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	✓	

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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IPD/2022/002

Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

Admitting Doctor: DR GNANAVELU **Speciality:** Cardiology

Advised Date & Time: 4/1/24 1:11 AM

Provisional Diagnosis:

RHD S/P MVR
CAD – S/P CABG

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): Nil —

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

Expected Duration of Stay: 4–5 days

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

Payer: ☑ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Monitor vital STSM.

Any other Instructions (if any):

—

Doctor's Signature	Name	Reg. No.	Date	Time
	BALAJI	17147	4/1/24	1:11 PM

For admission desk staff only:

Room Category:
- ☐ General Ward
- ☐ Single Room
- ☐ Twin Sharing
- ☐ Deluxe Room
- ☐ Suite Room
- ☑ Others CCV

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
4/1/24	1:11 AM	4/1/24	1:11 AM

Source:
- ☐ OPD
- ☐ ER
- ☑ Direct

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

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

Front office Staff Signature	Name	Emp. No.	Date	Time
	Leenath Kumar	MH10273	4/1/24	1:11 AM

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status: Married Occupation:	Full Address: No. 3, 1st Cross Street - Ram Nagar, Chennai - 600082.	Telephone Number: 9444745944.

Referred from	Date of Admission	Time of Admission	Date & Time of Discharge	Total No. of Days
Dr. Mohan Kumar. MR Pillai	04/01/2024.	1:11AM	8/1/24	5 days

UNIT: Cardiology — MLC ☐ Yes ☐ No — If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
CONGESTIVE CARDIAC FAILURE CLASS IV, ATRIAL	I50.2
FIBRILLATION WITH RAPID VENTRICULAR RATE	I48.9
DEGENERATIVE BIO-PROSTHETIC MITAL VALVE	
MODERATE MITRAL REGURGITATION, MODERATE	I34.0
PAH. LARGE LA CLOT, MODERATE TO SEVERE LV	I27.21
DYSFUNCTION, S/P. MVR WITH BIOCOR-BIOPROSTHETIC	I50.1
VALVE AND CABG, CONGESTIVE HEPATOPATHY	K76.1

DATE	OPERATION / PROCEDURES	ICPM Code
—	—	

DATE	TYPE OF ANESTHESIA
—	☐ 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	

39469
Signature of the Consultant

8568
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 S. JAYADHARAN. who is my Father (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.

ıave 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 நருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்
Signature of Admitting Nurse

தேதி
Date 4/01/2024.

எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of the Patient / Relative / Gurdian

Son
உறவுமுறை
Nature of Relationship

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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/008

Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

I JANARDHANAN S 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		S JAYAR DHARAN.	4/1/24	1:11 PM
Surrogate/Guardian (if applicable #)		J MOHAN BABU. *(Write name and relationship with patient)*	4/1/24	1:11 PM
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		D. SATHISH	4/1/24	1:11 PM
Interpreter (if applicable)				

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

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

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 Cardiovascular 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
	✓	BALAJI	12215	4/1/24	1.15

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
	✓	BALAJI	122519	5/1/24	12.30 p.

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU
ONAM

MH/PRINT /0036/ ICU / NRS

Medway Hospitals
The way to better health

:# 2/26,1st Main Road, United India Colony, Kodambakkam,
Chennai - 600024. Tel : 044 - 2473 4455 | Mobile No : 9962 985 985
:No.142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai,
Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 612103.
(Tanjore Dist).Ph: 0435 - 2412345 | Mob : 7397720491
E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com

DIL / HIGH RISK FORM

I Dr. Gnanavelu was informed that ~~Mr./Mrs~~ J. Mohan Babu
under the care of Dr. Gnanavelu is seriously Ill.

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

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

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

I also accept the prognosis of the patient.

Witness :

1.

2.

Signature : J. Mohan Babu

Relationship : Son

MRD

DISCHARGE SUMMARY

IP No.	: IPH2024000025	**D.O.A**	: 04/01/2024
UHID	: MHI202481589	**D.O.D**	: 08/01/2024
Name	: Mr. JANARDHANAN. S	**Room No.**	: 203
Age / Gender	: 83Years / MALE		
Consultant	: **Dr. G. Gnanavelu. MD., DM., (cardio) FACC** **Chief Cardiologist**		

DIAGNOSIS:

CONGESTIVE CARDIAC FAILURE CLASS IV
ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RATE
DEGENERATIVE BIO-PROTHETIC MITRAL VALVE
MODERATE MITRAL REGURGITATION
MODERATE PAH
LARGE LA CLOT
MODERATE TO SEVERE LV DYSFUNCTION
S/P MVR WITH BIOCOR – BIOPROSTHETIC VALVE AND CABG (LIMA TO LAD, SVG TO OM) – 2011
CONGESTIVE HEPATOPATHY

BRIEF HISTORY:

Mr. Janardhanan. S, 83years old male, Presented with complaints of shortness of breath at rest and bilateral pedal edema for 1 week. Initially he went to outside hospital, Baseline investigations were done, ECG showed atrial fibrillation with rapid ventricular rate. He was referred to Medway heart institute on 04.01.2024 for evaluation and further management.

No H/O diarrhea, vomiting.

N/K/C/O hypothyroidism, seizure disorder, COPD, Type II diabetes mellitus, HTN.

ON EXAMINATION:

Patient drowsy, arousable, communicating obeys oral commands
HR : 166bpm
BP : 140/90mmHg
SPO_2 : 99% on room air

CVS : S1S2 (+)
RS : B/LAE B/L crepts(+)
Abd : Soft
CNS : NFND

SURGICAL HISTORY:

- S/P MVR – Biocor – Bioprosthetic Valve
  CAD – S/P CABG LIMA to LAD, SVG TO OM – 2014

INVESTIGATIONS:

BLOOD(04.01.2024) : SGOT – 843 u/l, SGPT – 835 u/l, Sodium - 129mmol/l, Potassium – 5.24 mmol/l.

BLOOD(05.01.2024) : Sodium - 129mmol/l, Potassium – 3.3mmol/l, Urea – 68 mg/dl, Creatinine – 1.75 mg/dl, PT – 19.8secs, INR – 1.6 secs.

BLOOD(06.01.2024) : SGOT – 429 u/l, SGPT – 735 u/l, Urea – 59 mg/dl, Creatinine – 1.53mg/dl, Sodium - 139mmol/l, Potassium – 3.61 mmol/l.

BLOOD(07.01.2024) : Sodium - 138mmol/l, Potassium – 3.69mmol/l, Urea – 52mg/dl, Creatinine – 1.31mg/dl, uric acid – 10.7mg/dL. HBsAg - negative

ECG(03.01.2024): Atrial fibrillation with RVR @ 156bpm, non specific ST T changes.

CXR: Mild cardiomegaly, B/L mild pulmonary vascular congestion, B/L minimal pleural effusion.

SCREENING ECHO(04/01/2024): S/P MVR with bicor. Mitral bioprosthetic valve dysfunction. Thickened mitral bioprosthesis. Moderate eccentric valvular leak. No paravalvular leak. MV gradient. Peak-15 mmHg, mean- 5mmHg. Thickened aortic valve. Trivial AR. No AS. Thickened tricuspid valve. Moderate TR. Moderate PAH. Dilated LA. Global hypokinesia of LV. Moderate LV systolic dysfunction. EF – 38%. Normal RV systolic function. IVC dilated and < 50% collapsing. Measures-22mm. Trace pericardial effusion posterolateral to LV and behind RA. Large right, mild left pleural effusion. LA clot present measures – 43 x 29mm.

SCREENING ECHO(08/01/2024): S/P CABG + MVR using biocor valve. Mitral bioprosthetic valve dysfunction. Thickened mitral bioprosthesis. Moderate eccentric valvular leak. No paravavular leak. Dilated LA. Global hypokinesia. Moderate LV systolic dysfunction. Normal RV systolic function. Thickened aortic valve. Trivial AR. No AS. Trivial TR. Mild PAH. Large LA clot present, measures:3.3x3.7cm. Moderate right, minimal left pleural effusion. No vegetation.

COURSE IN THE HOSPITAL:

Mr. Janardhanan. S, 83years old male, admitted with above mentioned complaints. Baseline investigation was done. ECG showed atrial fibrillation with RVR @ 156bpm and reverted with Inj. Amiodarone 150 IV bolus followed by 60mg/ hour for 6 hours & 30mg/ hour for 18 hours. Liver enzymes were increased. He had complaints of difficulty in swallowing & DR. Karthik (gastroenterologist) opinion was obtained and found to be hypoxic hepatitis and orders followed. He was treated with IV diuretics, antiarrhythmics, Antibiotics, anticoagulant, statin and other supportive measures. He improved symptomatically. His medications were optimized and he is being discharged in a clinical stable condition with advise medication.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile
General condition Stable

GCS	-	15/15			
Temp	-	98.6°F	BP	-	120/70mmHg
PR	-	94/min	SPO2	-	96% in room air

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	**TAB. ACITROM**	2 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
2.	**TAB. DIGOXIN**	0.25 MG	½	0	0	ORAL	AFTER FOOD	5/7 DAYS
3	**TAB. ALDACTONE** (SPIRONOLACTONE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
4	**TAB. LASIX** (FUROSEMIDE)	40 MG	1	½	0	ORAL	AFTER FOOD	TO CONTINUE
5	**TAB. RENOSAVE**	500/150 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	**TAB. CORDARONE** (AMIODARONE)	200 MG	½	0	1	ORAL	AFTER FOOD	TO CONTINUE
7	**TAB. URSETOR** (URSODEOXYCHOLIC ACID)	300 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
8	**TAB. FEBUGET** (FEBUXOSTAT)	40 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
9	**TAB. OXRA** (DAPAGLIFLOZIN)	10 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
10	**TAB. PAN** (PANTAPRAZOLE)	40 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE

JCI ACCREDITED NABH ACCREDITED

Medway Heart Institute

Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

DISCHARGE ADVICE	
DIET	LOW SALT DIET, FLUID RESTRICTION <1000ML/DAY
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH **DR. G. GNANAVELU / DR. MOHAN KUMAR AFTER 1 WEEK WITH PT/INR, RFT & LFT REPORTS.**

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

Dr. G. Gnanavelu. G MD., DM., (cardio) FACC
Chief Cardiologist

Typed by: Ezhilarasi.

M. Indumathi

"I understood the Conte... discharge summary."

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

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/ICU/2022/036

Medway Heart Institute
Every heart beat counts

CONSENT FORM FOR CRITICAL CARE (ICU)

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

☑ Read

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

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

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

CENTRAL VENOUS CATHETER INSERTION

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

Intended benefits:
Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:
Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.
The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

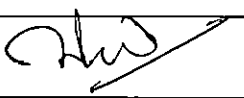
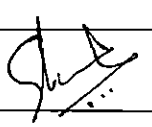
Intended benefits:
The procedure might be needed for you / your patient for any of the following reasons:
- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
-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

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

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

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		S Roshan Babu *(Write name and relationship with patient)*	4/1/24	1.15
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		M.I. Shree Mukesh	4/1/24	1.15
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 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
Doctor		BHAT	123619	4/1/24	1.15

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

MHI/ICU/2022/036

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உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

□ வாசித்திருக்கிறேன்

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

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

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

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:
ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:
மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

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

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/ICU/2022/036
Medway Heart Institute
Every heart beat counts

CONSENT FORM FOR CRITICAL CARE (ICU)

I, MR. JANARDHANAN the ☐ Patient or ☐ Representative of patient have *(please tick the correct option above and below):*

☐ Read

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

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

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

CENTRAL VENOUS CATHETER INSERTION

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

Intended benefits:
Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:
Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.
The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

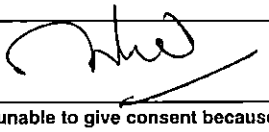
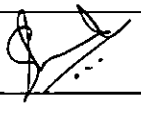
Intended benefits:
The procedure might be needed for you / your patient for any of the following reasons:
- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
-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

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

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

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		Son / S. molenbor *(Write name and relationship with patient)*	4/1/24	1.30
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		M. I. Shaik Nurses In	4/1/24	1.30
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 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
Doctor		MCH.	BAC037	4/1/24	1.30

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(A Unit of United Alliance Healthcare Pvt Ltd)

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

MHI/ICU/2022/036

Medway Heart Institute
Every heart beat counts

உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

□ வாசித்திருக்கிறேன்
□ சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.
□ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

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

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:
ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:
மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியியழுத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

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

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

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

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU
Consultant

MHI/IP/2022/107

Medway Heart Institute
Every heart beat counts

INPATIENT INITIAL ASSESSMENT

Date: 4/1/24 **Time of arrival in ward:** CD @ 1.11

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others

Vital Signs: Temp: 97.9 (°F) | Pulse / HR: 100 (beats/min) | BP: 140/90 (mmHg)
Respiration: 21 (breaths/min) | SpO_2: 99 (%) | Height: 166 (cms) | Weight: 80 (kgs) | BMI: 29.8 kg/m²

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

c/o SOB
leg swelling 3 week.

PAST MEDICAL HISTORY (with duration of illness):

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

Others:

Past Surgical History:

Bivor Bioprosthetic valve (2016)
CAD - S/P CABG LAD.

Present Medication *(for Medication Reconciliation)*:

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	UROVIT			0-0-1	31/1/24 @9.00	☐ Yes ☐ No
2	RYOLD PRO-D			1-0-0	31/1/24 at 8am	☐ Yes ☐ No
3	T. ALDACTONE	25g		1-0-0	31/1/24 at 8am	☐ Yes ☐ No
4	T. DILZEM	90g.		0-0-1	2/1/24 at 8pm	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

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

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

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

Others: _____

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

General Physical Examination:

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

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

SYSTEMIC EXAMINATION

CVS:

$S_1 S_2$ (+)

Respiratory System:

NVBS

Gastrointestinal System:

Soft

Central Nervous System:

NFND

Urinary / Reproductive / Locomotor System:

N

Skin / Opthalmic / ENT

N

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:

RHD S/P MVR

CAD - S/P CABG

Plan of Care:

Medical managent.

Investigations Advised:

CBC
RFT, LFT
w/ RLG.

Diet Advice:

☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet

☐ Semisolid diet ☐ Soft solid diet ☑ South Indian normal diet ☐ North Indian normal diet

☐ Neutropenic liquid diet ☐ Others: _____

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

Special support needed at home	☑ 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. BALAJI	122615	4/1/24	1.15
Consultant		DR-G NANAVELU	39463	4/1/24	1.15
Patient Attendant		Relationship SON		4/1/24	1.15

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NABH ACCREDITED

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
Every heart beat counts

ICU PROGRESS NOTES

Date : 4/1/24
Time : 10.50 AM
Doctor's Name: J. Madhukar

ICU SCORES (as Appropriate)	CLIF ACLF / AD score:	MELD score:	AARC score:
	SOFA score:	SAPS II score:	APACHE II score:

ICU Day Background
Ca Stomach - post GJ + GJ status (2011) - locally advanced disease.
CAD c MVR + CABG status
+ AF ~~ablation~~ ablation 22/4/2014
Severe MS/MR - PAH :

Issues last 24 hours

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M
Pain score BJ 5
Pupils 4
Drains

Cardiovascular system
HR - 106 Rhythm - AF Cardiac Output -
BP 130/78 CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – B/L cups
Saturation / PaO2-
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

GIT
P/A
Bowels – Y / N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds Not taken today.
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines R IJ SC line
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1. Zone 1g BD
2.
3.

Labs UPT elevated
Hb 11.9 TC 11600 Platelets
Urea Creatinine
Na 129 K 5.2
Bilirubin 1.9 AST ALT
INR Sat - 843
Pr - 835
Others
sup - 140

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y/N
Alpha bed Y/N

Plan for the day

Plan

→ I/o charting
→ Zone 1g BD
→ T. Doxy 100 BD x 5 days
→ nal cindsl semisolid diet as tolerated, if not IVF 30 ml/hr
→ Intermittent NIV PS - 8/5
→ others as per chart
→ H1N1 / COVID RTPCR TO D/w primary team
→ Maintain negative Balance.

J. madh
105717.

Doctor	Signature	Name	Reg. No.	Date	Time
	J. madh	Dr. Madhukar	115724	4/1/24	10:50

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MHI/IP/2022/041

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Medway Heart Institute
Every beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
04/01/24 12.50am	S/B: Dr. Karthik Sebapathi
	K/c/o RHD S/P MVR - Biocor - Bioprosthetic Valve.
	CAD - S/P CABG LIMA to LAD, SVG to OM (2011)
	Now SOB at Rest → 1week.
	Swelling of legs → 1week.
	Decreased sensorium → 1week.
	Not K/c/o SHT/T2DM.
	O/E: Drowsy, arousable.
	Communicating, obeys oral commands.
	CVS: S1S2 (+)
	BP: 130/80 ~ AF ... R
	PR: 150/m B/L Crepts (+) D/C, Fluids <1L/day
	SpO2: 94% NIV - SOS
	E4V2? Back Rest / Nasal O2
	Inj. Lasix 40mg stat f/b 3mg/hour infusion
	T. Aldactone 25 1-0-0
	Inj. Digoxin 0.25 IV stat
	Inj. Amiodarone 150mg IV bolus f/b 60mg/hour for 6hours 30mg/hour for 18hours
	Inj. Heparin 5000 IV

Left margin notes:

Guarded Prognosis explained

To do: CBC, RFT, LFT, Urine Out, ABG, ECG, ...

ECHO: RHD, Prosthetic valve Mitral post., Dysfunct. PG: 30, MG: 12. Mitral Rock. Severe MR. Dilated LA. LA clot 3x3cm. Severe TR, TRPG: 46. IVC 2.3cm not collapsing. Mod. PAH. Severe LV Dysfunction. TAPSE 8mm. Global Hypokinesia. EF: 28%.

[signatures]

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/041

Medway Heart Institute
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
4/1/24 9:00.	↓ ASP (R) SCU central vein cathetarisation has been done. All 3 ports have been checked. Back flow was also checked. Procedure went uneventful.
	R, CxR
	[signature]
	DNI/DNR.
4/1/24 7:00.	Patient Mr. Janardhanan. S came with c/o chest pain. He is diagnosed to have AF, severe Mitral regurgitation. Mitral prolapse with low EF - 21%. He is having prosthetic valve which is dysfunctional which has lead to the above complications. For the above complication I request and consent for DNI/DNR if the patient deteriorates.
	[signature] 39469
	[signature] (J. Mohan Babu) Son

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Dr.G. GNANAVELU

MHI/ICU/2022/040

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Date : 4/1/2024
Time : 4:10 pm
Doctor's Name : Dr. G. Ale...

ICU PROGRESS NOTES

ICU SCORES *(as Appropriate)*	CLIF ACLF / AD score:	MELD score:	AARC score:
	SOFA score:	SAPS II score:	APACHE II score:

ICU Day (D2)
Background
CA - stomach - S/P ... (2011)
RHD - S/P MVR
CAD - S/P CABG
AF - Ablation done 22/4/2014.
Severe MS/MR - PAH.

Issues last 24 hours
... - Pre / DNI status.

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E4 V5 M6 15/15 Pupils B/L Pere
Pain score Drains Nil

Cardiovascular system
HR - 89 b/m Rhythm - NSR Cardiac Output -
BP - 100/60 CVP -
Cardiac Medications: S1S2 (+).

Respiratory system
Oxygen supplementation –
Saturation / PaO2- 98 % @ 2l O2.
Ventilator : Spontaneous / Controlled
BeAe (+)
Last C x R -
Drains -
RR = 22/ ...

GIT
P/A Soft -
Bowels - Y / N Loose stools / Melena
Drains
NG tube : Y / N- Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines (R) SC line.
1. ~~...~~ 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1. ? ... ignored.
2.
3.

Labs
Hb TC Platelets
Urea Creatinine
Na K
Bilirubin AST ALT
INR
Others

DVT prophylaxis - Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis - Y/N
Drugs
Pressure sore Y / N-
Alpha bed Y / N

Plan for the day

- Drugs as per chart
- I/O chart
- Nursing
- Intermittent NIV
- ~~Stop Cordarone inj~~
- Continue inj. Cordarone infusion @ 0.5mg/min

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. [illegible]	91810	4/1/24	4:20 PM

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04/01/2024/IPH2024000025
Dr.G. GNANAVELU

DOCTOR'S PROGRESS NOTES

DATE	NOTES
5/1/24 7:00	S/B: Dr. Gnanavelu + team.
	pt symptomatically better.
	SOB ↓ ↓
	Output: 200ml.
	No fever.
	O/E: Drowsy
	arousable, communicating
	CVS: S1S2 (+)
	BP: 140/90 RS: B/L AE.
	PR: 112/m
	Rx: (1) Collect Report
	[signature] 9:30

DATE	NOTES
6/1/2024 9:30	S/b Dr. G. Gravans
	S/p CABG + MVR + AF Ablation + LAA ligation 2014
	Bovine bioprosthetic valve
	S/p CBD & JJ for CBD stones 2014
	now AF RVR CHF CKD
	Decomp liver disease
	CA ..., Degenerative prosthetic valve
	Mild hyponatremia
	Severe LV dysfunction
	Conscious P117 BP 130/B
	SpO2 100% RA RR
	Pt 3/6 Hrs
	CVS ...
	Secondary Adv/Rx
	Inj Lasix 20mg IV BD
	For AF RVR. T. Aldactone 25 1-0
	T. Ivabradine 5mg 1/2 OD
	Inj Cordarone 1mg/min ...
	T. Lanoxin 1/2 OD
	Inj Heparin 7500 IU SC BD
	~~T. Apixaban 2.5mg BD~~
	Inj Ceftriaxone 1gm IV BD

[signature]
19469

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Dr.G. GNANAVELU

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date : 4/1/23
Time : 8-ur
Doctor's Name : Dr. Balaji

ICU SCORES *(as Appropriate)*	**CLIF ACLF / AD score:**	**MELD score:**	**AARC score:**
	SOFA score:	**SAPS II score:**	**APACHE II score:**

ICU Day Background Ca - Stomach
Surg MS/MR
CAD - S/P CABG.

Issues last 24 hours
DNI/DNR

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M Pupils
Pain score Drains

Cardiovascular system
HR - 88 Rhythm - Cardiac Output -
BP - 130/80 CVP - 2
Cardiac Medications:

Respiratory system
Oxygen supplementation – RA.
Saturation / PaO2-
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

GIT
P/A
Bowels – Y / N ✓ Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines ® SUC.
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports
Antimicrobials with days
1.
2.
3.

Labs
Hb TC Platelets
Urea Creatinine
Na K
Bilirubin AST ALT
INR
Others

DVT prophylaxis – Y/N ✓
Drugs : Mechanical – TEDS / SCD
Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

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Dr.G. GNANAVELU

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date :

Time :

Doctor's Name :

ICU SCORES *(as Appropriate)*	**CLIF ACLF / AD score:**	**MELD score:**	**AARC score:**
	SOFA score:	**SAPS II score:**	**APACHE II score:**

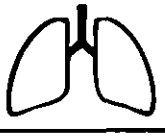
ICU Day
Background

Issues last 24 hours

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M Pupils
Pain score Drains

Cardiovascular system
HR - Rhythm - Cardiac Output -
BP - CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation –
Saturation / PaO2-
Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

GIT
P/A
Bowels – Y / N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1.
2.
3.

Labs

Hb	TC	Platelets
Urea	Creatinine	
Na	K	
Bilirubin	AST	ALT
INR		
Others		

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

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Dr.G. GNANAVELU

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
5/1/24 7:30 AM	S/B Dr. Gnanavelu team
	— pt reviewed
ECG → AF c̄ CVR	O/E: conscious, oriented
I 699.5 / O 3055	PR - 84/min, BP - 122/57 (79)
	SpO2 98% on 2 L O2
	CVS: S1S2 (+)
CBG - 123	RS: BAE (+)
	B/L basal crepts (+).
	Ur/Cr → awaited
	Adv
	— Cordarone infusion stopped today morning
	— Plan to start oral Cordarone & oral anticoagulant
	— Others cont the same.
	Cordarone 200mg 1 — 0 — 1
	Acitrom 2mg 0 — 0 — 1
	97211
	PT / INR
	Sr electrolytes
	Shift to ward
	38449

DATE	NOTES
05/01/24	S/B Dr. C. Sri Lasya (DMO).
10:30PM.	Patient reviewed.
	c/o Dizziness.
	O/E: pt is conscious, oriented, afebrile.
BP- 106/64 mmHg	S/E: CNS: Si, S2 (+), no murmurs
PR- 114 bpm	RS: B/L AE (+), B/L crepts heard.
SpO2- 97% on RA	P/A: S/NT
	CNS: NFND
	Adv:
	TAB @ CORDARONE 200mg 1-0-1
	TAB. ACITROM 2mg 0-0-1
Dr. C. Sri Lasya	
1/5/24	

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ICU PROGRESS NOTES

Date : 5/1
Time : 8.30.
Doctor's Name : Dr. Balaji

ICU SCORES *(as Appropriate)*
CLIF ACLF / AD score:
SOFA score:
MELD score:
SAPS II score:
AARC score:
APACHE II score:

ICU Day
Background Ca. stomach s/p CABD CABG
on MR

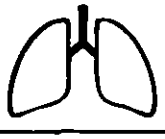
Issues last 24 hours

DNI/DNR
Plan CXR. Card. Inf stopped.

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M Pupils
Pain score Drains

Cardiovascular system
HR - 96. Rhythm - Cardiac Output -
BP - 110/60 CVP - 2
Cardiac Medications:

Respiratory system
Oxygen supplementation – Room 2 L O2
Saturation / PaO2-
Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

GIT
P/A Soft
Bowels – Y / N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines CVP SCV-2
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1. Zone 1g BD.
2.
3.

Labs
Hb TC Platelets
Urea 68 Creatinine 1.7
Na K
Bilirubin AST ALT
INR
Others

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

Plb
at Home

Doctor	Signature	Name	Reg. No.	Date	Time
	✓	DR. BALAJI	123119	5/11/24	8:30

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/24	S/B. Dr. Sijitha.B (DMO)
9:45AM	Case of SOB.
	S/P. Murefar 2016, S/P CABG 2011.
BP - 120/60 mmHg	
HR - 86 bpm	Pt reviewed.
SPO2 - 95% RA	c/o constipation.
	O/E - Pt conscious,
Input - 699.5 ml	oriented,
Output - 3050 ml	Afebrile.
	S/E CVS - S1,S2 (+),
	RS - BAE (+),
	PA - soft,
	Adv
	- vitals monitoring
	- follow diet chart
	- W/F desaturation
	- Inform SOS
	B.S. 183573

DATE	NOTES
6/11/24	Sr. Nc. Cardio Team (?)
10.30	
	c/o constipation (+)
	No CP / SOB
	O/E conscious
	SpO2 98 (RA)
	PR 96/m
	BP 120/80
	CVS (?)
	RS NVBS (?)
	No cyp (?)
	[illegible] 300 / 6 / 3000
	(23000 ml)
	plan
	To do RFT, LFT
	Dulcolax suppository
	Clamp Foley's and remove
	Add - OXRA 10g 1 — 0 — 0
	Azitrim 2 & 3 mg on alt days
	Medical GE opinion
	(signature) 10.24

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
6/1/24 11:20	Course in hospital.
	4/1/24 pt. presented to ER c̄ c/o SOB and Chest pain & leg swelling for 1 week. Hence pt. got admitted under Dr. G. Gnanavelu. pt. Investigation sent. pt. SGOT 843, SGPT - 830, ALP - 140, GGT - 75, K+ - 5.2, Na - 129, Dr. Karthick Sabapathy Sir reviewed the pt. & advised ordered Inj. lasix, T. aldactone, Inj. Digoxin, Inj. Amiodarone. pt. Condition improved on 5.1.24. Infusion cordarone stopped and tab. cordarone started along c̄ Oral Anticoagulant pt. Condition Improved. Then pt. shifted to ward on 5/1/24 after Dr. Gnanavel Sir review. pt. feels clinically better, vitals improved. Then pt planed. Discharge
	K. B. 134559

DATE	NOTES
6/1/24 @ 18:30	S/B Dr Karth
	Thank you for the referral
	Imp: C/O diff. in swallowing / odynophagia
	Hypoxic hepatitis
	Adv
	- USG abdomen I/V [illegible]RONAL 1.2g 1-0-1 x3 day
	- HbsAg
	- anti HCV
	- Ba. swallow TAB VRSGTOR (300) 1-0-1 x 2weeks
	[signature] 16:35

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Dr.G. GNANAVELU

22/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
06/01/24	S/B. Dr. C. Sri Lavya (DMO).
	case of. S/P MV Repair 2016, CABG 2011
BP-132/74 mmHg PR-96bpm SPO2-98% RA	patient reviewed. C/O odynophagia.
	O/E: pt is conscious, oriented & afebrile S/E: CVS - S1S2+V RS - B/L AE+ P/A - Soft.
	Rx : - Stop VDILIV. Add - TAB. URSETOR 1-0-1 (300) x 2 weeks INJ. BRONAC 1-2g 1-0-1 x 3 days. TAB. FEBUGET 40mg AF 1-0-0
	To do: USG Abdomen BA swallow. HBsAg & Anti Hcv. RFT. Dr. C Sri Lavya (84205)

DATE	NOTES
	S/B Dr. Mohamed Yahya
6/1/24 10pm	
	Post OP Case of MV Repair (2016)
	S/P Post Status CABG (2011) c/o Patient conscious oriented Afebrile
	Intake PR- 96/min RR- 18/min BP- 130/80mmHg SpO2- 97%.
	CVS → S1 S2 + RS → BAE + P/A → S/NT, NT
	Adv - Monitor vitals - To follow drug chart
	Thomas

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Dr.G. GNANAVELU

22/041
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
7/1/24	S/B Dr. GG team
9:0	No fresh symptoms
	no SOB
	no fever
	uri output good
	I/O 1400/2150 CVS S1S2 + ; No B/L RR + ; BP 136/70 ; Rx: ① Daily weight chart ② Cont other meds
	93329
7/1/24 6:15pm	S/B Dr. Sujith B (DNB)
	Pt reviewed. K/c MV Repair / CABG / SOB
	- No complaints
Vitals reviewed	Pt conscious oriented afebrile
	S/E - CVS - S1S2 + ; RS - BAE + ; PA - Soft
	Adv: - vitals monitoring - follow daily chart - Fluid restriction - cont medication - Daily weight checking
	183073

DATE	NOTES
	S/R Dr. Mohamed Hydroos
7/1/24	
10PM	S/p MV Repair) Post Status CABG (2011)
	Patient Comfortable
	No c/o Shortness of breathlessness
	Conscious
	Vitals Stable — Oriented
	Afebrile
	Patient on T. Acitrom 3mg — CVS → S1S2 (+)
	RS → BAE (+)
	P/A → Soft, NT
	Adv
	- Monitor vitals
	- To follow drug chart
	- Daily weight check
	- To do USG Abdomen & Ba. Swallow.
	10PM

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/24	S/b Dr Cardio Team
9:00	pt comfortable
	No SOB / Bleeding
	O/E conscious
	oriented, BMD
	SpO2 - 96%
	BP - 120/70
	PR - 94/min
	(2 card reg bad)
	plan
	- PT/INR
	- pt request discharge today
	[illegible]

MHI/DIET/2022/147

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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: RHD | S/P MVR (2011) | CAD | S/P CABG (2011) | Anaemia (11.9gm%) | EF - 26% | C/o abdominal				
Height: 166 cms	Weight: 82 Kgs	Food allergies: Yes/ ~~No~~; if yes, specify..........		
Religious Beliefs:	☑ Vegetarian	☐ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1500 calorie, low fat, low salt, 1000ml fluid restricted, rice with soft solid 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)	9
	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, 10:00
Maria Catherine John
Senior Dietitian (2401)

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
4/1/22, 11:00	A 83 year old gentleman came c/o shortness of breath & leg swelling since (1 week) was assessed to be well nourished as evident by SGA. K/c/o - CAD | RWMA | Anaemia. Patient visited to ward. Educated the patient and family on 1600 calories, low fat, low salt, iron rich, 1000 ml fluid restricted, soft solid diet. Emphasized on small frequent meals.	Maria Catherine John, Senior Dietitian
7/1/22, 13:00	Patient visited to ward. Reemphasized on the diet restriction. Initiated on avoid vitamin K diet. Motivated to eat well. Diet modification done.	Maria Catherine John, Senior Dietitian
8/1/22, 10:00	Oral intake is good. Educated the patient and family on 1600 calories, low fat, low salt, 1000 ml fluid restricted diet on discharge. Emphasized on small frequent meals c̄ iron rich food. Diet modification and clarification done. Diet chart given on discharge.	Maria Catherine John, Senior Dietitian

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83/Malc/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

re)

PSYCHOLOGICAL WELLBEING REPORT

Date: 06.01.24 Time: 12.00 pm.

Unit: 208A

Clinical diagnosis: S/P MV repair (2016) S/P CABG (2011), SOB.

Surgery/ Procedure:

Impression: Sleep ↓ . appetite ↓, Suicidal ideations Ⓔ

- calm affect, oriented, responsive
- sleep ↓, appetite ↓ (since - ?)
- feels like burden ↳ children, active suicidal ideations + death wishes.
- Supportive counseling provided encouraging ↳ understand the importance behind the care of children.

Employee ID: MH1027/PSY Signature of the Psychologist:

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Dr.G. GNANAVELU

URINE ROUTINE ANALYSIS — MICROBIOLOGY SHEET

DATE	3/1/24		
COLOUR	pale yellow		
REACTION			
SPECIFIC GRAVITY	1.015		
APPEARANCE	Slightly turbid		
ALBUMIN	Trace		
SUGAR	NIL		
ACETONE	NIL		
BILE SALT	NIL		
BILE PIGMENT	NIL		
UROBILINOGEN			
PUS CELLS	6-8		
EPITHELIAL CELLS	8-10		
RBC	NIL		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL		

MICROBIOLOGY-CULTURE REPORTS

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

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Dr.G. GNANAVELU

DIABETIC CHART

ACTUAL WEIGHT ± 82 kg HbA1c —

PREVIOUS DIABETIC MEDICATIONS .....

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
4/1/24	2:00	142 mg/dl	—		DR. Balaji
4/1/24	8:30	90 mg/dl	—		DR. Balaji
5/1/24	6:30	123 mg/dl	—		DR. Balaji

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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04/01/2024/IPH2024000025
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BLOOD GROUP —

INVESTIGATION SHEET

(outside)

Date	3/1/24	4/1/24	5/1/24	6/1/24	7/1/24	
HAEMATOLOGY						
Hb	11.9					
P.C.V	35					
Platelets	1.14					
TLC	11800					
Polymorphs						
Lymphocytes	34					
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY						
Urea	50.0		68.	59.	52	
Creatinine	1.2		1.75	1.53	1.31	
Sodium		129.	129	139	138	
Potassium		5.24	3.30	3.61	3.69	
Bicarbonate				25	27	
Chloride				96.9	98.7	
Magnesium						
Calcium				7.9	7.7	
Phosphorus				2.3	2.3	
LFT						
T.Bilirubin		1.99		1.94		
D.Bilirubin		1.13		1.87		
I.Bilirubin		0.86		0.07		
S.G.O.T		843		429		
S.G.P.T		885		735		
ALP		140		136		
GGT		75				
Total Protien		7.2		5.7		
S.Albumin		3.6		2.8		
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Uric acid 10.7

Date	5/1/24					
COAGULATION PT / INR	19·8/1·6					
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						
THYROID FUNCTION T.S.H						
T.3						
T.4						
SEROLORY						
HIV						
HBsAg						
V.D.R.L						
COVID 19						
RT- PCR						
IgM Ig						
HBA1C						
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality **URINE**						
Osmolality						
Spot - Na						

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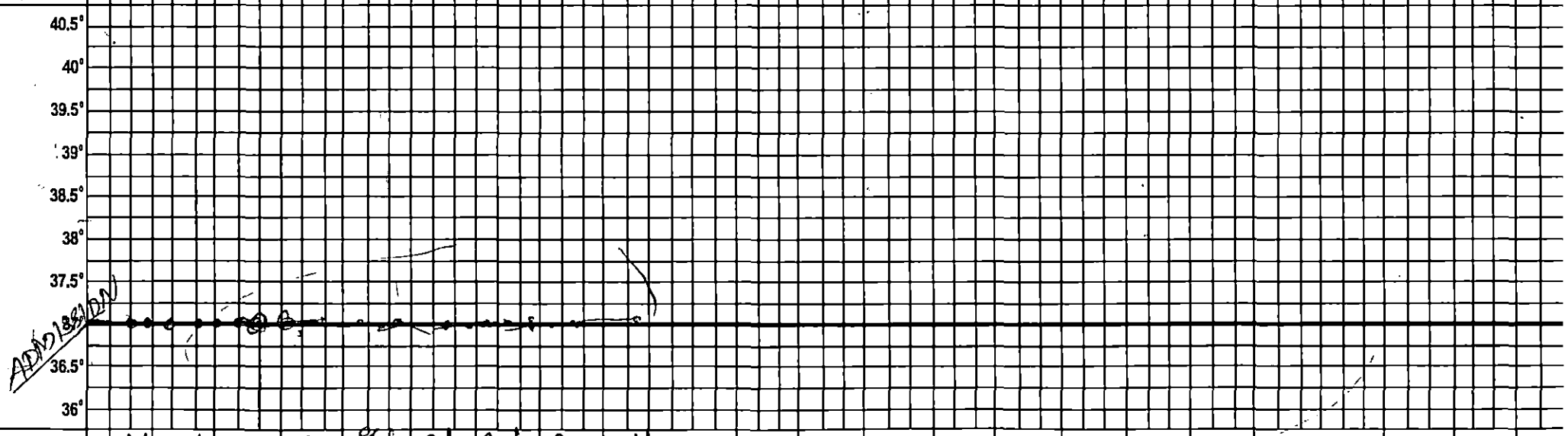
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

VITAL INFORMATION SHEET

BLOOD GROUP	
ON ADMISSION	
Height in CM	Weight in
166	82

Diagnosis: RHD S/P MVR / CAD - S/P CABG **Procedure :**

NO. OF DAYS		1				2				DAY-3				DAY-4				Day-5			
DATE		4/1/24				5/1/24				6/1/24				7/1/24				8/1/24			
HOUR	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10
PULSE		166	101				77	114		86/m	96			92/m	88			94b/m			
RESP		21	22				17	20		20/m	20			20/m	20			22/m			
B.P.		150/83	109/60				123/64	106/64		121/62	132/74			128/72	130/70			120/70			
SPO2		99	98%				100%	97%		95%	99%			94	94			96%			
DAILY WEIGHT		±82kg					±82kg			61.8 kg											
24 HRS INTAKE		96ml					699.5ml			1400 ml				1350 ml							
24HRS OUTPUT		2000ml					3055ml			2150ml				1550 ml							
BALANCE		104+					2355.5ml			750ml				-300 ml							
MOTION		✓					✓			✓				✓							



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Dr.G. GNANAVELU

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EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE / TIME	5/1/24 12:00	5/1/24 18:00	5/1/24 22:00	6/1 2:00	6/1 6:00	6/1 10:00	6/1/24 14:00	6/1/24 18:00	6/1/24 22:00	7/1/24 6:00	7/1/24 10:00	7/1/24 14:00	DATE / TIME
A+B Respirations Breath/ 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 respiratory failure only use 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	70	72	72	80	82	78	82	80	70	82	72	74	70 mmHg
C Pulse Beats / min	>131						3							>131
	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	>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		0	0	0	0	0	0	0	0	0	0	0	0	
Monitoring Frequency		4H	4H	4H	4H	4H	4H	4H	4H	4H	4H	4H	4H	
Escalation of Care Y/N		No	No	No	No	No	No	No	No	No	No	No	No	
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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53/Female/MHI202381408
05/01/2024/IPH2024000041
Dr.ANBARASU MOHANRAJ

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EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE	5/1	8/1	8/1	DATE
	TIME	22:00	2:00	6:00	TIME
	>25				>25
Respirations 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 % eg: in hypercapnic respiratory failure only use 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	80	48	22	mmHg
C Pulse Beats / min	>131			3	>131
	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	48	80	82	Alert
	Confusion			3	Confusion
	V			3	V
	P			3	P
	U			3	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		0	0	0	
Monitoring Frequency		4th	4th	4th	
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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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/066
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INTAKE & OUTPUT CHART

Date From: 5/1/24	To: 6/1/24	Bed No:	
24 Hrs : Started Time : 7.00		Ended Time : 7.00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	50	375ml	370ml	1 Lit/day
OUTPUT	150	1000	2000 ml	

Total Intake: 795 Total Output: 3350 ml Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
	TOTAL		INTAKE	-		50.
13.20	125					175
17.00	250					425
19.50	20					445
20.25	125					570
21.05	125					695
6.00	100					795

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total
	TOTAL		OUTPUT	-		150
18.30	1000					1350
22.00	500					1850
2.00	500					2350
6.00	1000					3350

Total Intake - 795 ml
output - 3350 ml

R/N Sign

Endorsed by

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INTAKE & OUTPUT CHART

Date From: 6/1/24 To: 7/1/24		Bed No: 208	
24 Hrs : Started Time : 7.00		Ended Time : 7.00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	515 ml	500 ml	520 ml	1 lit / day
OUTPUT	800 ml	700 ml	650 ml	

Total Intake: 1400ml Total Output: 2150 ml Difference: -750ml

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
8.20	120					120
9.10	145					265
11.00	250					515
13.00	100					615
13.45	120					735
16.50	80.					815.
19.45	200.					1000
19.30	50.					1050
20.40	125					1250
21.35	25					1250
3.05	65					1300
6.10	90					1400

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
10.00	800					800		
15.30	300					1100		
18.40	400.					1500		
21.30	300					1800		
00.15	250					2050		
6.00	100					2150		
		TOTAL	INTAKE	-	1400ml			
		TOTAL	OUTPUT	-	2150ml			
								Neeraja
								024

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Date	From: 8/4/24	To: 9/4/24	Bed No:	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 7.00		Ended Time : 7-00		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	680 ml			
OUTPUT	400 ml			

Total Intake: Total Output: Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
7.40	100					100
8.30	180					280
10.55	200					480
11.40	200					680

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
9.00	50					50		
10.30	100					150		
11.00	50					200		
12.15	200					400		

Total Intake – 680ml
Total output – 400ml

Nag
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PRE/POST OPERATIVE ECHO

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Screening Echo Report

Date & Time	
04/11/24	S/P MVR T BIOCOR
	- Mitral Bioprosthetic Valve dysfunction.
	- Thickened mitral Bioprosthesis.
	- Moderate Eccentric Valvular leak.
	- No paravalvular leak.
	- MV Gradient :- peak- 15 mmHg, mean- 5 mmHg
	- Thickened Aortic Valve
	- Trivial AR, no AS. LA Volume: 108 ml
	- Thickened Tricuspid Valve TR Gt: 41 mmHg
	- moderate TR, moderate PAH RVSP: 51 mmHg
	- Dilated CA.
	- Global hypokinesia of LV.
	- moderate LV systolic dysfunction.
	- Normal RV systolic function.
	- IVC dilated and <50% collapsing. measures: 22mm
	- Trace pericardial Effusion posterolateral to LV and Behind RA
	- Large right, mild left pleural Effusion.
	- LA clot present - measures:- 43 x 29 mm
	- AF during study:- 107 bpm
	LVIDD : 55 mm
	LVIDS : 45 mm
	EF: 38 % Echo done By
	RVTDI: 10 cm/s Ms. Lokeshwari. K
	TAPSE: 14 mm (Cardiac tech)
	MHI0180

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04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/066
Medway Heart Institute
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INTAKE & OUTPUT CHART

Date	From: 8/1/24	To: 8/1/24	Bed No:
24 Hrs : Started Time : 7.00		Ended Time : 7.00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	585 ml	550 ML	400 ml	
OUTPUT	270 ml.	280 ML	800 ml	

Total Intake: 1350 ml | Total Output: 1550 ml | Difference: −200 ml

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
8.40	210					210
9.15	250					460
11.02	125					585
12.55	100					685
13.05	50					735
13.5	25					760
14.32	25					785
16.2	150					935
20.00	100ml					1050
1.00	150 ml					1200ml
7.00	150ml					1350ml

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
10.20	90					90		
10.40	100					190		
11.05	80					270		
13.3	200					470		
22.30	300					770ml		
2.30	200ml					970ml		
4.00	200ml					1170ml		
6.30	400ml					1550ml	AA	
							OOR	
		TOTAL	INTAKE - 1350ml					
		TOTAL	OUTPUT - 1550ml					
								Noor
								024

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04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/053

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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 4/1/24 Time of Arrival: 1.11 Mode of Admission: ☐ Walking ☑ Wheelchair ☐ Stretcher

Accompanied by Relative: ☐ Yes ☑ No If Yes, Name of the Relative: MR. MOHAN BABU.

Relationship with Patient: FATHER Contact Person's Name: MR. MOHAN BABU Relationship: BROTHER

Contact No.: 9444[illegible]9944 Primary language spoken: ☑ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☐ Yes ☑ No

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

Menstrual History : LMP : — Menopause: _____

Medical History : DM / HTN / Co - Morbility : Nil Yes If yes specify

Drugs History : Antiplatelet — (Specify)

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

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

If Yes, specify details: —

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

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 168 (beats/min) | BP: 140/93 (mmHg)

Respiration: (breaths/min) | SpO_2: 9 (%) | CBG: 172 (mg/dl) | Height: 166 (cms) | Weight: 82 (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: SOFT DIET

Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: MRS. CATHERINE Time: 8.00

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

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

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

Functional Assessment:

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

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

Total Score: 14 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

Variables		Numeric Value
History of falling (immediate or within 6 months)	No	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
Ambulatory Aid None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait Normal / Bed Rest / Wheel Chair		0
Weak		10
Impaired		20
Mental Status Oriented to own stability		0
Overestimated or forgets limitations		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics	No	0
	Yes	15
Score Interpretation: *0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk* **Total Score**		50

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT): *Tick the score obtained (✓)*

Final Score 0

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**	✓	—	4/11/24	1.02
Moderate Risk	**1 to 2**				
High Risk	**3 to 8**				

Personal Belongings / Valuables:

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

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

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	[signature]	S. Mohanbabu	Relationship: Son	4/11/24	1.25
Nurse	[signature]	Mathiya	02HO	4/11/24	1.25
Unit In-Charge	[signature]	[signature]	0002	4/11/24	1.25

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

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: RHD S/P NVR / CAD S/P CABG
GCS: 15/15
NEWS / PEWS Score: –
POD: –
Ventilator day: –
Central line days: D1
Peripheral line day: Right: – Left: METACARPAL
Ryle's Tube: ☐ Yes ☐ No Day:
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: D1
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: 4L/Min ONFLOW
IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 97.8°F) | Pulse / HR: 166 (beats/min) | Respiration: 26 (breaths/min)
BP: 140/90 (mmHg) | SpO_2: 96 (%) | Height: 166 (cms) | Weight: 80 (kgs) | BMI: 29.8 kg/m²
Others : –
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA
Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: → Soft 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	[signature]	Nathiya.	8240	4/1/24	7:30
Handover taken by	[signature]	S. Abinayani	0162	4/1/24	7:30
Document endorsed	[signature]	[illegible]	[illegible]	4/1/24	7:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
4/1/24 @ 1.11	Receiving Notes	
	→ pt on c/o SOB / leg swelling v/s checked & recorded IV line patent, CBP ⊕ cont, ECG, BBG done. DR. KARTHICK SIR order to ECG CBG done. Inj. lasix 40mg At IV given sir advice for CCU admission pt on shifted to CCU, pt on NIV support aflow. FR. 1 lit / per day.	0240
1.30	→ DR. BALAJI SIR order CVP line Inserted & patient Inj. Amiodarone 150 mg bolus IV given.	0240
2.20	→ DR. KARTHICK SIR order to Inj. Amiodarone 5ml/hrs onflow, lasix 2ml/hrs onflow	0240
4.30	→ DR. BALAJI SIR orded to lab CFT, urea, creatinine send	0240
5.30	→ pt on morning care CBD & back care given	
6:00	→ pt ECG taken, CBG checked & Recorded.	0240
7.30	→ pt handing over to morning duty staff	0240

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYASRI	002	4/1/24	10.00

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UI 04/01/2024/IPH2024000025
DI Dr.G. GNANAVELU
DI
Co

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: RHD S/P MVR / CAD - S/P CABG GCS: 15/15
NEWS / PEWS Score: POD:
Ventilator day: Central line days: D1
Peripheral line day: Right: Left: metacarpal
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: FMO2 4 litres on flow IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 99.2°F) | Pulse / HR: 109 (beats/min) | Respiration: 24 (breaths/min)
BP: 133/74 (mmHg) | SpO_2: 98 (%) | Height: ±166 (cms) | Weight: ±82 (kgs) | BMI: 29.8 kg/m²
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 0/5 **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: (N) 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: NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		S. Alagumani	OIUR	4/1/24	13.00
Handover taken by		R. Mohanraj	2352	4/1/24	13.00
Document endorsed				4/1/24	13.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
4/1/24		
7:30	patient took hand over taken from night duty staff pt Concious and Oriented pt Under Cardiac monitory. pt Fm O2 4 litter Onflow Infusion Inj. Amiodrone 5ml/hr and Inj. Lasix 3ml/h Onflow. C-line (P) (R) Side U-Cath (P) DD pt was haemodynamicated Stable	[signature]
8.10	Dr. Karthik Sir Visit the pt Advice to Change to NIVPS mode FiO2 40% peep 6 psabove peep 10.	[signature]
9.00	⇒ Dr. Gnanavelu Sir visit the pt Advice to Inj. Ceftrixone 1gm IV BD. Change the drugs. Continue the Inj. Amiodrane	[signature]
10.00	⇒ pt had little bit Soupe given due to medication.	[signature]
10.30	⇒ Inj. xone 1 gm IV given as per dr chart.	[signature]
12.00	⇒ monitor Vital Sigs and I/O Chart also.	
12.30	⇒ pt c/o Thorax pain Infor to Dr. madhan Advice to tab dolo Coilhad boong P/o given.	[signature]
13.00	⇒ pt hand over given to Next duty Staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYASRI	0002	4/1/24	16.00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: RHD S/P MVR / CAD - S/P CABG. GCS: 15/15
NEWS / PEWS Score: — POD: —
Ventilator day: — Central line days: 01
Peripheral line day: Right: — Left: Nepacopel.
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: D2
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B — BACKGROUND

Type of surgery: — Date of surgery: —
Allergies if any: Unknown
On room air / oxygen: Room Air O2 IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 97.8 (°F) | Pulse / HR: 108 (beats/min) | Respiration: 22 (breaths/min)
BP: 122/63 (mmHg) | SpO_2: 100 (%) | Height: 106 (cms) | Weight: 82 (kgs) | BMI: 29.3 kg/m².
Others : _____
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 45 **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: NIL
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	R. Mohamed	R. Mohamed.	2362	4/1/24	7.20pm.
Handover taken by		Nathiya	0040	4/1/24	7.30
Document endorsed	Jayl	[illegible]	0001	4/1/24	7.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/1/24	Evening duty Notes:	
13.00.	patient & patient records	
	taken over from morning duty	
	staff. pt conscious & and oriented	
	pt on DNI/DNR. pt on CBD D2	
	pt CVP line D1 pt abdomen	[signature] 280
	soft. Abdomen CA.	
14.00	pt Had a liquid diet.	[signature] 280
	administered the medication	
	as per drug chart	
15.00.	pt comfortable position. pt vitals	[signature] 2...
	record [illegible]	
17.00.	pt Had a stem, Inj. Lasix 20mg IV given	[signature] 280
19.00	pt Handing over the Night duty	[signature] 280
	staff.	

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	[signature]	Jayapriya	00[illegible]	4/1/24	20.00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: RHD s/p MVR / CAD - s/p CABG GCS: 15/15
NEWS / PEWS Score: POD: —
Ventilator day: Central line days: 01
Peripheral line day: Right: Left: Metacarpal
Ryle's Tube: ☐ Yes ☐ No Day: — VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: 00 —
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: 2L of NP O2 FLOW IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 99 (beats/min) | Respiration: 26 (breaths/min)

BP: 113/59 (mmHg) | SpO_2: 99 (%) | Height: 166 (cms) | Weight: 80 (kgs) | BMI: 29.8 kg/m²

Others : —

Pain Score: 9/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT

Fall Risk Score: 45 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High

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

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

Current diet: Drains: —

→ Liquid diet

R

RECOMMENDATION

Referral doctors: } Nil
Pending medications: } Nil
Pending medication indent: } Nil
Pending lab reports / Investigations: urea, creatine to be follow.
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: } Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Nathiya	0240	4/1/24	7:30
Handover taken by	[signature]	S. Alliyammal	0160	5/1/24	7:30
Document endorsed	[signature]	JAYADEVI	002	5/1/24	7:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
4/1/24 @ 19.00	NIGHT DUTY NOTES ⇒ pt taken over from evening duty staff, pt on Consious & oriented, v/s checked & recorded. IV line patent CVP Ⓟ - DI CBD Ⓟ - DI no complaints	
20.30	⇒ pt had dinner done medication given as per drug chart	
22.30	⇒ pt on Confortable bleep no complaints & v/s Checked & recorded.	
22:30	⇒ Inj. ofol 1 G pt on IV given as per drug chart	
2:00	⇒ Pt Provide comfort position.	
4:00	⇒ Pt Inves CBC, RFT sample send to the lab.	
5:00	⇒ Pt ECG & CBG Checked & Reported.	
6:00	⇒ Pt hourly I/O chart monitored.	
7:00	⇒ Pt handingover to morning duty Staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYARAJ N	6002	4/1/24	10.00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

SAFETY FIRST

Date: 5/1/24 Shift: ☐ Morning ☐ Evening ☑ ~~Night~~

S — SITUATION

Diagnosis: RHD S/P MVR / CAD
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: 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: ON ROOM AIR
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 22 (breaths/min)
BP: 120/70 (mmHg) | SpO_2: 97 (%) | Height: 160 (cms) | Weight: 82 (kgs) | BMI: 24.2 kg/m²
Others : NIL
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ ~~High~~
Braden Score: ☐ Minimal Risk: 23-19 ☑ ~~At Risk-Mild Risk: 18-15~~ ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ ~~No~~ ☐ NA Wound Dressing done: ☐ Yes ☑ ~~No~~ ☐ NA
Current diet: NORMAL Diet Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0088	6/1/24	7.00
Handover taken by		M. Lukuls	2268	6/1/24	7.30
Document endorsed		S. Nalini	0084	6/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
6/1/24	NIGHT DUTY NOTES	
19.00	Patient handovers taken from the evening duty staff Patient is stable	0084
20.00	Due medications are given to the patient	0084
22.00	Vital signs are checked & recorded	0084
6.00	N/o chart is maintained	0084
7.00	Patient handovers given to the morning duty staff.	0084

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0024	6/1/24	8:00

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Patient Details (Affix Label here)
Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: RHD S/P MVR/CAD - S/P CABG
GCS: 15/15
NEWS / PEWS Score: —
POD: —
Ventilator day: —
Central line days: D2
Peripheral line day: Right: Left: metacarpal
Ryle's Tube: ☐ Yes ☐ No Day:
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: D3
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery:
Date of surgery: —
Allergies if any: NKAD.
On room air / oxygen: O2 2 litres NP
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 84 (beats/min) | Respiration: 23 (breaths/min)
BP: 121/63 (mmHg) | SpO_2: 100 (%) | Height: 166 (cms) | Weight: 82 (kgs) | BMI: 29.8 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 45 **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: Ⓝ diet
Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Na^+, K^+, PT-INR. To be Collected.
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: _____
Pending follow-up orders:
Special instructions if any: NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		S. Alleinmyan.	0162	5/1/24	12.36
Handover taken by		R. Sylvia	0861	5/1/24	12.30
Document endorsed	Nalini	S. Nalini	0024	5/1/24	13:0

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
5/1/24 7:30	patient took hand over taken from night duty staff pt conscious and oriented pt c/o (L) (Rt) side pt ulcer (L) pt (L) metacarpal present. pt was	[signature]
8.00	⇒ pt had normal diet given the medication as per dy chart.	[signature]
9.00	⇒ Dr. [illegible] visit the pt advice to ward shift.	[signature]
10.00	⇒ Tab. Cordarone, Tab Atorva Add.	
11.00	⇒ 1 dose Cordarone given as per dy chart.	[signature]
12.30	pt shift to ward hand over given to ward staff.	[signature]
13.30	Received Notes	
	⇒ pt handing received from CCU.	
	⇒ pt conscious & oriented	
	⇒ pt handing over given by.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0084	5/1/24	14:00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

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

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

B — BACKGROUND

Type of surgery: —
Allergies if any: NKDA
On room air / oxygen: RA
Complaints / New Symptoms in last shift:

Date of surgery: —
IV fluids on flow: —

A — ASSESSMENT

Vital Signs: Temp: 97.4°F) | Pulse / HR: 76 (beats/min) | Respiration: 18 (breaths/min)
BP: 120/80 (mmHg) | SpO_2 99 (%) | Height: 166 (cms) | Weight: 82 (kgs) | BMI: 29.8 kg/m^2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 45 **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: Ⓝ 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		R. Sulthan	0201	5/1/24	19:30
Handover taken by		B. Vanitha	0195	5/1/24	19:30
Document endorsed		S. Nalini	0084	5/1/24	20:0

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
5/11/24 @	Evening Notes	
12.30	⇒ Pt handling over taken from evening duty staff.	
12.30	⇒ Pt conscious & oriented	
14.00	⇒ Pt had @ diet.	
14.30	⇒ Pt due drugs were given.	
16.00	⇒ Pt u-cath Day- 2.	
	⇒ Pt both leg swelling in 2 weeks.	
17.00	⇒ Pt IV line present.	
18.30	⇒ Pt v/s charted & monitored.	
19.00	⇒ Pt I/O chart maintained.	
19.30	⇒ Pt handing over given by Night duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nag	S-Nagathi	0024	5/11/24	20:00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: RAD | S/P. mmR | CAD
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: not known
On room air / oxygen: RA
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 78/mt (beats/min) | Respiration: 22/mt (breaths/min)
BP: 140/70 (mmHg) | SpO_2: 98 (%) | Height: 160 (cms) | Weight: 82 (kgs) | BMI: 24.2 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: 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		Suresh	2208	6/1/24	12-30
Handover taken by		R. Sushma	0201	6/1/24	12:30
Document endorsed		S. Nalini	0024	6/1/24	13:00

MHJ/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
6/1/24. at 7.40	Morning duty Records	
	patient handing over taken from night duty staff.	Sulazza
	patient conscious & oriented patient V/S checked & recorded. vitals are stable	
	patient had normal diet	
8.30	morning due drugs given as per chart	Sul1108
10.00	patient mobilised well. I/O chart maintained. otherwise no complaints	Sulzzol
11.00	(On [illegible] Dr Advise) LFT, RFT blood sended. (R) To be collected. CBD clamped. after there sensation (P)	Sulzzuf
12.30	patient handed over given to Evening duty staff.	Sulzzolo

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0034	6/1/24	13:00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

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

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

B — BACKGROUND

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

Date of surgery:
IV fluids on flow:

A — ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 18 (breaths/min)
BP: 130/80 (mmHg) | SpO_2: 97% (%) | Height: 160 (cms) | Weight: 82 (kgs) | BMI: 24.2 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: Nil
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date:
Pending follow-up orders:
Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0281	6/1/24	1900
Handover taken by		A. ALBINUS	0480	6/1/24	1930
Document endorsed		S. Nalini	0094	6/1/24	2010

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
6/1/24	Evening duty Notes	
@		
12.00	⇒ patient handing over taken from evening duty staff.	
12.00	⇒ pt Positions & Oriented	
14.00	⇒ pt oral drugs were given.	
14.30	⇒ pt had @ diet.	
16.00	⇒ pt well hydrated	
18.00	⇒ pt I/o checked & recorded.	
19.00	⇒ pt v/s checked & Recorded.	
17.30	⇒ pt handing over given by night duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0084	6/1/24	2:00

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

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: S/P MVR
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: 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: 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: 130/70 (mmHg) | SpO_2: 97 (%) | Height: 160 (cms) | Weight: 82 (kgs) | BMI: 24.3 Kg/m²

Others : Nil

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

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

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

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

Current diet: NORMAL DIET
Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0088	7/1/24	7:00
Handover taken by		E. Catherine	0007	7/1/24	7:30
Document endorsed		E. Nalini	0084	7/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
6/1/24	NIGHT DUTY NOTES	
19.00	Patient handovers taken from the evening duty staff. Patient is stable	0088
20.00	Due medications are given to the patient	0088
22.00	vitalsigns are checked & recorded	0088
6.00	I/o chart is maintained	0088
7.00	Patient handover given to the morning duty staff	0088

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nea	S Nalini	0024	7/1/24	8:00

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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: S/P MVR
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: 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:
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/70 (mmHg) | SpO_2: 98 (%) | Height: 160 (cms) | Weight: 88 (kgs) | BMI: 24.3 Kg/m^2

Others : —

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

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

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

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

Current diet: Normal diet
Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	F. Cathi	F. Cathrine	0207	7/1/24	12.30
Handover taken by		R. Suguna	0261	7/1/24	12.30
Document endorsed		S. Nalini	0024	7/1/24	13.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/23 @	Morning duty Notes	
7.30	⇒ pt handed over taken by morning duty staff	F-Cat° 0207
	⇒ pt Conscious & oriented	
	⇒ pt v/s checked & recorded	
8.30	⇒ pt had diet, patient due drugs are given	F-Cat° 0207
10.00	⇒ pt v/s checked & recorded	F-Cat° 0207
12.30	⇒ pt v/s checked & recorded	
	⇒ pt I/o chart maintained	F-Cat° 0207
	⇒ pt well mobilized	
	⇒ pt handed over to evening duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0084	7/1/24	13:00

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Dr.G. GNANAVELU

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: S/P MVR
NEWS / PEWS Score: 0
Ventilator day: —
Peripheral line day: Right: — Left:
Ryle's Tube: ☐ Yes ☑ No Day: —
Urinary Catheter: ☐ Yes ☑ No Day: —
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —

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

B — BACKGROUND

Type of surgery: —
Allergies if any: NKDA
On room air / oxygen: RA
Complaints / New Symptoms in last shift: —

Date of surgery: —
IV fluids on flow: —

A — ASSESSMENT

Vital Signs: Temp: 97.1 °F) | Pulse / HR: 78 (beats/min) | Respiration: 18 (breaths/min)
BP: 130/80 (mmHg) | SpO_2: 97 (%) | Height: 160 cms) | Weight: 82 (kgs) | BMI: 24.3 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:
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: —
Pending follow-up orders:
Special instructions if any: To do USG Abdomen tomorrow

Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0281	7/1/24	19.30
Handover taken by		Jeniya.	0284	7/1/24	19.30
Document endorsed		R. Nalini	0084	7/1/24	20.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/24 @	Evening duty staff Notes	
12.00	⇒ pt handing over taken from Evening duty staff	
12.00	⇒ pt Conscious & Oriented	
13.30	⇒ pt had @ diet	
14.00	⇒ pt due drugs are given.	
14.30	⇒ pt well Mobilized.	
18.00	⇒ pt F/o chart maintained	
18.45	⇒ pt V/S checked & Recorded	
19.00	⇒ pt handing over Night duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S-Nalini	0084	7/1/24	20:00

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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: S/P MVR.
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: 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: 98 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 18 (breaths/min)
BP: 130/80 (mmHg) | SpO_2: 97 (%) | Height: 160 (cms) | Weight: 82 (kgs) | BMI: 24.8 kg/m2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 20 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA *Wound Dressing done:* ☐ Yes ☐ No ☑ NA
Current diet: Normal diet.
Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: 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	Jem	Jeniprija.	0284	7/1/24	19.00
Handover taken by	MRaj	M. Revathi	0225	8/1/24	7.30
Document endorsed		S. Nalini	0024	8/1/24	8.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	NIGHT DUTY NOTES	
7/1/2024		
19.30	=> Pt hand over taken from NIGHT EVENING DUTY.	
20.00	=> Pt consciouses and orientation.	Soni
	=> Vitals checked and Recorded.	
	=> Pt due drugs are given as per duty chart.	
22.00	=> Pt Mobilized well	Soni
23.00	=> Pt Deep well.	
6.00	=> Pt Vitals checked.	
	=> Pt I/O chart Maintain	
7.00	=> Pt hand over taken given to morning duty staff.	Soni

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

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: RHD/SIP MVR/CAD
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: 015
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: 96.8 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/70 (mmHg) | SpO_2 96 (%) | Height: 160 (cms) | Weight: 82 (kgs) | BMI: 24.2 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: Today plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by	M.Ry	M. Revathi	0225	8/1/24	12.30
Handover taken by		R. Sukanya	0201	8/1/24	12.50
Document endorsed		S. Nalini	0084	8/1/24	13.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
08/1/24 at	Morning duty note.	
7.30	⇒ Patient hand over taken to the night duty staff.	
	⇒ conscious & oriented.	
	⇒ Vital signs Checked &	
8.30	⇒ Patient had a normal diet	
	⇒ Medication given as per as doug chart.	
9.00	⇒ Patient Good mobilized.	
10.00	⇒ Medication given as per as doug chart.	
11.30	⇒ Vital signs Checked & recorded	
	⇒ I/O chart monitored	
12.30	⇒ patient hand over given to evening duty staff.	
	Discharge Note	
8/1/24 @ 19.15	⇒ pt discharge summary explain to the pt attender	
	⇒ pt V/s checked & recorded.	
	⇒ pt IV line removed	
	⇒ pt ID band removed	
	⇒ pt old report given	
19.40	⇒ pt went to home	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0024	8/1/24	22:00

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/ICN/2022/102

Medway Heart Institute
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HAI BUNDLE

Date & Time of Intubation	Date of extubation:	Date of Reintubation:	Total Days

S.no	VAE Bundle (DATE)	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Elevate HOB 30° - 45° & patient not sliding down															
2	Perform hand hygiene before & after each respiratory care															
3	Perform regular oral care with antiseptic oral rinse if needed															
4	Review sedation target daily															
5	Assess readiness to wean and extubate to daily															
6	Drain condensate of the ventilator circuit before repositioning of patients															
7	Check and maintain appropriate ETT cuff pressure 25 - 30 cmH2o															
8	verify correct placement of the NG tube at regular interval															
9	Regular assessment of patient's tolerance to NG tube feeding															
10	Stress ulcer prophylaxis															
11	DVT prophylaxis															

Date & Time of Insertion	Date of Removal:	Date of Reinsertion:	Total days:
4/1/24 @ 2:00	5/1/24 @ 11.20		2 days

S.no	CLABSI Bundle (DATE)	M (4/1/24)	E	N	M (4/1/24)	E	N	M (5/1/24)	E	N	M	E	N	M	E	N
1	Perform hand hygiene			✓	✓	✓	✓	✓								
2	Dressing intact and labelled properly			✓	✓	✓	✓	✓								
3	Site inspected			✓	✓	✓	✓	✓								
4	Catheter stabilized/no tension on line			✓	✓	✓	✓	✓								
5	Dormant lumens clamped			✓	✓	✓	✓	✓								
6	Caps changed-administering blood & if there is visual observation of blood in the caps			✓	✓	✓	✓	✓								
7	Caps sanitized with alcohol before & after each use. "scrub the hub".			✓	✓	✓	✓	✓								
8	Lumens flushed with minimum volume 10cc every 12 hours			✓	✓	✓	✓	✓								
9	Iv bags and tubing's labelled properly			✓	✓	✓	✓	✓								
10	All tubing changed every 24 hours			✓	✓	✓	✓	✓								

Date & Time of Insertion	Date of Removal:	Date of Reinsertion:	Total days:
3/1/24 (outside)	6/1/24 @ 13.30		4 days

S.no	CAUTI Bundle (DATE)	M (3/1/24)	E	N	M (4/1/24)	E	N	M (5/1/24)	E	N	M (6/1/24)	E	N	M	E	N
1	Maintain sterlity of closed urinary drainage			✓	✓	✓	✓	✓	✓	✓	✓					
2	Wash hands prior to handling the urinary drainage system & catheter			✓	✓	✓	✓	✓	✓	✓	✓					
3	Maintain unobstructed urinary flow & specimens from sampling port			✓	✓	✓	✓	✓	✓	✓	✓					
4	Keep collection bag below the bladder & off the floor			✓	✓	✓	✓	✓	✓	✓	✓					
5	Don't change indwelling catheter or collection bag routinely			✓	✓	✓	✓	✓	✓	✓	✓					
6	Tie/secure catheter to patient tubing to bed			✓	✓	✓	✓	✓	✓	✓	✓					
	RN SIGNATURE / E. NO:			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					

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

MHI/ICN/2022/102

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SURGICAL SITE INFECTION

Ward :	Contact No :	Consultant Name :
Diagnosis :		Surgeon Name :
Surgery / Procedure :		ASA GRADE : 1 2 3 4 5 E
DOA :	DOS :	DOD :
Diabetes :	HB A1C	Pre op FBS : mg/dt Time :
Weight / BMI :		

PRE OPERATIVE PREPARATION

S.NO:	CRITERIA	DATE	TIME	RN NAME
1	Pre operative chlorhexidine bath (Previous day of surgery) - 1			
2	Pre operative skin preparation (Previous day of surgery)			
3	Pre operative chlorhexidine bath (On the day of surgery) - 1			
4	Pre operative chlorhexidine mouth wash gargle (on the day of surgery)			
5	Sterile preparation (before shifting to OT)			

TO BE FILLED BY OT NURSE

Incision Time :	Duration of Surgery :

1ST DOSE OF ANTIBIOTICS DETAILS

IF SURGERY EXCEEDING MORE THAN 4 HOURS INTRA OPERATIVE ANTIBIOTICS DETAILS

TIME	DRUG NAME	DOSE	TIME	DRUG NAME	DOSE

POST OPERATIVE ANTIBIOTICS DETAILS

DRUG NAME	DOSE	FREQUENCY	FROM	TO	TOTAL DOSAGES

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.JANARDHANAN S
83/Male/MH1202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
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Initial Date: 4/1/24	Time: 8.00	Modified Date:	Time:
Reason for Modification:		Diagnosis: RHD S/P MVR / CAD – S/P CABG	

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 (N) diet	[illegible]
			E Pt Had a diet	[illegible]
			N Pt on normal diet	[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 FM O_2 4 litres	[illegible]
			E Pt on FM O_2 [illegible] O_2	[illegible]
			N Pt on NP 2 lit O_2 flow	[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 Pt oral intake taken	[illegible]
			E Pt take a oral fluids	[illegible]
			N Pt on I/O chart maintained	[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 communication E pt good verbal communication N Pt on Good communication	[illegible] [illegible] [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 medication given as Per drug chart. E Administration medication as per drug chart N Medication given as per drug chart	[illegible] [illegible] [illegible]

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jay[illegible]	JAYAPR[illegible]	[illegible]	5/1/23	10:00

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ADULT NURSING CARE PLAN

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
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Initial Date: 4/1/24 **Time:** 1.10 **Modified Date:** **Time:**

Reason for Modification:

Diagnosis: RHD S/P MVR / CAD - S/P CABG

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 N 5 pt on soft 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 E N 5 pt on RA 1 LPM/ onflow	
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 N 5 pt on RA, 1L/ per day.	

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	
			N Spton blood communication	[signature] 002
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	
			N Spt ormedication given as per docment	[signature] 002

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jay	JAYADEV	002	5/1/24	10.00

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

ADULT NURSING CARE PLAN

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 5/1/24	Time: 8:00	Modified Date:	Time:
Reason for Modification:		Diagnosis: RHD S/P MVR / CAD - S/P CABG.	

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 ⓝ bland ⓝ diet	[signature]
			E	pt ⓝ diet	[signature]
			N	pt on normal diet	[signature]
OXYGENATION ☐ Room Air ☑ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will 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 NPO 2 2 litres on flow.	[signature]
			E	pt SPO_2 99%.	[signature]
			N	SPO_2 - 96%	[signature]
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M	Pt oral intake taken	[signature]
			E	pt I/O chart maintained	[signature]
			N	I/O chart maintained	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-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 bed mobilized. E Pt bed Mobilized N Pt well mobilized	
ELIMINATION ☑ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt CBD (P) D_2 E pt CBD - D_2 N Elimination Pattern good	
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 integrity E Pt (N) ~~Pat~~ Skin Integrity N Skin is intact	

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 clean & well groomed E Pt clean & well groomed N PE 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 (+). E Pt ID band (+) N ID Band (+)	
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 position. E Pt comfortable position N Pt on comfortable position	
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 are checked & recorded. E Pt V/S checked N PE vitals is 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 Pt psychological support given. E Pt psychological support given N Psychological Support given	

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 communication E Pt well communication N Pt well Communication	
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 drug chart E due drugs are given N due drugs are given	

	Signature	Name	Emp. ID	Date	Time
Endorsed by		R. Nalini	0024	5/11/24	18:00

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ADULT NURSING CARE PLAN

Patient Details
Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 6/1/24	Time: 8.00	Modified Date:	Time:
Reason for Modification:		Diagnosis: RHD /s/p MVR /s/p CABG	

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 (N) Diet E Pt had (N) diet N Pt had (N) diet	SD SD SD 06/06
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 Pt SpO2 99% N SpO_2 - 96%	SD 06/06 SD 06/06 SD 06/06
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt I/O chart monitored E Pt I/O chart monitored N I/O chart monitored	SD 5.12 SD 06/06 SD 06/06

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	[illegible]
			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 self voided	[illegible]
			E	Pt self voided	[illegible]
			N	Pt self voiding	[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	—	
			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 good hygiene maintained E Pt good hygiene. N Pt on good hygiene	5.D.
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 Checked E Pt ID band. Checked N ID Band ✓	5.D.
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 & Recorded E pt v/s checked N V/S is checked	5.D.
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	S.D
			E	Pt Communication well	
			N	Pt Communication well	
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 Due medication	S.D
			E	pt due medication	
			N	Due medication are given	

Endorsed by	Signature	Name	Emp. ID	Date	Time
		S. Nalini	0024	6/1/24	13:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 7/1/24.	Time: 7.00	Modified Date:	Time:
Reason for Modification:		Diagnosis: RHD / S/p MVR	

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 Ⓝ diet	[signature] 0207
			E pt had Ⓝ diet	[signature]
			N pt had Ⓝ diet	[signature]
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will 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 is on room air	[signature] 0207
			E pt SpO_2 99%	[signature]
			N pt is on room air.	[signature]
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt I/O chart maintained	[signature] 0207
			E pt I/O chart maintained	[signature]
			N pt I/O chart maintained.	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-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 well mobilized **E** Pt well Mobilized **N**	[illegible] 0207 [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 normal elimination pattern **E** Pt @ Elimination pattern **N**	[illegible] 0207 [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** — **E** — **N**	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☑ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☑ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M pt well groomed E pt well groomed N Pt well groomed	EC 0207 [illegible] [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 ID Band (+) E pt ID band (+) N pt ID (+) band	EC 0207 [illegible] [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 — 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 & recorded E pt v/s checked & recorded N pt V/S checked recorded	EC 0207 [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 — 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 well communicated	RC 0807
			E Pt well communicated	[illegible] 0801
			N Pt well communicated	[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 due drugs are given	RC 0807
			E Pt due drugs are given	[illegible] 0801
			N Pt due drugs are given	[illegible]

	Signature	Name	Emp. ID	Date	Time
Endorsed by	[illegible]	S. Nalini	0084	7/11/24	18:00

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(A Unit of United Alliance Healthcare Pvt Ltd)

ADULT NURSING CARE PLAN

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

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:** RHD, S/P MVR	

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 (N) 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 is on 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 I/O chart monitoring 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 4000 mobilized	02/25
			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** Normal Elimination Pattern	02/25
			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** Maintain Normal skin intact	02/25
			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 Good hygiene E N	0225
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 ID Band Present E N	0225
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M — E N	
OBSERVATION ☐ Vital Signs ☑ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Vital Signs Checked recorded E N	0225
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 good communication **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 given as Per doug Chart **E** **N**	

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nag	L. Nalini	0084	8/1/24	1800

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

Medway Heart Institute
Every heart beat counts

ORAL ANTICOAGULATION CHART

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

NAME ..... AGE: ..... SEX: ..... UHID No : .....

DOS: . ..... DRUG: ..... VALUE USED: .....

DATE	P.T.	I.N.R.	DOSE TO BE GIVEN	DR.SIGN	GIVEN BY S/N SIGN	W/B S/N SIGN
5/1/24			T. Acitrom 2mg			
5/1/24	19.8.	1.6.	—			
6/1/24			T. Acitrom 2 mg			
7/1/24.			T. Acitrom 3mg			

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

NABH ACCREDITED

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 4	4	4
					Time: 14	8	20
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	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	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	2	2	2
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or 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	3	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		3	3	3
				TOTAL SCORE	16	16	16
				Initial & Emp. No. of Staff Nurse:	02444	28	
				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*

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MHI/NUR/2022/045

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 4	1	24
					Time:		10
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
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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
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
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			3
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				TOTAL SCORE			17
				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*

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MHI/NUR/2022/045

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 5	1	2
					Time: N	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 oyer 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	3	3	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	1	1	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	2	2	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	3	3	4
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	16	16	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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Dr.G. GNANAVELU

MHI/NUR/2022/045

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 6	1	14
					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	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:	SD 02		
				Initial & Emp. No. of Sr. Staff Nurse:	Nee 24	Nee 24	Nee 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*

S.No. : 22

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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

				Date:	7	1	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	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
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FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	23	23	23
				Initial & Emp. No. of Staff Nurse:	[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				**Initial & Emp. No. of Sr. Staff Nurse:**	[illegible] 24	[illegible] 24	[illegible] 24

S.No. : 22

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Dr.G. GNANAVELU

MHI/NUR/2022/045

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 8		
					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		
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				TOTAL SCORE	22		
				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*

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Dr.G. GNANAVELU

MHI/NUR/2022/052

Medway Heart Institute
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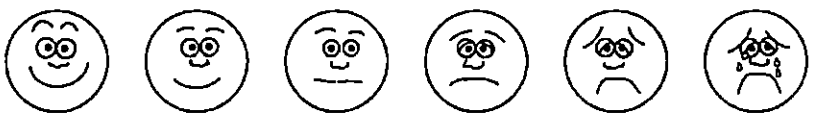
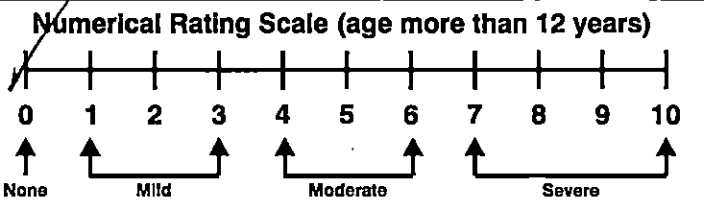
PAIN RE-ASSESSMENT & MONITORING CHART

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.
4/1/24 1.15	0/10	No pain	—	—	—	0240	
2.15	0/10	No pain	—	—	—	0240	
3.15	0/10	No pain	—	—	—	0240	
4.15	0/10	No pain	—	—	—	0240	
5.15	0/10	No pain	—	—	—	0240	
6.18	0/10	No pain	—	—	—	0240	
7.15	0/10	No Pain	—	—	—	02HH	
8.15	0/10	No Pain	—	—	—	02HH	
9.00	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.
4/11/27 10.00	0/10	No pain	—	—	—		
11.00	0/10	No pain	—	—	—		
12.00	0/10	No pain	—	—	—		
13.00	0/10	No pain	—	—	—		

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)	 
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Pharmacological Interventions as per doctor's prescription	

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MHI/NUR/2022/052

F Mr.JANARDHANAN S
N 83/Male/MHI202481589
U 04/01/2024/IPH2024000025
D
D Dr.G. GNANAVELU
C

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.
14.00	0/10	No pain	—	—	—		
15.00	0/10	No pain	—	—	—		
16.00	0/10	No pain	—	—	—		
17.00	0/10	No pain	—	—	—		
18.00	0/10	No pain	—	—	—		
19.00	0/10	No pain	—	—	—		
20.00	0/10	No pain	—	—	—		
21.00	0/10	No pain	—	—	—		
22.00	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.
4/1/24 23:00	0/10	No pain	—	—	—	D24	
24:00	0/10	No pain	—	—	—	D24	
1:00	0/10	No pain	—	—	—	D24	
2:00	0/10	No pain	—	—	—	D24	

PAIN SCALES

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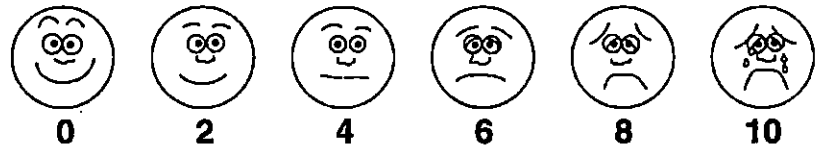
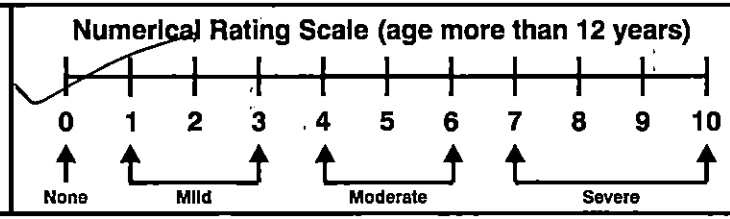
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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Dr.G. GNANAVELU

MHI/NUR/2022/052

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.
5/1/24 3:00	0/10	No pain	—	—	—	0240	
4:00	0/10	No pain	—	—	—	0240	
5:00	0/10	No pain	—	—	—	0240	
6:00	0/10	No pain	—	—	—	0240	
7:00	0/10	No pain	—	—	—	0240	
8:00	0/10	No Pain	—	—	—		
9:00	0/10	No Pain	—	—	—		
10:00	0/10	No pain	—	—	—		
11:00	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.
12:00	0/10	No pain	—	—	—		
16:00	0/10	No pain	—	—	—		
20:00	0/10	No Pain	—	—	—		
5/1/24 0:00	0/10	No Pain	—	—	—		

PAIN SCALES

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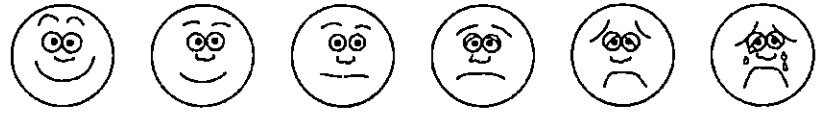
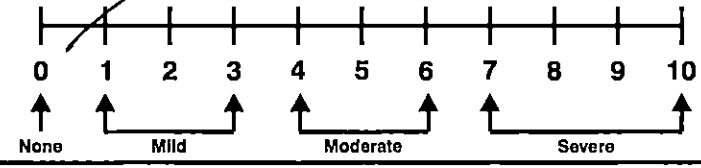
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 **Numerical Rating Scale (age more than 12 years)** 
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Dr.G. GNANAVELU
Consultant.

MHI/NUR/2022/052

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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.
6/1/24 10.00	0/10	No Pain	—	—	—	S.D. 0112	Naa 024
14.00	0/10	No pain	"	"	"	0124	Naa 024
18.00	0/10	No pain	"	"	"	0124	Naa 024
22:00	0/10	No Pain	"	"	"	00188	Naa 0024
7/1/24 2:00	0/10	No Pain	"	"	"	00188	Naa 024
6.00	0/10	No Pain	"	"	"	0086	Naa 024
10.00	0/10	No pain	"	"	"	R.C 0807	Naa 024
14.00	0/10	No pain	"	"	"	0201	Naa 024
18.00	0/10	No pain	"	"	"	021	Naa 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.
20:00	0/10	No Pain	—	—	—	[illegible]	[illegible]
22:00	0/10	No Pain	—	—	—	[illegible]	[illegible]
6:00	0/10	No Pain	—	—	—	[illegible]	[illegible]
10:00	0/10	No Pain	—	—	—	[illegible]	[illegible]

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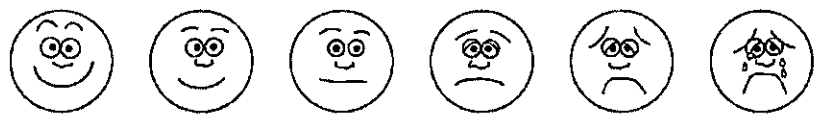
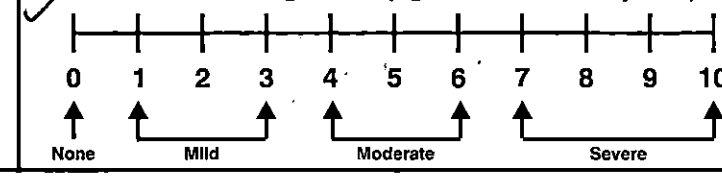
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	
	Numerical Rating Scale (age more than 12 years) 
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Dr.G. GNANAVELU

MHI/NUR/2022/047

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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	4/1/24	5/1/24	6/1/24	7/1/24	8/1/24		
	Time	1.20	2:00	6.00	4.00	6.00		
S. No.	**PARAMETERS**							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0		
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	0	0		
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0		
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0		
5	Entire leg swollen (Assess for both legs)	0	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	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		
9	Previously documented DVT (Assess for both legs)	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		
	FINAL SCORE	0	0	0	0	0		
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	low	low	Low	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 & Emp. No. of Sr. RN							

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NABH ACCREDITED

MHI/NUR/2022/046

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Dr.G. GNANAVELU

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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	4/1/24	4/1/24	4/1/24	4/1/24	5/1/24	5/1	5/1/24	6/1/24	6/1
		Time	1.20	8:00	14:00	20:00	8:00	14:00	22:00	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			60	45	45	45	45	45	45	30	30
Low Risk (0 - 24)											
Medium Risk (25 - 44)											
High Risk.(45 or above)											
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN											

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

INTERVENTIONS *Tick as per the Risk Score*	Date	4/1/24	4/1/24	4/1/24	4/1/24	5/1/24	5/1	5/1	5/1	
	Time	1:00	8:00	14:00	20:00	8:00	14:00	22:00	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		✓	NA	NA	NA	NA	NA	NA	NA	NA
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	6/1/24	7/1/24	7/1	8/1/24	8/1/24				
		Time	22.00	8.00	14.00	20.00	8.00				
History of falling (immediate or within 6 months)	No		0	0	0	0	0	0	0	0	0
	Yes		25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No		0	0	0	0	0	0	0	0	0
	Yes		20	20	20	20	20	20	20	20	20
AMBULATORY AID											
None / Bed Rest / Nurse Assist			0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker			15	15	15	15	15	15	15	15	15
Furniture			30	30	30	30	30	30	30	30	30
GAIT											
Normal / Bed Rest / Wheel Chair			0	0	0	0	0	0	0	0	0
Weak			10	10	10	10	10	10	10	10	10
Impaired			20	20	20	20	20	20	20	20	20
MENTAL STATUS											
Oriented to own stability			0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations			15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, 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	50				
Low Risk (0 - 24)											
Medium Risk (25 - 44)											
High Risk (45 or above)			✓	✓	✓	✓	✓				
Signature & Emp. No. of RN			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				
Signature & Emp. No. of Sr. RN			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				

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

INTERVENTIONS *Tick as per the Risk Score*	Date	6/1/24	7/1/24	7/1	8/1/24	8/1/24				
	Time	22.00	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		NA	NA	NA	NA	✓				
Accompany the patient while going to bathroom		NA	NA	NA	NA	✓				
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]	[illegible]	[illegible]	[illegible]				
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				

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NABH

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/055

Medway Heart Institute
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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 4/1/24 Time 1.30 Nurse Signature : _____

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	4/1/24	L	P	O	5/1/24	L	P	O	6/1/24	L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics		P	OD	V		P	OD	V		P	OD	J	
☐ Treatment		P	OD	V		P	OD	V					
Medications										P	OD	J	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	J	
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☑ Reporting of pain		P	OD	V		P	OD	V		P	OD	V	
☑ Pain Management		P	OD	V		P	OD	V		P	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
		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)

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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04/01/2024/IPH2024000025
Dr.G. GNANAVELU
Consultant:

MHI/IP/2022/055
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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 8.30 Nurse Signature : E-Cat 0207

Learning Record

Need	Date 4/1/24	Visit 1 L	P	O	Date 8/1/24	Visit 2 L	P	O	Date	Visit 3 L	P	O	Signature
Disease													Doctor
☐ Information on Disease / Diagnostics		P	OD	V	P	P	OD	V					13455
☐ Treatment													
☐ Medications		P	OD	V		P	OD	V					Doctor / Nurse
☐ Information on Safe and Effective use of medicines		P	OD	V		P	OD	V					NCO 0224
☐ Information on drug / drug and drug / food interactions		P	OD	V		P	OD	V					E-Cat 0207
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☑ Reporting of pain		P	OD	V		P	OD	V					
☐ Pain Management		P	OD	V		P	OD	V					NCO 0224
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													
☐ 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 : M. Padumathi Signature : M. Padumathi

Name of Discharge Nurse S. Nalini Signature : Nalini 0024

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NABH ACCREDITED

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/ICU/2022/056

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Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 4/1/24 **Time:** 1.15

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor	J. Madhukar	J. MADHUKAR	103767	4/1/24	1.15
Nursing Staff	Jay	JAYASHREE	0022	4/1/24	1.15
Dietician		Maria Catherine John Senior Dietitian	2401	4/1/24	10.50
Physiotherapist					
Patient Care Service Staff					

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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/054

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IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 5/1/24 Time: 12.30 Transferred from: CCU To: IInd Floor 208.

Diagnosis: RHD S/P MVR / CAD - S/P CABG.

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 124. (beats/min) | BP: 105/73 (mmHg) | Respiration: 21 (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	T. Aldactone	25mg		1-0-0	5/1/24 @ 8.00	☑ Yes ☐ No
2	T. DIGOXIN	0.25mg		½-0-0	5/1/24 @ 8.00	☑ Yes ☐ No
3	INJ-PAN	40mg		1-0-0	5/1/24 @ 8.00	☑ Yes ☐ No
4	T. RENOSAVE			1-0-1	5/1/24 @ 8.00	☑ Yes ☐ No
5	T. UDILIV	300mg		1-1-1	5/1/24 @ 8.00	☑ Yes ☐ No
6	INJ-LASIX	20mg	IV	1-1-0	5/1/24 @ 8.00	☑ Yes ☐ No
7	T. NATRISE			½-0-0	5/1/24 @ 8.00	☑ Yes ☐ No
8	INJ. HEPALIN		S/C	BD.	5/1/24 @ 8.00	☑ Yes ☐ No
9	T. Cardace	200mg		BD.	5/1/24 @ 8.00	☑ Yes ☐ No
10	T. Azithro	2mg.		HS		☐ Yes ☐ No
						☐ 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]	BALAJI	123819	5/1/24	12.30
Receiving Doctor	[signature]	Dr. Mohamed Ayaz	165308	5/1/24	1400

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: ______ Rate: ______ li/min	[✓] Yes [ ] No
NG Tube / Oral	[ ] Yes [✓] No [ ] For Feeding [ ] Gastric Suction [ ] Fluid Restriction	[✓] Yes [ ] No
Foley's Catheter	[✓] Yes [ ] No	[✓] Yes [ ] No
Intravenous Access	[✓] Peripheral Line [ ] Central Venous Line [ ] Others: ______	[✓] Yes [ ] No
Pressure Injury	[ ] Yes [✓] No If Yes, give details: ______	[✓] Yes [ ] No
Score	Fall Risk: 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	Tim
Transferring Nurse	[signature]	S. Allwin gnanapra	0162	5/1/24	
Receiving Nurse	[signature]	R. Sushma	0201	5/1/2	

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83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/IP/2022/051
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FAMILY COUNSELLING FORM

CONSULTANT- DR. G. GNANAVEL | DIAGNOSIS- RHD S/P MVR / CAD - S/P CABG

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
4/1/24	DOCTORS	Son	PT Condition Explained ?			
5/1/24	Doctor.		Family updated about cond.			

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/HOSP/2022/032
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PHONE / VERBAL ORDER FORM / CRITICAL VALUE REPORTING FORM

☐ Telephone order ☐ Verbal order ☑ Critical value reporting form

Name of the Drug ☑ N/A	Dose	Route	Additional information if any

Lab / Radiology Critical result reporting *(if any)*: ☐ N/A **Informed to Dr.:** BALAJI

AST - 843

ALT - 835

Non Medication Order *(if any)*: ☐ N/A

Order Recipient Response: *Please Tick*

Write Down ☑ Yes ☐ No **Read Back** ☑ Yes ☐ No **Confirm** ☑ Yes ☐ No

Received by	**~~Ordering Physician~~ / Informing Staff**
Signature:	**Signature:**
Name: Nathiya.	**Name:** Balaji
Emp. No.: 0240	**Emp. No.:** 2853
Date: 4/1/24	**Date:** 4/1/24
Time: 7:40	**Time:** 7:40

Action Taken *(only in Cases Of Critical Value)*:

	SIGNATURE	NAME	REG. NO.	DATE	TIME
Doctor	✓	BALAJI	MMP	4/1/24	7:40

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MHI/IP/2022/116

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025

IP No. / UHID No 2024/81589

AGE / SEX : Dr.G. GNANAVELU

Ward / Bed No. CCU 1.4.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
4/1/24	1.20	Rt metacarpal	0/5	patent	flushed	followed	
4/1/24	8.00	Rt metacarpal	0/5	Patient	flushed	followed	
	14.00	Lt metacarpal	0/5	patient	flushed	followed	
	20.00	Rt metacarpal	0/5	patent	flushed	followed	
5/1/24	8.00	Rt metacarpal	0/5	Patient	flushed	followed.	
	14.00	Lt metacarpal	0/5	Patent	flushed	followed	
	22.00	Lt METACARPAL	0/5	Patient	flushed	followed	
6/1/24.	8.00	Lt metacarpal	0/5	patent	flushed	—	
	14.00	Lt metacarpal	0/5	Patient	flushed	—	
	22.00	Lt METACARPAL	0/5	Patent	flushed	—	
7/1/24	8.00	Lt metacarpal	0/5	patent	flushed	—	
	14.00	Lt metacarpal	0/5	patent	flushed	—	
	20.00	Lt Metacarpal	0/5	Patent	flushed	—	
				LINE REMOVED			
8/1/24	RT FOREARM	RT Cubital	0/5	Patent	flushed	—	

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA : 4/1/23
UHID No. : CCU
Room No. : 4

S.No.	Date	Medicine Name	Qty.
1	4/1/23	STERILE BLADE 11 & 12	2

Nurse Name

Pharm Bill & Name

10:00 MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Name of Patient
Age / Sex
Consultant Name

IP No. :
DOA :
UHID No. :
Room No. : CCU.

No.	Date	Medicine Name	Qty.
1	5/1/24	TAB. Cal micronise Domagh	10.
2	"	TAB. Acitrom 2mg	10.
3	"	20 G Venflon	1
4	"	Easy fix	1
5	"	10 Cm Extension	1
6	"	11 Size Ryles tube	1

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

12:30

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REQUISITION FOR MEDICINE

Name of Patient	Mr.JANARDHANAN S	IP No.	:
Age / Sex	83/Male/MHI202481589	DOA	:
Consultant Name	04/01/2024/IPH2024000025	UHID No.	:
	Dr.G. GNANAVELU	Room No.	: CCU.

S.No.	Date	Medicine Name	Qty.
1.	4/1/24	TAB. DIGOXIN 0.25MG	5
2	"	TAB. PARACETAMOL 500MG	4
3	"	INJ. AMIODARONE 1 FOMY	5

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Name of Patient
Age / Sex :
Consultant Name :

IP No. :
DOA : ICU
UHID No. :
Room No. :

S.No.	Date	Medicine Name	Qty.
1	4/1/24	Inj. pan 40mg	1
2	"	T. Rennlace 500/150	5
3	"	T. udiliv 300mg	5
4	"	Inj. lasix 40mg	2
5	"	T. Nalise 5mg	5
6	"	Inj. monocef 1gm	2
7	"	Normal Saline 100ml	2
8	"	Gadine B Syringe 5ml	3
9	"	" " 10ml	3
10	"	" 20ml	2

Nurse Name

Pharm Bill & Name

@ 6:47

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : CCU

S.No	Date	Medicine Name	Qty.
1	2/1/24	T. ALDACTONE	5
2	"	T. URBOLIT	5
3	"	RBP flush	8
4	"	2ml (Syringe)	2
5	"	Thumb [illegible]	1

0240

Nurse Name **Pharm Bill & Name**

2 MHI/PHARM/2022/060

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

Medway Heart Institute
Where heart beat never stops...

REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex :

Consultant Name :

IP No. :

DOA :

UHID No. :

Room No. : ICU

No.	Date	Medicine Name	Qty.
5	11	NIV mask (adult)	1
6	11	NIV circuit	1
7	11	Urine bottle	1
8	11	Central line (triple lumen)	1
9	11	24G [illegible]	1
10	11	Xylocaine 2%	1
	11	10 ml D/S	5
12	11	5ml D/S	5
13	11	50 ml D/S	3
14	11	100 ml D/S	3
15	11	2-0 Ethilon	1

Nurse Name [signature]

Pharm Bill & Name

2Am MHI/PHARM/2022/060

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

Medway Heart Institute
Where heart beat never stops...

REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : CCU

No.	Date	Medicine Name	Qty.
16	11/1/22	[illegible]	10
17	"	Micropore (small)	1
18	"	Hand crew	2
19	"	Cotton	1 pack
20	"	Linen pad	20
21	"	F.c. Needle	1
22	"	Mouth wash	1
23	"	Kidney tray	1
24	"	Inj Lasix 40mg	3
25	"	IV set	1
26	"	Pro line	2
27	"	16 G Needle	5
28	"	Inj Cordarone 200	5
29	"	Inj. Clexane 0.6ml	1
30	"	Inj. Digoxin 1ml	1

Nurse Name **Pharm Bill & Name**

MHI/PHARM/2022/060

3:AM

Medway Hospitals®
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Medway Heart Institute
Where heart beat never stops...

REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : [illegible] (OP)

No.	Date	Medicine Name	Qty.
[illegible]	[illegible]	Co [illegible]	1
22	〃	Cap [illegible] Gomg	5
23	〃	T. Cilnidi[illegible] [illegible] 10mg	5
24	〃	T. [illegible]	5
25	〃	T. [illegible]	

Nurse Name [signature]

Pharm Bill & Name

(50)

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(A Unit of United Alliance Healthcare Pvt Ltd)

NABH

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

MHI/PHARM/2022/028

Medway Heart Institute
Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1 Height (cms): 166 Weight (kg): 82

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

Drug Details	Description of Allergy	Doctor's Sign:
—	NKDA	T. Madhukar Name: T. Madhukar Reg. No.

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
4/1/24	1.30	INJ. LASIX	40mg	IV		12619		0040	1.30
4/1/24	2.20	INJ. AMIODARONE	150mg	IV		12619		0040	2.20
4/1/24	3.00	INJ. DIGOXIN	0.25	IV		12619		0040	3.00
4/1/24	13.00	T. DOLO (650mg + 1g)		P/O				0162	13.00

Clinical Pharmacist

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

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

Time ↓

DRUG NAME
T. ALDACTONE

Dose	Route	Frequency
25mg PO	1-0-0	

Dr. Sign & Reg. No. / Seal

Start Date & Time: 4/1/24 @ 1:15

Stop Date & Time:

Additional Info:

8.00 | 4/1/24 | 8:30 | 8:30 | 8:30

DRUG NAME
INJ. HEPARIN

Dose	Route	Frequency
7500U	IV	1-0-1

Dr. Sign & Reg. No. / Seal

Start Date & Time: 4/1/24 @ 1:15

Stop Date & Time: 4/1/24 @ 8.00

Additional Info:

8.00 | 14.00 | 20.00

DRUG NAME
T. URBOUIT

Dose	Route	Frequency
	P/O.	0-0-1

Dr. Sign & Reg. No. / Seal

Start Date & Time: 4/1/24 @ 1:15

Stop Date & Time: 5/1/24 @ 7:00

Additional Info:

20.00

DRUG NAME
T DIGOXIN (LANOXIN)

Dose	Route	Frequency
0.25mcg	P/O	½-0-0

Dr. Sign & Reg. No. / Seal

Start Date & Time: 4/1/24 @ 1:15

Stop Date & Time:

Additional Info:

8.00 | 8:30 | 8:30

DRUG NAME
Inj. PAN

Dose	Route	Frequency
40mg	IV	1-0-0

Dr. Sign & Reg. No. / Seal

Start Date & Time: 4/1/24 @ 9:00

Stop Date & Time:

Additional Info:

7.00 | 7.00 | 7.00 | 7.30

Area In-charge Nurse Signature:

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

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

DRUG NAME T. RENOSAVE

Dose	Route	Frequency
500/150mg	P/O	1 — 0 — 1

Dr. Sign & Reg. No. / Seal: 97211

Start Date & Time: 4/1/24 @ 1020

Stop Date & Time:

Additional Info:

Time								
8.00			8:30	8:31	8:45			
20.00		20-00	20-00	20-00				

DRUG NAME T-UDILN

Dose	Route	Frequency
300mg	P/O	1 — 1 — 1

Dr. Sign & Reg. No. / Seal: 9724

Start Date & Time: 4/1/24 @ 1020

Stop Date & Time: 5/1/24 @ 8.30

Additional Info:

Time								
8.00			8:30					
14.00								
20.00		20-0						

DRUG NAME Inj. LASIX

Dose	Route	Frequency
20mg	IV	1 — 1 — 0

Dr. Sign & Reg. No. / Seal: 9724

Start Date & Time: 4/1/24 @ 1020

Stop Date & Time:

Additional Info:

Time								
8.00			8:30	8:30	8:30			
16.00					16.15			

DRUG NAME T-NATRISE

Dose	Route	Frequency
15mg	P/O	1/2 — 0 — 0

Dr. Sign & Reg. No. / Seal: 9724

Start Date & Time: 4/1/24 @ 1020

Stop Date & Time: 6/1/24 @ 10.30

Additional Info:

Time								
8.00			8:30					

DRUG NAME INJ. HEPARIN

Dose	Route	Frequency
7500 IU	S/C	BD

Dr. Sign & Reg. No. / Seal: J. Madhukar 105767

Start Date & Time: 4/1/24 @ 8.30

Stop Date & Time:

Additional Info:

Time								
8.00			8:30	8:30	8:47			
20.00		20-00	20-00	20-00				

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 ↓ | 5/11 | 6/11 | 7/11 | 8/11

DRUG NAME T. CARDARONE

Dose	Route	Frequency
200 mg		1-0-1

Dr. Sign & Reg. No. / Seal: L

Start Date & Time: 5/11/24 @ 10.00

Stop Date & Time:

Additional Info:

8.00 | 8.30 | 8.30 | 8.50

20.00 | 20.00 | 20.00

DRUG NAME T. AZITROM

Dose	Route	Frequency
1g		HS

Dr. Sign & Reg. No. / Seal: L

Start Date & Time: 5/11/24 @ 10.00.

Stop Date & Time:

Additional Info:

19.00

DRUG NAME T. URSETOR

Dose	Route	Frequency
300	P/O	1-0-1

Dr. Sign & Reg. No. / Seal: Dr. [illegible] 13/4/24

Start Date & Time: 06/04/24 6:30Pm

Stop Date & Time:

Additional Info:

8.00 | 8.30 | 8.30

20.00 | 20.00

DRUG NAME T. FEBUCOT

Dose	Route	Frequency
40 mg	P/O	1-0-0

Dr. Sign & Reg. No. / Seal: Dr. [illegible] 13/4/24

Start Date & Time: 06/04/24 6:30Pm

Stop Date & Time:

Additional Info:

8.00 | 8.30 | 8.30

20.30

DRUG NAME INJ. BROMAC

Dose	Route	Frequency
1-2g	IV	1-0-0

Dr. Sign & Reg. No. / Seal: [illegible]

Start Date & Time: 06/01/24 6:30Pm

Stop Date & Time:

Additional Info:

8.00 | 8.30 | 8.30

21.00

Area In-charge Nurse Signature: Nee 24 | Nee 24 | Nee 24 | Nee 24

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 ↓	8/11/24
8.00	8.55 [signature]

DRUG NAME T. ORRA

Dose	Route	Frequency
10mg.	oral	1-0-0

Dr. Sign & Reg. No. / Seal	Start Date & Time	Stop Date & Time
[signature] 183573	7/11/24	

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: [signature]

Clinical Pharmacist ... Heart Institute

Clinical Pharmacist
Medway Heart Institute

ANTIMICROBIALS

To be filled in by Doctors only

ANTIMICROBIALS (To be filled in by Doctors only)			Date → / Time ↓	To be filled by Nursing Staff only. Sign and time given							
				4/1/24	5/1/24	6/1	7/1/24				
DRUG NAME Inj. CEFTRIAXONE			10.30	[illegible]	[illegible]	10.30	10.30				
Dose 1.0g	Route IV	Frequency 1—0—1									
Dr. Sign & Reg. No. / Seal [signature] 97211		Start Date & Time 4/1/24 @ 1020		D1	D2	D3	D4				
		Stop Date & Time	22.30	0040	22.00	22.00	22.00				
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:				[signature]	[signature] 24	[signature] 24	[signature] 24				

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
4/1/24	1:20	Normal diet		12367					
5/1/24	8:00	Normal diet		12349					
6/1/24	8:00	Normal diet	K.Bo	134559					
7/1/24	8:00	Normal diet	K.Bo	134559					
8/1/24	8:00	Normal diet	K.Bo	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning				7/1/24	Morning	Suruthi	2268	M.
	Evening				7/1/24	Evening	Parameshwari	2333	N.
4/1/24	Night	Nathiya	0240		8/1/24	Night	Jeni priya.	0284	Jeni
4/1/24	Morning	Allwin gnanaraj	0162		8/1/24	Morning	M. Rohathi	0225	M.Rohathi
4/1/24	Evening	P. Mohamed	2352			Evening			
4/1/24	Night	Nathiya.	0240	N		Night			
5/1/24	Morning	S. Allwin gnanaraj	0162			Morning			
5/1/24	Evening	A. Nandhini	0178			Evening			
5/1/24	Night	A. ALBINUS	0088			Night			
6/1/24	Morning	M. Suruthi	2268	M.		Morning			
6/1/24	Evening	A. Nandhini	0178			Evening			
7/1/24	Night	B. Vanisri	0195			Night			

Asst:- RHD S/P MVR / CAD - S/P CABG

MHI/ICU/2022/076

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Medway Heart Institute
Every heart beat counts

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Age	Sex	Sheet No.
83	M	1

Height	Weight	BSA
± 166	± 82	1.86m²

A

SURGICAL PROCEDURE: DATE OF SURGERY: POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
4/1/24	1:20	NIV PC	15		12	6		321	421	375	40							
4/1/24	2:20	NIV PC	15		13	6		365	396	462	40							
4/1/24	3:00		PT	ON	Split FM			ON	FIO2									
	4:00				"													
	5:00				"													
	6:00				"													
	7:00				"													

CRITICAL CARE FLOWCHART

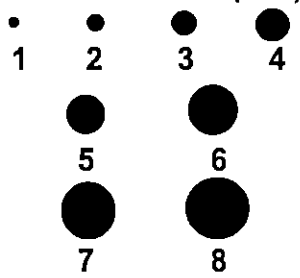
NEURO

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

4½:- RHD s/p MVR / CAD -/p CABG

MHI/ICU/2022/076

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Medway Heart Institute
Every heart beat counts

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Age 84 | Sex M | Sheet No. 2

Height 166 | Weight 82 | BSA 1.36 | A

SURGICAL PROCEDURE: DATE OF SURGERY: POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
4/1/24	8.00			PATIENT			ON	FM	O2	4 litter.								
	9.00	NMV/PS				6		17.4	826	750	40%							
	10.00	"				"												
	11.00				PATIENT	ON		FM	O2	4 litter ON FLOW.								
	12.00							"				"						
	13.00							"										
	14.00							"										
	15.00							"										
	16.00							"										
	17.00							"										

CRITICAL CARE FLOWCHART

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

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Oriented-5
Confused/Disoriented-4
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Sounds-2
No response-1

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Localise pain-5
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MOTOR ARMS/LEGS
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Wk-Weak
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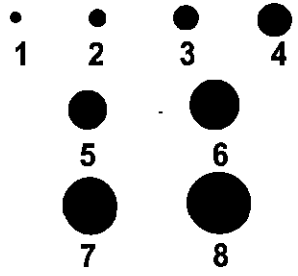
A-Anasthesia
CP-Chemical paralysis

PUPILS SCALE (mm)


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S1 S2
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Valve Replaced / Shunt
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COLOUR
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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
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Dr-Dependent Drainage

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F-Firm
Tn-Tender
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GASTRIC RESIDUAL
G-Green
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N-Normal
E-Enlarged

ΔSIS: RHD E MVR / CAD - S, P CAF

MHI/ICU/2022/076

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JCI ACCREDITED NABH ACCREDITED

Medway Heart Institute
Every heart beat counts

Name	Mr.JANARDHANAN S	Sheet No.
UHID	83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU	Age 88y · Sex M · 2
Blood group	Height 166 · Weight 82 · BSA 1.86m²	A

SURGICAL PROCEDURE: DATE OF SURGERY: POST-OP DAY:

CRITICAL CARE FLOWCHART

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_3	SAT%	BE
4/1/24	18.00				NP on	2 litre	O2.											
	19.00					"												
	20.00					"												
	21.00					"												
	22.00					"												
	23.00					"												
5/1/24	00.00					"												
	1.00					"												
	2.00					"												
	3.00																	

NEURO

EYES
Spon-4
Opens to speech-3
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Oriented-5
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S-Strong
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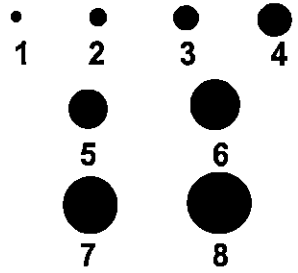

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HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
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NECK VEINS
JVP
N-Normal
In-Increased

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

A SK :- RHD S/P MVR / CAD - S/P CABG

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MHI/ICU/2022/076

Name	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025		Sheet No. 9
UHID No.	Dr.G. GNANAVELU	Age 58y / Sex M	
Blood Group	Height ±166	Weight ±82	BSA 1.36 m² A

SURGICAL PROCEDURE: DATE OF SURGERY: POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS										BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2	pH	PCO_2	PO_2	HCO_2	SAT%	BE
5/1/24	A 1:00	PA	on	NP-2		10 H	on	flow.									
	5:00					"											
	6:00					"											
	7:00					"											

CRITICAL CARE FLOWCHART

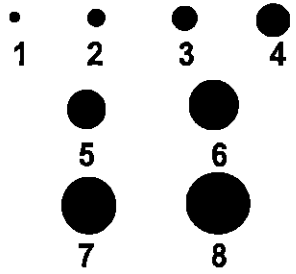
NEURO

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
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LIVERSIZE
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A SM:- RHD S/P MVR / CAD - S/P DBCP

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MHI/ICU/2022/076

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Name			Sheet No.
UHID No.	Age 83	Sex M	5
Blood Group	Weight 82	BSA 1.86m²	A

SURGICAL PROCEDURE: DATE OF SURGERY: POST-OP DAY:

DATE	TIME	VENTILATORS PARAMETERS										BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2	pH	PCO_2	PO_2	HCO_2	SAT%	BE
5/1/24	8.00		PATIENT		ON	NP	O2		2 litter.								
	9.00					"			"								
	10.00			PT	ON	ROOM			AIR								
	11.00					"											
			PATIENT		SHIFTED		TO		WARD.								

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
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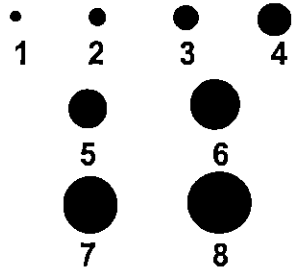
MOTOR ARMS/LEGS
S-Strong
Wk-Weak
O-Absent
A-Anasthesia
CP-Chemical paralysis

PUPILS SCALE (mm)


PUPILS REACTION
Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL
Br-Brisk
Sl-Sluggish
O-Absent

EDEMA
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O-Absent

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

LIVERSIZE
N-Normal
E-Enlarged

MHI/ICU/2022/076

Sheet No.	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU		Age	Sex
B		Height	Weight	BSA
		166	82	1.86 m²

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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		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
4/1/24	1:20									95%	33	137/84	98F						
4/1/24	2:20									94%	35	137/69	98F						
4/1/24	3:00									91%	29	120/90	98.2						
	4:00									90%	21	138/80	98.6						
	5:00									98%	22	125/71	98.2						
	6:00									90%	22	125/71	98.6						

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	1:20	4:00				
	EYES	4	4				
	VERBAL	4	4				
	MOTOR	5	5				
	ARMS R/L	WK	WK				
	LEGS R/L	WK	WK				
PUPILS	R.SIZE/REACTIION	BR	BR				
	L.SIZE/REACTION	BR	BR				
CARDIO-VASCULAR	HEART SOUNDS	S1S2	S1S2				
	VALVE CLICK	+	+				
	CAPILLARY REFILL	BR	BR				
	EDEMA	D	D				
	NECK VEINS	N	N				
PULMONARY	WORK OF BREATHING	AD	AD				
	SUCTION	—	—				
	SECREATIONS	—	—				
GASTRO INTESTINAL	BOWEL SOUNDS	+	+				
	ABDOMINAL TONE	SO	SO				
	N/G POSITION	—	—				
	GASTRIC RESIDUAL	—	—				
	LIVER	N	N				

	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	Drop Horly	Drop Horly				
	CHEST-PHYSIO	—	—				
	ACTIVITY	DE	DE				
	S/N NAME	Nathijah	Nathijah				
	TIME	1:20	4:00				
	SIGNATURE	[signature]	[signature]				

A 9d :- RHD S/P. MVR / CAD - S/P CABG.

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Sheet No.	Name			
	UHID No.		Age 83y	Sex M
B	Blood Group	Height 166	Weight 82	BSA 1.36 m²

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MHI/ICU/2022/076

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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_1BP	TEMP°F	Abd^{cm}G	TIME	IABP RATIO	IABP DURATION	PACEMAKER SETTING RATE	PACEMAKER SETTING MODE
5/1/24	8.00								B/L	98	26	129/64	97.1						
	9.00								B/L	89	21	116/60	97.1						
	10.00								B/L	98	26	113/51	97.1						
	11.00								B/L	100	21	105/73	97.1						
				PATIEN			SHIFTED			TO WARD.									

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	800					
	EYES	4					
	VERBAL	5					
	MOTOR	6					
	ARMS R/L	WK					
	LEGS R/L	WK					
PUPILS	R.SIZE/REACTIION	Br					
	L.SIZE/REACTION	Br					
CARDIO-VASCULAR	HEART SOUNDS	S_1S_2					
	VALVE CLICK	+					
	CAPILLARY REFILL	Br					
	EDEMA	0					
	NECK VEINS	N					
PULMONARY	WORK OF BREATHING	N					
	SUCTION	-					
	SECREATIONS	-					
GASTRO INTESTINAL	BOWEL SOUNDS	+					
	ABDOMINAL TONE	Soft					
	N/G POSITION	-					
	GASTRIC RESIDUAL	-					
	LIVER	N.					

	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	2hrly					
	CHEST-PHYSIO	-					
	ACTIVITY	PE					
	S/N NAME	Alwin					
	TIME	800					
	SIGNATURE						

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Medway Heart Institute
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Sheet No.	Name	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU		
	UHID No.		Age 83y	Sex M
B	Blood Group	Height 166	Weight 52	BSA 1.36 m²

DATE	TIME	BIOCHEMISTRY							VITAL PARAMETERS							CARDIAC ASSIST DEVICE			
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
5/1/4	4:00						4:00		Brcl	94	34	120/64	98.6						
	5:00						5:00		Brcl	98	14	123/64	98.6						
	6:00						6:00		Brcl	94	16	123/64							
	7:00						7:00		Brcl	96	14	120/70	96.4						

CRITICAL CARE FLOWCHART

	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						

MHI/ICU/2022/076

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Sheet No.		Age	Sex
3		88	M
B	Blood Group	Height ±166	Weight ±82	BSA 1.36m²

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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_1BP	TEMP°F	Abd^{cm}G	TIME	IABP RATIO	IABP DURATION	PACEMAKER SETTING RATE	PACEMAKER SETTING MODE
4/1/24	18.00						18.00		Bld.	98%	21	120/60	98.1°F						
	19.00						19.00		Bld.	97%	16	125/56	97.8°F						
	20.00						20.00		BrL	96	18	108/51	98						
	21.00						21.00		BrL	97	20	125/64	97.8						
	22.00						22.00		BrCL	98	24	121/61	98.6						
	23.00						23.00		BrCL	91	19	109/67	98.6						
5/1/24	00.00						0.00.00		BrCL	83	20	110/89	98.6						
	1.00						1.00		BrCL	93	25	124/55	98.						
	2.00						2.00		BrCL	99	14	109/61	98.6						
	3.00						3.00		BrCL	98	17	109/61	98.						

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	8:00	12:00			20:00	00:00
	EYES					4	4
	VERBAL					5	5
	MOTOR					6	6
	ARMS R/L					WK	WK
	LEGS R/L					WK	WK
PUPILS	R.SIZE/REACTIION					BV	BV
	L.SIZE/REACTION					BV	BV
CARDIO-VASCULAR	HEART SOUNDS					S1S2	S1S2
	VALVE CLICK					+	+
	CAPILLARY REFILL					BV	BV
	EDEMA					0	0
	NECK VEINS					N	N
PULMONARY	WORK OF BREATHING					AD	AD
	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					C	C
	PD - FUNCTION					—	—
	DRAINAGE					—	—
	PD - SITE					—	—
SKN	COLOUR					—	—
	Sx WOUND-CHEST					—	—
	LEG					—	—
	DRESSING					—	—
	PRESSURE SORE-SITE					—	—
	AREA					—	—
	DRESSING CONDITION					—	—
MISCELL	POSITION CHANGE					2hrly	2hrly
	CHEST-PHYSIO					4hrly	4hrly
	ACTIVITY					PE	PE
	S/N NAME					NM	NM
	TIME					20:00	24:00
	SIGNATURE					[illegible]	[illegible]

MHI/ICU/2022/076

Sheet No.	Mr.JANARDHANAN S 33/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU	Age	Sex
(2)		33/4	m
B		Height 166	Weight 82	BSA 1.86m²

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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
4/1/24	8.00								BHC	96	28	125/84	97.8.						
	9.00								BHC	100	26	143/77	97.1						
	10.00								BHC	100	28	149/83	97.1						
	11.00								BHC	98	24	122/73	97.1						
	12.00								BHC	99	23	138/81	97.1						
	13.00								BHC	100	25	129/69	97.1						
	14.00								Bld.	95	26	115/69	98.1						
	15.00								Bld	99	23	105/60	98.1						
	16.00								Bld	98	24	93/57	98.2						
	17.00								Bld.	99	22	97/52	98.1						

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	8.00	12.00	4pm			
	EYES	4	4	4			
	VERBAL	4	4	5			
	MOTOR	5	5	6			
	ARMS R/L	WK	WK	WK			
	LEGS R/L	WK	WK	WK			
PUPILS	R.SIZE/REACTIION	Br	Br	Br			
	L.SIZE/REACTION	Br	Br	Br			
CARDIO-VASCULAR	HEART SOUNDS	S1S2	S1S2	S1S2			
	VALVE CLICK	+	+	+			
	CAPILLARY REFILL	Br	Br	Br			
	EDEMA	D	D	D			
	NECK VEINS	N	N	N			
PULMONARY	WORK OF BREATHING	Ab	Ab	Ab			
	SUCTION	-	-	-			
	SECREATIONS	-	-	-			
GASTRO INTESTINAL	BOWEL SOUNDS	+	+	+			
	ABDOMINAL TONE	Soft	Soft	Soft			
	N/G POSITION	-	-	-			
	GASTRIC RESIDUAL	-	-	-			
	LIVER	N.	N.	N.			

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE	-	-	cl			
	PD - FUNCTION	-	-	-			
	DRAINAGE	-	-	-			
	PD - SITE	-	-	-			
SKN	COLOUR	-	-	-			
	Sx WOUND-CHEST	-	-	-			
	LEG	-	-	-			
	DRESSING	-	-	-			
	PRESSURE SORE-SITE	-	-	-			
	AREA	-	-	-			
	DRESSING CONDITION	-	-	-			
MISCELL	POSITION CHANGE	2hrly	2hrly	2hrly			
	CHEST-PHYSIO	-	-	-			
	ACTIVITY	BE	BE	BE			
	S/N NAME	Allwin	Allwin	Letha			
	TIME	8.00	12.00	4pm			
	SIGNATURE						

MHI/ICU/2022/076

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Every heart beat counts

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Sheet No. 1

Age	Sex
83	M

Height	Weight	BSA
±166	±82	1.96m²

C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		Inj. Lasix 40/40	Inj. Amiodarone 150/50	Inj. Amiodarone 600/60			
4/1/23	1:00	50												50	3	↓	↓			
4/1/23	2:00	50												50	3	50	↓			
4/1/23	3:00	25												25	3	D/C	5			
	4:00	25												25	3		5			
	5:00	50												50	3		5			
	6:00	50												50	3		5			
	7:00	-												-	3		5			

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

MHI/ICU/2022/076

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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Age	Sex	Sheet No.
83Y	M	2

Height	Weight	BSA	
166	82	1.26	C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		INJ. Amiclox 625/6c	INJ. LASIX 40/6c				
4/1/24	8.00	200	200											200	5	3				
	9.00	150	350											350	5	3				
	10.00	150	500											500	5	3				
	11.00	100	600											600	5	3				
	12.00	170	770											770	5	3 D/C				
	13.00	150	920											920	5					
	14.00	150	1070											1070	5					
	15.00	100	1170											1170	5					
	16.00	130	1300											1300	5					
	17.00	150	1450											1450	D/C 25					

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

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R-Redness
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DRAINAGE

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MHI/ICU/2022/076

Name	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU			Sheet No. 3
UHID		Age 88	Sex M	
Blood Group	Height ±166	Weight ±82	BSA 1.86.	C

CRITICAL CARE FLOWCHART

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		Inj Amiodarone					
4/1/24	18pm	250	1700											1700	2.5·					
	19.00	200	1900											1900	2.5					
	20.00	200	2100											2100	2.5					
	21.00	210	2310											2310	2.5·					
	22.00	100	2410											2410	2.5					
	23.00	155	2565											2565	2.5					
5/1/24	24.00	70	2635											2635	2.5					
	1.00	60	2695											2695	2.5					
	2.00	100	2795											2795	2.5					
	3.00	100	2895											2895	2.5					

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

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PRESSURE SORE

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Name	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU		Sheet No. 4
UHID No.		Age 83 Sex M	
Blood Group		Height 166 Weight 82 BSA 1.36 m²	C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		I.V Cardaron					
5/1/24	4:00	50	2945											2945	2.5					
	5:00	100	3045											3045	2.5					
	6:00	5	3050											3050	2.5					
	7:00	5	3055											3055	2.5					

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
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HC-High Coloured

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FUNCTION

Dr-Draining
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Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Name			Sheet No.
UHID No.	Age 83	Sex M	5
Blood Group	Weight 82	BSA 1.86 m²	C

+166

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL							
5/1/24	8.00	200	200											200						
	9.00	250	450											450						
	10.00	150	600											600						
	11.00	200	800											800						
							PATIENT				Shift									

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME	
		central line (Rt side) removed B/o DR. Gnanavelu at 10.30AM

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

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LINES / TUBES CONDITION

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Dr-Draining
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HL-Heparin Lock
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Name	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025		Sheet No.
UHID No.	Dr.G. GNANAVELU	ge 83y Sex M	
Blood Group		Weight ± 82 BSA 1.36m²	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 AMT.	N/G/ORAL TOTAL	TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
5/1/24	4:00						2.5	–	600	692	2253	74	sinus						Warm	++			
	5:00						2.5	–	600	694.5	2350.5	75	sinus						Warm	++			
	6:00						2.5	–	600	694	2353	67	Sinus						Warm	++			
	7:00						2.5	–	600	699.5	2355.5	70	Sinus						Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY ..... HRS

DRAINAGE: **TOTAL INTAKE:**

URINE : **TOTAL OUTPUT:**

TOTAL BALANCE:

P.T.O.

Mr.JANARDHANAN S
83/Male/MHI2024S1589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

Name		Sheet No.	
UHID No.	Sex M		
Blood Group	Height ± 166 / Weight ± 82 / BSA 1.86 m²	D	

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FLUID ASSESSMENT (contd.) **HAEMODYNAMICS** **Blood Group:**

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL AMT.	N/G/ORAL TOTAL	TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
5/1/24	8.00							100	100	100	100	95	Sinus						warm	H.			
	9.00							100	200	200	250	84	Sinus						warm	H.			
	10.00								200	200	400	95	sinus						warm	H			
	M.00							100	300	300	500	92	Sinus						warm	H			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY ..... 24 hrs ..... HRS

DRAINAGE: —

URINE : — 3055

TOTAL INTAKE: = 699.5ml

TOTAL OUTPUT: = 3055 ml

TOTAL BALANCE: = 2355.5ml

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	80		
B.P.	116/60.		

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
C-line	(RP)	4/1/23	2		✓R		
U.Cath		4/1/23	2		✓		

Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU		Age 83/4	Sex m	Sheet No. 2
	Height 186	Weight 82	BSA 1.36 m²	D

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FLUID ASSESSMENT (contd.) **HAEMODYNAMICS** **Blood Group:**

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL AMT.	N/G/ORAL TOTAL	TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
4/4/24	8.00						8	-	-	8	-192.	115	AF						Nam	H.			
	9.00						8	-	-	16	-384	113	AF						Nam	H.			
	10.00						8	1-	-	24	-476	114	AF						Nam	H			
	11.00						8	50	50	82	-518	110	Af						Nm	H			
	12.00						8	50	100	140	-630	101	Af						Nam	H			
	13.00						5	-	100	145	-775	99	Sinus						Nam	H.			
	14.00						5	200	300	350	-720	112	Sinus						Nam	H			
	15.00						5	-	300	355	-815	90	Sinus						Nam	H			
	16.00						5	-	300	360	-940	86	Sinus						Nam	H			
	17.00						2.5	-	300	362.5	-1087.5	89	Sinus						Nam	H			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY ..... **HRS**

DRAINAGE: - **TOTAL INTAKE:** - 96 ml

URINE : - 200ml **TOTAL OUTPUT:** - 200ml

TOTAL BALANCE: -104

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	107		
B.P.	147/87.		

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
Metacaud	(LF)	3/1/24	D2			✓	
CVP	(RJ)	3/1/24	D2			✓	
U Cath		3/1/24	D2			✓	

Mr.JANARDHANAN S
83/Male/MHI202481589
04/01/2024/IPH2024000025
Dr.G. GNANAVELU

	Age	Sex	Sheet No.
	83	M	01

Height	Weight	BSA	
166	82	1.36 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
								AMT.	TOTAL														
4/1/24	1:00						3	—	—	3	44⁻	162	AF						warm	++			
4/1/24	2:00						53	—	—	56	6⁻	132	AF						warm	++			
4/1/24	3:00						8	—	—	64	39⁻	138	AF						warm	++			
	4:00						8	—	—	72	47⁻	128	AF						Warm	++			
	5:00						8	—	—	80	30⁻	120	AF						Warm	++			
	6:00						8	—	—	88	38⁻	115	AF						Warm	++			
	7:00						8	—	—	96	96⁺	110	AF						Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY ..... **HRS**

DRAINAGE: **TOTAL INTAKE:**

URINE : **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			136 b/min
B.P.			130/84

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
Metacarbol	(Rt)	3/1/24	D2				✓
CVP	Rt	1/1/23	D1				✓
U-cath	—	3/1/23	D2				✓

Name	Mr.JANARDHANAN S 83/Male/MHI202481589 04/01/2024/IPH2024000025 Dr.G. GNANAVELU			Sheet No.
UHID		Age 83	Sex M	8
Blood Group		Height 166	Weight 82	BSA 1.36	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 AMT.	N/G/ORAL TOTAL	TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
31/24	18.00						2.5	—	300	365	-1335	99	Sinus.						Warm	47.			
	19.00						2.5	100	400	467.5	-1432.5	83	Sinus						Warm	42			
	20.00						2.5	50	450	520	-1580	94	Sinus						Warm	44			
	21.00						2.5	70	520	592.5	-1717.5	96	Sinus						Warm	++			
	22.00						2.5	—	520	595	-1815	94	Sinus						Warm	++			
	23.00						2.5	50	570	641.6	-1914.5	95	Sinus						Warm	++			
1/1/24	00.00						2.5	—	570	650	-1985	98	Sinus						Warm	++			
	1.00						2.5	—	570	652.5	-2042.5	83	Sinus						Warm	++			
	2.00						2.5	—	570	659.5	-2135.5	87	Sinus						Warm	++			
	2.00						2.5	30	600	689.5	-2205.5	83	Sinus						Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY ..... **HRS**

DRAINAGE: **TOTAL INTAKE:**

URINE : **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			NP2 WF
B.P.			108/ST.

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT