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
7/1/24 20:00	S/B. Dr. Sajith.R (DMO)
	pt received to forward
POD-2	S/p - OPCAB x 4 graft
	pt reviewed.
	c/o - pain at surgical site.
Intake: 2374ml	O/E pt conscious
Output: 2900ml	oriented,
	Afebrile
BP - 150/70 mmHg	S/R CVS-S1S2 (+)
HR - 98 bpm	RS - RAE (+)
SpO2 - 98%	Adv
	- vitals monitoring
	- RR 2-2 c/dy
	- chest physio/mobilize
	- Nebulisation
	- Spirometry
	- Timato follow chart
	- w/f desaturation
	- I/o monitor

Signature 183573

DATE	NOTES
8/1/24	S/B Dr. Mohamed Hydros
	Post OP case of CABG × 4 graft
	POD-2.
	Patient Conscious
	Oriented
	Afebrile
	CVS → S1S2 (+)
	RS → BAE (+)
	P/A → Soft, NT
	Vitals
	PR - 88/min
	RR - 18/min
	BP - 130/80 mmHg
	SpO2 - 97% with 2 litre O2
	Adv
	- Vitals monitor
	- To follow diet chart
	- R.F - 2.2 litre/day
	- nebulisation/ spirometry
	(signature)
	(…)

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/24 3:40pm	S/B. Dr. Sujitha B. (DMO)
POD-3	S/p - OPCAB x 4 graft.
	pt reviewed. - No complaints
vitals stable	S/R pt conscious, oriented, Afebrile
SpO2 - 98% C 2L O2 (nasal prong)	S/R - CVS - S1 S2 (+) Re - BAE (+)
	Adv - vitals monitor - follow diet chart - FR (2.2 L/day) - nebulisation / spirometry
	[signature] 123573

DATE	NOTES
8/12/24	S/B Dr. Anusuya
2:30	
POD-3	Patient reviewed
	c/o pain in the surgical site
	O/E patient conscious, oriented
	S/E: CVS - S1 S2 (+)
	RS - BAE (+)
F.R - 2.2 litre/day	CNS - NFND
	P/A - soft, non-tender
	Vitals: HR - 82 b/m
	BP - 110/80 mmHg
	RR - 18/min
	L/E: Dressing intact
	no soakage
	Right diabetic foot
	Advice
	- monitor vitals
	- Continue the drugs as per chart.
Bhanu	Plan: SR tomorrow.
	mobilise the patient

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60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
	S/B Dr. Mohamed Hydroos
9/1/24.	
	Post op Case of OPCAB x 4graft.
10AM.	
	Patient Conscious oriented Afebrile.
	Vitals.
	PR- 100/min
	RR- 20/min
	BP- 120/80mmHg
	SpO2- 97%
	POD - IV
	CVS → S1S2 (+)
	RS → BAE (+)
	P/A → Soft, NT
	AEW
	- Monitor vitals
	- To follow I/O chart
	- Suture removed
	- Mobilise the Patient.
	- Spirometry/ nebulisation
	Advice given

DATE	NOTES
9/1/24 4:00 PM.	S/B. Dr Sujith. B. (DMO)
	POD-4 S/P- OPCAB x4 graft.
	- pt. reviewed.
	feels tired.
vitals stable	O/E- pt. conscious,
	oriented,
	Afebrile
	S/E - CVS - S1S2 (+)
	RS - BAE (+)
	PA - soft
	Adv.
	- vitals monitoring.
	- Follow drug chart
	- ? foam sos
	- w/f deterioration.
	BD 183573

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
9/1/24	S/B Dr. Aniruddha
	s/p OPCAB X4 graft
21.00	Patient reviewed
	c/o mild pain in the surgical site
POD-4	O/E Patient conscious, oriented, Afebrile
	S/E: CVS - S1S2 (+)
	RS - BAE (+)
	CNS - NFND
vitals stable	I/E: wound healthy & healing
	no discharge
	Advice
	- monitor vitals
	- continue drugs as per chart
	- mobilise the patient
	- continue Chest Physio & spirometry
Hb 13.4mg	

DATE	NOTES
10/1/24	S/B Dr. Anusuya
22.00	S/P OPCAB X 2 grafts
POD-10	Patient reviewed
	c/o: pain in the surgical site.
	O/E: patient conscious, oriented,
	S/E: CVS - S1S2 ⊕
F-R-2-2/1100	RS - BAE ⊕
day.	CNS - NFND
	P/A - soft, non-tender.
	L/E: wound healthy & healing
	no soakage.
	Ⓡ diabetic foot. Advice
	dressing intact - monitor vitals
	no soakage - continue the drugs as per chart.
	- mobilise the patient
	- Check CBG tds
K.M 1349579	

MHI/IP/2022/041

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60/Female/MHI202381349
04/01/2024/IPH2024000033
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
11/1/24 10:20AM	S/B. Dr. Sujith B. (Daro)
POD-6	S/P - OPCAB x 4 grafts
	Pt. reviewed.
	- no complaints
vitals fine	O/E - Pt. conscious
	oriented
	Afebrile
	S/E - CVS - S1 S2 (+)
	RS - BAE (+)
	Adv
	- vitals monitoring
	- follow diet chart
	- no BP
	- w/f hypoglycemia
	- Plan to today plan d/c
	[signature] 183877

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Mrs.CECILIA SUBASHINI.H
60/Female/MH1202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

E-OPERATIVE CHECKLIST

Name :		Age :	Gender :	UHID No. :
Ward :		Bed No. :	**B.S.**	**A.S.**
	Clinical Diagnosis : CAD-TVD, PERIPHERAL VASCULAR DISEASE		✓	✓
	Proposed Procedure : CABG		✓	✓
	CHECKLIST			
1.	Identification Band on Hand Checked ?		✓	✓
2.	Surgical consent Signed? a. Special Consent signed if required.		✓	✓
3.	Anesthetist Consultation (If required?)		✓	✓
4.	History AND Physical Onchart? a. Height..... 152 Cms ..... b. Weight..... 65 kgs		✓	✓
5.	Allergic to drugs ? NKDA		✓	✓
6.	Surgical Preparation done ?		✓	✓
7.	Nill by Mouth From 12MN		✓	✓
8.	Blood Grouping & Rh Typing ..... B POSITIVE		✓	✓
9.	Investigation ☒ X - Ray ☒ ECG ☒ LAB		✓	✓
10.	Blood Sugar..... 180 mg/dl. Time..... 6:30		✓	✓
11.	TPR Chart Pulse..... 72 ..... Temp..... 98.4 ..... BP 110/70 ..... RR..... 20		✓	✓
12.	Time Voided a. Retention ☐ Yes ☒ No		✓	✓
13.	Enema - ☐ Yes ☒ No		✓	✓

14.	a. Prosthesis Removed ☐ Yes ☐ No / ☑ Not Applicable b. Plates present Removed ☐ Yes ☐ No / ☑ Not Applicable c. Contract Lenses Removed ☐ Yes ☐ No / ☑ Not Applicable d. Dentures Removed ☐ Yes ☐ No / ☑ Not Applicable	✓	✓
15.	Valuables and Jewellery Removed ☑ Yes ☐ No Secured ☑ Yes ☐ No	✓	✓
16.	Pre-Operative Medication Admistered ..... Given ..... a. Time ..... 6:00 ..... b. Nurse ..... Hay	✓	✓
17.	Blood Transfusion requisition Onchart 2.0 PCV	✓	✓
18.	X-Ray ..... 1 ..... No	✓	✓
	ECG / ECHO 1/1	✓	✓
	Ultra Sound		
	C.T. Scan.....		
	MRI Scan		
	TMT		
	Medication		
	4/1/24 TAB. PAN 40mg } given @ 21:00		
	TAB. ALPRAX 0.25mg }		
	5/1/24 TAB. PAN 40mg Given @ 6:00		
	Others		

Hayolos

Nurse Signature

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/OT/2022/116

Medway Heart Institute
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Btve

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Mrs. Cecilia Subashini. H Age 60/F UHID MHI202381349

Diagnosis CAD – Triple Vessel disease / Good LV EF: 55% Plan CABG.

Serology Negative

EURO Score / STS Score 0.93%

T. Clopilet A & T. Oxras Stopped on 31/12/23.

PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):

Diabetes Mellitus (HB1AC) 10.3%.

T2DM / SHTN

Associated Illness

No flow limiting disease

Carotid Doppler

93.119 T4. 11.0 TSH. 5.12

Thyroid Enzymes

Sr. Creatinine 0.80
INR: 1.0.

Any other illness of concern

Allen's Test

Myocardial viability if needed

Varicose Veins

Pulmonologist Clearance —

Nephro Clearance: —

Neurology Clearance : —

Dental Clearance: —

Mitral Regurgitation Assessment - Trivial MR / No PAH

Nursing:

Billing Clearance:

Physiotherapy

Spirometry taught

Concerns from Surgical Team :

SIGNATURE :

Dr Manoj. (MHI0217)

Mrs. Cecilia Subashini 60/F a K/C/o T2DM, SHTN, Anemia, Peripheral vascular disease, (Rt) diabetic foot, Sepsis, CAD - on medical management, triple vessel disease, Good LV has come for CABG. Pt. was doing well with medications till month ago when she developed breathlessness on exertion NYHA class II-III. H/o cough and vomiting (+). H/o giddiness & generalised tiredness, (+) she was taken to Prashanth Hospital where her Trop T and Pro BNP levels were elevated. ~~She was~~ She was managed conservatively. Her ~~[illegible]~~ culture report showed positive for micro-organism growth. She was started on broad spectrum sensitive antibiotics and after medical stabilization, she underwent coronary angiogram. on 15/12/23 which showed TVD. She then came to MHI and was advised early CABG

50

MHI/OT/2022/082

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NABH

Medway Heart Institute
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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

CONSENT FOR SURGERY

~~Mr/Ms~~./Mrs .CECILIA....SUBASHINI.....H.....☑ the Patient or ☑ Representative of patient have *(Please tick correct option and below):*

☑ Read

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

☑ Been explained this consent form in English, which I fully understand and understood the information provided about the disease .CORONARY ARTERY DISEASE/TRIPLE VESSEL DISEASE..... and about the procedure ....CORONARY ARTERY BYPASS GRAFTING..... *(full name of operation / procedure given below in this consent form)*

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

I have been told about additional procedure that may be come necessary during the surgery which includes ....Re exploration.....
.....

I also understand that sometimes a planned operation / procedure may need to be postponed or cancelled if patient's clinical condition worsens or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequence by submitting the withdrawal in writing.

I am aware that I may require administration of blood and / or blood products during or after the operation / procedure as found necessary by the doctor (for which a separate consent shall be obtained).

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

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

- Possible risks & complications 1. Bleeding 2. Infection 3. Stroke 4. Arrythmia 5. Prolonged ICU stay 6. Acute limb ischemia 7. Risk to life ~ 10%.
- Benefits Symptom free survival
- Alternatives High risk PTCA
- The likelihood of success of the surgery (Percentage / Other commands) 92 %.
- Possible results of non-treatment 1. Myocardial Infarction 2. Heart Failure.
- I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my sign this form.

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	H. CECILIA SUBASHINI	JOHNSAMUEL
Relationship	Patient	Son
Signature	H. Cecilia Subashini	I. Johnsamuel
Date & Time	4/1/24 at 18.30	4/1/24 at 18.30
Name & Signature of Doctor with Registration No.:	Dr. PRAVEEN TEYAKUMAR 112236	

Dr. Anbarasu Mohanraj
Reg No: 55476

Doctor Seal

MHI/OT/2022/082

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நோயாளி விவரங்கள்: (Affix Label here)
வயர் :
UHID :
பிறந்த தேதி : பாலினம் :

அறுவை சிகிச்சை ஒப்புதல் படிவம்

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

☐ படியுங்கள்

☐ எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.

ந்த ஒப்புதல் படிவம் ஆங்கிலத்தில் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகிச்சையின் செயல்பாட்டின் முழுப்பெயர் செயல்முறை பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.

- நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கிடைக்கச் செய்கிறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும் நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கிறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும் மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் தொடர்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கிறேன்.

- நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில நேரங்களில் திட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்
- மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நிர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் (ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).

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

- சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் _____

_____

_____

- நன்மைகள் _____

- மாற்றுவழிகள் _____

- அறுவை சிகிச்சையின் வெற்றி வாய்ப்பு (சதவீதம் / பிற கட்டளைகள்) _____

- சிகிச்சையின்றி சாத்தியமான முடிவுகள் _____

- செயல்பாடு / நடைமுறை மற்றும் வழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்பார்க்கப்படும் போக்கையும் நான் அறிவேன். சி நேரங்களில் தீவிரமான பராமரிப்பு அலகு மற்றும் / அல்லது மருத்துவமனையில் அனுமதிக்கப்படும் கால அளவு தேவைப்படலாம் மற்றும் / அல்லது கூடுதல் மருந்துகள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம். இதன் மூலம் உடல் சிகிச்சையில் அதிகரிக்கும்.

- இந்த செயல்பாடு / நடைமுறையை நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய எந்தவொரு திசு அல்லது உடல் பகுதியை அகற்ற மருத்துவமனையை நான் அங்கீகரிக்கிறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட தகவல்களை நான் பெற்றேன் மற்றும் முழுமையாகப் புரிந்து கொண்டேன் என்று அறிவிக்கிறேன். எனது வியாதி, செயல்பாடு / நடைமுறை தொடர்பான கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அதன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும் நோக்கம் கொண்ட நன்மைகள் மற்றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும் பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நான் கையெழுத்திடும் நேரத்தில் என் முன்னிலையில் செருகல் மற்றும் நிறைவு செய்ய வேண்டிய அனைத்து துறைகளும் (இந்த வடிவத்தில்) நிரப்பப்பட்டன என்று நான் மேலும் அறிவிக்கிறேன்.

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

மருத்துவரின் முத்திரை

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Patient Details (Affix Label here)
Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/OT/2022/083

Medway Heart Institute
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CONSENT FOR ANAESTHESIA SERVICES

I, CECILIA SUBASHINI . H ☑ the patient or ☐ the representative of patient have,
(please tick the correct option above and below)

☑ Read
☐ I / We have been explained the current clinical condition of me / my patient
☑ Been explained this consent form in English, which I fully understand and understood the information provided about

Operation / Procedure CORONARY ARTERY BYPASS GRAFTING

(full name of operation / procedure given below in this consent form)

- My surgeon has explained the risks of the procedure and has advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anaesthesia services are needed for this operation, so that my doctor can perform the operation or procedure.
- It has been explained to me that all forms of anaesthesia involve some risks. Although rare, unexpected severe complications with anaesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.
- I understand that these risks apply to all forms of anaesthesia and that additional or specific risks have been identified below, as they may apply to a specific type of anaesthesia. I understand that the type(s) of anaesthesia service checked below will be used for my procedure and that the anaesthetic technique to be used is determined by many factors including my / my relative's physical condition, the type of procedure, my doctor's preferences, as well as my own desire.
- It has been explained to me that sometimes an anaesthetic technique which involves the use of local anaesthesia, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anaesthesia.

It has been may be needed explained to me that the following may be needed as part of anaesthesia during or after surgery
☑ Central Venous catheter ☑ Arterial Line ☑ Lumbar Puncture ☑ Tracheostomy
☑ Transesophageal ☐ Blood & Blood product Transfusion ☑ ICU Admission / Recovery ☐ Others

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

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

PRENATAL / EARLY CHILDHOOD ANAESTHESIA

- Potential long term negative effects on memory, behaviour and learning with prolonged or repeated exposure to general anaesthesia / moderate sedation / deep sedation during pregnancy and in early childhood
- I, the above named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	H. Cecilia Subashini	H. CECILIA SUBASHINI	4/1/24	18.00
Surrogate/Guardian (if applicable #)	I. JohnSamuel	I. JOHNSAMUEL *(Write name and relationship with patient)*	4/1/24	18.00
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		R. Sushma	4/1/24	18.00
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by		Geetha	71617	4-1-24	18-30

Medway Hospitals®
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(A Unit of United Alliance Healthcare Pvt Ltd)

நோயாளி விவரங்கள் : *(Affix Label here)*
பெயர் :
UHID:
பிறந்த தேதி: பாலினம்:
சேர்க்கை தேதி:
மருத்துவர்:

MHI/OT/2022/083

Medway Heart Institute
Every heart beat counts

மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1. ☐ நோயாளி .....அல்லது ☐ நோயாளியின் பிரதிநிதி,

மேலேயும் கீழேயும் சரியான விருப்பத்தைத் தேர்ந்தெடுங்கள்) படித்தல்

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

செயல்பாடு/செயல்முறை _____

_____

இந்த ஒப்புதல் படிவத்தின் கீழே கொடுக்கப்பட்ட செயல்பாட்டு நடைமுறையின் முழு பெயர்)

* எனது அறுவை சிகிச்சை நிபுணர் நடைமுறையின் அபாயங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி என்னிடம் கூறினார். எனது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து சேவைகள் தேவை என்பதையும் நான் புரிந்து கொள்கிறேன். இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.

* அனைத்து வகையான மயக்க மருந்துகளும் சில அபாயங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத கடுமையான சிக்கல்கள் ஏற்படலாம். தொற்று நோய், இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு செயல்பாடு, பக்கவாதம், மூளை பாதிப்பு அல்லது மரணம் போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.

* இந்த அபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை நான் புரிந்து கொள்கிறேன்.

* சில நேரங்களில் உள்ளூர் மயக்க மருந்துகளைப் பயன்படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் முழுமையாகப் பெறாமல், மற்றொரு நுட்பத்தை மயக்க மருந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.

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

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

பிறப்புக்கு முந்தைய / ஆரம்பகால குழந்தை பருவ மயக்க மருந்து

★ நினைவாற்றல், நடத்தை மற்றும் கற்றலில் நீண்டகால எதிர்மறை விளைவுகள் பொது மயக்க மருந்து / மிதமான மயக்கம் / கர்ப்ப காலத்தில் மற்றும் ஆரம்ப பருவத்தில் ஆழமான மயக்கத்துடன் நீண்ட அல்லது மீண்டும் மீண்டும் மீண்டும் வெளிப்படுதல்

★ நான் / மேற்கூறிய நோயாளி / பெயரிடப்பட்ட நோயாளியின் பிரதிநிதி, இந்த வடிவத்தில் கையெழுத்திடப்பட்ட தேதி, மன ரீதியாக ஒலி மற்றும் எந்தவொரு பயமும் இல்லாமல் ஒப்புதல் அளிக்கிறேன் என்று நான் 18 வயதுக்கு மேற்பட்டவன் என்று இதன்மூலம் அறிவிக்கிறேன்.

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

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்	தேதி	நேரம்
பெறப்பட்ட ஒப்புதல்					

MHI/OT/2022/094

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ANAESTHESIA RECORD

Medway Heart Institute
Every heart beat counts

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Type of Surgery : ☐ Day Care ☑ Elective ☐ Emergency

Blood Group : B+ve Height : 152 cms Weight : 65 Kgs

Pre-Operative Diagnosis: CAD - TVD . DM , HT Peripheral vascular disease

Proposed Surgery: CABG (Hybrid)

Anaesthetic Plan: GA

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

History of Present Illness:
- ☐ ANGINA
- ☑ DYSPNOEA on exertion
- ☐ SYNCOPE
- ☐ MI
- ☐ CCF
- ☐ OTHERS

H/o admission for surgery (R) diabetic foot

Previous Surgery : 10/12/23 → 16/12/23 B/L cataract surgery.

COMORBIDITY
- ☑ HT 1yr
- ☑ DM 25yr
- ☐ ASTHMA / COPD
- ☐ HYPO THYROID
- ☐ STROKE / TIA
- ☐ EPILEPSY
- ☐ SMOKING
- ☐ ALCOHOL
- ☐ GERD
- ☐ CKD / NEPHROPATHY
- ☐ DRUG ALLERGY
- ☐

Present Medication :
T OXRA → 31/12/23.
T Eptus . T Amaryl
T Dytor, Unicor

Anti Platelet Stopped on : T. clopilet → 31/12/23

Physical Examination :
- ☐ JAUNDICE
- ☐ PEDEL OEDEMA
- ☐ CYANOSIS
- ☐ CAROTID BRUIT
- ☐ CLUBBING

SYSTEMC EXAMINATION

CVS : S1 S2 (+)

RS : VBS (+)

CNS : NFND.

Others :

HR : 82 NIBP : 130/80 SPO2 : 96 TEMP :

INVESTIGATION

HB	11.7	T.BILIRUBIN	0.3	T3	119
PLAT	499000	I.D.	0.13	T4	11
TC	11660	D.	0.22	TSH	5.12
UREA	31	T-PROTEINS	7.9	HBA1C	10.3
CREAT	0.8	S.ALBUMIN	3.7	RBS	
Na+	136	PTT / INR	1		
K+	4.3	APTT	29.2		

SEROLOGY: NR

Urine: plenty of pus cells

Others:

ANGIO: LM → mild plaque LAD - Calcified.

ECG: HR - PVT 70%, RCA - Ostial critical stenosis. Sinus.

CXR: normal

ECHO: EF 55%
No RWMA , Grade I DD
↑ LV filling pressure
(N) RV
PML annular calc

AIRWAY

Teeth: (N)

Mallampatti class: I

Mouth Opening: Adequate

Neck Movement: (N)

TM Distance: (N)

CAROTID DOPPLER
Calcific plaque in (L) CCA + (R) carotid bulb
Chronic clot in (L) carotid bulb
no flow density disease

Other Opinions:
Doppler → both lower limbs 50-60% narrowing of B/L femoral art (outside investigation)

Pre OP Instruction : NPO From: 12 midnight

Pre Medication : T Pan 40mg HS.

Night Before Surgery : T Alprax 0.25

Day of Surgery: T Pan 40mg 6am

Special Instruction :

Blood Reservation

PCV : 2 PC Platelet :

FFP : CRYO :

Whole Blood:

Remarks:

Dr. AJEETHA. P.K
Reg. No: 74617

Anaesthetist Name with Reg.No. : Signature :

Date: 5/1/24	Anaesthetist: Dr. Sylvester / Dr. Anitha	Surgeon: Dr. Anbarasu / Dr. Praveen	Anaesthesia Technique: ☑ GA ☑ Regional ☐ Others

PRE INDUCTION ANAESTHESIA RECORD

82 Pulse: 180/60 mmHg BP: — RR: 14/mt
Sensorium: WNL
Sign-in Completed: ☑ Yes ☐ No
~~Equipment Checked: ☐ Yes ☐ No~~
Sign: — Name: Dr. S. Sylvester
Time:

Dr. A. SAMUEL SYLVESTER
Reg. No. 43570

~~PATIENT SAFETY~~

Position on Table: Supine
Pressure points checked & Padded: ☑ Yes ☐ No
Eye Care: ☑ Yes ☐ No
Safety Belt: ☑ Yes ☐ No
Warming Blanket: ☑ Yes ☐ No
Fluid Warmer: ☐ Yes ☑ No
TED Stockings: ☐ Yes ☑ No
Sequential Compression / Decompression: ☐ Yes ☑ No

MONITORS AND EQUIPMENTS

☐ NIBP ☐ Left ☐ Right
☑ ECG ☑ Pulse Oximeter ☑ End Tidal CO_2
☐ Gas Analyzer ☐ Oxygen Sensor
☑ Disconnect ☐ Temperature Probe
☑ Foley Catheter ☐ Nerve Stimulator
☐ TEE ☐ Others:
☑ CVC Type: 4 lumen 10 cm Site: (R) IJV
☑ Standard Asepsis ☐ USG Guidance
☐ Complications: ☐ Yes ☑ No
If Yes, details:
☑ Arterial Line Type: (L) radial 20 G Site:
☑ PVC Type: 18 G Site: (R) cubital fossa
☐ PVC Type: Site:
☐ Others:

GENERAL ANAESTHESIA

INDUCTION:
☑ Pre O_2 ☐ Rapid Sequence ☑ IV
☑ Inhalation - Agent used: Isoflurane
Mode of Ventilation: ☑ Spontaneous ☑ Controlled

AIRWAY MANAGEMENT:
Intubation: Oral / Nasal ETT Size: 7.5 Type: Cuffed
CL Grade: I / (II) / III / IV Secured at: 20 cm
Any difficulties and accessories: NO
Throat Pack: ☐ Yes ☑ No ☐ Removed
NG / OG Tube: ☑ Yes ☐ No

OTHER AIRWAY DEVICES:
☐ LMA Type & Size:
☐ Via Tracheostomy ☐ Face Mask ☐ Nasal Prongs
☐ Others:

Antibiotic / Dose / Time
Inj. Ceftriaxone 1.5 G IV 9.05 AM

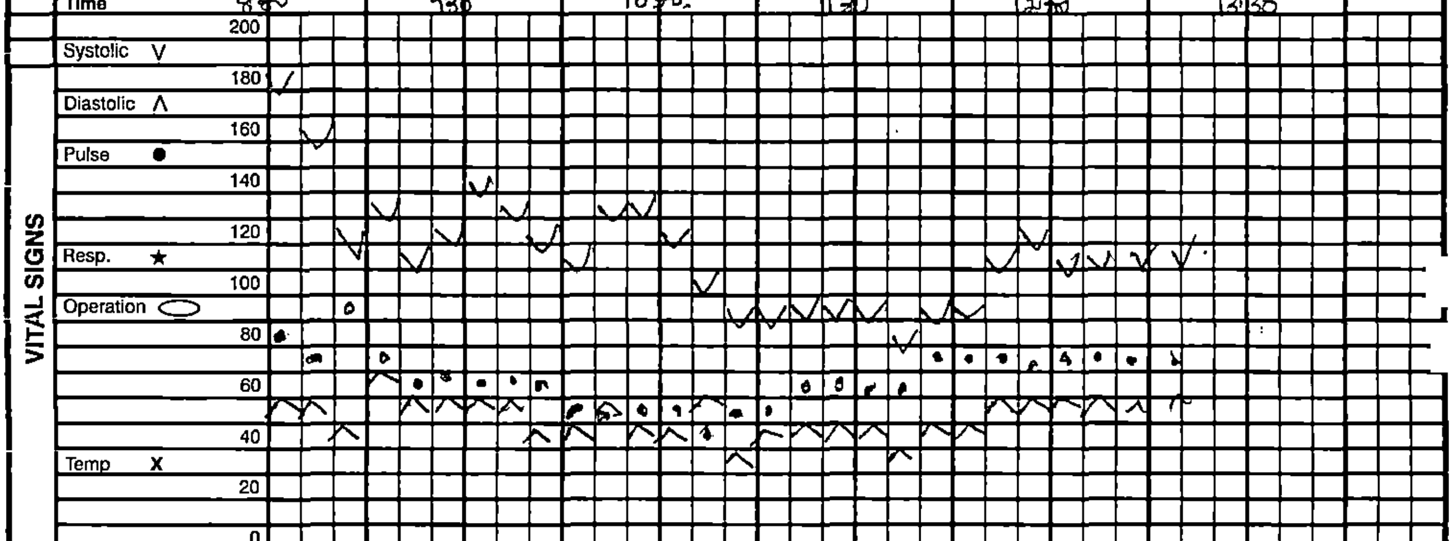
Reversal of Anaesthesia

DRUGS

Drug	1	2	3	4	5	6	7	8	9	10	11	12
PROPOFOL												
MIDAZOLAM	3											
FENTANYL	125	125		75	50		50	75				
MORPHINE												
VECURONIUM	8	1		1	1		1	1				
ETOMIDATE												
KETAMINE												
SUXA/ROCURONIUM												
CISATRACURIUM/ATRACURIUM												
SEVO/ISOFLURANE	✓	✓	✓	✓	✓	✓	✓	✓				
Air/N_2O	✓	✓	✓	✓	✓	✓	✓	✓				

VITAL SIGNS

Time: 830 | 930 | 1030 | 1130 | 1230 | 13:30



MONITOR

	1	2	3	4	5	6	7	8	9
SPO2	100%	100%	100%	100%	100%	100%	100%	100%	100%
CVP	10	10	9	8	8	9	8	8	8
PAP									
$ETCO_2$ 33	[illegible]	22	23	22	21	22	22	21	23
Urine Output	← 800 ml →								

ABG

	1	8
PH	7.405	7.58
PCO_2	41.4	26.3
PO_2	96.6	301.7
Na^+	134	135
K^+	4.28	4.42
HCT	33	23
RBS	123 mg%	156 mg/dl
LAC		
BE	0.6	-1.0
HCO_3	25.4	21.6

	START	STOP
ANAESTHESIA	8.35	13.05
PROCEDURE	9.35	13.00.

CPB — OPCAB —

AXC

CUF : MUF:

FLUID TRANFUSED		BLOOD PRODUCTS
CRYSTALOID	COLLOID	—
KABILYTE 1U.	—	
2U		
3U		

HEPARIN

DOSE	TIME	ACT
125 mg	10:25	396 Secs

PROTAMINE

DOSE	TIME	ACT
100 mg	12.25	118 Secs

PRESSURE MONITOR

PRE OP

PA	RV	PCWP

ABP —

POST OP

PA	RV	PCWP

ABP —

INOTROPES & INFUSIONS

DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
NORADRENALINE (4 mg/50 cc)	0.02 - 0.05 µg/kg/mt	10.25	Contd.
ADRENALINE (6 mg/50 cc)	0.02 - 0.04 µg/kg/mt	10.25	13.00

DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
NITROGLYCERINE (25 mg/50 cc)	0.5 - 0.75 µg/kg/mt	10.25	13.00

REGIONAL ANAESTHESIA [YES] / NO

DETAILS : BIL ESPB

25 ml + 25 ml of 0.25% ROPIVACAINE + 50 Mics DEXMEDETOMIDINE

LEFT FEMORAL NERVE BLOCK - 10 ml of 0.25% ROPIVACAINE

IABP : NIL

ECMO: NIL

TEE: NIL

REMARKS / CRITICAL EVENTS

ANAESTHESIOLOGIST NAME : Dr. A. SAMUEL SYLVESTER

REG.NO. Reg. No: 43570

SIGNATURE

POST OPERATIVE PLAN

Transfer to: ☑ SICU ☐ Others, specify: _____

Arrival in Recovery / ICU Time: 13:15

SpO_2: 100 % HR: 73 beats/min Rhythm: Regular RR: 14 breaths/min

ABP: 110/60 mmHg CVP: 11 mmHg PAP: _____ mmHg C.O: _____ L/min

Conscious state: Sedated Pain score: _____

VENTILATOR SETTINGS: Volume control; RR 14/mt; TV 500 ml; PEEP 5 cmH2O FIO_2: 1.0.

IONOTROPES:

Inj. Noradrenaline 0.05 µg/kg/min

POST OP ORDERS:

1) DO ABG / chest xray / ACT
2) Wean & extubate when fully awake.

MODIFIED ALDRETE'S SCORE *(Score against each criteria)*

CRITERIA	PARAMETER	Scale
Activity, able to move, voluntarily or on command	4 extremities	2
	2 extremities	1
	No	0
Breathing	Able to breath deeply and cough freely	2
	Dyspnea, shallow or limited breathing	1
	Apnea	0
Consciousnesss	Fully awake	2
	Arousable on calling	1
	unresponsive	0
Circulation (Blood Pressure)	+20% of pre-anaesthesia level	2
	+20% to 49% of pre-anaesthesia level	1
	+50% of pre-anaesthesia level	0
SPO_2	Maintains SPO_2 >92% in ambient air	2
	Maintains SPO_2 > 90P% with O_2	1
	Maintains SPO_2 <90% with O_2	0

Total Score: 10

Patient fit for discharge: ☑ YES ☐ NO

Anaesthetist Name & Reg.No.: Dr. A. SAMUEL SYLVESTER Reg. No: 43570

Signature

MHI/OT/2022/081

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Medway Heart Institute
Every heart beat counts

OPERATION NOTES

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Pre-Operative Diagnosis : CAD / TVD / Good LV function

Post-Operative Diagnosis : CAD / TVD / Good LV function

Operation Procedure : Off Pump CABG x 4 grafts
LIMA → LAD SVG → OM + LAD endarterectomy
SVG → Diag SVG → dRCA

D.O. Operation | 0 | 5 | 0 | 1 | 2 | 0 | 2 | 4 |

Please tick the type of procedure :
Closed ☑ Open ☐

Operation Commenced :	9.35	Operation Completed :	13.00	Nature of Anaesthetic :	General

Surgeons Dr. Anbarasu / Dr. Praveen / PA · Karthika

Perfusionist –

Anaesthetist Dr. Sylvester

Nurse Ms Abitha

Incision Midline Sternotomy

Cannulation — Arterial — Venous

Oxygenator

Total CPB Time
Total ACC Time
Total TCA Time

Findings and Relevant Details :

LIMA of good calibre and flow ~1.75mm
Lt SVG of good calibre ~3.5mm
Targets :
LAD - 1.25 Atherosclerosis +
Calcified.
Diag - 1.25 "
OM - 1.25 Healthy
dRCA - 1.5 Healthy.

Median Sternotomy – Thymus dissected – Vertical pericardotomy – Targets assessed – LIMA and Lt SVG harvested – Systemic heparinisation – LIMA divided and prepared – Myocardium stabilised with stabilizer – SVG anastomosed to OM and Diagonal – LIMA anastomosed to LAD after endarterectomy – SVG anastomosed to dRCA – Pericardial fat cleared – Dena applied – 2 Aortotomy with 4 mm punch – dRCA and OM grafts anastomosed to Aorta – Diag graft anastomosed to OM graft with 7-0 prolene – Protamine – Haemostasis – Drains placed – Sternum closed with NO-5 Steel wire – Wound closed in layers.

POST-BY PASS HAEMODYNAMICS

RA			**LA**		**Cardiac Output**
RV			**LA**		**C I**
	SVS			**SYS**	
PA		**MEAN**	**BP**		**MEAN**
	DIAS			**DIAS**	
P A C W					

Support: Isoprin, Dopamine, Dobutrex — Adrenaline, I A B P, Others — Noral - 0.05 µg/kg/min.

POST-OPERATIVE INSTRUCTIONS :

To do - ABG, ACT, chest xray

Watch for:

1. Bleeding
2. Hypotension

Blood loss - 300 ml

Blood transfusion - Nil

Drains: Chest - (1) L+ Pleural
Mediastinal - (1)
Pericardial
Others

Sponge Count : Correct.

Dr. Anbarasu Mohan...
Reg No: 55476

Surgeon : Dr. ANBARASU MOHANRAJ **Date :** 05/01/2024

OPERATION NOTES

NAME: Mrs. CECILIA SUBASHINI. H	**AGE/GENDER:** 60Years / FEMALE
UHID NO: MHI202381349	**IP NO:** IPH2024000033
DOA: 04/01/2024	**DOS:** 05/01/2024
SURGEON: DR. ANBARASU MOHANRAJ	**ANESTHETIST:** DR. SAMUEL SYLVESTER
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	**PHYSICIAN ASSOCIATE:** MS. SAIKUMARI/MS. KARTHIKA
SCRUB NURSE: MS. ABITHA	

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

CALCIFIC CORONARIES

RECENT ACUTE CORONARY SYNDROME

ADEQUATE LEFT VENTRICULAR FUNCTION (EF – 54%)

RECENT EPISODE OF SEPSIS

CHRONIC UNCONTROLLED DIABETES MELLITUS

SYSTEMIC HYPERTENSION

PERIPHERAL VASCULAR DISEASE

RIGHT DIABETIC FOOT ULCER

SURGERY DONE:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4

LIMA TO LAD (EXTENSIVE ENDARTERECTOMY)

SVG TO RAMUS INTERMEDIUS

SVG TO OM

SVG TO DISTAL RCA

FINDINGS:

Good myocardial contractions

Emphysematous lungs

All Coronaries were severely calcified

LIMA – 1.75mm, Good quality, good flow

SVG – 4mm, from left leg, Good quality

LAD –Diffuse calcifications, long arteriotomy and extensive endarterectomy done, LIMA onlay patch

RAMUS INTERMEDIUS – 1.8mm, calcified vessel

OM – 1.6mm, calcified vessel

DISTAL RCA – 2.0mm, Healthy target

Good distal run off in all the grafts

PROCEDURE:

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

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

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

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Long arteriotomy was made. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD (EXTENSIVE ENDARTERECTOMY))

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

Aorta occluded partially. Two 4mm holes were made on the aorta with aortic punch. Proximal anastomosis of vein grafts done onto aorta with 6-0 prolene suture. Proximal of RAMUS INTERMEDIUS vein graft done on to proximal of OM vein graft using 7-0 prolene sutures. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural tubes insitu

SUPPORTS:

He was shifted to ICU with inj. Nor Adrenaline 0.05µg/kg/min support.

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

CONSULTANT SIGNATURE
Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)
Director and Clinical Head - Cardiac, Vascular and Thoracic Surgery

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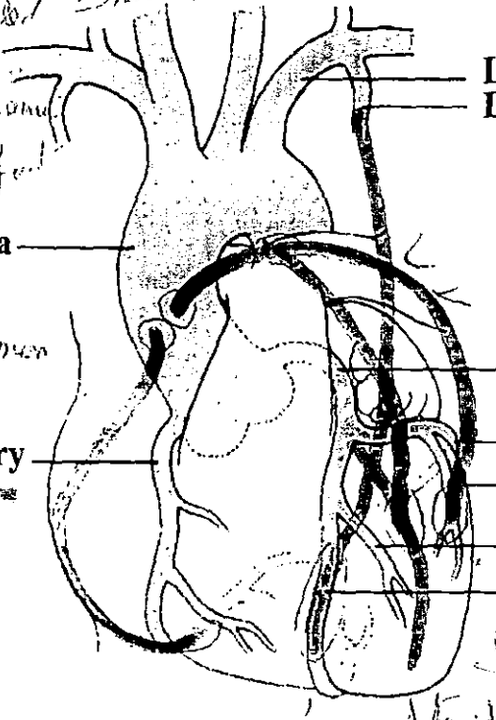
(A Unit of United Alliance Healthcare Pvt Ltd)

Medway Heart Institute

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



Name Mr. [illegible] Date of Surgery 05/01/2023 UHID. No. MHI-2023[illegible]

Operation Performed OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (CABG)

SAFETY FIRST

MHI/ICU/2022/092

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Medway Heart Institute
Every heart beat counts

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

IT'S INFORMATION SHEET

NAME	AGE / SEX	UHID NO

CONSULTANT	SURGEON	ANAESTHETIST
DR. ANBARASU	DR. ANBARASU	DR. SYLVESTER

DIAGNOSIS (In Capital Letters)	1. CAD - TVD
	2. CALCIFIC CORONARIES
	3. ADEQUATE LV SYSTOLIC FUNCTION
	4. CONCENTRIC LVH
	5. GRADE-I DIASTOLIC DYSFUNCTION AORTIC VALVE SCLEROSIS.
	6. TRIVIAL AR, TRIVIAL MR, TRIVIAL TR
	7. NORMAL RV SYSTOLIC FUNCTION
	8. EF = 55%
PRESENT PROCEDURE/ SURGERY	OPCAB X 4 GRAFTS LIMA → LAD (EXTENSIVE ENDARTERECTOMY) SVG → OM SVG → RAMUS INTERMEDIS, SVG → DISTAL RCA
PREVIOUS PROCEDURE/ SURGERY	H/O LSCS X 1995 BILATERAL CATARACT SURGERY X 2013 AND 2018
CONTACT NO. & RELATIONSHIP	1. MR. JOHN (SON) V.C 9176710730
	2. MRS. HEPSI (DAUGHTER) (V.C) 9176932530

ND: NO: 08/08

INSURANCE

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	4/1/23	Tab. DYTOR	10mg	p/o	1-0-0	
2	4/1/23.	Tab. EPTUS	25mg	p/o	0-1-0	
3	4/1/23	Tab. ATORVA	40mg	p/o	0-0-1	
4	4/1/23.	Tab. FLAVEDON MR	35mg	p/o	1-0-1	
5	4/1/23.	Tab. GLIAREN-D	1 tab	p/o	0-0-1	
6	4/1/23	Tab. PULMOCLEAR	1 tab	p/o	1-0-1	
7	4/1/23	Syp. CREMAFFIN	15ml	p/o	0-0-1	
8						
9						
10						

ANTIPLATELET STOPPED ON : 31/12/2023

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	5/1/24 ~~Syp. SUCRAFIL~~	SYP. SUCRAFIL	10ml	PO	1-1-1	
2	"	NEB. LEVOLIN	0.63mg	NEB	QBH	
3	"	T. FRUSEMIDE	40mg	PO	1-1-0	
4	"	T. SPIRONOLACTONE	25mg	PO	1-1-0	
5	"	T. CLOPILET A	75/75	PO	0-1-0	
6	6/1/24	T. ROSUVAS	40mg	PO	0-0-1	
7	6/1/24	T. PARACETAMOL	650mg	PO	1-1-1	
8	"	SYP. CREMAFFIN PLUS	15ml	PO	0-0-1	
9	"	T. GLIAREN D	1TAB	PO	0-1-0	
10	"	T. METOPROLOL	25mg	PO	1-0-1	
"	"	T. PREGALIN	75mg	PO	1-0-1	

ANY RELEVANT INFORMATION:

Admission / OT Receival **Date and Time :** 5/1/2024. At 13:15 **From :** OT **To :** SICU	**Condition of the Patient :** ON VENTI 1. Stable / Unstable		2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated
Transfer Out **Date and Time :** 5/1/25 at 11:35 **From :** SICU **To :** FO3	**Condition of the Patient :** 1. Stable / Unstable		2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated
Transfer In **Date and Time :** **From :** **To :**	**Condition of the Patient :** 1. Stable / Unstable		2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated

	Year	Months	Days
1) Known Case of **Diabetic Mellitus**	30 years		
2) Known Case of **Hypertension**	—	6 months	
3) Known Case of **Bronchial Asthma/COPD**	—		
4) Known Case Of **Others**	—		

Denture	☐ Yes ☑ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent
Allergic Reaction : Drugs/Food	☐ Yes ☑ No If you means mention about Drug / Food Name :
Pressure Ulcer Present	☑ Yes ☐ No If you means mention about **Grade :** 1 / 2 /3 / 4 & Site: GRADE-2 (RT) LEG DIABETIC FOOT.

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site: RIGHT CUBITAL. 2. Site: LEFT CUBITAL 3. Site:	1. Inserted Date and Time 5/1/2024 @8:35 2. Inserted Date and Time 5/1/2024 AT 08:35 3. Inserted Date and Time	1. Removed on : 10/1/24 at 17:00 2. Removed on : 6.1.23 @ 11:30 3. Removed on :	
Neek Line : ~~IJL~~ / EJL	Site: RIGHT	Inserted Date and Time 5/1/2024 @ 9:05	Removed on 7/1/24 at 10:45	
Arterial Line : Right/~~Left~~	Site: RADIAL.	Inserted Date and Time 5/1/2024 @ 9:10	Removed on 6/1/24 @ 11:30	Suraja
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on	
Pressure Bandage	Site: (R) RADIAL	Inserted Date and Time 6/1/24 at 11:30	Removed on 7/1/24 at 6:00	
Drain Site	1. **Mediastinal :** Inserted Date and Time + 5/1/2024 @ 13:00 2. **Pleural Right / ~~Left~~ :** Inserted Date and Time		Removed on 6/1/24 at 13:30 Removed on	
Urinary Catheterization	Inserted Date and Time 5/1/2024 @ 9:15	Removed on 7/1/24 at 5:00		
Nasal / Oral Gastric Tube	Inserted Date and Time 5/1/2024 @ 13:15	Removed on 5/1/2024 @ 16:40		
Intubation Date and Time 5/1/2024 @ 13:15	Extubation Date And Time (3 HRS 30 MIN) 5/1/2024 @ 16:45	Reintubation Date And Time		
Other Information	pt had complaints of SOB X1 month ECG DONE ON : 04/01/2024. S. ECHO DONE ON : 18/12/2023. CAROTID DOPPLER DONE ON: 27/12/2023 CAG DONE ON: 15/12/2023.			

MHI/ICU/2022/092

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

PATIENT'S INFORMATION SHEET

NAME	AGE / SEX	UHID NO

CONSULTANT	SURGEON	ANAESTHETIST
DR·ANBARASU	DR·ANBARASU	

DIAGNOSIS (In Capital Letters)	1. CAD - TVD
	2. ADEQUATE LV FUNCTION EF - 55%
	3. PML ANNULAR CALCIUM PRESENT / CONCENTRIC LVH / AORTIC VALVE SCLEROSIS
	4. UNCONTROLLED T2DM / SHTN
	5. RIGHT DIABETIC FOOT
	6. TRIVIAL MR / TR
	7. —
	8. —
PRESENT PROCEDURE/ SURGERY	CABG1
PREVIOUS PROCEDURE/ SURGERY	H/O LSCS done in 1995. H/O B/L Cataract surgery done on 2013 & 2015.
CONTACT NO. & RELATIONSHIP	1. MR·EMMANUEL 9176710730 (HUSBAND). 2.

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	15.12.23	T-DYTOR	10MG	P/O	1-0-0	
2	"	T-EPTUS	25MG	P/O	0-1-0	
3	"	T-ATORVAS	40MG	P/O	0-0-1	
4	"	T-CONCOR	2.5MG	P/O	1-0-1	
5	"	T-FLAVEDON MR	35MG	P/O	1-0-1	
6	"	CAP-CLOPILET-A	75/75	P/O	0-1-0	31.12.23
7	"	T-AMARYL M2	1TAB	P/O	1-0-1	
8	"	INJ-HUMAN MIXTARD 25/75		S/C	20U-0-8U	
9	"	T-PULMOCLEAR	1TAB	P/O	1-0-1	
10	"	SYP-DUPHALAC	15ML	P/O	0-0-1	

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	04.1.23	T-DYTOR	10MG	P/O	1-0-0	
2	"	T-EPTUS	25MG	P/O	0-1-0	
3	"	T-ATORVAS	40MG	P/O	0-0-1	
4	"	T-CONCOR FLAVEDON-MR	35MG	P/O	1-0-1	
5	"	T-GLIAREN-D	1TAB	P/O	0-0-1	
6	"	T-PULMOCLEAR	1TAB	P/O	1-0-1	
7	"	SYP-DUPHALAC	15ML	P/O	0-0-1	
8						
9						
10						

ANY RELEVANT INFORMATION:

Admission / OT Receival **Date and Time :** 4/1/24 **From :** Admission **To :** 1pm	**Condition of the Patient :** 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer Out **Date and Time :** **From :** **To :**	**Condition of the Patient :** 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer In **Date and Time :** **From :** **To :**	**Condition of the Patient :** 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
1) Known Case of **Diabetic Mellitus**	Year: 30yrs	Months:	Days:
2) Known Case of **Hypertension**	Year: 6months	Months:	Days:
3) Known Case of **Bronchial Asthma/COPD**	Year:	Months:	Days:
4) Known Case Of **Others**	Year:	Months:	Days:
Denture	☐ Yes ☑ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	☐ Yes ☑ No If you means mention about Drug / Food Name :		
Pressure Ulcer Present	☑ Yes ☐ No If you means mention about **Grade :** 1 / 2 /3 / 4 & Site: Grade-I, (R) Diabetic foot.		

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site: 2. Site: 3. Site:	1. Inserted Date and Time 2. Inserted Date and Time 3. Inserted Date and Time	1. Removed on : 2. Removed on : 3. Removed on :	
Neek Line : IJL / EJL	Site:	Inserted Date and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on	
Pressure Bandage	Site:	Inserted Date and Time	Removed on	
Drain Site	1. **Mediastinal :** Inserted Date and Time 2. **Pleural Right / Left :** Inserted Date and Time		Removed on Removed on	
Urinary Catheterization	Inserted Date and Time	Removed on		
Nasal / Oral Gastric Tube	Inserted Date and Time	Removed on		
Intubation Date and Time	Extubation Date And Time	Reintubation Date And Time		
Other Information	20 pcv Reservation done Confirmed with staff Venkat			

MHI/OT/2022/086

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NABH ACCREDITED

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Name of the Procedure : OPCAB (CH) Location : CTOT Date & Time : 5/1/24 C 13:10

Does the Procedure involve Procedural Sedation : ☑ Yes ☐ No GA

SIGN IN 8.20 Before Induction of Procedural Sedation		TIME OUT 9.32 AM After procedural Sedation and before procedure		SIGN OUT 13:10 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	☑ Yes	Identity by two identifiers	☐ Yes	Name of the Procedure done written down ☐ Yes OPCAB
Procedure	☐ Yes	Procedures	☑ Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA confirms labeling and sent to lab OPCAB
Side	☑ Rt ☐ Lt ☐ NA Check Reg	Side Expected Blood loss 200ml	☐ Rt ☐ Lt ☐ NA	
Consent	☑ Yes	Position supine	☑ Yes	Any recovery concerns : ☐ Yes ☑ None If Yes, Pls. specify :
Known Allergy	☐ Yes ☐ No Not known If yes, plaese specify	Consent	☐ Yes	
		Required equipment and implants available	☐ Yes ☐ NA	
Difficult airway / aspiration risk / dentures	☐ No ☐ Yes, equipment and assistance available	Essential Imaging displayed	☑ Yes ☐ NA	
		Antibiotic prophylaxis within last 60 minutes	☐ Yes ☐ NA	
Possibility of hypothermia	☐ No ☐ Yes, warmer in place	Name of the Antibiotic given Inj. Ceftriaxone 1.5g e.o.s		Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☐ None If Yes, Pls. specify :
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☐ NA	
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	☐ Yes	
☐ Spo2 ☐ NIBP ☐ Others pls. specify		Anticipated blood loss briefed	☑ Yes ☐ NA	
Pre OP medication taken	☑ Yes ☐ No	Adequate fluids and blood available	☑ Yes ☐ NA	
		Team briefed on any critical or unexpected steps	☐ Yes	Corrective action :
Required equipment for procedure available	☑ Yes ☐ NA	For procedural sedation cases		Sponge, Gauze, Instruments Needle counts Correct
		Any patient specific concerns :	☐ Yes ☑ None	
		Intra procedure glycemic control	☐ Yes ☐ NA	
		Any concerns about sterility	☐ Yes ☐ None	

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse :	Technician :	Others Please Specify :
Dr. SYLVESTER	Dr. [illegible]	Abitha E	Balakrishnan	OTINC
Date : 5/1/24 C	Date : 5/1/24 C	Date : 5/1/24 C	Date : 5/1/24 C	Date :
Time : 13:10	Time : 13:10	Time : 13:10	Time : 13:10	Time : 13:10

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MHI/IP/2022/067

Medway Heart Institute

CONSENT FOR BLOOD / BLOOD COMPONENTS

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

Red Cells	for bleeding or low hemoglobin
Platelets	for bleeding or low counts
Plasma	for restoring blood volume or providing clotting factors
Cryoprecipitate	for special clotting factors

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

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

Witness .....
Doctor ..... BR 13455
Time 18.00
Date 4/1/24

Patients name ..... H. CECILIA SUBASHINI
Patient signature ..... H. Cecilia Subashini
or Guardians name ..... I. JOHNSAMUEL
Guardians signature ..... I. Johnsamuel
Relationship to patient ..... Son

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

Time: 18.00 Date: 4/1/24 Doctors Signature: BR 13455

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MHI/IP/2022/067

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ஒப்புதல் : இரத்தம் / இரத்தத்தின் பாகங்களை செலுத்துதல்

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

சிவப்பு அணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு
தட்டணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு
குருதிநீர்	இரத்த கன அளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு
கிரையோபிரைஎிபிடேட்	சிறப்பு உறைவு அம்சங்களுக்காக

எனக்கு / நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்

1. இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானமளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அலோஜெனிக்) அல்லது சுயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானமளிப்பதற்கு வாய்ப்புள்ளது.

2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்பட்டிருந்தாலும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்ட் ஹெபடைடிஸ் மற்றும் இதர வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையு நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம். இவை காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொண்டேன்.

3. இரத்தம் செலுத்துவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலை துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம் என்றாலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.

4. இரத்தம் செலுத்துதல், மாற்று சிகிச்சை முறைகள், சிகிச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய விவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.

5. முறையான மருத்துவ பராமரிப்பின் பொருட்டு, இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முழுமையான காலகட்டத்திற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக் கொள்கிறேன்.

நோயாளியின் பெயர்.....

சாட்சி ..... நோயாளியின் கையொப்பம் .....

மருத்துவர் ..... அல்லது பாதுகாவலரின் கையொப்பம் .....

நேரம் ..... பாதுகாவலரின் கையொப்பம் .....

தேதி ..... நோயாளியுடனான உறவு ....

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

நேரம் :

நோயாளியின் பெயர் : மருத்துவரின் கையொப்பம்.....

தேதி :

இந்த ஒப்புதல் படிவம் கையெழுத்திடப்பட்ட நேரத்திலிருந்து 72 மணி நேரத்திற்கு மட்டும் செல்லத்தக்கதாகும்

MHI/HOSP/2022/093

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NABH ACCREDITED

Medway Heart Institute
Every heart beat counts

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

ID BLOOD PRODUCTS RECEIVED AND FEED BACK

PROCEDURE : OPCAB x HVRRS INDICATION Low Hb 8.7 UNIT: OT | AICU | PICU | CCU

BLOOD GROUP & TYPE : B+ve

DATE / TIME OF RECEIVED	NAME OF PRODUCTS	BAG NO	TRANSFUSION START	TRANSFUSION END	NAME & DR. SIGN	ANY REACTION YES	ANY REACTION NO
04/01/2024	1 U PRBC	4371	15:00		DR. GJNBSTBR		✓
@ 14:45					8/11225		
				✓			✓

Note: **IF REACTION YES,** Report to Blood Bank and collect Reaction form, Fill and send along with 5ml plain sample, 2 ml **EDTA** sample, Urine Sample and remaining Blood bag with IV - Administration set.

IF NO REACTION Please send this feed back form to Blood Bank without delay.

S.No. : 20

MEDWAY HOSPITALS BLOOD CENTRE

(A Unit of United Alliance Healthcare Pvt. Ltd.)

Patroned by RYA COSMO UGTA FOUNDATION

Ground Floor, New No. 8, Old No. 22, 4th Cross Street, Trustpuram, Kodambakkam, Chennai - 24. Ph : 72990 57877

LICENCE NO : 473 / 28C

BLOOD DONOR SCREENING & CROSS MATCHING REPORT

Recipient's Name : MRS. CECILIA SUBASHINI. H
Age / Sex : 60y | F
I.P. Number : 0033
Hospital : MEDWAY HEART INSTITUTE
Ref. by Dr. : –
Date : 05|01|2024

DONOR		Blood Group / Sub Group Rh Type	RECIPIENT	
B	POSITIVE		B	POSITIVE
	~~NEGATIVE~~			~~NEGATIVE~~

UNIT PARTICULARS

Blood Bag No. : 4371
D.O. Collection : 26|12|2023
D.O. Expiry : 06|02|2024

CROSS MATCHING

Saline Cross Matching	✓
Bovine Albumin Cross Matching	–
Coombs Cross Matching	✓
Gel Method	✓

COMPONENT

1. Whole Human Blood I.P.	–
2. Fresh Frozen Plasma BP 93	–
3. Packed Red Blood Cell I.P	✓
4. Platelet Concentrate I.P	–
Apheresis	
5. Plateletpheresis	–
6. Leucapheresis	–
7. Plasmapheresis	–

BLOOD IS CHECKED FOR

ABO Grouping / Sub Grouping	✓
Rh Typing	✓
Haemoglobin Content	✓
PCV Determination	✓

BLOOD IS NEGATIVE FOR

HIV 1 & 2	✓
Hepatitis B Surface Antigen (Hbs Ag)	✓
Heapatitis C Virus (HCV)	✓
Malarial Parasite (MP) & MF)	✓
Serological Test for Syphilis (VDRL)	✓

COMBATIBILITY

Compatible	YES.
Incompatible	–

UNIT PARTICULARS

Number of Units issued :	UNIT
Active substance ml :	280ml
Issued on :	05/01/24
Issued time :	1:45pm

NONE OF THE ABOVE TEST HAVE BEEN DONE FOR THE RECIPIENT

K. Vennila
Blood Bank medical Officer / Technician

(For use of Hospital Staff Only) (TO BE FILLED WITH PATIENT'S CASE RECORDS)

PRE TRANSFUSION CHECK

Transfused on : 05|01|2024
To Patient : Mrs. CECILIA SUBASHINI. H
Transfused by : Sundarjanani
Blood Group / Rh Type : B+ve
Blood Bag Number : 4371
Remarks : Nil

Time : 15:00 Started at : 16:00 Completed at : 17:00

12236
Signature of M.O.

PLEASE AVOID RETURN OF THIS BLOOD UNIT

Medway Hospitals ®
The way to better health

BLOOD TRANSFUSION MONITORING CHART

Mrs.CECILIA SUBASHINI.H
60/Female/MH1202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Date : 06/01/24 Time : 15:00

Patient Name : Age : Sex : M / F

Doctor Name : OP / IP No. : Blood Group : B+ve

Blood component checked by : Name : K. SOWNDARYAM. Signature :

Blood component cross-checked by : Name : MAHALAKSHMI Signature :

Transfusion Starting Time : 16:00 Bag No. : H3471 Type : Blood / Component 1U PRBC

Time of Transfusion	Temperature	Pulse	Respirations	Blood Pressure	Blood drop Rate / Min	Remarks
0 Hours	92.9°F	84	24	106/58		
15 min	98°F	78	14	109/60		
30 min	93.7	78	20	110/70 (86)		
1 hour	93.7	78	18	120/67		
1 hour 30 mins	94.5°F	80	24	138/66		NSI
2 hours	94.5°F	74	22	128/65		
2 hours 30 mins	96.0	74	19	124/65		
3 hours	96.0	74	22	128/65		
Blood Transfusion completion Time	17:00	—	—	—	—	—

Post Transfusion V ital Signs :

Time	Temperature	Pulse	Respirations	Blood Pressure	Blood drop Rate / Min	Remarks
17:05	96.7°	84	24	126/74		NH
18:00	96.3°F	81	21	130/72		

K. Sowndaryam
Name of the Staff

Signature

06/01/2024 @18:00
Date & Time

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NABH ACCREDITED

Mrs.CECILIA SUBASHINI.H
60/Female/MH1202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/PHY/2022/050

Medway Heart Institute
Every heart beat counts

CONSENT FORM - PHYSIOTHERAPY

I, Mrs- cecilia subashini the ☐ Patient or ☑ representative of patient have *(please tick the correct option above and below):*

☑ Read

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

☐ Been explained this consent form in Tamil *(Name of language)* which I fully understand and understood the information provided about ~~Operation~~ / procedure

Post operative cardio pulmonary rehabilitation

(full name of ~~operation~~ / procedure given below in this consent form)

Brief description of the ~~Operation~~ / Procedure: Breathing, Spirometry exs, chest percussion, [illegible] exs to ble ul sll, mobilization

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

To Improve Joint Rom, To Improve ADL, To Improve lung expansion & lung clearance

I understand that all procedures carry certain risks. The potential risks and complications from this procedure:

Pain

I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:

—

I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

Signature of Patient / Patient's Relative *(only if Patient is unable to sign)*: I. Hephzibah

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

MYS. Hephzibah

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	I. Hephzibah	Daughter *(Write name and relationship with patient)*	05/01/24	18.00
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		K. Sundarjeem.	05/01/24	18:00
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by		J. VIJAYARAGHAVAN	2102	05/01/24	18:00
Procedure performed by		J. VIJAYARAGHAVAN	2102	05/01/24	18:00

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/PHY/2022/049

Medway Heart Institute
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IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints: c/o Cough & cold x4 days
PT c/o SOB x 1 month.
c/o radiation of pain over lt side of arm x 1 month
c/o Dyspnea on exertion x 1 month

Occupation: ☐ Heavy Activity ☑ Moderate Activity ☐ Light Activity

Past Medical / Surgical History:

K/c/o DM x 30 yrs.
K/c/o HTN x 6 month.
K/c/o Diabetic wound x R foot x 6 month
S/p – LSCS – (1995) / B/L Cataract Surgery (2013 & 2015)

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

On Palpation: ☐ INSIGNIFICANT
Tenderness: ☐ Yes ☑ No | Warmth: ☐ Yes ☑ No | Muscle spasm: ☐ Yes ☑ No
Oedema: ☐ Yes ☑ No | Crepitus: ☐ Yes ☑ No | Tone: ☑ Normal ☐ Abnormal

FALL RISK SCREENING NIL

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

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

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

Respiratory Status:
☑ Room Air ☐ O_2 Support ☐ Ventilatory Support ☐ BIPAP
☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask
Intubated: ☐ Yes ☑ No
Tracheostomy: ☐ Yes ☑ No

Brain Injury *(if applicable)*: NIL
☐ Traumatic ☐ Non Traumatic
☐ Mild ☐ Moderate ☐ Severe
☐ Conscious ☐ Unconscious
GCS: E +V +M = | RLA: levels

Spine Injury: ☐ Present ☑ Absent

AIS:ISNCSCI SCALE: NIL

☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx

Associated Injuries: Speech impaired: ☐ Yes ☑ No

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

ASHWORTH SCALE: NIL

☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit

Balance: ☑ Good ☐ Fair ☐ Poor | Co-ordination: ☑ Good ☐ Fair ☐ Poor

Functional Activities

Self Care: ☑ Independent ☐ Dependent | Bed Mobility: ☑ Independent ☐ Dependent

Transfers: ☑ Independent ☐ Dependent | Ambulation: ☑ Independent ☐ Dependent

FIM Score:

Breathlessness *(If applicable)*:

Dyspnoea Grading Scale: Grade - 2

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

Abnormal Breathing Pattern: Abdominal breathing

Pain Assessment: Pain: ☑ Yes ☐ No

Pain Score: 6/10

Tick whichever is applied: ☑ Numerical Rating Pain Scale ☐ Visual Analog Scale ☐ Wong-Baker Faces

☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC

Location: Lt arm Duration: 1 month Frequency: — Character: ~

☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☑ Radiating ☐ Numbness

☐ Sharp ☐ Cramping ☑ Stabbing ☐ Crushing

Aggravating Factors:	Relieving Factors:
—	~

Examination *(Please tick and mention abnormal findings only)*:

☐ Range of Motion:

Normal

☐ Muscle Strength:

Normal

☐ Reflexes:

Normal

Plantar Response: ☐ Diminished ☐ Brisk ☐ Clonus

Biceps: ☑ Diminished ☐ Brisk ☐ Clonus

Triceps: ☑ Diminished ☐ Brisk ☐ Clonus

Supinators: ☑ Diminished ☐ Brisk ☐ Clonus

Knee: ☑ Diminished ☐ Brisk ☐ Clonus

Ankle: ☑ Diminished ☐ Brisk ☐ Clonus

Sensation: Good

☑ X-Ray ☑ ECG ☐ ECHO ☐ CAG ☑ SIP Surgery

CAD - TVD / T_2DM / SHTN / EF - 55% Good LV

Physiotherapy Management Plan:

- DBE, Spirometry 5rs, Chest percussion to B/L Chest wall, AROM to B/L UL&LL, Mobilization

Post OP Cardiothoracic rehabilitation Phase - I

: PROM to B/L UL&LL Mobilize outside the room, Stair climb encouraged

	Signature	Name	Emp. No.	Date	Time
Physiotherapist	G.E Akash	AKASH. G.E	0256	5/01/24	18:00

RE-ASSESSMENT FORM

Date & Time	
4/1/24 & 10:00	**Fall Risk Score:** – **Pain Score:** 3/10
	Surgery / Procedure : OPCAB × 4 grafts **Respiratory status Post OP :** – In Room Air
	Post intention pain score : 2/10 **Treatment case & plan :** – DBE given = Spirometry given Encouraged = Chest percussion to B/L chest wall – AROM to B/L UL & LL – Mobilization
	Post Intervention Pain Score: 2/10 **Treatment Care & Plan:** Post operative Cardiac Pulmonary Rehabilitation

	Signature	Name	Emp. No.
Physiotherapist	G.E. Akash	Akash G.E	0251

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TÜV South Asia ISO 9001:2008

OPCAB × 4 grafts

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
		S/B J.VIJAYARAGHAVAN	
05/01/24	15:45.	– Ex oral /nasal suctioning Done yielded moderate thick Secretion	[signature] MMC-2102
05/01/24	16:45.	S/B J.VIJAYARAGHAVAN – Ex oral /nasal suctioning done yielded moderate thick secretion – Patient extubated and connected to O2 NP-4 ltr/min. – Speech voice clear & audible. – DBE's encouraged – Spirometry ex encouraged Ins-600cc Exp-600cc – Active ex to B/L UL & LL	[signature] MMC-2102
05/01/24	21:00	S/B AKASH – DBE encouraged – Spirometry ex encouraged Ins: 600cc Exp: 600cc – chest percussion to B/L chest wall	G.E. Akash MH 0256

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PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
06/01/24	06:00	-AROM to B/L UL & LL S/B AKASH - DBE encouraged - Spirometry ex encouraged Ins: 6000cc Exp: 6000cc - chest percussion to B/L chest wall - AROM to B/L UL & LL	G.E. Akash MHI0256
06/01/24	9:00	S/B J. VIJAYARAGHAVAN -DBE's encouraged - chest percussion done to B/L Chest wall - Spirometry ex encouraged Ins-6000cc Exp-6000cc - Active ex to B/L UL & LL - Mech Vibrator given	J. Vij MMC-2102
06/01/24	17:00	S/B J. VIJAYARAGHAVAN -DBE's encouraged - chest percussion done to B/L chest wall - Spirometry ex encouraged Ins-6000cc Exp-6000cc - Active ex to B/L UL & LL - Patient mobilized	J. Vij MMC-2102

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PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
		- Mech. vibrator given to chest wall	
06/01/24	21:00	S/B AKASH - DBE encouraged - Spirometry 3s encouraged Ins: 6000cc Exp: 6000cc - Chest percussion to B/L chest wall - AROM to B/L UE & LE - Vibrator given to B/L chest wall	G.B Akash MH10256
07/01/24	06:00	S/B AKASH - DBE encouraged - Spirometry 3s encouraged Ins:6000cc Exp: 6000cc - Chest percussion to B/L chest wall - AROM to B/L UE & LE - Vibrator given to B/L chest wall	G.B Akash MH10256
7/1/24	9:30	S/B Ramanathan P - DBE's encouraged - Chest percussion to B/L Chest wall - AROM B/L to B/L UL & LL - Spirometry B/L encouraged Ins: 600cc Exp: 600cc	MH10260

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PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
8/1/24	10:00	S/B AKASH - DBE encouraged - Sprometry ex encouraged Ins: 600cc Exp: 600cc - Chest percussion to B/L Chest wall - AROM to B/L UL & LL - PT Mobilized - Vibrator given	G.B Akash MH10256
9/1/24	10:00	S/B AKASH -Dbex encouraged -Sprometry ex given Ins: 600cc Exp: 600cc -Chest percussion to B/L Chest wall -AROM to B/L UL/LL -PT Mobilized	G.B Akash MH10256
10/1/24	11:00	S/B AKASH -Dbex encouraged - Sprometry ex encouraged Ins: 600cc Exp: 600cc -Chest percussion to B/L chest wall	G.B Akash MH10256

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PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
		- AROM exs to Bl UL & LL - PT standing walk encouraged	

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URINE ROUTINE ANALYSIS — MICROBIOLOGY SHEET

DATE	18/12/23		
COLOUR	PALE YELLOW		
REACTION			
SPECIFIC GRAVITY	1.015		
APPEARANCE	TURBID.		
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN	NORMAL		
PUS CELLS	PLENTY		
EPITHELIAL CELLS	3-5		
RBC	2-4		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL		

MICROBIOLOGY-CULTURE REPORTS

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

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DIABETIC CHART

Urea-31
Creat-0.8

ACTUAL WEIGHT ..... 65 kg ..... HbA,c ..... 10.3 .....

PREVIOUS DIABETIC MEDICATIONS Inj. HM (25/75) 20-0-8 (B/B) T. AMARYL M2mg. 1-0-1. (A/F).

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
4/1/24	12.30	171 mg/dl	-		
	18.30	128 mg/dl	T. Amaryl M2mg		
			Inj. HM 25/75	8U	
5/1/24	5.00	64 mg/dl	INJ-DEXTROSE 25%	@5:10 Hay10105	DR. ANUSUYA
	6:30	180 mg/dl	NPO	Hay10105	DR. ANUSUYA

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone [ ]

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

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DIABETIC CHART

T. FOXIGA 10mg 1-0-0 (AF)

ACTUAL WEIGHT 65 kg HbA1c 10.3

PREVIOUS DIABETIC MEDICATIONS T. AMARYL M2mg 1-0-1 (A-F) INJ. HM (30/70) 20-0-8 (BF)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
5/1/24	13:20	210 mg/dl	Inj Human Actrapid 4U/hr infusion on flow.	[illegible] 0219	Dr. PRAVEEN
1/24	16:35	106 mg/dl	Inj. Human Actrapid stopped	[illegible]	Dr. SYNTESTER
5/1/24	23:00	252 mg/dl.	Inj. H. Actrapid 6U/hr on flow.	[illegible]	DR. AJEETHA
6/1/24.	01.00	191 mg/dl .	Inj H. Actrapid 2 units/hr onflow.	[illegible]	DR. AJEETHA
6/1/24	4.00	132 mg/dL	Stopped.	[illegible]	DR. PRAVEEN
6-1-24	07.30	158 mg/dl	T-AMARYL M2mg, Human Insulin 20U S/C, T. FOXIGA given at 09.00	[illegible]	Dr. Praveen
6/1/24	12:30	174 mg/dl	—	[illegible]	DR. PRAVEEN
6/1/24	18:00	161 mg/dl	T. AMARYL M 2mg given at 21:00	[illegible]	DR. PRAVEEN
7/1/24	6.00	131 mg/dl	INJ. HM 20 S/C at 8:30, T. FOXIGA 10mg P/O at 9:00, T. AMARYL M2 mg at 9:00 given	[illegible]	DR. PRAVEEN
	12:30	187 mg/dl.	—	[illegible]	DR. Praveen
	18.30	143 mg/dl	T-AMARYL M2 (1)	[illegible]	Dr Pravn
8/1/24	6:30	98 mg/dl	T. Amaryl M2mg ~~after breakfast~~		[illegible]

INSTRUCTIONS FOR INSULIN INFUSIONS

T. Foxiga 10mg. Inj. HM (30/70) 20U

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

· Urine Acetone

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

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Inj. HM (30/70) 20 - 0 - 8U (A/F)

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T. AMARYL M 2/500 1-0-1 (B/F)
Inj HM 30/70 20-0-8 (SC)

DIABETIC CHART

ACTUAL WEIGHT 65 kg HbA1c 10.3 %

PREVIOUS DIABETIC MEDICATIONS Inj. HM (30/70) 20-0-8 (A/F) T. AMARYL M2mg 1-0-1 (A/F)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
8/1/24	6.30	98 mg/dl	T. AMARYL M2 ① T. FORXIGA 10mg ① INJ. MIXTARD 30/70 20U	given at 8.45 [illegible]	DR. HYDROOS
	12.30	202 mg/dl.	Inj Mixtard 5U 30/70	[illegible]	Dr Praveen
	18:30	180 mg/dl.	T Amaryl (30/70) ① Inj HM (30/70) 8U	[illegible]	Dr Praveen
9/1/24	6:30	105 mg/dl	T Amaryl M2mg T. H.M - 20U	[illegible]	[illegible] 134079
	12.30	184 mg/dl	—	[illegible]	[illegible]
	18.30	89 mg/dl	T Amaryl M2 ① Inj. H.M 30/70 - 8U	[illegible]	Dr Praveen
10/1/24	6:30	95 mg/dl	INJ. HM 20U T. Amaryl M2mg	given at [illegible]	[illegible] 134079
	12.30	178 mg/dl	—	[illegible]	[illegible] 16533
	18:30	118 mg/dL.	Inj H.M 8U A/F T. Amaryl M2 ① A/F	[illegible]	Dr Praveen

INSTRUCTIONS FOR INSULIN INFUSIONS

- Mix 40u short acting Insulin in 40 ml. of normal Saline (IJ - 1 ml.)
- Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).
- Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.
- Target Blood Sugar 150-200 mgs.
- To monitor K+ separately.

Urine Acetone

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

DIABETIC CHART

ACTUAL WEIGHT 65 kg HbA1c 10.3 %

PREVIOUS DIABETIC MEDICATIONS — Inj H.M (30/70) 15-0-6 (A/F) — T. AMARYL M2mg 1-0-1 (A/F).

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
11/1/24 6.00	6.00	~~100 mg/dl~~ 169 mg/dl	—	[illegible]	DR. praveen
	7:00	100 mg/dl	Inj H.M (30/70) 20units A/F T. Amaryl M2 (1) A/F	[illegible] 7.00	Dr. praveen for [illegible]
	12.00	238 mg/dl	10 units Actrapid	0271 @ 14:00	Dr. praveen for [illegible]
	[illegible]	[illegible]			

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

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Dr.ANBARASU MOHANRAJ

BLOOD GROUP
'B' POSITIVE

INVESTIGATION SHEET

Date	18/12/23					
HAEMATOLOGY						
Hb	11.7					
P.C.V	35.8					
Platelets	499000					
TLC	11660					
Polymorphs						
Lymphocytes	19.7					
Eosinophils	2.6					
Mono / Basophils	3.8 / 0.3					
E.S.R						
BIO-CHEMISTRY						
Urea	31					
Creatinine	0.80					
Sodium	136					
Potassium	4.32					
Bicarbonate	23					
Chloride	95.4					
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.35					
D.Bilirubin	0.13					
I.Bilirubin	0.22					
S.G.O.T	35					
S.G.P.T	31					
ALP	85					
GGT	24					
Total Protien	7.9					
S.Albumin	3.7					
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Date	18/12/23					
COAGULATION	12.1					
PT / INR	12.5 / 1.0					
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						
THYROID FUNCTION						
T.S.H	5.12					
T.3	119					
T.4	11.0					
SEROLORY						
HIV						
HBsAg	NEGATIVE					
V.D.R.L						
COVID 19						
RT- PCR						
IgM						
Ig						
HBA1C	10.3					
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						
APTT	29.2					

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BLOOD GROUP

B POSITIVE

INVESTIGATION SHEET

Date	18/12/23	05/01/2024	6.1.24	7/1/24	9/1/24	
HAEMATOLOGY		RBPCV				
Hb	11.7	8.9	9.7	8.7	8.1	
P.C.V	35.8	27.5	29.6		25.0	
Platelets	499000	301000	297000		290000	
TLC	11660		14940		10730	
Polymorphs			88.6		78.1	
Lymphocytes	19.7		7.6		13.8	
Eosinophils	2.6		0.1		5.6	
Mono / Basophils	3.8/0.3		3.6/0.1		4.2/0.3	
E.S.R						
BIO-CHEMISTRY						
Urea	31		27.	29	55	
Creatinine	0.80		0.84	0.88	0.80	
Sodium	136			132	136	
Potassium	4.32			4.93	4.42	
Bicarbonate	23					
Chloride	954					
Magnesium		2.2	1.9			
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.35		0.49			
D,Bilirubin	0.13					
I.Bilirubin	0.22					
S.G.O.T	35					
S.G.P.T	31					
ALP	85					
GGT	24					
Total Protien	7.9					
S.Albumin	3.7		3.0			
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK			229			
CK - M.B. MASS			17.6			
LDH						
Ntpro bnp						

Date	18/12/23					
COAGULATION	121					
PT / INR	12.5 / 1.0					
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
V.L.D.V						
THYROID FUNCTION						
T.S.H	5.12					
T.3	119					
T.4	11.6					
SEROLORY						
HIV						
HBsAg	NEGATIVE					
V.D.R.L						
COVID 19						
RT- PCR						
IgM Ig						
HBA1C	10.3					
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						
APTT	29.2					

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

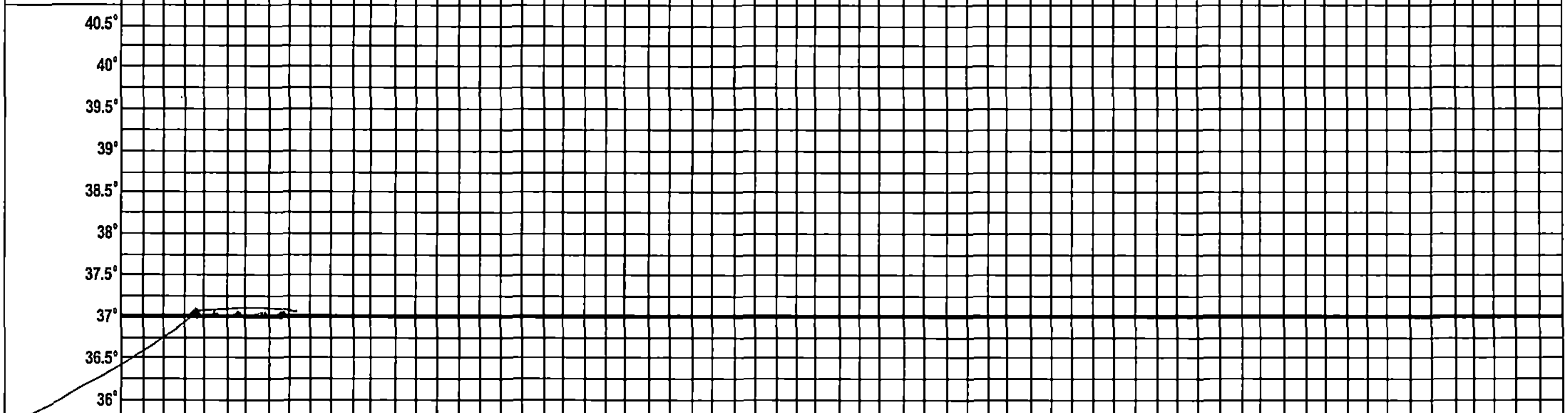
VITAL INFORMATION SHEET

BLOOD GROUP	'B' POSITIVE
ON ADMISSION	
Height in CM	**Weight** in Kg.
152 cms	65 kgs

Diagnosis: CAD - TVD

Procedure :

NO. OF DAYS	DOA	DAY-1
DATE	4/1/24	5/1/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10



	DOA	DAY-1
PULSE	76	72
RESP	20	20
B.P.	130/90	110/70
SPO2	96.	98%
DAILY WEIGHT		
24 HRS INTAKE	850ml	
24HRS OUTPUT	950ml	
BALANCE	100ml	
MOTION	✓	x.

Antiplatelet stopped on 1/1/24

DIABETIC / HYPERTENSIVE

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

BLOOD GROUP B+ve

VITAL INFORMATION SHEET

ON ADMISSION	
Height in CM	Weight in Kg.
152 cm	65 kg

Diagnosis: CAD – TVD, ADEQUATE LV.

Procedure: OPCAB x 4 GRAFTS (EXTENSIVE ENDARTECTOMY)
LIMA → LAD.
SVG → OM., SVG → RAMUS INTERMEDIUS
SVG → DISTAL RCA.

NO. OF DAYS	DOS	I POD	II POD	POD-III	POD-IV	POD-V	POD-VI
DATE	05/01/24	06/01/2024	7/1/24	8/1/24	9/1/24	10/1/24	11/1/24
PULSE	81/mt 84	98/mt 93/mt 88		90 96	100/96	70 80	90
RESP	14/mt 20	18/mt 14/mt 18		20 22	22/20	20 20	20
B.P.	99/58 104/73	117/57 105/71 110/70		120/90 110/70	120/80	100/60 110/70	110/80
SPO2	100% 100%	100% 93% 95%		96 96%	88% 96%	90 96	80
DAILY WEIGHT	BED FAST	BED FAST	BED FAST				
24 HRS INTAKE	3011.2ml	2374 ml	1150 ml	1615 ml	1480 ml	1682 ml	
24HRS OUTPUT	250 ml	2955 ml	1550 ml	3050 ml	1600 ml	2150 ml	
BALANCE	+761.2ml	-581 ml	-400 ml	-1435 ml	-200 ml	-468	
MOTION	X	X X	X	X ✓	X ✓	✓	

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
art beat counts

EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE / TIME		DATE / TIME
A+B Respirations eath/ min	>25	3	>25
	21-24	2	21-24
	18-20		18-20
	15-17		15-17
	12-14		12-14
	9-11	1	9-11
	<8	3	<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96		>96
	94-95	1	94-95
	92-93	2	92-93
	<91	3	<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % eg: In hypercapnic ratory failure only cale 2 under the tion of qualified	>96 on oxygen	3	>96 on oxygen
	95-96 on o2	2	95-96 on o2
	93-94 on O2	1	93-94 on O2
	>93 on air		>93 on air
	88-92		88-92
	86-87	1	86-87
	84-85	2	84-85
	<83%	3	<83%
Air or Oxygen ?	A= Air		A= Air
	O2litre/ min	2	O2litre/ min
	Device		Device
C Blood Pressure	>220	3	>220
	201-219		201-219
	181-200	2	181-200
	161-180		161-180
	141-160		141-160
	121-140		121-140
	111-120		111-120
	91-100	1	91-100
	81-90	2	81-90
	71-80	3	71-80
	61-70	3	61-70
	51-60	3	51-60
	<50	3	<50
astolic BP	mmHg		mmHg
	>131	3	>131
lse Beats / min	121-130	2	121-130
	111-120	2	111-120
	101-110	1	101-110
	91-100	1	91-100
	81-90		81-90
	71-80		71-80
	61-70		61-70
	51-60		51-60
	41-50	1	41-50
	31-40	3	31-40
	<30	3	<30
D Consciousness Score for New onset of confusion (no score If chronic)	Alert		Alert
	Confusion	3	Confusion
	V	3	V
	P	3	P
	U	3	U
E Temperature Degree Celsius	>39.1 degree Celsius	2	>39.1 degree Celsius
	38.1-39.0	1	38.1-39.0
	37.1-38.0		37.1-38.0
	36.1-37.0		36.1-37.0
	35.1-36.0	1	35.1-36.0
	< 35.0	3	< 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 2nd Hourly
	2	Every 4th Hourly

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Medway Heart Institute
Every heart beat counts

EARLY WARNING SC[illegible] CHART

Name: _____ Age/Sex: Patient Id No:

NEWS key 0 1 2 3	DATE / TIME													DATE / TIME
		7/11 11:00	7/11 13:30	7/11 19:30	8/11 3:30	8/11 7:00	8/11 11:00	8/01 15:00	8/01 19:00	8/11 23:30	9/11 3:30	9/11 7:30	9/11 12:00	
A+B Respirations Breath/ min	>25													>25
	21-24						2							21-24
	18-20													18-20
	15-17													15-17
	12-14													12-14
	9-11						1							9-11
	<8													<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96													>96
	94-95						1							94-95
	92-93						2							92-93
	<91													<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % in hypercapnic [illegible]atory failure only [illegible]ale 2 under the direction of qualified clinician	>96 on oxygen													>96 on oxygen
	95-96 on o2						2							95-96 on o2
	93-94 on O2						1							93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87						1							86-87
	84-85						2							84-85
	<83%						3							<83%
Air or Oxygen ?	A= Air													A= Air
	O2litre/ min						2							O2litre/ min
	Device													Device
C Blood Pressure	>220						3							>220
	201-219													201-219
	181-200						2							181-200
	161-180													161-180
	141-160													141-160
	121-140													121-140
	111-120													111-120
	91-100						1							91-100
	81-90						2							81-90
	71-80						3							71-80
	61-70						3							61-70
	51-60						3							51-60
	<50						3							<50
istolic BP	mmHg													mmHg
	>131						3							>131
Pulse Beats / min	121-130						2							121-130
	111-120						2							111-120
	101-110						1							101-110
	91-100						1							91-100
	81-90													81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	41-50						1							41-50
	31-40						3							31-40
	<30						3							<30
D Consciousness Score for New onset of confusion (no score If chronic)	Alert													Alert
	Confusion						3							Confusion
	V						3							V
	P						3							P
	U						3							U
E Temperature Degree Celsius	>39.1 degree Celsius						2							>39.1 degree Celsius
	38.1-39.0						1							38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0													36.1-37.0
	35.1-36.0						1							35.1-36.0
	< 35.0						3							< 35.0
NEWS Total		3	3	3	3	2	2	0	0	0	0	0	0	
Monitoring Frequency		4hly	4hly	4hly	4hly	4hly	4hly	12hly	12hly	4hly	4hly	4hly	4hly	
Escalation of Care Y/N		N	N	N	N	N	N	N	N	N	N	N	N	
Initials by RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Initials by Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

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

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	3	Every 2nd Hourly
	2	Every 4th Hourly

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EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE / TIME		DATE / TIME
A+B Respirations	>25		>25
Breath/ min	21-24	2	21-24
	18-20		18-20
	15-17		15-17
	12-14		12-14
	9-11	1	9-11
	<8	3	<8
A+B Spo2 Scale 1 Oxygen Saturation (%)	>96		>96
	94-95	1	94-95
	92-93	2	92-93
	<91	3	<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % in hypercapnic respiratory failure only Scale 2 under the direction of qualified clinician	>96 on oxygen	3	>96 on oxygen
	95-96 on o2	2	95-96 on o2
	93-94 on O2	1	93-94 on O2
	>93 on air		>93 on air
	88-92		88-92
	86-87	1	86-87
	84-85	2	84-85
	<83%	3	<83%
Air or Oxygen ?	A= Air		A= Air
	O2litre/ min	2	O2litre/ min
	Device		Device
C Blood Pressure	>220	3	>220
	201-219		201-219
	181-200	2	181-200
	161-180		161-180
	141-160		141-160
	121-140		121-140
	111-120		111-120
	91-100	1	91-100
	81-90	2	81-90
	71-80	3	71-80
	61-70	3	61-70
	51-60	3	51-60
	<50	3	<50
Diastolic BP	mmHg		mmHg
	>131	3	>131
Pulse Beats / min	121-130	2	121-130
	111-120	2	111-120
	101-110	1	101-110
	91-100	1	91-100
	81-90		81-90
	71-80		71-80
	61-70		61-70
	51-60		51-60
	41-50	1	41-50
	31-40	3	31-40
	<30		<30
D Consciousness Score for New onset of confusion (no score if chronic)	Alert		Alert
	Confusion	3	Confusion
	V		V
	P		P
	U		U
E	>39.1 degree Celsius	2	>39.1 degree Celsius
Temperature Degree Celsius	38.1-39.0	1	38.1-39.0
	37.1-38.0		37.1-38.0
	36.1-37.0		36.1-37.0
	35.1-36.0	1	35.1-36.0
	< 35.0	3	< 35.0
NEWS Total			
Monitoring Frequency			
Escalation of Care Y/N			
Initials by RN			
Initials by Sr. RN			

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Dr.ANBARASU MOHANRAJ

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

INTAKE & OUTPUT CHART

Date From: 4/01/24 To: 5/01/24 Bed No: 114

24 Hrs : Started Time : 13.00 Ended Time : 7.00

NPO Started at : NPO Over at :

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE		350ml	500ml	
OUTPUT		300ml	650ml	

Total Intake: 850ml Total Output: 950ml Difference: 100ml

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
13:30	150					150	16:00	200					200		
14:00	50					200	18:00	100					300		
17:30	100					300	22:30	250					550		
18:30	50					350	2:00	200					750		
21:00	150					500	6:30	200					950		
22:00	100		Dig.			600									
23:00	150					750									
5:30			Inj. Dextrose 25% 100ml			850			Total Intake - 850ml						
									Total output - 950ml						
									Balance - 100ml						

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MHI/IP/2022/066

Medway Heart Institute
Every heart beat counts

Date	From: 7/1/24	To: 8/1/24	Bed No: 103	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 7-00		Ended Time : 7.00.		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	350 ml	300 400 ml.	400 ml	
OUTPUT		450ml.	700ml	

Total Intake: (1150 ml) Total Output: (1550 ml) Difference: 400 ml

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
			Till 11.5 Total Intake			350ml
14.10	150					500
16.10	100					600
17.10	50					650
18.10	100					750
20.00	200					950
10.00	100					1050
6.00	100					1150

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Total output			300ml		
			Total balance			+50		
14.10 200	200					500		
18.10	250					750		
22.00	300					1050		
12.15	200					1250		
1.30								
6.00	200					1550ml		

Total intake - 1150ml
Total output - 1550ml
Balance - 400ml

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INTAKE & OUTPUT CHART

Date From: 8/1/24 To: 9/1/24 Bed No: 203

24 Hrs : Started Time : 7/00 Ended Time : 7/00

NPO Started at : NPO Over at :

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	905	400	310ml	2.2 Lit/day
OUTPUT	850	1600	600ml	

Total Intake: 1615ml Total Output: 3050ml Difference: 1435ml

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
7.30	230					230	6.30	480					480		
9.15	225					455	11.30	400					850		
10.30	300					755	13.30	300					1150		
11.30	150					905	14.55	400					1550		
13.15	125					1030	16.00	400					1950		
14.00	100					1130	18.30	500					2450		
15.00	125					1255	20.30	300					2750		
17.00	50					1305	6.00	300					3050		
8.	10ml					1315									
21.00	100ml					1415									
2.00	100ml					1515									
6.00	100ml					1615									

Total intake – 1615ml
Total output – 3050ml
balance – 1435ml/Neg
[signature]

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MHI/IP/2022/066

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INTAKE & OUTPUT CHART

Date	From: 9/1/24	To: 10/1/24	Bed No: 103
24 Hrs : Started Time : 7:00		Ended Time : 7:00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	450		350	2 lit/day
OUTPUT	700		600ml	

Total Intake: 1400ml | Total Output: 1600ml | Difference: ~~[illegible]~~ 200

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
7.45	100					100	7.00	300					300		
9.00	150					250	11.30	400					700		
11.00	150					400	12.00 upto 1 diapper								
11.30	50					450		(400). changed.					1100		
12.00 up to 18.30 Total Intake 500						950	21.00	200					1300		
20.30	100					1000									
21.10	150					1300ml	2.00	300					1600		
[illegible]	200					1400ml							-1600		
							6.00	100							

Total Intake - 1400ml
Total Output - 1600ml
Balance - 200.

[signature]

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MHI/IP/2022/066

Medway Heart Institute
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Date	From: 10/1/24	To: 11/1/24	Bed No: 103
24 Hrs : Started Time :	7:00	Ended Time :	7:00
NPO Started at :		NPO Over at :	

INTAKE & OUTPUT CHART

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	400	985 ml	1682 ml	2.0 l/day
OUTPUT	200	1350 ml.	2150 ml	

Total Intake: 1682 Total Output: 2150 Difference: Balance 468

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
8:00	250					250
9.35	150					~~400~~
11.00	00					400
3.00	400					850
1H00	125					975
15 MM	100					1075
12:00	150					1285
17.40	100					1285
17.50	100					1385
20.00	200					1582
0.00	100					1682

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
10:10	200					200		
12:30	300					500		
18x.20								
1x.00	300					800		
17:00	400					1200		
19.00	300					1500		
20.00	300					1800		
22.00	200					2000		
6.00	100					2150		

Total Intake - 1682
Output - 2150
BALANCE - 468

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MHI/IP/2022/066

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Date	From: 4/1/24	To: 12/1/24	Bed No: 103	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 7:00		Ended Time : 7:00		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	600			
OUTPUT	800			

Total Intake: | Total Output: | Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
8:00	180					180
9:00	300					480
11:00	180					600

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
8:30	250					250		
11:30	280					530		

MHI/DIET/2022/147

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAD - TVD / DM/HTN / Peripheral Vascular Disease / EF - 55% / CABG				
Height: 152 cms	Weight: 66 Kgs	Food allergies: Yes/ No, if yes, specify		
Religious Beliefs:	☐ Vegetarian	☑ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1500 calories, low fat, low salt, high protein, diabetic diet.				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A)	Patient's related Medical History				
	1)	Weight Change (overall change in past 6 months)				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 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:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 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)					
		☐ 1	☐ 2	☐ 3	☑ 4	☐ 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					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
2)	Sign of muscle wasting					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
Total Score = Sum f above 7 components						

Nutritional Status : Based on this patient is			
	Well Nourished	☑ (7 to 14)	10
	Moderately Malnourished	☐ (15 to 18)	
	Severely Malnourished	☐ (19 to 35)	
Nutrition Intervention:			
	☑ Oral	☐ Enteral	☐ Parenteral
Diet counselling provided:	☑ Yes	☐ No	
Frequency of re-assessment:	☑ Weekly	☐ Fort - night	☐ Monthly
Enteral / Parenteral	☐ Daily	Calorie count: ☐ Yes	☑ No

Dietitian Signature / Name / Date / Time: [signature] 4/1/24, 12:00
Maria Catherine John
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
4/1/24, 17:00	A 60 year old female came c/o chest pain (on & off) was assessed to be well nourished as evident by SGA. K/c/o DM/HTN/TVD. Educated the patient and family on 1600 calories, 60 fat, 6g salt, high protein, diabetic diet. Emphasized on small frequent meals c low glycemic control.	Maria Catherine John Senior Dietitian (4/1/24)
5/1/24, 14:45	Patient shifted to OT for surgery (CABG) and kept on NBM. Patient moved to SICU. Will initiate on diabetic liquid diet as per doctor's advice.	Maria Catherine John Senior Dietitian (5/1/24)
6/1/24. 10:00AM	NBM over. Patient tolerated Diabetic liquid diet. Can initiate Diabetic soft solid, high protein diet	T0286
7/1/24, 12:40.	Patient moved to ward. Reemphasized on the diet restriction. Motivated to eat well.	Maria Catherine John Senior Dietitian (7/1/24)

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Dr.ANBARASU MOHANRAJ

MHI/DIET/2022/148

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Department of Dietetics

(1)

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
9/1/24, 10:00	Oral intake is good. Diet modification and clarification done.	(signature) (24/01) ...ia Catherine John, Senior Dietitian
11/1/24, 10:00	Oral intake is good. Educated the patient and family on 1600 calories, low fat, low salt, high protein, diabetic diet on discharge. Emphasized on small frequent meals & low glycemic control. Diet modification and clarification done. Diet chart given on discharge.	(signature) (24/01) Senior Dietitian

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Dr.ANBARASU MOHANRAJ

e)

PSYCHOLOGICAL WELLBEING REPORT

Date: 08/1/24 Time: 1.50pm

Unit: 103

Clinical diagnosis:

Surgery/ Procedure: OPCABX4 grafts - Pod III.

Impression: Depressed

- depressed affect, oriented, responsive
- sleep disturbances, appetite ↓
- feeling low, useless, guilty for being bedridden.
- retirement expectations - unfulfilled.
- supportive counseling provided, increasing self care attitude & engaging in self care behaviours.

Employee ID: MH10278PSY

Signature of the Psychologist:

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INTRAOPERATIVE NURSING RECORD

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Consultant : Dr. Arm

Name of Surgery OPCAB (Closed Heart)

Date of Surgery : 5/1/24

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

Anaesthesia Type : ☐ Epidural ☐ Spiral ☐ LOC ☐ MAC
☑ GEN ☐ Regional ———

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

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

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

Electrocautery : ☑ Monopolar ☐ Pad Loacation-Right Upper arm ☐ Bipolar

Tourniquet ☐ Location ----------
☐ Applied Time ---------- ☐ Released Time ----------
☐ Applied Time ---------- ☐ Released Time ----------
☐ Applied Time ---------- ☐ Released Time ----------

Other equipment used : ----------

Personal : ☐ Surgeon ---Dr. Arm--- ☐ Asst. ---Dr. Praveen---
☐ Anaesthetist ---Dr. SG--- ☐ Asst. ----------

Type of Specimen : —

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

Packing / ~~Drains~~ / Catheters

Type	Size	Site	Type	Size	Amount	Sign
Romsons	28Fr	Lt. Pleura				
Romsons	28Fr	Mediastinum				

Urinary Catheterization done by MS. Saipreethi used 14 Fr Foley's catheter & 12(-)

Sponge Court Record

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

☑ Count Correct

Corrective action taken ----------

Surgeon informed

Chest Bone with mepore & leg with Dressingpads & crepebandages

Dressing / ~~Cast Immobilizer~~

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

Transferred to : SICU ☐ Patient Room ☐ CCU ☐ Recovery Room

Scrub Nurse Signature

Name :

Date & Time : 13:10

Circulating Nurse Signature

Name ;

Date & Time 13:10

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Pati Mrs.CECILIA SUBASHINI.H
Nan 60/Female/MHI202381349
UHI 04/01/2024/IPH2024000033
DOE Dr.ANBARASU MOHANRAJ
BOA
Con

MHI/NUR/2022/053

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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 4/1/24 Time of Arrival: 13:00 Mode of Admission: ☑ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☑ Yes ☐ No If Yes, Name of the Relative: —

Relationship with Patient: — Contact Person's Name: MR. Immanuel Relationship: Husband.

Contact No.: 9176710730 Primary language spoken: ☑ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☑ Yes ☐ No

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

Menstrual History : LMP: — Menopause: 10 yrs.

Medical History : DM / HTN / Co - Morbility : DM 30 yrs / 6 yrs HTN Yes If yes specify

Drugs History : Antiplatelet 1/1/24 Stopped. 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: 97.1 (°F) | Pulse / HR: 76 (beats/min) | BP: 130/90 (mmHg)

Respiration: 18 (breaths/min) | SpO_2: 96 (%) | CBG: 171 (mg/dl) | Height: 152 (cms) | Weight: 65 (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: Dm diet

Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: MRS. Cathrine Time: 1300

Orient Patient if: ☑ Conscious **Orient Patient Attendant if:** ☐ Unconscious ☐ Disoriented

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

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

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	☑ Yes ☐ No	Cataract (2013) (2015)	
Hearing Impairment	☐ Yes ☑ No		
Chewing Difficulty	☐ Yes ☐ No		
Walking Difficulty	☐ Yes ☑ No		

- LSCS (2015)

DVT RISK ASSESSMENT

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

S. No.	Parameters	Yes / No	Score
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	☐ Yes ☑ No	
2	Bedridden recently >3 days or major surgery within four weeks	☐ Yes ☑ No	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	☐ Yes ☑ No	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	☐ Yes ☑ No	
5	Entire leg swollen (Assess for both legs)	☐ Yes ☑ No	
6	Localized tenderness along the deep venous system (Assess for both legs)	☐ Yes ☑ No	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	☐ Yes ☑ No	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	☐ Yes ☑ No	
9	Previously documented DVT (Assess for both legs)	☐ Yes ☑ 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.	☐ Yes ☑ No	

Risk Score Interpretation (Probability of DVT): **Final Score**

Tick the score obtained (✓)

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**				
Moderate Risk	**1 to 2**		1 to 2	4/1/24	18.00
High Risk	**3 to 8**				

Personal Belongings / Valuables:

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

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

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant		J. IMMANUEL	*Relationship* ←	4/1/24	18.00
Nurse		R. Sushma	D201	4/1/24	13.30
Unit In-Charge	Nal	S. Nalini	0024	4/1/24	13:30

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 4/1/23. Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery:
Date of surgery:
Allergies if any: NKDA
On room air / oxygen: RA
IV fluids on flow:
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 18 (breaths/min)
BP: 130/80 (mmHg) | SpO2: 96% (%) | Height: 152 (cms) | Weight: 65 (kgs) | BMI: 28.1 kg/m²
Others :
Pain Score: 0/10 **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: Dm diet Drains:

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0201	4/1/23	19:30
Handover taken by	Hay	Hannah Grace	0105	4/1/23	19:30
Document endorsed		S. Nalini	0024	4/1/23	20:00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
4/1/24 @ 13.00	Admission Note ⇒ patient walking [illegible] from [illegible]. got admitted in 4st floor.	[signature] 0821
13.00	⇒ patient Conscious & Oriented	
14.00	⇒ patient due drugs are given.	[signature] 0821
14.30	⇒ pt had @ diet	
16.00	⇒ pt well mobilized	[signature] 0821
16.30	⇒ pt I/O chart maintained ⇒ pt plan CABG tomorrow.	
18.30	⇒ pt v/s checked & Recorded	[signature] 0821
19.00	⇒ pt handing over given by Night duty staff	[signature] 0821

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0084	4/1/24	20:00

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: CAD - PVD GCS: 15/15
NEWS / PEWS Score: 0 POD: —
Ventilator day: Central line days: —
Peripheral line day: Right: — Left: —
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: —
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

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: 97.8 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 98 (%) | Height: 152 (cms) | Weight: 65 (kgs) | BMI: 28.1 kg/m²
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS ✓ / CPOT
Fall Risk Score: 30 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☑ No ☐ NA
Current diet: DM diet Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent: } Nil
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: CAG CP with cathlab, Diabetic wound (+) both toe, Dressing done.

	Signature	Name	Emp. No.	Date	Time
Handover given by	Hy	Hannah Grace	005	5/1/24	7:30
Handover taken by	—	Shifted to	OT	—	
Document endorsed	Nil	& [illegible]	[illegible]	5/1/24	8:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
4/1/24	Night Duty Notes	
19:30	Patient handing over taken from Evening duty Staff in a hemodynamically Stable Condition	Hay 0105
20:00	Vital Signs Checked and Recorded	Hay 0105
21:00	Due drugs are given as per drug chart	Hay 0105
22:00	Patient is Stable, Leg wound (L) Dressing done	Hay 0105
23:00	patient is Sleeping well	Hay 0105
2:00	patient is Sleeping well, had no Complaints	Hay 0105
4:50	Patient had Complaints of giddiness CBG Checked 84mg/dl IV line Secured, INJ. DEXTROSE 25% Connected	Hay 0105
5:30	Patient Stable and Conscious	Hay 0105
7:00	Patient Shifted to OT hand over given to OT Staff CAG CD with Cath lab	Hay 0105

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S-Mullanp	0024	5/1/24	9.10

Mrs.CECILIA SUBASHINI.H
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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

N... ES

Date & Time	Observations / Action	Signature with Emp No.
	CTOT RECEIVAL REPORT	
	Patient Received From (Ward) To (CTOT) With Blue Op File And Case Sheet	
	ECG: | ECHO: | X-RAY: | ANGIO CD: CD c Attender.	
5/1/24	CT FILE: Nil	
	Patient Posted For Procedure: OPCAB (closed heart)	
e	Under Anesthesia: ↓GA	
8:20	Allergy Status: Not known	
	Known Case Of: DM, HTN.	90
	Past Surgical History: H/o LSCS (1992), H/o B/L cataract (2012 & 2012)	
	VITAL SIGN: TEMP: 26°C HR: 90 SPO2: 100% BP 110/80	
	CTOT SHIFTING REPORT	
	Patient Shifted From CTOT To SICU With Blue Op File And Case Sheet Along With	
	*Surgery Safety Check List *Intra Operative Record	
5/1/24	*Nurses' Record *	
	ECG: ① ECHO: ① X-RAY: ① ANGIO CD: Nil	
e	CT FILE: Nil	
13:10	Patient Posted And Underwent For Procedure: OPCAB (CH) Under Anesthesia: ↓GA	125
	Procedure: OPCAB (CH) LIMA → LAD. SVG → Ramus SVG → Lcx, SVG → PDA (early)	
	Drain tube size and placement: 28 Fr < Lt. Pleura, Mediastinum.	
	Pacing wire placement: Present/~~Absent~~ Site: Nil	
	Implants: Nil	
	Cautery burn/skin peeling/towel clip mark: Present/~~Absent~~ Site:	
	VITAL SIGN: TEMP: 98°F HR: 75 b/mt SPO2: 100% BP: 100/60 mmHg.	
	Notes: Right Diabetic foot ulcer present. Dressing done yesterday around 10.30 PM. Left middle ... got ulcer	

	Signature	Name	Emp. No	Date	Time
Document endorsed by	[signature]	Christy	0026	5/1/24	13:10

SAFETY FIRST

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 05/01/2024 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: CAD PWD
NEWS / PEWS Score: NIL
Ventilator day: D1
Peripheral line day: Right: Left: D1
Ryle's Tube: ☑ Yes ☐ No Day: D1
Urinary Catheter: ☑ Yes ☐ No Day: D1
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

GCS:
POD: DOS
Central line days: D1
VIP Score: 0/5

B — BACKGROUND

Type of surgery: OPCAB X HURAFIS
Allergies if any: NKDA
On room air / oxygen: Ventilator
Complaints / New Symptoms in last shift: NIL

Date of surgery: 05/01/2024
IV fluids on flow: KABILYTE

A — ASSESSMENT

Vital Signs: Temp: 98.9°F) | Pulse / HR: 75 (beats/min) | Respiration: 14 (breaths/min)
BP: 160/82 (106) mmHg) | SpO_2: 100 (%) | Height: 162 (cms) | Weight: 65 (kgs) | BMI: 28.2 m²
Others : ABP- 120mmHg
Pain Score: 0/8 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 65 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☑ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ No ☐ NA Wound Dressing done: ☐ Yes ☑ No ☐ NA
Current diet: NPO
Drains: Mediastinal + (L) Pleural

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Sandeepkumar	D022	05/1/24	19:30
Handover taken by	Meera	Meera Selvam.	0276	51.124	19.30
Document endorsed			0003	6/1/24	9.40

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No:
06/01/2024	RECEIVAL REPORT ON 06/01/2024	
@13:15		
13:15	Received the patient from a hemodyna-mically stable condition with inotropic support Inj. Noradrenaline 0.05 mcg on flow. On ventilator VCV mode rate 14 peep 5.0 FiO2 0.6 TV 600, Bilateral air entry ⊕ lungs are clear abdomen soft Bowel sound ⊕. peripherals are warm pulses felt.	[signature]
13:20	ABG analysed for the parameter values are normal and satisfied.	[signature]
13:25	As per Dr. Sylvester advised to transfuse 1 ⊙ PCV.	[signature]
15:00	1 ⊙ PCV — B.No 4371; B.G B+ve; S.T 15:00; E.T 17:00	
16:00	Vital signs were checked for the parameter values are normal and satisfied.	[signature]
16:30	PS ABG analysed for the parameter values normal and satisfied	
16:45	patient got extubated and connected O2 mask [illegible] on flow.	[signature]
18:00	ABG analysed for the parameter values are normal	
18:30	Patient [illegible] are [illegible] explained	[signature]
19:00	Patient was handed over to nearby stay	

Document endorsed by	Signature	Name	Emp. No:	Date	Time
	[signature]	[signature]	2003	6/1/24	9.00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 5/1/2024. Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

Diagnosis: CAD-TVD.
NEWS / PEWS Score: -
Ventilator day: -1
Peripheral line day: Right: SUBITAL D1 Left: SUBITAL D1
Ryle's Tube: ☐ Yes ☐ No Day:
Urinary Catheter: ☑ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

GCS: 15/15
POD: DOS
Central line days: D1
VIP Score: 015.

B — BACKGROUND

Type of surgery: OPCAB x 3 GRAFTS.
Allergies if any: NKDA.
On room air / oxygen: Nasal purge - 4ltr/min.
Complaints / New Symptoms in last shift: -

Date of surgery: 5/1/2024
IV fluids on flow: Kabilyte 50ml/hr.

A — ASSESSMENT

Vital Signs: Temp: ____ (°F) | Pulse / HR: 99 (beats/min) | Respiration: 12. (breaths/min)
BP: 148/72. (mmHg) | SpO_2: 100 (%) | Height: 152 (cms) | Weight: 65 (kgs) | BMI: 28.2 m^2.
Others: CVP: 7mmHg.
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 65 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☑ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA Wound Dressing done: ☐ Yes ☑ No ☐ NA
Current diet: Liquid diet- Drains: MEDIASTINAL + LEFT PLEURAL.

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	S.Meena	Meena Selvam	0296.	5/1/24	07.30
Handover taken by		Suryalatha.S.P	0232	6/1/24	07.30
Document endorsed		Dhanam	0007	6/1/24	9.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
5/1/24	Patient hand over taken.	
19:00.	Vitally Stable. on Nasal cannula	
	4Lpm O2. Inj. Noradrenaline.	
	0.05mic/kg infusion. Inj. Fentanyl,	
	3oml/hr infusion. Abdomen Soft.	
	Bowel sounds Present. peripheries	
	warm.	S. Meera 0276.
20:30.	vitals monitored	Meera 0276.
21:00.	Syp. Sucralfate given. Rice Kanji	
	given.	S. Meera 0276
22:00	vitals I+O chart monitored	Meera 0276
23:00	RBG taken. Showed to DR. Ajeetha.	
	advised. to given NS 0.9%. 500ml one.	
	5Hours. Advised to Start Insulin	Meera 0276.
	Infusion.	
02:00	vitals I+O chart monitored.	S. Meera
04:30	Blood sample taken.	Meera
05:00	morning care given. All Pres care given.	Meera
06:00	Diabetic ulcer care given.	Meera
06:30.	RBG taken. I+O chart Informed	
	to DR, Ajeetha, advised to give oral.	Meera 0276
07:00	Hand over given.	
05:00	Before starting morning care.	
	BP Reduced. Increase Inj. Noradd.	Meera 0276

Document endorsed by.	Signature	Name	Emp. No.	Date	Time
		Aiman	0023	6/1/24	9.0

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NABH ACCREDITED

Patient Details (Affix Label here)
Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 6-1-24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: CAD - TVD
GCS: 15/15
NEWS / PEWS Score: -
POD: 1
Ventilator day: -
Peripheral line day: Right: CUBITAL(D_2) Left: CUBITAL(D_2)
Central line days: D_2
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day:
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: OPCAB X 4 GRAFTS
Date of surgery: 5-1-24
Allergies if any: NKA
On room air / oxygen: on nasal prongs
IV fluids on flow: -
Complaints / New Symptoms in last shift: -

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 88 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/58 (mmHg) | SpO_2: 100(%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 m^2

Others : CVP - 8 mmHg

Pain Score: 2 | 10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

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

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

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

Current diet: Liquid diet
Drains: Left pleura + mediastinal

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		SURYAKALA - SP	0232	6.1.24	12:30
Handover taken by		K. ANBARASU	0285	6/1/24	12:31
Document endorsed			9003	6/1/24	9.00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
07.30	Morning duty patient received from Night duty staff Nurse. While receiving pt was Conscious & oriented. pt is on Nasal prongs c 2 litres O_2. IJV (+). Line was flushed and Checked. Line was patent. No oozing, no discolouration present over the (Rt) IJV site. chest tube present. Dressing was intact. Abdomen soft. 'A' line (+) in (Lt) radial artery. Line was patent. IV line [peripheral] present in (Lt) antecubital and (Rt) Cubital line. Lung was clear. Bowel sound present. peripheries are warm. peripheral pulse are felt. Hemodynamically stable. pt on Continuous Hemodynamic Monitoring.	0287
@7:45am	Due drugs are given as per drug Chart order.	0287
@8:00am	pt had Breakfast [Kanji]. Aspiration was not present.	0287
@8:30am	While on doctor order rounds. Dr. Rajesh sir sir adviced to give Tab. Dytor 10mg stat dose. due to OHA adviced.	0287
@9:00am	Due drugs given as per drug chart order.	0287
@10:15am	patient drug Veg. soup.	0287
@11:15am	Arterial line removed. Site was normal. No hematoma oozing was not present. Applied pressure bandage	0287
@11:30am	(Lt) peripheral line removed & applied bandage	0287
@11:45am	urine output was low. Informed to doctor. He adviced to give dytor Infusion.	0287
@12:00pm	Infusion dytor started, as per doctor advice	0287
@12:30pm	Handing over given to Afternoon duty Staff Nurse.	0287

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	[signature]	0221	6/1/24	9.00

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MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 6/1/24. Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: CAD-TVD
NEWS / PEWS Score: —
Ventilator day: —
Peripheral line day: Right: Cannula Left: D2
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☑ Yes ☐ No Day: D2
Barrier nursing: ☑ Yes ☐ No . MDR: ☐ Yes ☑ No. If Yes, specify organism: —

GCS: 15/15
POD: 1
Central line days: D2
VIP Score: 015

B — BACKGROUND

Type of surgery: OPCAB x 4 GRAFT
Allergies if any: NKDA
On room air / oxygen: NP-2 Lpm

Date of surgery: 5/1/24
IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp 96.8 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 24 (breaths/min)
BP: 127/57 (mmHg) | SpO_2: 100% (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m²
Others : BSA - 1.6 m²
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ☑ NRS / CPOT
Fall Risk Score: 60 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☑ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: Liquid diet Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		K. Nirmala	0235	6/1/24	19:30
Handover taken by		SONIA FLORANCE.S	0054	6/1/24	19:30
Document endorsed			0053	6/1/24	9.0

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No:
6/1/24 at 13:00	TOOK OVER the patient is an hemodynamically stable. HR-74/mt, Bp-128/53mmHg, Spo2-100% in NIP-2 lit, RR-24/mt. Inj. Dytor Infusion on flow.	
13:30	⇒ patient Mediastenal + Lt pleural drain tube removed & dressing done.	
14:00	⇒ patient had lunch and due medication given	
14:30	⇒ Drain removal x-ray done	
	⇒ provided comfortable position & patient sleeping well. No Specific complaints.	
15:00		
16:00	⇒ Evening due medication given	
	⇒ Nebulization and Spirometry given as per order.	
18:00	⇒ CBG checked and recorded	
	⇒ vibration given	
	⇒ chair mobilization done.	
18:30	⇒ patient hemodynamically stable.	
19:30	⇒ patient handover given to next duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
			20005	6/1/24	9.00

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 6/1/24 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: OPCAB [CAD-TVD]
NEWS / PEWS Score: —
Ventilator day: —
Peripheral line day: Right: Cubital Left: D2
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☑ Yes ☐ No Day: 2
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

GCS: 15/15
POD: 1 POD
Central line days: D2
VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB
Allergies if any: NKDA
On room air / oxygen: ON O2 via NC
Complaints / New Symptoms in last shift: —

Date of surgery: 5/1/24
IV fluids on flow: —

A

ASSESSMENT

Vital Signs: Temp: 99.6 (°F) | Pulse / HR: 97 (beats/min) | Respiration: 18 (breaths/min)
BP: 155/71 (mmHg) | SpO_2: 95 (%) | Height: 152 (cms) | Weight: 60 (kgs) | BMI: 28.2 Kg/m²
Others: BSA: 1.6m²

Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☑ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☑ Yes ☐ No ☐ NA
Current diet: Restricted diet Drains: Removed.

R

RECOMMENDATION

Referral doctors: Dr. Praveen Jayakumar
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: NIL
Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		Maria Florance S	0074	7/1/24	7.00
Handover taken by		Sathiya Vani M	0265	7/1/24	7.20
Document endorsed		Mahalaxmi	0219	7/1/24	8:00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
6/1/24 19-7.00	Took over the patient in a haemodynamically maintaining condition without supports.	
	She is conscious, oriented and afebrile.	
19.30	Due medication given.	
20.30	She had idli & tolerated well.	
	Administered due medication.	R/N [illegible]/0074
21.30	Nebulization given with levolin 0.63mg and spiro encouraged.	
22.00	Patient condition informed to Dr. [illegible], No special order advised to remove U.Cath in the morning and shift her to ward.	R/N [illegible]/0074
00.00	Reassessment done and interpreted.	
04.30	Blood sample collected and sent for routine investigation.	R/N [illegible]/0074
5.00	Oral care and sponge bath given.	
5.30	Line care and given with tincture under aseptic precaution.	
	* U.Cath removed.	R/N [illegible]/0074
6.00	* CBG checked values satisfactory	
7.00	* She got handed over to next duty in a haemodynamically maintaining condition without supports.	R/N [illegible]/0074

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Mahalakshmi	0219	7/1/24	8:00

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 07/01/24 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TVD
GCS: 15/15
NEWS / PEWS Score: -
POD: II
Ventilator day: —
Central line days: D3
Peripheral line day: Right: cubital Left: D3
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B

BACKGROUND

Type of surgery: OPCABG X 4 GRAFTS
Date of surgery: 5/1/24
Allergies if any: NK
On room air / oxygen: O2 2 lit
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 102 (beats/min) | Respiration: 20 (breaths/min)

BP: 146/75(99) (mmHg) | SpO_2: 96 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m²

Others: BSA 1.6 m²

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

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

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

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

Current diet: NORMAL DIET
Drains: NIL

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
} NIL

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

Pending follow-up orders:
Special instructions if any:
} NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Sathiya Vani.M	0265	7/1/24	11:35
Handover taken by	[signature]	M. Devi U	0[illegible]	7/1/24	[illegible]
Document endorsed	[signature]	Mahalakshmi-M	0219	7/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/24	Took over the patient in heamodynami-	
7:20	cally stable condition with nil	
	Support.	Sathya 0385
	Patient is conscious and oriented.	
8:30	Patient had food orally and well	
	tolerated.	
9:00	Medicines are given as per orders.	
9:30	Spirometery exercise, vibratratic	Sathya
	exercise and nebulization given	
	for patient.	
10:00	Patient walked few steps	
	tolerating well.	
10:20	Dr. Rajesh came and seen the patient	
	adviced to shifte the patient	Sathya 0385
	with O_2 support.	
10:45	Removed IV as per orders.	
11:10	Patient had soup orally and	
	well tolerated.	
11:35	Shifted the patient to 103	
	with stable condition & with O_2 support.	Sathya 0385
	Handed over medicines, case files and	
	kit bag things.	
	Received notes	
11:40	→ patient to day received from	[signature]
	II nd floor.	
	→ patient in line (P)	
	→ patient is stable. on O_2 [illegible]	
	given	[signature]
1230	→ patient [illegible] patient hand over given	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Mahalakshmi	0279	7/1/24	1600

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NABH

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD - TVD
NEWS / PEWS Score: NIL
Ventilator day: ~~D1~~
Peripheral line day: ~~Right:~~ Left:
Ryle's Tube: ~~☑ Yes~~ ☐ No Day:
Urinary Catheter: ~~☑ Yes~~ ☐ No Day:
Barrier nursing: ~~☑ Yes~~ ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

GCS: 15/15
POD: 11
Central line days: D3
VIP Score: 015

B — BACKGROUND

Type of surgery: OPCABG & URPPS
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: 96.2°F) | Pulse / HR: 98 (beats/min) | Respiration: 20 (breaths/min)
BP: 180/70 (mmHg) | SpO_2: 97 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg
Others: BSA 1.6m 2
Pain Score: 4/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☑ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: Normal diet Drains: NIL

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		PN Bhavatha	0274	7/1/24	19.00
Handover taken by		A. Monisha	SCA	7/1/24	19.20
Document endorsed	Nil	R. Nalini	0084	7/1/24	20.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/23	Evening duty notes	
14:00	patient handovers from morning duty notes.	
14:10	Afternoon due medications as per orders.	
14:30	vitals checked & recorded Vitals are stable.	
15:00	Patient Side no issue Patient Sleeping now	
18:00	Monitor Patient & Output.	
18:30	vitals Checked & recorded Vitals Are Stable.	
19:30	patient hand over by night duty Staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		C. Nalini	0084	7/1/24	2:00

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: CAD - TVD
GCS: 15/15
NEWS / PEWS Score: -
POD: II
Ventilator day: -
Central line days: -
Peripheral line day: Right: D3 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: OPCAB x 4 graft
Date of surgery: 5/1/24.
Allergies if any: not known
On room air / oxygen: on room air
IV fluids on flow: -
Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 96 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m²
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS (circled) / 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: Nil

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent: } Nil
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	[signature]	A. Monisha.	0141	8/1/24	7:30
Handover taken by	[signature]	Pavithra	0072	8/1/24	7:30
Document endorsed	[signature]	C. Nalini	0084	8/1/24	8:00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/24	night duty note	
	pt hand over taken	
21:30	from evening duty staff. pt is stable & conscious.	[signature] 0116
	vital are checked & recorded	
22:30	pt taken food medication were given as per chart	[signature] 0121
23:00	provided comfortable position. pt sleep well pre these & no complaint pt sleep well	[signature] 0121
2:00		[signature] 0126
6:00	vital are checked & recorded.	
8:00	pt hand over to morning duty staff	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0084	8/1/24	8:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: CAD TVD
GCS: 5/6
NEWS / PEWS Score: 0
POD: —
Ventilator day: —
Central line days: —
Peripheral line day: Right: — Left: —
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B

BACKGROUND

Type of surgery: OPCABx 4 graft
Date of surgery: 5/1/24
Allergies if any: not known one
On room air / oxygen: on room air
IV fluids on flow: —
Complaints / New Symptoms in last shift: Nil

A

ASSESSMENT

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

BP: 120/80 (mmHg) | SpO_2: 96 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m2

Others : —

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

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

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

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

Current diet: Normal diet
Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Nil
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	[signature]	G. Devi...	0..	8/1/24	1230
Handover taken by	[signature]	A. Nandhini	0170	8/1/24	12.30
Document endorsed	[signature]	S. Nalini	0084	8/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8/1/24	morning duty	
7am	→patient hand over taken night duty	
	→patient is stable & vital signs checked	
7:30	→patient normal diet	
8:00	→patient medication given as per drug chart record	
	→patient Bed Bath checked	
	→patient vital signs checked	
10:00	→Patient Mobilization given	
11:30	→patient Bed clean	
12:00	→patient hand over given to evening duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0024	8/1/24	13:00

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

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

B — BACKGROUND

Type of surgery: OPCAB X 4 GRAFTS. Date of surgery: 5/1/24
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: 97 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/70 (mmHg) | SpO_2: 97 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m²
Others: —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Diabetic diet Drains: —

R — RECOMMENDATION

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

NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Kanchini	0170	8/1/24	19:30
Handover taken by		Jeniprya	0264	8/1/24	1930
Document endorsed		S. Nalini	0024	8/1/24	2000

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8/1/24 @	Evening duty Notes	
12.30	=> patient taken over from Morning duty Staff Nurse	
	=> patient conscious oriented	
	=> patient vital Signs checked & recorded	
14.00	=> Medication given as per drug chart	
16.00	=> Nebulization given	
	=> patient mobilized to chair	
	=> T/c Chart monitored	
	=> to do CBC, Urea, Create, Nat, K+ Tomorrow	
	=> T/c chart Monitored	
18.30	=> patient vital Signs checked & recorded	
19.30	=> patient handing over to Night duty Staff Nurse	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	00824	8/1/24	20:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD - TVD
NEWS / PEWS Score: Nil
Ventilator day:
Peripheral line day: Right: DR Left:
Ryle's Tube: ☑ Yes ☐ No Day:
Urinary Catheter: ☑ Yes ☐ No Day:
Barrier nursing: ☑ Yes ☐ No

GCS: 15/15
POD: 11
Central line days: D3
VIP Score: 05
MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B — BACKGROUND

Type of surgery: OPCAB X 4GRAFTS
Allergies if any: NKDA
On room air / oxygen: on Roomair

Date of surgery: 5/1/24
IV fluids on flow: —
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 96. (°F) | Pulse / HR: 98 (beats/min) | Respiration: 20 (breaths/min)
BP: 130/70 (mmHg) | SpO_2: 97 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg
Others : BSA 1.6 m2
Pain Score: Nil **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: DM diet. Drains: Nil

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
} Nil

Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: —
Pending follow-up orders:
Special instructions if any: F/U Morrow Plan suture removal.

	Signature	Name	Emp. No.	Date	Time
Handover given by	Seni	Seni priya.	0284	9/1/24	09.30
Handover taken by		B. Vidhya	8195	9/1/24	1.30.
Document endorsed		S. Nalini	0084	9/1/24	8.45

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8.1.2024 @	NIGHT DUTY NOTES	
19.30	=> Pt hand over taken from Evening duty staff.	
	=> Pt vitals checked and recorded	
	=> Pt consciouses and orientation.	
22.00	=> Pt dose drugs are given. as per drug chart.	
	=> Pt Nebulization was given.	
23.00	=> Pt mobilized well.	
	=> Pt Sleep well.	
6.00	=> Pt Vitals check and recorded.	
	=> Pt I/O Chart Monitored.	
7.00	=> Pt hand over to Morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nali	S. Nalini	0084	9/1/24	8:00

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD-TVD
GCS: 15/15
NEWS / PEWS Score: NIL
POD: IV
Ventilator day: —
Central line days:
Peripheral line day: Right: D6 Left: —
Ryle's Tube: ☐ Yes ☐ No Day:
VIP Score:
Urinary Catheter: ☐ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: OPCABX 4 Grafts
Date of surgery: 5/1/24
Allergies if any: NKDA
On room air / oxygen: On RA
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 96 (beats/min) | Respiration: 22/m (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 96 (%) | Height: 152 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m²
Others: —
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM Diet
Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		B. Vanisri	0195	9/1/24	12.30
Handover taken by		Hannah Grace	0155	9/1/24	12:30
Document endorsed		S. Nalini	0084	9/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Mrng duty s/w Report	
8/1/24		
7.30	=> pt is taken over from night duty staff.	Ooj 6100
	=> pt is concious & oriented vitals are checked.	
8.30	=> pt S/R done & wound Dressing done. Healthy wound	Ooj 6100
9.00	=> pt had a Food	
	=> Due medication was given as per doctor order	Ooj 6100
10.00	=> Nebulization done.	
	=> S/B Dr. Anbarasu O/B to Add T. Cengin OD.	
	=> pt condition stable no any other complaints	Ooj 6100
	=> mobilised with support.	
12.00	=> I/O chart maintained.	Ooj 6100
	=> pt Details Handing over to Evening duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	C. Nalini	0084	9/1/24	13:00

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD-TVD
NEWS / PEWS Score: 0
Ventilator day:
Peripheral line day: Right: D6 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

GCS: 15/15
POD: IV
Central line days: —
VIP Score: 0 / 15

B — BACKGROUND

Type of surgery: OPCABX4 Grafts
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: 110/70 (mmHg) | SpO_2: 97 (%) | Height: 162 (cms) | Weight: 66 (kgs) | BMI: 25.2 kg/m²
Others : _____
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains:

R — RECOMMENDATION

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

NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by	Hay	Hannah Grace	0105	9/1/24	19:30
Handover taken by					
Document endorsed		S. Nalini	0024	9/1/24	20:05

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/1/24	Evening duty notes	
12:30	patient handing over taken from morning duty staff in a hemodynamically Stable Condition.	Hay 0105
13:00	Vital Signs Checked & Recorded	Hay 0105
14:00	Oxy drugs are given as per drug chart	Hay 0105
16:00	Nebulization was given	Hay 0105
17:00	Patient had no Complaints	
18:00	patient Stable ; patient vital Signs checked and Recorded. I/o Chart Maintained	Hay
19:00	patient handing over given to Night duty Staff	Hay 0105

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nur	S Nalini	0024	9/1/24	2:00

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD-TVD
NEWS / PEWS Score:
Ventilator day: –
Peripheral line day: Right: D6 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☐ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

GCS: 15/15
POD: IV
Central line days: –
VIP Score: 0/5

B — BACKGROUND

Type of surgery: OPLAB×4 GRafts
Allergies if any: NKAP
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: 97.2 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 97 (%) | Height: 162 (cms) | Weight: 66 (kgs) | BMI: 25.2 kg/m²
Others : –
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet
Drains: –

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Nil
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		Soniya.	0284	9/1/24	19:30
Handover taken by		Pavitra	0072	10/1/24	7:30
Document endorsed		S. Nalini	0084	10/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/1/24 @19-45	Pt hand over taken from Evening duty staff. Pt was hemodynically stable. Pt on room air. Pt V/S are checked and recorded.	
20.00	Pt Oral dinner taken.	(M) 02HH
20.30	Pt medication given as Per drug chart.	
22.00	Pt was sleeping	
00.00	Pt V/S are checked and recorded.	(M) 02HH
4.00	Pt was comfortable sleep.	
6.00	Pt V/S are checked and recorded. Pt UO was maintained	(M) 02HH
7.30	Pt hand over to morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nur	S. Nalini	0084	10/1/24	8:00

MHI/NUR/2022/048

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Patient Details (Affix Label here)
Mrs.CECILIA SUBASHINI.H
60/Female/MH1202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD+IVD
GCS: 15/15
NEWS / PEWS Score: —
POD: IV
Ventilator day: —
Central line days: —
Peripheral line day: Right: 07 Left: —
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —

B

BACKGROUND

Type of surgery: OPCAB x 4 grafts
Date of surgery: 5/1/24
Allergies if any: Nil
On room air / oxygen: On room air
IV fluids on flow: —
Complaints / New Symptoms in last shift: Nil

A

ASSESSMENT

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 82 b/m (beats/min) | Respiration: 20 b/m (breaths/min)

BP: 110/70 (mmHg) | SpO_2: 97 (%) | Height: 162 (cms) | Weight: 66 (kgs) | BMI: 25.2 kg/m²

Others : —

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

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

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

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

Current diet: DM diet
Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
} Nil

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

Pending follow-up orders: —

Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	M. Devi	018	10/1/24	1 pm
Handover taken by	[signature]	R.N. Bharathi	0241	10/1/24	12:30
Document endorsed	[signature]	S. Nal/PNP	0021	10/1/24	16:20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/1/24	Morning notes	
7.30		
	→ patient hand over taken from	[signature]
	night duty staff	
	→ patient is stable & vital signs	
	chart	
8.30	⇒ patient medication given as	[signature]
	per drug chart	
	– xp	
9.00	– Patient s/b Dr. Anbarasu sir	
	advised to discharge the patient	[signature]
	tomorrow	
10.00	– vital signs checked & recorded.	[signature]
12.30	– patient handed over to evening	
	duty staff	[signature]

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	[signature]	S. [illegible]	1 0024	10/1/24	16.30

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/11/24 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION
Diagnosis: CAD - TVD
NEWS / PEWS Score: —
Ventilator day: —
Peripheral line day: Right: 0# Left: —
Ryle's Tube: ☐ Yes ☑ No Day: —
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —
GCS: 15/15
POD: IV
Central line days: —
VIP Score: 0 15

B

BACKGROUND
Type of surgery: OPCAB X 4 grafts Date of surgery: 5/11/24
Allergies if any: NKDA
On room air / oxygen: On Room air IV fluids on flow: —
Complaints / New Symptoms in last shift: Nil

A

ASSESSMENT
Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 02 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 96 (%) | Height: 162 (cms) | Weight: 68 (kgs) | BMI: 28.2 kg/m2
Others : —
Pain Score: 0 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: PO diet Drains: —

R

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		RN Bhavesh	0271	1/10/24	19:30
Handover taken by		Sangeeta	0284	10/10/24	19:30
Document endorsed		S. Neelima	0024	11/11/24	16:28

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/11/24	Evening duty Notes	
14:00	Patient hand over from morning duty Staff	0271
14:30	Afternoon due medication given as per.	0271
18:00	Vitals checked & recorded Vitals are Stable.	0271
16:00	Patient Side no issue patient stable well.	0271
19:00	Monitor Intake & Output chart.	0271
19:30	Patient hand over by Night duty Staff	0271

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. [illegible]	0021	11/11/24	16:00

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD - NURSES

Date: 10/1/24 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: OPCAB x4 VEIN GRAFT
Date of surgery: 5/1/24
Allergies if any: NKDA
On room air / oxygen: on Roomair.
IV fluids on flow: -
Complaints / New Symptoms in last shift: Nil

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 22 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 96 (%) | Height: 162 (cms) | Weight: 66 (kgs) | BMI: 28.2kg/m²
Others : -
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM Diet. Drains: -

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	Jeni	Jeniponge.	0284	10.1.24	9.30
Handover taken by		M. Raja		10/1/24	12.30
Document endorsed		S. Nurse/PNP	0024	10/1/24	16.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	NIGHT DUTY NOTES	
10/1/24		
19.30	=> Pt chard over taken from evening duty staff.	
	=> Pt conscious and oriention.	
	=> Pt Vitals checked and recorded.	
20.00	=> Pt dose drugs are given	
	=> Pt Mobilized well.	
23.00	=> Neubulization was given to the patient.	
	=> Pt Sleep well.	
6.00	-> Pt Vitals checked	
	=> Pt I/O chart Monitered	
7.00	=> Pt handing over to morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S [illegible]	0024	10/1/24	16/10

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

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

B

BACKGROUND

Type of surgery: OPCABG X 4 ARTT Date of surgery: 5/1/24
Allergies if any: NKDA
On room air / oxygen: On room air IV fluids on flow: –
Complaints / New Symptoms in last shift: NIL

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 74b/m (beats/min) | Respiration: 22b/m (breaths/min)

BP: 120/80 (mmHg) | SpO_2: 96 (%) | Height: 162 (cms) | Weight: 66 (kgs) | BMI: 28.2 kg/m²

Others : –

Pain Score: 0/10 **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: DM Diet Drains: –

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent: } NIL
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	[signature]	M. Daisy	010	11/1/24	1230
Handover taken by	–	discharged	–		
Document endorsed	[signature]	S. Nalini P	0026	11/1/24	16.20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12/1/24 @	Morning duty	
7.00	->patient hand over taken from night duty staff	
	->patient pre Diet	[signature]
	->patient is stable & vital sings check records	
8.00	->patient medication given as per drug chart	
	->patient ID band check	
	->patient ® vital sings checked	
	->patient S/R done.	[signature]
10.00	->patient nebulization given	
	->patient is stable & vital sings checked	
11.30	->patient S/o chest rounds	
12.30	->patient hand over given per evening duty staff	[signature]
	Discharge Notes	
14.00	Patient handover from morning duty staff. Afternoon due medication given as per	[signature] 0271
15.50	Patient IV line removed & Id band removed. Explained discharge summary. patient get discharge	[signature] 0071

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0071	12/1/24	16.50

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ADULT NURSING CARE PLAN

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 4/4/23 Time: 16:00 | Modified Date: Time:

Reason for Modification: | Diagnosis: CAD-TVD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☑ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M		
			E	Pt had DM diet	[signature]
			N	Pt had DM diet	Hay
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☑ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M		
			E	Pt SpO_2 99%.	[signature]
			N	Pt was stable on room air	Hay 8/00
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M		
			E	Pt I/O chart maintained	[signature]
			N	I/O chart Maintained	Hay 8/00

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☑ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E pt well Mobilized N Patient Mobilized well	 Hay 0100
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☑ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☑ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M E pt @ pattern N pt had normal elimination Patteen	 Hay 0100
SKIN INTEGRITY ☐ Maintain normal skin integrity ☑ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M E pt Skin Integrity N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M E Pt well groomed N Patient groomed well	 Hay 0105
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M E Pt ID band checked N ID band present	 Hay 0105
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M E — N —	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M E Pt v/s checked N Pt vital signs are normal	 Hay 0105
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M E — N —	

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nali	C. Nalini	0084	4/1/24	18:00

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NABH ACCREDITED

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/112

Medway Heart Institute
Every heart beat counts

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 05/01/2024 **Time:** 13:15	**Modified Date:** **Time:**
Reason for Modification:	**Diagnosis:** CAD-TVD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
PAIN ☑ Comfortable Position ☑ Pain Scale ☑ Pain Score ☐ Others:	☑ Patient will have less pain	☑ Evaluate location, character, quality and severity of pain ☑ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M	—	
			E	Administered medication as per order	[illegible]
			N	Patient is on Analgesics.	[illegible]
OXYGENATION ☐ Room Air ☐ Oxygen Hood ☐ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☐ Patient will have no shortness or difficulty of breathing	☑ Provide well ventilated environment ☐ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M	—	
			E	→ Provided well ventilated environment	[illegible]
			N	on Nasal cannula, 4lt/min.	[illegible]
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M	—	
			E	—	
			N		
MOBILITY ☐ Mobile / ~~Immobile~~ ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M		
			E	Patient is on bed rest	[illegible]
			N	Patient is on Bed Rest.	[illegible]

S.No. : 8

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☑ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☑ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	**M** —	
			E Monitor Intake and output chart	[illegible] 2002
			N I/O chart monitored.	[illegible] 0276
RISK OF INFECTION ☑ Prevent Infection ☐ Others:	☑ The patient will be discharged with no hospital acquired infection	☑ Use aseptic technique in all aspect of patient care ☑ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	**M** —	
			E use aseptic techniques in all aspects of patient care	[illegible] 2002
			N Aseptic technique followed.	[illegible] 0276
RISK OF FALL ☐ Giddiness ☐ Independent State ☐ Dependent State	☐ The patient will have safe, free from fall hospitalization	☐ Keep bed on low position ☐ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	**M** —	
			E —	
			N Bed is lowest, locked position.	[illegible] 0276
SKIN &WOUND CARE ☐ Observe REEDA ☐ Oozing ☐ Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	**M** —	
			E —	
			N	
DIET & NUTRITION ☑ NPO ☐ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☑ Patient will have adequate nutrition with no nausea and vomiting	☑ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	**M**	
			E Patient is on NPO	[illegible] 2002
			N on liquid diet.	[illegible] 0276

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.	☑ Patient will have patent, properly maintained catheters, drains etc	☐ Check the catheters, drains etc frequently ☑ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M — E Observe I/O Chart N I/O chart	 [illegible]
DISTURBED BODY IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M — E — N	
OBSERVATION ☑ Vital Signs ☑ GCS ☐ Blood Sugar ☑ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☑ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	M E Patient is on hemodynamically Stable condition N vitals monitored.	 [illegible]
HEALTH EDUCATION ☑ Patient ☑ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:	☑ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☑ Provide proper education regarding follow-up diet ☐ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☐ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M E Provided Hlt regarg diet and exercise N Health Education given.	 [illegible] meen 0276
ANY OTHER NEEDS			M E N	

	Signature		Name		Emp. ID		Date	Time
Endorsed by		[signature]	—	Mahalakshmi	0219		7/1/24	8:00

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NABH

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/112

Medway Heart Institute
Every heart beat counts

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 06/01/24. **Time:** 8am. **Modified Date:** — **Time:** —

Reason for Modification: **Diagnosis:** CAD.

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☑ Comfortable Position ☐ Pain Scale ☑ Pain Score ☐ Others:	☑ Patient will have less pain	☐ Evaluate location, character, quality and severity of pain ☑ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☑ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M Administered drug as per drug chart order. E Maintained proper position N Administered due mediation as per chart	0204 0204 0204
OXYGENATION ☐ Room Air ☐ Oxygen Hood ☑ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☑ Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☑ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M checked vital signs. Monitored saturation level of the patient E maintained Spo2-100% in NP-2 lpm N SPO2-94% ON Nasal prongs NGT	0204 0204 0204
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M NA E NA N	0204 0204
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ *Patient will mobilize freely* ☐ Patient will perform physical activity independently or within limits of disease ☑ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ *Apply Anti-Embolic stocking / SCD* ☐ Evaluate the need for assistive devices ☑ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Assessed the safety measures Siderails protected fall risk flagged at foot end E provided Comfortable position N ON chair fast	0204 0204 0204

S.No. : 8

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☑ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☑ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Monitored Intake and output chart E Checked IV line site N IV line patent and healthy	[illegible] [illegible] [illegible]
RISK OF INFECTION ☑ Prevent Infection ☐ Others:	☑ The patient will be discharged with no hospital acquired infection	☑ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☑ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M Followed aseptic techniques. Followed moments of hand hygiene E Administered antibiotic as per order. N Aseptic techniques followed.	[illegible] [illegible] [illegible]
RISK OF FALL ☐ Giddiness ☐ Independent State ☑ Dependent State	☑ The patient will have safe, free from fall hospitalization	☑ Keep bed on low position ☑ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	M Kept bed on low position. E Provided side rails N fall risk precaution followed.	[illegible] [illegible] [illegible]
SKIN &WOUND CARE ☐ Observe REEDA ☑ Oozing ☐ Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	☑ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☑ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M checked all drains from the operation site more frequently E Skin intact. N wound healthy	[illegible] [illegible] [illegible]
DIET & NUTRITION ☐ NPO ☑ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☑ Patient will have adequate nutrition with no nausea and vomiting	☑ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M Encouraged patient to consume nutritive diet E Patient had liquid diet N On semi solid diet	[illegible] [illegible] [illegible]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.	☑ Patient will have patent, properly maintained catheters, drains etc	☑ Check the catheters, drains etc frequently ☐ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☑ Maintain adequate cleaning and dressing	**M** Checked the catheters, drains etc frequently **E** maintained adequate cleaning **N** ON CBD U.output adequate	[illegible] [illegible] [illegible]
DISTURBED BODY IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	**M** NA **E** NA **N**	[illegible] [illegible]
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	**M** Monitored vital signs regularly. Pt is on regular hemodynamic monitoring **E** monitored vital signs **N** Haemodynamically stable	[illegible] [illegible] [illegible]
HEALTH EDUCATION ☐ Patient ☑ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:	☑ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ Provide proper education regarding follow-up diet ☑ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☐ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	**M** provided education regarding hand hygiene for family members. **E** Educated about follow up diet **N**	[illegible] [illegible]
ANY OTHER NEEDS			**M** **E** **N**	

Endorsed by	Signature	Name	Emp. ID	Date	Time
	[illegible]	[illegible]	0003	6/1/24	9.00

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NABH

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/112

Medway Heart Institute
Every heart beat counts

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 4/1/24 **Time:** **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** CAD - HTD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☑ Comfortable Position ☐ Pain Scale ☑ Pain Score ☐ Others:	☑ Patient will have less pain	☐ Evaluate location, character, quality and severity of pain ☐ Administer pain medication as prescribed and as needed ☑ Observe for any changes in vital signs ☑ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M Maintained proper position for patient. E provided comfortable position N provided comfortable positi	
OXYGENATION ☐ Room Air ☐ Oxygen Hood ☑ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☑ Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☑ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M Patient is on nasal prongs 2 lit. E Pt on room air N spo2 - 98%	
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M NA E N	
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☑ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Provided safe environment. E Pt well mobilized N Pt mobilized well	

S.No. : 8

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ✓ ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☑ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Monitored I/O every hour.	0265
			E Monitored I/O [illegible]	[illegible]
			N I/O chart monitored	[illegible]
RISK OF INFECTION ☑ Prevent Infection ☐ Others:	☑ The patient will be discharged with no hospital acquired infection	☑ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M Followed aseptic techniques.	0265
			E followed aseptic technique	[illegible]
			N —	
RISK OF FALL ☐ Giddiness ☐ Independent State ☐ Dependent State	☐ The patient will have safe, free from fall hospitalization	☐ Keep bed on low position ☐ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	M Followed risk fall prevention.	0265
			E followed risk fall prevention	[illegible]
			N —	
SKIN &WOUND CARE ☐ Observe REEDA ☐ Oozing ☐ Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M Skin is intact.	0265
			E skin is intact	[illegible]
			N —	
DIET & NUTRITION ☐ NPO ☐ Soft Diet ☐ Semisolid Diet ☑ Solid Diet ☐ RT Feeds	☑ Patient will have adequate nutrition with no nausea and vomiting	☑ Encourage patient to consume prescribed diet ☑ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M Encouraged the patient to take adequate diet.	0265
			E monitored vital signs	[illegible]
			N pt feed [illegible]	[illegible]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.	☐ Patient will have patent, properly maintained catheters, drains etc	☐ Check the catheters, drains etc frequently ☐ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M	observed I/O chart.	0265
			E	monitored I/O chart	
			N	I/O chart monitored	
DISTURBED BODY IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M	NA	0265
			E	←	
			N	←	
OBSERVATION ☐ Vital Signs ☑ GCS ☑ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☑ Monitor GCS of patient	M	Monitored vitals & assessed GCS.	0265
			E	monitored vitals & GCS	
			N	vital stable	
HEALTH EDUCATION ☐ Patient ☐ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:	☐ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ Provide proper education regarding follow-up diet ☐ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☐ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M	Educated regarding diet, treatment.	0265
			E	health education about diet	
			N	Health education given	
ANY OTHER NEEDS			M		
			E		
			N		

Endorsed by	Signature		Name	Mahalakshmi	Emp. ID	0219	Date	Time
							7/1/24	8:00

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ADULT NURSING CARE PLAN

Patient Details (Affix Label here)
Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 8/1/24 **Time:** 8.00	**Modified Date:** **Time:**
Reason for Modification:	**Diagnosis:** CAD - TVD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt DM Diet E Pt had DM diet N Pt had DM diet	
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt room air E Pt Pt is on Room Air N Pt is on RA	
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt electorty plan E I/o chart monitored N I/o chart monitored	

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

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by		S. Nalini	0024	8/1/24	12:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 9/1/24	**Time:** 8 am	**Modified Date:**	**Time:**
Reason for Modification:		**Diagnosis:** CAD - TVD	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had a DM diet E patient had DM diet N Pt had DM diet	[illegible] Hay [illegible]
OXYGENATION ✓ ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on Room air E Patient was stable on room air N Pt on Room air	[illegible] Hay [illegible]
FLUID & ELECTROLYTES ✓ ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O chart maintained E I/O chart Maintained N Pt I/O was maintained	[illegible] Hay [illegible]

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☑ Bed-Bath ☐ Assist-Bath ☑ Self-Care ☐ CBD Care (if present) ☐ Others:	☑ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☑ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt groomed with assist E Patient groomed well N Pt clean & well groomed	[illegible] [illegible] 0100 [illegible]
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☑ Patient will have no life-threatening situations	☑ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M pt checked ID Band E ID band present N Pt ID band ⊕	[illegible] [illegible] 0100 [illegible]
COMFORT AND SLEEP ☑ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☑ Patient will verbalize / or through behavior about pain relief and adequate sleep	☑ Provide clean calm and restful environment ☑ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M provided comfortable position E — N Pt comfortable position	[illegible] [illegible]
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Vitals are checked E Patient vital signs are stable N Pt V/S are checked and recorded	[illegible] [illegible] [illegible]
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☑ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☑ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☑ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M provided psychological support E — N P —	[illegible] —

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt well communicated	01/25
			E Pt Communicated well	0100
			N Pt well communication	02HH
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Due medication was given	01/00
			E Due drugs are Given	0100
			N Pt medication given as Per drug chart	02HH

	Signature	Name	Emp. ID	Date	Time
Endorsed by		R. Nalini	0027	9/1/24	12:00

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ADULT NURSING CARE PLAN

Mrs.CECILIA SUBASHINI.H
Pati 60/Female/MHI202381349
Na 04/01/2024/IPH2024000033
UH Dr.ANBARASU MOHANRAJ
D
Consultant.

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 10/1/24 **Time:** 8:00 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** CAD - TVR

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt had ADIN diet E patient had DM diet N Pt on Room diet	
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on Room Air E Patient was stable on room air N pt on room air	
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O chart maintained E I/O chart maintained N Pt I/O was maintained	

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

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	Pt communication well	
			E	Pt communication well	[illegible]
			N	Pt communication well	[illegible]
✓ SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M	Pt medicino given	
			E	Pt medication given	[illegible]
			N	Pt medication given	[illegible]

Endorsed by	Signature	Name	Emp. ID	Date	Time
	[illegible]	S. Nalinp	0021	10/1/24	16:00

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ADULT NURSING CARE PLAN

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 4/1/24	Time: 8:00	Modified Date:	Time:
Reason for Modification:		Diagnosis: CAD - TVD	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt DM Diet E N	
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt room air E N	
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt electrolytes fluid E N	

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

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	pt communicative well	[illegible]
			E		
			N		
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M	medication as given.	[illegible]
			E		
			N		

	Signature	Name	Emp. ID	Date	Time
Endorsed by	[illegible]	S. [illegible]	00 [illegible]	[illegible]	[illegible]

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NABH

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 04/01/24	
					Time: E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	4
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	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	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
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		4	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
				TOTAL SCORE		23	20
				Initial & Emp. No. of Staff Nurse:		[illegible]	Hay 0606
				Initial & Emp. No. of Sr. Staff Nurse:		Lea 24	Nil 24

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

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NABH

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 5/1/24	5/1/24	
					Time: 15:00	19:00	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	1	1	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	1	1	2
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	1	1	2
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	1	1	2
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		1	1	2
				TOTAL SCORE	6	6	13
				Initial & Emp. No. of Staff Nurse:	2032	[illegible]	[illegible]
				Initial & Emp. No. of Sr. Staff Nurse:	[illegible]	[illegible]	[illegible]

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

S.No. : 22

MHI/NUR/2022/045

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 6/1/24 | 7/1/24 | |
Time: 10:00 | 8:00 | |

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	3	3	3
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	3	3	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	2	3	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	2	3	3
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	2	3	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		2	3	3
				TOTAL SCORE	14	18	18
				Initial & Emp. No. of Staff Nurse:	[illegible]	[illegible]	[illegible]
				Initial & Emp. No. of Sr. Staff Nurse:	[illegible]	[illegible]	[illegible]

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

S.No. : 22

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NABH

Patient Details *(Affix Label here)*
Name:
UHID:
DOB: Sex:
DOA:
Consultant:

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date:		
					Time:		
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. Rarely 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 diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		4	
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	
					TOTAL SCORE	23	
					Initial & Emp. No. of Staff Nurse:		
					Initial & Emp. No. of Sr. Staff Nurse:		

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

S.No. : 22

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NABH

Pa[illegible] Details (Affix Label here)
Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE [illegible] RISK

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

S.No. : 22

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NABH ACCREDITED

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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

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

S.No. : 22

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NABH

Patient
Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date:	19	01	23
					Time:	M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
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ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	2	4	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	
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				TOTAL SCORE	23	23	
				Initial & Emp. No. of Staff Nurse:			
Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**			

S.No. : 22

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MHI/NUR/2022/052

Patie Mrs.CECILIA SUBASHINI.H
Nam 60/Female/MHI202381349
UHID 04/01/2024/IPH2024000033
DOB: Dr.ANBARASU MOHANRAJ
DOA:
Cons

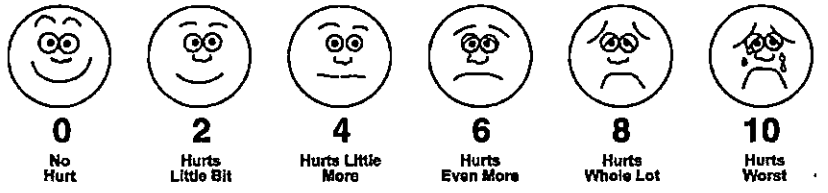
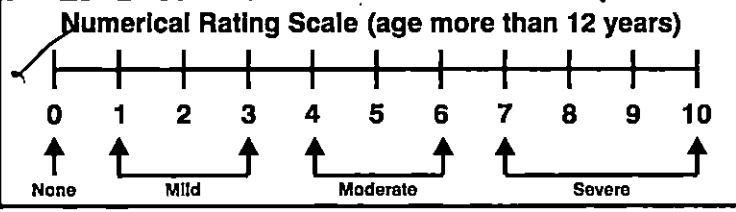
Medway Heart Institute
every heart beat counts

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.
13.00	0/10	No pain	—	—	—	0024	Nur 0024
19.00	0/10	No pain	—	—	—	0024	Nur 0024
22.00	0/10	No pain	—	—	—	0024	Nur 0024
				Patient	is Sleeping		
5/1/24 6.00	0/10	No pain	A	—	—	0024	Nur 0024

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

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological 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)	 
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 - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/052

Medway Heart Institute
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
5/1/2023 14:00	0/8	—	—	—	Assessed by CPOT	[illegible]	[illegible]
16:00	2/10	Achy pain	120sec	Surgical Site	→ Non-Pharmacological Management done	[illegible]	[illegible]
18:00	1/10	DUU pain	210sec	⊕ Scapula region	→ Pharmacological Management done	[illegible]	[illegible]
20:00	1/10	DUU pain	210sec	⊕ scapula region	→ Non-Pharmacological Management done	[illegible]	[illegible]
22:00	1/10	Achy pain.	15 sec	Back pain	Comfortable position given.	[illegible]	[illegible]
6/1/24 00:00	1/10	Achy pain.	10 sec	Back pain.	Comfortable position given.	[illegible]	[illegible]
02:00	0/10	Patient is sleeping	—	—	—	[illegible]	[illegible]
04:00	0/10	Patient is sleeping	—	—	—	[illegible]	[illegible]
06:00	1/10	Achy pain	10sec	Sternum	Comfortable position given.	[illegible]	[illegible]

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
08:00	2/10	Achy pain.	10-15 secs.	Backpain	pharmacological Intervention.	0287	0003
10:00 am	1/10	Dull pain.	5-10 secs	Sternum	Non-pharmacological Intervention.	0287	
12:00 pm	1/10	Dull pain.	5-10 secs	Sternum	pharmacological Intervention.	0287	0003
04:00	1/10	Dull pain	>5sec	Sternum	pharmacological Interventions given.	0287	0003

PAIN SCALES

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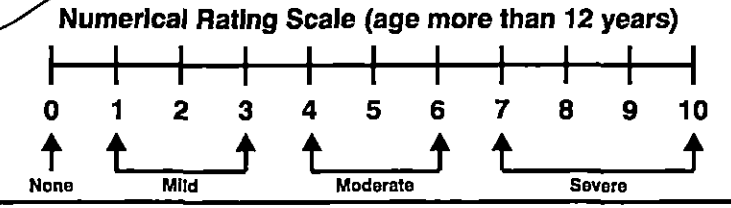
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; 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 - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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MHI/NUR/2022/052

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
6/1/24 16:00	1/10	Dull pain	3sec	Back	Non-pharmacological interventions given	0283	0003
18:00	1/10	Dull pain	1sec	back	Non-pharmacological interventions given	0283	0003
20:00	2/10	Achy pain	<5 Sec	Abdomen	Pharmacological management done.	0074	0249
22:00	1/10	dull pain	10 Sec	back	Comfortable position given.	0074	0249
00:00	–	–	–	–	She is comfortable	0074	0249
02:00	–	–	–	–	She is comfortable	0074	0249
04:00	–	–	–	–	She is comfortable	0074	0249
06:00	1/10	dull pain	<5 Sec	Abdomen	Non pharmacological management done	0074	0249
8:00	1/10	Dull ache	15 Sec	Surgical Site	Non-pharmacological intervention done.	0265	

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10:20	1/10	Dull ache	15 sec.	Surgical site	Non-pharmacological intervention done.	0365	
14.00	Yes	dull ache	15 sec	Surgical site	Pharmacological intervention done		
18.00	Yes	dull ache	15 sec	Surgical site.	Non-pharmacological intervention given		
22:00	0/10	no pain	—	—	—	5/11	

PAIN SCALES

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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.***
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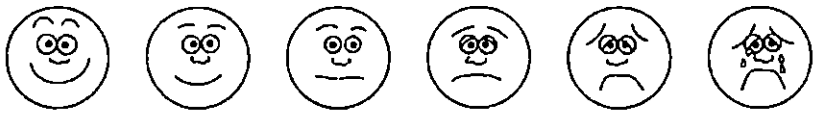
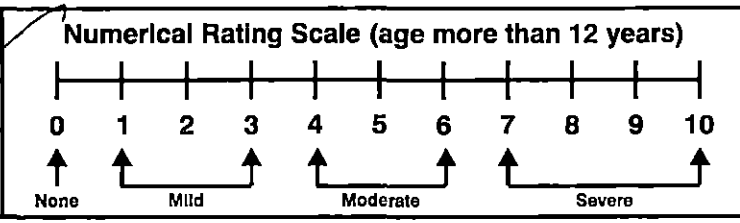
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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PAIN RE-ASSESSMENT & MONITORING CHART

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.
8/1/24 2:00	0/10	No pain	—	—	—	[illegible] ANI	Nurse 024
6:00	0/10	No pain	—	—		[illegible] ANI	Nurse 024
10:00	0/10	No pain	—	—	—	[illegible] 0187	Nurse 024
14:00	0/10	No pain	—	—	—	[illegible] 2337	Nurse 024
18:00	0/10	No pain	—	—	—	[illegible] 2337	Nurse 024
20.00	0/10	No Pain	—	—	—	[illegible]	Nurse 024
22.00	0/10	No Pain	—	—	—	[illegible]	Nurse 024
6.00	0/10	No pain	—	—	—	[illegible]	Nurse 024
10.00	0/10	Dull pain	On & OFF	Surgical site	provided comfortable position	[illegible] 0187	Nurse 024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
14:00	1/10	Dull pain	on & off	Surgical site	Phaemacological intervention given	Hay 0105	Nur 024
18:00	1/10	Dull pain	on & off.	Surgical site.	Non-phaemacological Intervention given	Hay 0105	Nur 024
22:00	1/10	Dull pain	on & off	Surgical site	non-phamacological intervention given.	02114	Nur 024
6-00	1/10	Dull pain	on & off.	surgical site	provide comfortable position.	Jen 0114	Nur 024

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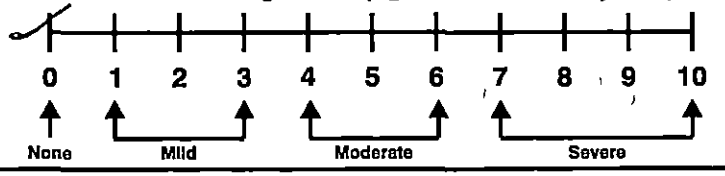
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 **Numerical Rating Scale (age more than 12 years)** 
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Patient Details (Affix Label here)
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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10.00	0/10	No pain	—	—	—		
14.00	0/10	No pain	—	—	—		
18.00	0/10	No pain	—	—	—		
20.00	0/10	No Pain	—	—	—		
22.00	0/10	No pain	—	—	—		
11/1/24 6.00	0/10	No Pain	—	—	—		
10.00	0/10	No pain	—	—	—		
14.00	0/10	No pain	—	—	—		

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

PAIN SCALES

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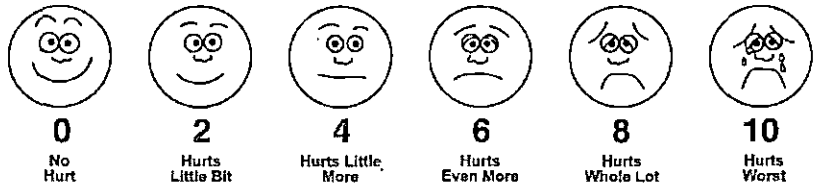
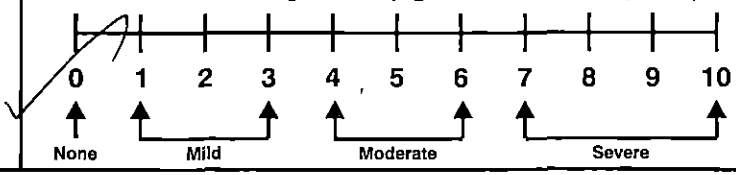
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 **Numerical Rating Scale (age more than 12 years)** 
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MHI/NUR/2022/047

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Every heart beat counts

DVT RISK ASSESSMENT

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

S. No.	PARAMETERS	Date / Time						
		04/1/2024 15:00	5/1/24 19:00	6/1/24 8:00am	7/1/24 2:00	8/1/24 8:50	9/1/24 6:00	10/1/24 9:00
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0	0	0
2	Bedridden recently >3 days or major surgery *within four weeks*	+1	+1	+1	+1	+1	+1	+1
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0	0	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0	0	0
5	Entire leg swollen (Assess for both legs)	0	0	0	0	0	0	0
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0	0	0	0	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0	0	0	0
9	Previously documented DVT (Assess for both legs)	0	0	0	0	0	0	0
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0	0	0	0	0
	FINAL SCORE	+1	+1	+1	+1	+1	+1	+1
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	MOD	MOD	Moderate	Mod	Mod	Mod	Mod
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

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Pa Mrs.CECILIA SUBASHINI.H
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Dr
Cc

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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	4/11/24	5/11/24					
	Time	13.00	6:00					
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0					
2	Bedridden recently >3 days or major surgery within four weeks	0	0					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0					
5	Entire leg swollen (Assess for both legs)	0	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0					
9	Previously documented DVT (Assess for both legs)	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					
	FINAL SCORE	0	0					
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low	Low					
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	[signature] 8861	[signature] 8005					
	Signature & Emp. No. of Sr. RN	[signature]	[signature]					

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DVT RISK ASSESSMENT

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

	Date	11/1/24						
	Time	7.00						
S. No.	**PARAMETERS**							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	+1						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (*Assess for both legs*)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0						
5	Entire leg swollen (Assess for both legs)	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0						
9	Previously documented DVT (Assess for both legs)	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						
	FINAL SCORE	+1						
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	MOP						
	DVT prophylaxis started	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

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Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	4/1/24	4/1/24							
	Time	14.00	20:00							
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, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	30							
Low Risk (0 - 24)										
Medium Risk (25 - 44)		✓	✓							
High Risk (45 or above)										
Signature & Emp. No. of RN		[signature]	[signature]							
Signature & Emp. No. of Sr. RN		[signature]	[signature]							

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

INTERVENTIONS *Tick as per the Risk Score*	Date	4/1	4/1/24							
	Time	18:00	20:00							
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		[illegible]	[illegible]							
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]							

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NABH ACCREDITED

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	5/1/2024	5/1/24	6/1/24	6/1/24	6/1/24	7/1/24	7/1/24	7/1/24	8/1/24
		Time	16:00	19:00	8:00	14:00	20:00	8:00	14:00	20:20	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, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Total Score			65	50	50	50	50	50	50	50	50
Low Risk (0 - 24)			—								
Medium Risk (25 - 44)			—								
High Risk (45 or above)			✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN											

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

INTERVENTIONS *Tick as per the Risk Score*	Date	26/01/24	1/1/24	01/24	6/1/24	7/1/24	7/1/24	7/1/24	8/1/24	
	Time	16:00	8:00	12:30	20:00	8:00	4:00	20:00	8:00	14:00
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		NA	NA	NA	✓	NA	✓	✓	✓	✓
Provide a commode at bedside (if appropriate)		NA	NA	NA	NA	NA	✓	✓		✓
Urinal/bedpan should be within easy reach (if appropriate)		✓	NA	NA	NA	NA	✓	✓	✓	✓
Encourage family members or other visitors to stay with them		NA	NA	NA	NA	NA	✓	✓	✓	✓
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

MHI/NUR/2022/046

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	8/1/24	9/1/24	9/1/24	9/1/24	10/1/24	10/1/24	10/1/24	11/1/24	11/1/24
		Time	20.00	8.00	14.00	20.00	8.00	14.00	20.00	8.00	14.00
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, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Total Score			50	50	50	50	80	50	80	80	50
Low Risk (0 - 24)											
Medium Risk (25 - 44)											
High Risk (45 or above)			✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN											

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

INTERVENTIONS *Tick as per the Risk Score*	Date	8/1/24	9/1/24	9/1/24	9/1/24	10/1/24	10/1/24	10/1/24	11/1/24	
	Time	20.00	8.00	12:00	20:00	8:00	14:00	20:00	8:00	
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓	✓	✓	✓
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓	✓	✓	✓
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓	✓	✓	✓
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓	✓		✓
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓	✓	✓	✓
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓	✓	✓	✓
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓	✓	✓	
Bed wheels should be locked		✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓	✓	✓	✓
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓		✓	✓	✓	✓	
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓	✓	✓	✓	✓
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓	✓	✓	✓
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓	✓	✓	✓
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓	✓	✓	✓	✓	✓	✓	✓	✓
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓	✓	✓	✓	✓	✓	✓
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓	✓	✓	✓	✓	✓
Use restraints and bed monitors as ordered by the doctor		✓	✓	✓	✓	✓	✓	✓		✓
Allow the patient to ambulate only with assistance		✓	✓	✓	✓	✓	✓	✓	✓	✓
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓	✓	✓	✓
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓	✓	✓	✓	✓	✓	✓
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓	✓	✓	✓
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓	✓	✓	✓	✓	✓	✓
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓	✓	✓	✓
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓	✓	✓	✓	✓	✓	✓	✓
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓	✓	✓	✓	✓	✓	✓	✓
Locate the high-risk patients in a room close to the nurses' station		✓	✓	✓	✓	✓	✓	✓	✓	✓
Answer these patients call bells as quickly as possible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Provide a commode at bedside (if appropriate)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Urinal/bedpan should be within easy reach (if appropriate)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage family members or other visitors to stay with them		✓	✓	✓	✓	✓	✓	✓	✓	✓
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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P: Mrs.CECILIA SUBASHINI.H
N: 60/Female/MHI202381349
U: 04/01/2024/IPH2024000033
D: Dr.ANBARASU MOHANRAJ
D:
C:

MHI/IP/2022/055

Medway Heart Institute
Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment — To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to	☐ Low motivation / desire to learn	☐ Written Instuctions
understand and follow directions		

Completed By : Date 5/1/24 Time [illegible] Nurse Signature : [signature]

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	5/1/24	L	P	O		L	P	O		L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics			P	OD	✓								[signature] 16530
☐ Treatment													
Medications			P	OD	✓								Doctor / Nurse
☐ Information on Safe and Effective use of medicines													
☐ Information on drug / drug and drug / food interactions			P	OD	✓								Nurse 0247
☐ Discharge Medications													
Surgical Instructions			P	OD	✓								Nurse
☑ Pre - Operative Instructions			P	OD	✓								[signature] 0201
☑ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☑ Reporting of pain			P	OD	✓								
☑ Pain Management			P	OD	✓								Nurse 0247
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient :_____Signature :_____

Name of Discharge Nurse

Signature :

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60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/055

Medway Heart Institute
Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to	☐ Low motivation / desire to learn	☐ Written Instuctions
understand and follow directions		

Completed By : Date 06/01/2024 Time 18:00 Nurse Signature : RN Anbarasu

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	5/1/24	L	P	O	6/1/24	L	P	O	7/1	L	P	O	
Disease		—	—	—									Doctor
☐ Information on Disease / Diagnostics		S	OD	V		S	OD	V		D	OD	V	
☐ Treatment		S	OD	V		S	OD	V					
Medications		S	OD	V		S	OD	V		D	OD	V	Doctor / Nurse
☐ Information on Safe and Effective use of medicines		S	OD	V		S	OD	V		D	OD	V	
☐ Information on drug / drug and drug / food interactions		—	—	—		S	OD	V					
☐ Discharge Medications		—	—	—		—							
Surgical Instructions		—	—	—		—							Nurse
☐ Pre - Operative Instructions		—	—	—		—							
☐ Post - Operative Instructions (Wound / Dressing Care)		S	OD	V		S	OD	V		D	OD	V	
Pain Management						S	OD	V					Nurse
☐ Reporting of pain		—	—	—		S	OD	V		D	OD	V	
☐ Pain Management		S	OD	V		S	OD	V					
Safe and effective use of medical Equipment (if required)		—	—	—		—							Doctor / Nurse
Name of Equipment Rehabilitation Techniques		—	—	—		—							

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	6/12	L	P	O		L	P	O		L	P	O	
Nutritional Guidance		—		—									Dietician
☐ Diet Instruction for patients at Nutritional risk		—		—									
☐ Diet advice for home		—	—										Nurse
Discharge Planning		—	—	—									
☐ Self care		—	—	—									
☐ Follow up		—	—	—									
☐ Reporting Concerns Immunizations		—	—	—									
☐ Parenting education		—	—	—									
☐ Others		—	—	—									
Risk Factor Reduction													
☐ Smoking Cessation		—	—	—									Doctor
☐ Weight Control													
☐ Exercise		—	—	—									
☐ Hypertension		—	—	—									
☐ Other Risks		—	—	—									

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

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

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

Written Material given and explained (if any)

NIL

Reports Given :

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

Name of Attendant / Patient :_____Signature :_____

Name of Discharge Nurse

Signature :

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PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☐ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☑ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to	☐ Low motivation / desire to learn	☐ Written Instuctions
understand and follow directions		

Completed By : Date 8/1/24, Time 8.00 Nurse Signature :

Learning Record

Need	Date 8/1/24	Visit 1 L	P	O	Date 9/1/24	Visit 2 L	P	O	Date 10/1/24	Visit 3 L	P	O	Signature
Disease													Doctor
☐ Information on Disease / Diagnostics		P	OD	V		P	OD	V		P	OD	V	
☑ Treatment		P	OD	V		P	OD	V		P	OD	V	
Medications						P	OD	V		P	OD	V	Doctor / Nurse
☑ Information on Safe and Effective use of medicines						P	OD	V		P	OD	V	
☑ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☑ Post - Operative Instructions (Wound / Dressing Care)		P	OD	V		P	OD	V		P	OD	V	
Pain Management						P	OD	V		P	OD	V	Nurse
☑ Reporting of pain		P	OD	V									
☑ Pain Management		P	OD	V		P	OD	V		P	OD	V	
Safe and effective use of medical Equipment (if required)						P	OD	V		P	OD	V	Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Angio CD given to pt Attender.
[illegible] Subarhani

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 :

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Dr.ANBARASU MOHANRAJ

MHI/IP/2022/055

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Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☐ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instuctions

Completed By : Date 11/1/24 Time 8:00 Nurse Signature :

Learning Record

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

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : M. CECILIA SUBRAMANIAM Signature : M. Cecilia Subramaniam

Name of Discharge Nurse Hannah Grace Signature : Hannah

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/054

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IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 7/1/24 Time: _____ Transferred from: SICU To: 103

Diagnosis: CAD - TVD

Vital Signs: Temp: 98 (°F) | Pulse / HR: 85 (beats/min) | BP: 121/54 (78) mmHg) | Respiration: 20 (breaths/min)

Part B *(to be filled by Physicians)*

Any Critical Investigations: _____

Check for	Transferring Doctor	Receiving Doctor
Respiratory *(Breath sounds)*	☐ Clear ☐ Crepitation ☐ Rhonchi ☐ Others: _____	☑ Yes ☐ No
Abdomen	☐ Soft ☐ Tender ☐ Distended ☐ Others: _____	☑ Yes ☐ No
Heart Sound	☐ Normal ☐ Feeble ☑ Loud ☐ Others: _____	☑ Yes ☐ No
CNS	☐ Conscious ☐ Oriented GCS Score: _____	☑ Yes ☐ No
For Surgical Patients (if applicable)	Surgical Site: ☐ Healthy ☐ Soakage ☐ Others: _____	☑ Yes ☐ No

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	SYP. SUCRALFATE	10ml	PO	1-1-1	7/1/24 at 7.30	☐ Yes ☐ No
2.	NEB. LEVOSALBUTAMOL	0.63mg	INH	QBH	7/1/24 at 9.30	☐ Yes ☐ No
3.	T. FRUSEMIDE	40mg	PO	1-1-0	7/1/24 at 8.30	☐ Yes ☐ No
4.	T. SPIRONOLACTONE	25mg	PO	1-1-0	7/1/24 at 10.30	☐ Yes ☐ No
5.	T. CLOPILET A	75/75	PO	0-1-0	6/1/24 at 14.00	☐ Yes ☐ No
6.	T. ROSUVAS	40mg	PO	0-0-1	6/1/24 at 21.00	☐ Yes ☐ No
7.	T. PARACETAMOL	650mg	PO	1-1-1	7/1/24 at 9:00	☐ Yes ☐ No
8.	SYP. CREMAFFIN PLUS	15ml	PO	0-0-1	6/1/24 at 21.00	☐ Yes ☐ No
9.	T. GLIMEN D	1/35	PO	0-1-0	6/1/24 at	☐ Yes ☐ No
10.	T. METOPROLOL	25mg	PO	1-0-1	7/1/24 at 8.30	☐ Yes ☐ No
11.	T. PREGABLIN	75mg	PO	1-0-1	7/1/24 at 9.30	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

—

Patient Condition: ☐ Stable ☐ Sick-need urgent care ☐ Others: ______

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	[signature]	DR. PRAVEEN [illegible]	112236	7/1/24	11:35
Receiving Doctor	[signature]	DR. C. SRI [illegible]	184 [illegible]	07/01/24	11:40

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

Check for	Transferring Nurse	Receiving Nurse
Drains	☐ Chest ☐ Abdominal ☐ Others: —	☑ Yes ☐ No
Respiratory	Air Way Type: ☐ Patent ☐ Tracheostomy ☐ Others: ______ Oxygen Therapy: ☑ No ☐ Yes via: Nasal prongs Rate: 02 li/min	☑ Yes ☐ No
NG Tube / Oral	☐ Yes ☑ No ☐ For Feeding ☐ Gastric Suction ☐ Fluid Restriction	☑ Yes ☐ No
Foley's Catheter	☐ Yes ☑ No	☑ Yes ☐ No
Intravenous Access	☑ Peripheral Line ☐ Central Venous Line ☐ Others: ______	☑ Yes ☐ No
Pressure Injury	☐ Yes ☑ No If Yes, give details: ______	☑ Yes ☐ No
Score	Fall Risk: WELLS: NEWS / PEWS:	☑ Yes ☐ No
Patient Belongings	☐ Yes ☑ No If Yes, give details: ______	☑ Yes ☐ No
Handover Details	Medication Administration Record explained: ☑ Yes ☐ No Lab & Diagnostic Reports handed over: ☑ Yes ☐ No	☑ Yes ☐ No
Patient Attendant Informed	☑ Yes ☐ No If No, give details: ______	☑ Yes ☐ No

Additional Details *(if any)*:

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	[signature]	Sathiya Vani. RN	0265	7/1/24	11:3[illegible]
Receiving Nurse	[signature]	Pavithra	0072	7/1/24	11[illegible]

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/ICU/2022/056
Medway Heart Institute
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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				
vailable for Assistance for ivities of Daily Living				
if any				
CARE SERVICES				
g satisfactory				
Adequate				
ble				
ervice				
ify)				

Inter Disciplinary Team Members

ture	Name	Reg. / Emp. No.	Date	Time
[signature]	B. Anushya	134575	04/1/23	
[signature]	K. Sujitha	0201	4/1/23	13.00

MHI/HOSP/2022/110

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60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

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WOUND ASSESSMENT CHART

DATE	9/1/24	6/1/24						
SITE OF WOUND								
CHEST	✓	✓						
LEG L/R	✓	✓						
ABDOMEN								
SACRAL REGION								
HEEL								
OTHERS								
SIZE OF THE WOUND								
SUPERFICIAL / DEEP IN NATURE								
PRESSURE *Specify system used :*								
RISK FACTORS *Specify system used :*	✓DM	HTN	Age	Obesity				
WOUND TISSUE TYPE(S) PRESENT								
necrotic	☐	☐	☐	☐	☐	☐	☐	☐
slough	☑	☑	☐	☐	☐	☐	☐	☐
undermining	☐	☐	☐	☐	☐	☐	☐	☐
granulation	☐	☐	☐	☐	☐	☐	☐	☐
overgranulation	☐	☐	☐	☐	☐	☐	☐	☐
epithelialisation	☐	☐	☐	☐	☐	☐	☐	☐
other	☐	☐	☐	☐	☐	☐	☐	☐
SURROUNDING SKIN TISSUE TYPE(S)								
macerated	☐	☐	☐	☐	☐	☐	☐	☐
erythema	☐	☐	☐	☐	☐	☐	☐	☐
oedematous	☐	☐	☐	☐	☐	☐	☐	☐
cellulitis	☐	☐	☐	☐	☐	☐	☐	☐
blistered	☐	☐	☐	☐	☐	☐	☐	☐
bruising	☐	☐	☐	☐	☐	☐	☐	☐
dry / scaling	☑	☐	☐	☐	☐	☐	☐	☐
healthy	☐	☐	☐	☐	☐	☐	☐	☐

WOUND ASSESSMENT CHART

EXUDATE AMOUNT								
none	☑	☑	☐	☐	☐	☐	☐	☐
evidence of some moisture	☐	☐	☐	☐	☐	☐	☐	☐
evidence of significant flow	☐	☐	☐	☐	☐	☐	☐	☐
EXUDATE								
serous	☐	☐	☐	☐	☐	☐	☐	☐
sero - sanguinous	☐	☐	☐	☐	☐	☐	☐	☐
Purulent	☐	☐	☐	☐	☐	☐	☐	☐
ODOUR								
none	☐	☐	☐	☐	☐	☐	☐	☐
some evidence of odour	☐	☐	☐	☐	☐	☐	☐	☐
significantly malodorous	☐	☐	☐	☐	☐	☐	☐	☐
PAIN AT WOUND SITE (nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)	1	1						
INFECTION SUSPECTED*	☐	☐	☐	☐	☐	☐	☐	☐
SWAB SENT	☐	☐	☐	☐	☐	☐	☐	☐
ANTIBIOTIC THERAPHY	☐	☐	☐	☐	☐	☐	☐	☐
BLOOD GLUCOSE / URINE ANALYSIS	☐	☐	☐	☐	☐	☐	☐	☐
PATIENT / CARER TO DO DRESSING	☑	☑	☐	☐	☐	☐	☐	☐
SIGNATURE								

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

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

***SUSPECT WOUND INFECTION IF :**

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

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Mrs.CECILI... ...ASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ
Consultant

MHI/IP/2022/051

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FAMILY COUNSELLING FORM

CONSULTANT- DR. ANBARASU. | DIAGNOSIS- CAD, TVD

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
05/01/24	K. Sandhya 0502	Mr. Immanuel (HUSBAND)	→ Explained about the condition of the patient. ICU stay.	—	[signature]	[signature] 112256
6/1/24	K.A. Nirmala 0235	Mr. John (son)	→ Explained about patient condition and treatment process. ICU stay today and drain removal.	—	[signature]	[signature] 112256

MHI/CP/2022/193

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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

HOME MEDICATION USAGE FORM

Allergies: NKDA

Diagnosis: CAD-TVD / T2DM / SHTN

Prescribed drug name	Medication name brought by Patient/ Attender	Dose	Freq.	Qty.	Batch No. & Expiry date	Temp.
T. Dytor	T. Dytor	10 mg	1-0-0	19	SN31381 7/25	<25°C
T. Glicaren D	T. Glicaren D	1 tab	0-0-1	11	PKNEQ28 1/25	<25°C
T. Concor	T. Concor	2.5 mg	1-0-1	5	M07AL2322 9/25	<25°C
T. Flavedon MR	T. Flavedon MR	35 mg	1-0-1	6	VS052301 4/26	<25°C
T. Atorva	T. Atorva	40 mg	0-0-1	9	I 302361 3/26	<25°C
T. Eptus	T. Eptus	25 mg	0-1-0	20	18220923 11/25	<25°C
T. Amaryl	T. Amaryl	1-0-1	500/2mg	18	3NG410 6/25	<25°C

	Signature	Name	Emp. No.	Date & Time
Doctor	[signature]	Dr. Anusuya	134559	4/1/24
Clinical Pharmacist	[signature]	Dr. V. Padmapriya	0224	4/1/24 17.00

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

	Signature/ Thumb impression	Name	Date	Time
Patient	H. cecilia subashini	cecilia subashini	4/1/24	17.00
Guardian		(Name and Relationship with the Patient)		

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff		Stal mongha	4/1/24	17:00

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

PATIENT NAME :

AGE / SEX :

IP No. / UHID No

Ward / Bed No. SICU-(4)

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
06/01/2024	15:00	RIGHT CUBITAL	0/5	Dr LINES PATENT	FLUSHED TNS	OBSERVATION DONE	0002
	19:00	RIGHT CUBITAL	0/5	PATENT	FLUSHED	DONE	0006
	19:00	LEFT CUBITAL	0/5	PATENT	FLUSHED	DONE	0006
06/01/2024	8:00 am	(RT) Cubital (LT) Cubital	0/5	Patent Rt cubital removed @ 11:30am	Flushed	on observation.	0007
	12:30	RT CUBITAL	0/5	IV LINE PATENT	FLUSHED	OBSERVATION	0025
	20.00	Rt Cubital	0/5	IV line patent	Flushed	No signs of phleb	0025
7/1/24	8:00	(R) CUBITAL	0/5	PATENT & HEALTHY	FLUSHED NS 0.9%	ON OBSERVATION	0016
	14.00	Rt cubital	0/5	Patent	flushed	No signs of phlebitis	0016
	20.00	Rt cubital	0/5	patent	flushed	—	0016
8/1/24	8:00	Rt cubital	0/5	patent	flushed	—	0016
	14.00	Rt cubital	0/5	Patent	flushed	—	0016
	20.00	Rt cubital	0/5	Patent	Flushed	—	0016
9/1/24	8.00	(RT) Cubital	0/5	patent	Flushed	—	0016
	20:00	(R) Cubital	0/5	Patient	flushed	Followed	0026
		—		IV line Removed	—		

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/PHARM/2022/028

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NABH ACCREDITED

Medway Heart Institute
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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1 Height (cms): 152 cm Weight (kg): 65 kg

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

Drug Details	Description of Allergy	Doctor's Sign:
NKDA	—	Name: Dr. Mohamed Hydroos Reg. No. 165???

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

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor Sign.	Doctor Reg. No.	Administered Sign.	Administered Emp. No.	Administered Time
4/1/24	21.00	T. PAN	40 mg	P/O	[signature]	134559	[signature]	0195	21.00
4/1/24	21.00	T. Alprax	0.25	P/O	[signature]	134559	[signature]	0195	21.00
05/1/24	6.00	T. PAN	40mg	P/O	[signature]	134559	[signature]	0605	6.00

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date → / Time ↓ — To be filled by Nursing Staff only. Sign and time given

Dates: 4/1/24, 5/1/24

Drug	Dose	Route	Frequency	Dr. Sign & Reg. No. / Seal	Start Date & Time	Stop Date & Time	Additional Info	Time	Administration
T. DYTOR	10mg	P/o	1-0-0	165307	4/1/24 @ 14:00			8.00	→ NPO
T. EPTUS	25mg	P/o	0-1-0	165307	4/1/24 @ 14:00			14.00	14:40
T. ATORVA	40mg	P/o	0-0-1	(165307)	4/1/24 @ 14:00			20.00	20.40
T. FLAVEDON MR	35mg	P/o	1-0-1	165307	4/1/24 @ 14:00			8.00 / 20.00	→ NPO / 20.40
T. GLIAREN D	1tab	P/o	0-0-1	(165307)	4/1/24 @ 14:00			20.00	20:40

Area In-charge Nurse Signature:

Clinical Pharmacist, Medway Heart Institute

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given						
Time ↓	4/1/24	5/1/24					

DRUG NAME
T-PULMOCLEAR

Dose	Route	Frequency
1 TAB	P/O	1-0-1

Dr. Sign & Reg. No. / Seal
LC M (134579)

Start Date & Time: 04/1/24
Stop Date & Time:

Additional Info:

8:00 — Npo

20:00 — 20:30 Hay

DRUG NAME
SYP · CREMAFFIN 1

Dose	Route	Frequency
15ML	P/O	0-0-1

Dr. Sign & Reg. No. / Seal
LC M (134579)

Start Date & Time: 04/1/24
Stop Date & Time:

Additional Info:

20:00 — 21:00 Hay

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:

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
05/1/26	5-15	2.5% DEXTROSE			I								

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
4/1/24	21:00	Lowsalt, Low Fat		134554					
5/1/24	8:00	NPO		134554					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
4/1/24	Evening	R. Sushma	0291	R.		Evening			
4/1/24	Night	B. Vanishi	0195			Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

MHI/PHARM/2022/028

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SAFETY FIRST

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug Chart: 2 of 1 Height (cms): 162 Weight (kg): 65 kg

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

Drug Details	Description of Allergy	Doctor's Sign: / Name: / Reg. No.
	NKDA	Sign: DR PRAVEEN Name: JEYAKUMAR Reg. No. 112236

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

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
5/1/24	16:30	INJ. MYDOPYROLOS	2.6ml	IV	✓	112236	✓	0002	16:30
5/1/24	21:00	T. ECOSPRIN	75 mg	PO.	✓	112236	MW	0276	21:00
6-1-24	09-15	INJ-PANTOMIDE	10mg	IV	✓	112236	✓	0232	09.15

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

DRUG NAME

INJ. PARACETAMOL

Dose	Route	Frequency
1gm	IV	Q 8th hourly

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 05/01/2024 @ 17:00
Stop Date & Time: 6/1/24 at 10.00

Additional Info:

Clinical Pharmacist, Medway Heart Institute

DRUG NAME

SYP. SUCRALFATE SUSPENSION

Dose	Route	Frequency
10ml	P/O	1-1-1

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 5/1/24 AT 20:00.
Stop Date & Time:

Additional Info:

Clinical Pharmacist, Medway Heart Institute

DRUG NAME

NEB. LEVOSALBUTAMOL

Dose	Route	Frequency
0.63mg	INH	Q 6th hourly

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 5/1/2024 @ 16:00
Stop Date & Time:

Additional Info:

Clinical Pharmacist, Medway Heart Institute

DRUG NAME

TAB. FRUSEMIDE

Dose	Route	Frequency
40mg	P/O	1-1-0

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 6/1/24 at 6
Stop Date & Time:

Additional Info:

Medway Heart Institute

DRUG NAME

TAB. SPIRONOLACTONE

Dose	Route	Frequency
25mg	P/O	1-1-0

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 6/1/24 at 10.00.
Stop Date & Time:

Additional Info:

Clinical Pharmacist, Medway Heart Institute

Area In-charge Nurse Signature:

Date →	To be filled by Nursing Staff only. Sign and time given						
Time ↓	5/1/24	6/1/24	7/1/24	8/1/24	9/1/24	10/1/24	11/1/24
1:00		9:00 MS					
9:00		09:00					
17:00	17:00						
07:30		7.30	7.30	7:30	7:30	7:30	7:30
13:20.		13:30	13:00	13:00	13:00	13:00	13:00
19.30	19:30	20:00	19:30	19:30	19:00		
4:00		04:00	4:40	5:00	6:00	6:00	6:30
10:00		10:00	9:00	10	10.20	10:00	10:15
16:00	16:00	16:00	16:00	16:00	16:20		
22:00	22:00	22:00	22:00	22:00	22:00	22:00	
08:00		08:00 W.H	9:00	9:15	9.30	9:00	9:00
16:00.		W.H	16:00	16:00			
10:00		10:00	10:30	10	10.30	10:00	10:10
17:00		17:00	17:00	17:00			

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given							
Time ↓	6/1/24	7/1/24	8/1/24	9/1/24	10/1/24	11/1/24		

DRUG NAME: TAB. BEPLEX FORTE

Dose	Route	Frequency
1 tab	p/o	1-0-0

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR, Reg. No:112236

Start Date & Time: 6/1/24 at 8.30

Stop Date & Time: 6/1/24 at 9.00.

Additional Info:

Time								
08:00	8.30							

DRUG NAME: TAB. CLOPIDOGREL + ASPIRIN

Dose	Route	Frequency
75/75mg	p/o	0-1-0

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR, Reg. No:112236

Start Date & Time: 6/1/24 at 14:00

Stop Date & Time:

Additional Info:

Time								
14:00	14:00	14:00	14:00	14:00	14:00			

DRUG NAME: TAB. ROSUVASTATIN

Dose	Route	Frequency
40mg	p/o	0-0-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR, Reg. No:112236

Start Date & Time: 6/1/24 at 21.00

Stop Date & Time:

Additional Info:

Time								
21:00	21:00	21:00	21:00	21:00				

DRUG NAME: TAB. PARACETAMOL

Dose	Route	Frequency
650mg	p/o	1-1-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR, Reg. No:112236

Start Date & Time: 6/1/24 at 14:00

Stop Date & Time:

Additional Info:

Time								
08:00	8.00	8.15	9.30	9.00	9.00			
14:00	14:00			14:00	14:00			
22:00	20:30	20:00	22:00	22:00				

DRUG NAME: SYP. BREMAFFIN PLUS

Dose	Route	Frequency
15mL	p/o	0-0-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR, Reg. No:112236

Start Date & Time: 6/1/24 at 21.00

Stop Date & Time:

Additional Info:

Time								
21:00	21:00	21:00	21:00	21:00				

Area In-charge Nurse Signature:

		NS 24	NS 24					

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date → | To be filled by Nursing Staff only. Sign and time given
Time ↓ | 6/1/2024 | 7/1/24 | 8/1/24 | 9/1/24 | 10/1/24 | 11/1/24

DRUG NAME
T. CLIAREN D

Dose	Route	Frequency
1 Tab	PO	0-1-0

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 6/1/24 14.00
Stop Date & Time:

Additional Info:

14.00 | 20.00

DRUG NAME
T. METOPROLOL (BETALOC)

Dose	Route	Frequency
25mg	PO	1-0-1

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 6/1/24 8.30
Stop Date & Time:

Additional Info:

8.00 | 8.30 | 9.00 | 9.30 | 9.30 | 9.00 | 9.00
20.00 | 20.30 | 20.00 | 20.00 | 20.00

DRUG NAME
T. PREGALIN

Dose	Route	Frequency
75mg	PO	1-0-1

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 6/1/24 21.00
Stop Date & Time:

Additional Info:

9.00 | 21.00 | 21.00 | 21.00 | 21.00 | 21.00

DRUG NAME
T. LIVOCEN

Dose	Route	Frequency
10mg	PO	1-0-0

Dr. Sign & Reg. No. / Seal

Start Date & Time: 2/1/24 @10.00
Stop Date & Time:

Additional Info:

8.00 | 9.00 | 9.00 | 14.30

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time:
Stop Date & Time:

Additional Info:

Area In-charge Nurse Signature:

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

ANTIMICROBIALS

To be filled in by Doctors only

Date → / Time ↓	To be filled by Nursing Staff only. Sign and time given							
	6/1/24	6/1/24						
6:05	D1	05:00 Mcc24 0276	Stop					
17:05	17:05	17:20 NC24 0286						

DRUG NAME
INJ. CEFUROXIME SODIUM

Dose	Route	Frequency
1.5gm	IV	Q12th hrly

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time 5/1/24 AT 09:00
Stop Date & Time 6/1/24 at 18:00

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal
Start Date & Time
Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal
Start Date & Time
Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal
Start Date & Time
Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal
Start Date & Time
Stop Date & Time

Additional Info:

Area In-charge Nurse Signature: 2005 | 2005

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
5/1/24	14:00	KABILYTE	500ML	100ML/HR	IV	—	—		[illegible]	112236	14:00	20:00	[illegible]
5/1/24	20:00	KABILYTE	500 mL	100mL 1HR	IV	—	—	—	[illegible]	112236	20:00	6/1/24 03:00	[illegible]
6/1/24	04:00	KABILYTE	500 mL	100mL HR.	IV	—	—	—	[illegible]	112236	04:00	07:00	[illegible]
6/1/24	22:00	NS CO.9%)	500 mL	100mL 1HR	IV	—	—	—	[illegible]	112236	22:00	04:00	[illegible]
6/1/24	00:00	KABILYTE	500ML	100ML/hr	IV	—	—	—	[illegible]	112236	00:00	5:00	[illegible]

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
06/01/24	13:15	NS 0.9%	50ml	2.4ml/Hr	IV	INJ. NOR-ADRENALINE	4mg	—	✓	112236	13:15	6-1-24 10:00	✓
06/01/24	13:15	NS 0.9%	40ml	4.0ml/Hr	IV	INJ. HUMAN ACTRAPID	40IU	—	✓	112236	13:15	17:00	✓
05/01/24	18:00	NS 0.9%	20ml	1.2ml/Hr	IV	INJ. FENTANYL	600mcg	—	✓	112236	18:00	07:00	✓
08/01/24	12:00	NS 0.9%	50mL	4 ml/hr	IV	INJ. DYTOR	40mg	—	✓	112236	12:00	17:30	✓

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
5/1/24	14:00	NPO	S	112236					
6.1.24	10.00	Liquid diet	S	112236					
7/1/24	8:00	SOLID DIET	S	112236					
8/1/24	9:0	Soft Solid diet	K.Bo	134559					
9/1/24	9:00	Normal diet		165307					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning				9/1/24	Morning	B. Vanisri	0195	
5/1/24	Evening	SOUNDARYAM. K	0022		9/1/24	Evening	Hennah.	0105	
5/1/24	Night	MEENA SELVAM	0276	Meena 0276	9/1	Night	Jeni priya.	0284	
6.1.24	Morning	Suryalakshmi. S.P	0236		10/1/24	Morning	M. Devika	0187	
6/1/24	Evening	K. Nirmala	0285		10/1	Evening	R.N Bhuvaneshwari	0271	
6/1/24	Night	Sonia Florance. S	0054		10/1/24	Night	Jeni priya.	0284	
7/1/24	Morning	Sathiya Vani. M	0265		11/1/24	Morning	Parameswari	2333	
7/1/24	Evening	R. Sushma	0201			Evening			
7/1/24	Night	Jayanthi	0161			Night			
8/1/24	Morning	M. Devika	0187			Morning			
8/1/24	Evening	A. Nanthini	0176			Evening			
8/1/24	Night	Jeni priya.	0284			Night			

OPCAB × 4 GRAFTS
LIMA → LAD (TBNSWE ENDARTERECTOMY)
SVG → OM
SVG → RAMUS INTERMEDIUS
SVG → DISTAL RCA

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MHI/ICU/2022/076

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Name			Sheet No.
UHID No.	Age	Sex	
Blood Group: B+ve	Height: 152 cm	Weight: 66 kg	BSA: 1.6 m²	A

SURGICAL PROCEDURE: DATE OF SURGERY: 05/01/2024 POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
5/1/24	22:00		Nasal cannula!								4lt/min	23:00	7.38	41.6	212.2	23.9	99.4	-0.8
	02:00		Nasal cannula								4lt/min.							
	03:00		Nasal cannula								2lt/min.							
	05:00		Room Air.									Room Air						
												am 6:50	7.41	35.5	57.0	22.5	90.2%	-2.2

CRITICAL CARE FLOWCHART

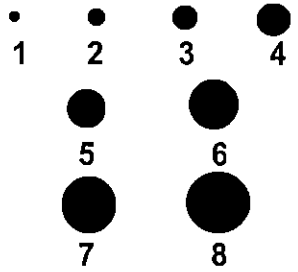
NEURO

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

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

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

MOTOR ARMS/LEGS
S-Strong
Wk-Weak
O-Absent
A-Anasthesia
CP-Chemical paralysis

PUPILS SCALE (mm)


PUPILS REACTION
Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL
Br-Brisk
Sl-Sluggish
O-Absent

EDEMA
D-Dependent
G-Generalised
O-Absent

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

NECK VEINS
JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER
Valve Replaced / Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING
Ab-Abdominal
TA-Thoraco-abdomial
L-Laboured

SUCTION
ET-Endotracheal
N-Nasal
Or-Oral

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

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

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

GASTROINTESTINAL

BOWEL SOUNDS
+Present
O-Absent

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

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

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

LIVERSIZE
N-Normal
E-Enlarged

MHI/ICU/2022/076

Sheet No.	Name	Mrs.CECILIA SUBASHINI.H 60/Female/MHI202381349 04/01/2024/IPH2024000033 Dr.ANBARASU MOHANRAJ		
	UHID No.		Age	Sex
B	Blood Group B+ve	Height 152 Cm	Weight 66 kg	BSA 1.6m2

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CRITICAL CARE FLOWCHART

DATE	TIME	BIOCHEMISTRY							VITAL PARAMETERS							CARDIAC ASSIST DEVICE			
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	TIME	IABP RATIO	IABP DURATION	PACEMAKER SETTING RATE	PACEMAKER SETTING MODE
5/1/24	23:00	11.0	132	5.69	0.59 / 29.		23.00		BL CL	100%.	20/mt		97.9F						
							0.00		CL	100%.	24/mt								
					191		01.00		CL	100%.	18/mt								
							02:00		CL	100%	20/mt								
							03.00		CL	100%.	18/mt		98.2F						
					132.		4.00		CL	100%.	18/mt								
							5.00		CL	100%.	18/mt								
6/1/24	6:00 am	8.9	132	4.69.	0.94		6.04		CL	100%.	16/mt		97.6F						

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME					23:00	08:00
	EYES					4	4
	VERBAL					5	5
	MOTOR					6	6
	ARMS R/L					St	St
	LEGS R/L					St	St
PUPILS	R.SIZE/REACTIION					3/BR	3/BR
	L.SIZE/REACTION					3/BR	3/BR
CARDIO-VASCULAR	HEART SOUNDS					S1S2	S1S2
	VALVE CLICK					-	-
	CAPILLARY REFILL					+	+
	EDEMA					-	-
	NECK VEINS					(N)	(N)
PULMONARY	WORK OF BREATHING					TA	TA
	SUCTION					-	-
	SECREATIONS					-	-
GASTRO INTESTINAL	BOWEL SOUNDS					+	+
	ABDOMINAL TONE					SOFT	SOFT
	N/G POSITION					-	-
	GASTRIC RESIDUAL					-	-
	LIVER					(N)	(N)

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE					CL	CL
	PD - FUNCTION					-	-
	DRAINAGE					-	-
	PD - SITE					-	-
SKN	COLOUR					-	-
	Sx WOUND-CHEST					CL	CL
	LEG					CL	CL
	DRESSING					-	-
	PRESSURE SORE-SITE					-	-
	AREA					-	-
	DRESSING CONDITION					-	-
MISCELL	POSITION CHANGE					Q2H	Q2H
	CHEST-PHYSIO					INEB/SPIRO	INEB/SPIRO
	ACTIVITY					PE	PE
	S/N NAME					S.mou	S.mou
	TIME					22:00	04:00
	SIGNATURE					mou	mou

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Medway Heart Institute
Every heart beat counts

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

MHI/ICU/2022/076

Nam			Sheet No.
UHII		Age	Sex
Blood Group B+ve	Height 152 Cm	Weight 66kg	BSA 1.6m2	C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		NS/RL	TOTAL	NORAD 4/50	H.ADR 40/40	FENTA 500/20	
31/1/24	23.00	110	1080		10			10	260				5.0	1345	100	1180	0.80	6.0	1.20	
61/1/24	00:00	90	1170		20			20	280				5.0	1455	100 NS 0.9%	1280	0.8	6.0	1.2	
	01:00	120	1290		10			10	290				5.0	1585	100	1380	0.8	6.0	1.2	
	2.00	70	1360		10			10	300				5.0	1665	100	1480	0.8	2.0	1.2	
	3.00	70	1430					1	300				5.0	1735	100	1580	0.8	2.0	1.2	
	4.00	75	1505						300				5.0	1810	100	1680	0.8	2.0	1.2	
	5.00	70	1575						300				5.0	1880	100 Kabilyle	1780	0.8	1.0	1.2	
	6.00	120	1695		20				320				5.0	2020	200	1980	1.5	—	1.2	
	7.00	110	1805		20				340				5.0	2150	200	2180	2.0		1.2	
																			—	

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

C-Clean
R-Redness
BD-Block discoloration

DRAINAGE

CL-Clear
BS-Blood

MISCELLANEOUS

OISITION CHANGE

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

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

TRANSDUCER ZERO

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

SKIN

COLOUR

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

SURGICAL (SX) WOUND

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

DRESSING

B-Betadine
Al-Antibiotic
Irrigation

PRESSURE SORE

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

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

DRESSING / Rx

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

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

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

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Name				Sheet No.
UHID No.			Sex	
Blood Group	B +ve	Height: 152 Cm	Weight: 66 kg	BSA: 1.6m2 — D

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MHI/ICU/2022/076

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Every heart beat counts

FLUID ASSESSMENT (contd.) **HAEMODYNAMICS** **Blood Group:** B+ve

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
						Milk		AMT.	TOTAL														
	23.00					2.0	10	100	400	1614.3	269.3	94	Sinus	0.00	150/75	(102)	10		WNL	+/-			
6/1/24	00.00					2.0	10	50	450	1674.3	279.3	98	Sinus	0.00	124/78	(100)	7		WNL	+/-			
	01.00					2.0	10	50	500	1834.3	+249.3	96	Sinus	0.01	106/59	(82)	7		WNL	+/-			
	2.00					2.0	6.0	50	550	1990.3	+325.3	86	Sinus	0.01	122/76	(78)	9		WNL	+/-			
	3.00					2.0	6.0	50	600	2146.3	+411.3	77	Sinus	0.00	121/54	(74)	6		WNL	+/-			
	4.00					2.0	6.0	50	600	2252.3	+442.3	76	Sinus	0.00	120/50	(82)	5		WNL	+/-			
	5.00					2.0	5.0	50	650	2407.3	+527.3	76	Sinus	0.00	110/56	(60)	5		WNL	+/-			
	6.00					2.0	4.7	100	750	2712	692	86	Sinus	0.01	104/48	(65)	6		WNL	+/-			
	7.00					2.0	5.2	100	850	3017.2	+861.2	90	Sinus	0.02	106/44	(65)	6		WNL	+/-			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY ..... **HRS**

DRAINAGE:

URINE :

TOTAL INTAKE:

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			✓
ORAL CARE			✓
EYE CARE			✓
BACK CARE			✓
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			✓
TUBINGS			✓
HUMIDIFIER H2O			✓
ELECTRODES			✓
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE			90
B.P.			105/48

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
ET TUBE		05/1/2024	1				P
~~NG~~ FJL		5/1/2024	1				P
A LINE		5/1/2024	1				P
PERI LINE		5/1/2024	1				P
PLEURAL	LT.	5/1/2024	1				P
MEDIA.		5/1/2024	1				P
U.CATH.		5/1/2024	1				P
S.TUBING		5/1/24	1				P
TR DOME		5/1/24	1				P

OPLAB x 4 GRAFTS
LIMA → LAD (IN SITU)
SVG → OM
SVG → RAMUS INTERMEDIUS
SVG → DISTAL RCA

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Name	Mrs.CECILIA SUBASHINI.H 60/Female/MHI202381349 04/01/2024/IPH2024000033 Dr.ANBARASU MOHANRAJ
UHID No.	

MHI/ICU/2022/076

Age	Sex	Sheet No.
		1

Blood Group	Height	Weight	BSA
B+ve	152cm	65kg	1.6m²

A

SURGICAL PROCEDURE:

DATE OF SURGERY: 05/01/2024

POST-OP DAY: POD5

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
05/01/24	13:15	VCV	14		26.0	5.0	10.0	6.9	600	496	0.6	13:20	7.503	25.7	221.4	22.5	99.6	3.1
											0.5							
	14:15	SIMV	12.	20.		5.0			600		0.5							
	15:45	SIMV	10	16	27	5.0	8.	5.5	500	541	50%							
	16:45	SIMV	8	12		5.0					0.5							
	16:15	PS/CPAP		10		5.0					0.5	16:35	7.380	31.6	141.0	22.0	98.8	3.4
	16:45		Extubated			O2	NASAL				6 Lit							
	18:00		ON	NASAL			CANNULA				4 Lit	PBU	7.405	38.7	181.5	23.7	99.3	1.1

CRITICAL CARE FLOWCHART

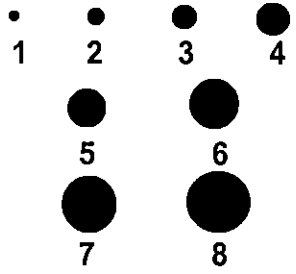
NEURO

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

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

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

MOTOR ARMS/LEGS
S-Strong
Wk-Weak
O-Absent
A-Anasthesia
CP-Chemical paralysis

PUPILS SCALE (mm)


PUPILS REACTION
Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL
Br-Brisk
Sl-Sluggish
O-Absent

EDEMA
D-Dependent
G-Generalised
O-Absent

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

NECK VEINS
JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER
Valve Replaced / Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING
Ab-Abdominal
TA-Thoraco-abdomial
L-Laboured

SUCTION
ET-Endotracheal
N-Nasal
Or-Oral

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

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

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

GASTROINTESTINAL

BOWEL SOUNDS
+Present
O-Absent

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

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

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

LIVERSIZE
N-Normal
E-Enlarged

MHI/ICU/2022/076

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Every heart beat counts

Sheet No.	Name	Mrs.CECILIA SUBASHINI 60/Female/MHI202381349 04/01/2024/IPH2024000033 Dr.ANBARASU MOHANRAJ		
1	UHID No.		Age	Sex
B	Blood Group: B+ve	Height: 152cm	Weight: 66kg	BSA: 1.6m²

CRITICAL CARE FLOWCHART

DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS									CARDIAC ASSIST DEVICE			
																IABP		PACEMAKER SETTING	
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	TIME	RATIO	DURATION	RATE	MODE
05/11/22	12:20	8.7	135	4.75	1.06 / 240		13:15		Cl	100%	VCV 14		92.9°F						
							14:00		Cl	100%	14								
							16:00		Cl	100%	VCV								
							16:00		Cl	100%	VCV		91.6°F						
							17:00		Cl	100%	VCV								
	16:35	11.0	138	4.60	0.98 / 196		18:00		Cl	100%	26/min		98.3°F						
							19:00		Cl	100%	13/min								
	18:00	10.2	135	4.66	1.04 /		20:00		Cl	100%	23/min		97.9°F						
							21:00		Cl	100%	26/min								
							22:00		Cl	100%	26/min								

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME			13:15		19:15	
	EYES			4		4	
	VERBAL			5		5	
	MOTOR			6		6	
	ARMS R/L			6		6	
	LEGS R/L			6		6	
PUPILS	R.SIZE/REACTIION			3		3 BR	
	L.SIZE/REACTION			3		3 BR	
CARDIO-VASCULAR	HEART SOUNDS			S1S2		S1S2	
	VALVE CLICK			—		—	
	CAPILLARY REFILL			<2		—	
	EDEMA			0		0	
	NECK VEINS			N		N	
PULMONARY	WORK OF BREATHING			TA		TA	
	SUCTION			—		—	
	SECREATIONS			—		—	
GASTRO INTESTINAL	BOWEL SOUNDS			+		+	
	ABDOMINAL TONE			SOFT		SOFT	
	N/G POSITION			NSNW		—	
	GASTRIC RESIDUAL			0		0	
	LIVER			N		N	

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE			CL		CL	
	PD - FUNCTION			—		—	
	DRAINAGE			—		—	
	PD - SITE			—		—	
SKN	COLOUR			—		—	
	Sx WOUND-CHEST			CL		CL	
	LEG			CL		CL	
	DRESSING			DT		—	
	PRESSURE SORE-SITE			NIL		—	
	AREA			—		—	
	DRESSING CONDITION			—		—	
MISCELL	POSITION CHANGE			Q2H		Q2H	
	CHEST-PHYSIO			NEB/SUCT		NEB/SPIRO.	
	ACTIVITY			PB		PE	
				ART/CVP		ART/CVP.	
	S/N NAME			[illegible]		MARY	
	TIME			13:15		19:15	
	SIGNATURE			[illegible]		MARY ORR.	

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Name	Mrs.CECILIA SUBASHINI.H 60/Female/MHI202381349 04/01/2024/IPH2024000033 Dr.ANBARASU MOHANRAJ		Sheet No. 1
UHID No		Age / Sex	
Blood Group: B+ve	Height: 152cm	Weight: 65kg	BSA: 1.6m²

C

CRITICAL CARE FLOWCHART

DATE	TIME	URINE AMT	URINE TOTAL	CHEST DRAINAGE RT.PL.	CHEST DRAINAGE LT.PL.	CHEST DRAINAGE MED	CHEST DRAINAGE PERIC	CHEST DRAINAGE HR.T	CHEST DRAINAGE G.T.	GASTRIC AMT.	GASTRIC TOTAL	LAB SAMPLE AMT.	LAB SAMPLE TOTAL	TOTAL OUTPUT	VOLUME INTAKE	VOLUME TOTAL	INFUSIONS NORAD 4/50	INFUSIONS ACTRA 40/40		
06/01/24	13:15																2.4	1.0		
	14:00	260	260									3.0	3.0	263	100	100	2.4	4.0		
	15:00	100	360		60			60	60				3.0	403	100	200	2.8	4.0		
	16:00	100	460		60			50	100				3.0	663	100	300	3.0	4.0		
	17:00	100	660		50			50	160			1.0	4.0	704	100	480	3.0	—		
	18:00	75	625		60			60	200				4.0	829	200	680	2.0		FENTA 600/20	
	19:00	75	700						200			1.0	5.0	905	100	780	2.0		30ml 1.2	
	20:00	70	770		30			30	230				5.0	1005	100	880	1.8		1.2	
	21:00	100	870		10			10	240				5.0	1115	100	980	1.5		1.2	
	22:00	100	970		10			10	250				5.0	1225	100	1080	0.8		1.2	

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

ACT:- 141 sec @ 13:30

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

C-Clean
R-Redness
BD-Block discoloration

DRAINAGE

CL-Clear
BS-Blood

MISCELLANEOUS

OISITION CHANGE

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

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

TRANSDUCER ZERO

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

SKIN

COLOUR

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

SURGICAL (SX) WOUND

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

DRESSING

B-Betadine
Al-Antibiotic
Irrigation

PRESSURE SORE

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

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

DRESSING / Rx

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

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

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

PATIENT NOT AWAKE AND MOVE ALL THE FOUR LIMBS @ 14:00

Name	Mrs.CECILIA SUBASHINI.H 60/Female/MHI202381349 04/01/2024/IPH2024000033 Dr.ANBARASU MOHANRAJ			Sheet No.
UHID No.			Sex	1
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CRITICAL CARE FLOWCHART

FLUID ASSESSMENT (contd.) **HAEMODYNAMICS** **Blood Group:**

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						Misc		AMT.	TOTAL														
5/1/24	13:15											74	Sinus	0.03	105/58	74	12	—	Cool	+/+			
	14:00					2.0	8.4			108.4	-144.6	87	Sinus	0.00	145/72	97	11		Cool	+/+			
	15:00					2.0	9.0			217.4	-186.6	78	Sinus	0.01	124/66	85	7		Warm	+/+			
	16:00					2.0	9.0			326.4	-326.6	90	Sinus	0.01	178/78	112	7		Warm	++			
	17:00					2.0	5.0			481.4	-222.6	85	Sinus	0.02	127/61	81	6		Warm	++			
	18:00					2.0	4.0	Sips of water		686.4	-143.6	90	Sinus	0.02	136/62	84	6		Warm	++			
	19:00					2.0	6.2	60	60	840.6	-64.4	93	Sinus	0.01	151/66	97	7		Warm	++			
	20:00					2.0	5.0	50	100	995.6	-9.4	90	Sinus	0.01	150/72	107	5		Warm	++			
	21:00					2.0	4.7	50	150	1150.3	+35.3	101	Sinus Tach	-0.00	136/63	(87)	5		Warm	++			
	22:00					2.0	4.0	150	300	1404.3	+179.3	94	Sinus	0.00	150/74	(100)	10		Warm	++			

STAT DRUGS TIME | 16:30 INJ. MYOPYROLATE 2.5ml HALF REVERSAL IV STAT GIVEN (Dr. [illegible])

PREVIOUS DAY .... **HRS**

DRAINAGE:

URINE :

TOTAL INTAKE:

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE		89	86
B.P.		160/70	166/74

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
FIXED AT 7.5 ET-TUBE	20cm	05/01/2024	1			P	—
NU TUBE	Rt NS	05/01/2024	1			P	—
IJC	Rt IJV	05/01/2024	1			P	P
ART-LINE	Lt RAD	05/01/2024	1			P	P
PERI-LINE	Rt	05/01/2024	1			P	P
IV EXTN		05/01/2024	1			P	P
MEDIA		05/01/2024	1			P	P
PLANDAL	Lt	05/01/2024	1			P	P
U-CATH		05/01/2024	1			P	P
S-TUBING		05/01/2024	1			P	P
V-TUBING		05/01/2024	1			P	—
O2-TUBING		05/01/2024	1			P	P
TR-DOME		05/01/2024	1			P	—
MARW VENT		05/01/2024	1			P	—

OPCAB x 4 GRAFTS
LIMA → LAD (EXTENSIVE ENDARTERECTOMY)
SVG → OM
SVG → RAMUS INTERMEDIUS
SVG → DISTAL RCA

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SURGICAL PROCEDURE: DATE OF SURGERY: 05/01/2024 POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
6-1-24	08.00	on nasal prongs									2L							

CRITICAL CARE FLOWCHART

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

VERBAL
Oriented-5
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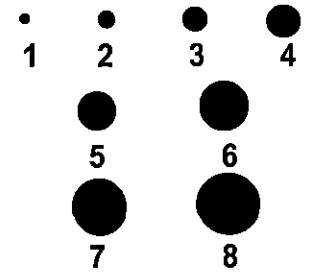

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DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS									CARDIAC ASSIST DEVICE			
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	TIME	IABP RATIO	IABP DURATION	PACEMAKER SETTING RATE	PACEMAKER SETTING MODE
	08:00						08:00		cl	100%	16/mt	132/62 (90)	98.4°F						
							09:00		cl	100%	16/mt	124/54 (80)							
							10:00		cl	98%	14/mt	126/68 (90)							
							11:00		cl	96%	12/mt	130/60 (70)							
							12:00		cl	95%	12/mt	126/66 (85)							
							13:00		cl	100%	24/mt	127/57 (80)							
							14:00		cl	100%	26/mt	128/56 (89)							
							15:00		cl	100%	24/mt	138/67 (91)							
							16:00		clear	100%	18 b/m	-							
							17:00		cl	100%	26/mt	155/88 (97)							

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME						
	EYES						
	VERBAL						
	MOTOR						
	ARMS R/L						
	LEGS R/L						
PUPILS	R.SIZE/REACTIION						
	L.SIZE/REACTION						
CARDIO-VASCULAR	HEART SOUNDS						
	VALVE CLICK						
	CAPILLARY REFILL						
	EDEMA						
	NECK VEINS						
PULMONARY	WORK OF BREATHING						
	SUCTION						
	SECREATIONS						
GASTRO INTESTINAL	BOWEL SOUNDS						
	ABDOMINAL TONE						
	N/G POSITION						
	GASTRIC RESIDUAL						
	LIVER						

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE						
	PD - FUNCTION						
	DRAINAGE						
	PD - SITE						
SKN	COLOUR						
	Sx WOUND-CHEST						
	LEG						
	DRESSING						
	PRESSURE SORE-SITE						
	AREA						
	DRESSING CONDITION						
MISCELL	POSITION CHANGE						
	CHEST-PHYSIO						
	ACTIVITY						
	S/N NAME						
	TIME						
	SIGNATURE						

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Medway Heart Institute
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Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033

MHI/ICU/2022/076

Name	Dr.ANBARASU MOHANRAJ			Sheet No.
UHID No.		Age	Sex	
Blood Group B+ve	Height 152 Cm	Weight 66 kg	BSA 1.6 m²	C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOTAL	NORAD 4/50			
6.1.24	08:00	60	60											60	0		1.5			
	09:00	70	130			60		60	60					190	—		1.0			
06/01/24	10:00	100	230					—	60					290			0.5			
	11:00	75	305						60					365			—			
	12:00	50	355						60					415				DUPTOR		
	13:00	180	535			20		20	80					615				4.0		
	14:00	200	735			—		—	—					815				4.0		
	15:00	250	985											1065				4.0		
	16:00	250	1235											1315				2.0		
	17:00	200	1435											1515				1.0		

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME	
		13:30. MEDIASTINAL + 2T PLEURAL DRAIN REMOVED BY KARTHIKA O/B DR. ANBARASU
		11:30 ARTERIAL LINE REMOVED O/B DR. ANBARASU.

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

C-Clean
R-Redness
BD-Block discoloration

DRAINAGE

CL-Clear
BS-Blood

MISCELLANEOUS

OISITION CHANGE

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

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

TRANSDUCER ZERO

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

SKIN

COLOUR

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

SURGICAL (SX) WOUND

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

DRESSING

B-Betadine
Al-Antibiotic
Irrigation

PRESSURE SORE

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

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

DRESSING / Rx

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

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

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

Mrs.CECILIA SUBASHINI.H
60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

Name				Sheet No.
UHID No.			Sex	
Blood Group	B +ve	Height: 152 Cm	Weight: 66 kg	BSA: 1.6 m²

D

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MHI/ICU/2022/076

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FLUID ASSESSMENT (contd.) **HAEMODYNAMICS** **Blood Group:**

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
						Nusc		AMT.	TOTAL														
	08:00					2.0	2.5			2.5	-56.5	84	Sinus	0.02	110/49	70	10		warm	F/F			
	09:00					2.0	3.0	200	200	206.5	18.5	82	Sinus	0.02	124/5	78	11		warm	F/F			
	10:00					2.0	2.5	100	300	309	19	86	SINUS	0.02	124/60	76	5		Warm	F/F			
	11:00					—	—		300	309	-56	80	Sinus	0.04	—				Warm	F/F			
	12:00							200	500	509	-94	76	Sinus	0.03	—				Warm	F/F			
	13:00						4.0		500	513	-102	72	Sinus	0.03					warm	F/F			
	14:00						4.0	100	600	617	-198	72	Sinus	0.02					warm	F/F			
	15:00						4.0	100	700	721	-344	78	Sinus	0.03					warm	F/F			
	16:00						2.0	50	750	773	-542	74	SINUS	0.02					Warm	F/F			
	17:00						1.0	100	850	874	-641	80	Sinus	0.05					warm	F/F			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY 12HRS 45mHRS

DRAINAGE: 340ml TOTAL INTAKE: 3017.2ml

URINE : 1805ml TOTAL OUTPUT: 2150ml

TOTAL BALANCE: + 861.2ml

P.T.O.

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

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
IJ LINE	RT IJ	5/1/24					
ART LINE	RT RAD	5/1/24					
PERI LINE	RT WD	5/1/24					
IV EXTN		5/1/24					
MEDIA		5/1/24					
PLEURAL	LT	5/1/24					
U-CATH		5/1/24					
S-PUBIC		5/1/24					
TR-DOME		5/1/24					

S → OPCAB × 4 GRAFTS
LIMA → LAD
SVG → OM
SVG → RAMUS INTERMEDIUS
SVG → DISTAL RCA

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MHI/ICU/2022/064

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04/01/2024/IPH2024000033

RMEDIATE CARE FLOWCHART

A

NAME : Dr.ANBARASU MOHANRAJ **UHID NO :** **AGE :** **SEX :**

POS
5/1/24

SURGICAL PROCEDURE :

POSTOP DAY : II POD **FLUID REQUIREMENT :** 2 × 2 lit / day

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
7/1/24 8:00												50	50	50	+ 50
9.00												100	150	150	+ 150
10.00	300	300					300					100	250	250	- 50
11:00		300					300					100	350	350	+ 50

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS

MHI/ICU/2022/064

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04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

RMEDIATE CARE FLOWCHART

B

NAME :

UHID NO :

AGE :

SEX :

BLOOD GROUP : B+ve

HEIGHT : 152cm

WEIGHT : 66kg

B.S.A : 1.6m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
98°F	104	SINUS	0·01	175/81	12	warm	++	22	cl	98%	On Nasal prongs 2Lit
	88	SINUS	0.00	153/71	98	warm	++	24	cl	98%	〃
	90	SINUS	0.00	132/64	87	warm	++	30	cl	95%	〃
	86	SINUS	0.06	121/57	78	warm	++	30	cl	97%	〃

PREVIOUS DAY - HOURS 24 hrs

DRAINAGE —

TOTAL INTAKE 2374 ml

URINE 2955 ml

TOTAL OUTPUT 2955 ml

BALANCE - 581 ml

S/P OPCAB X 4 GRAFTS
LIMA → LAD
SVG → OM
SVG → RAMUS INTERMEDIUS
SVG → DISTAL RCA

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MHI/ICU/2022/064

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60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

INTERMEDIATE CARE FLOWCHART

A

NAME : UHID NO : AGE : SEX :

SURGICAL PROCEDURE :

POSTOP DAY : I POD

FLUID REQUIREMENT : 2 2 lit/day

DOS 5/1/24

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
5/1/24 at 18:00	250	1635					1765					250	1100	1124	-641
19:00	100	1735					1865					250	1350	1374	-491
20:00	150	1985					1985					100	1450	1474	-514
21:00	150	2135					2135					150	1600	1624	-511
22:00	100	2235					2235						1600	1624	-611
23:00	100	2335					2335						1600	1624	-711
00:00	150	2485					2485	KABILASE 100				100	1700	1824	-661
01:00	100	2585					2585	100					1700	1924	-661
2:00	70	2655					2655	100					1700	2024	-631
3:00	90	2745					2745	100					1700	2124	-621
4:00	100	2845					2845	100					1700	2224	-621
5:00	110	2955					2955					150	1850	2274	-681
6:00	R	2955					2955						1850	2274	-681
7:00		2955					2955					100	1950	2374	-581

SPECIFIC OBSERVATIONS/REMARKS

5.00 U. CATH REMOVED [DR. ANBARASU].

MEDICATION / DRUGS

MHI/ICU/2022/064

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60/Female/MHI202381349
04/01/2024/IPH2024000033
Dr.ANBARASU MOHANRAJ

:RMEDIATE CARE FLOWCHART

B

NAME : UHID NO : AGE : SEX :

BLOOD GROUP : B+ve

HEIGHT : 152 cm WEIGHT : 66 kg B.S.A : 1.6 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
96.3°F	84	Sinus	0.02	132/61 (85)		warm	F/F	24/mt	Cl 98%	98%	On nasal prongs 2 l/m
	96	Sinus	0.05	147/57 (77)		warm	F/F	16/mt	Cl	98%	〃
	98	SINUS	0.06	165/71	99	warm	F/F	18/mt	cl	94%	
99.6°F	104	SINUS	0.06	174/86	115	warm	F/F	15/mt	cl	97%	
	98	SINUS	0.003	154/73	100	warm	F/F	24/mt	cl	94%	
	97	SINUS	0.03	150/70	89	warm	F/F	17/mt	cl	92%	
	96	SINUS	0.03	150/77	101	warm	F/F	19/mt	cl	93%	
98°F	90	SINUS	0.02	120/77	78	warm	F/F	21/mt	cl	94%	
	92	SINUS	0.03	130/61	85	warm	F/F	20/mt	cl	97%	
	91	SINUS	0.03	118/58	76	warm	F/F	18/mt	cl	93%	
	93	SINUS	0.04	150/78	92	warm	F/F	22/mt	cl	94%	
98.4°F	90	SINUS	0.02	128/60	82	warm	F/F	21/mt	cl	90%	CBG: 131 mg/dl
	101	SINUS	0.03	130/90	85	warm	F/F	18/mt	cl	90%	
	100	SINUS	0.01	146/75	99	warm	F/F	20/mt	cl	88%	On room air.. (signature) 20/1/24

PREVIOUS DAY - HOURS

DRAINAGE

TOTAL INTAKE

URINE

TOTAL OUTPUT

BALANCE