

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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Mrs. SHARON RUTH D
49/Female/MHI202381499
02/01/2024/IPH2024000016
Dr. K. JAISHANKAR



MHI/IPD/2022/002



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ADMISSION SLIP

Admitting Doctor:

Dr. Jaishankar

Speciality:

Cardiologist

Advised Date & Time:

2/1/24 @ 15:29

Provisional Diagnosis:

PSVT - ? AINRT

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):

CAT + EP + RFA BD

Blood Product Requirement:

☐ No

☒ Yes

(Kindly specify details of components required in space below)

Expected Duration of Stay:

3-4 days

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

Payer: ☒ Self ☐ Insurance ☐ Others:

Rs. 27,61,000/-

Instructions to Nurse (if any):

→ semiprivate category

→ cat's part app. request. (R) take collected

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

Dr. Jaishankar
ICM
2/1/24

Dr. Jaishankar

49448

2/1/24

15:29

For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☒ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others _____

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

2/1/24

15.29a

2/1/24

3.35pm

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



Raveen

0283.

2.1.24

3.35pm

ADMISSION FORM

Marital Status M	Full Address Plot. No. 110, MEENAKSHI ELLAM, MANI NAGAR, CHINNA NOLUMBUR, MOGAPPAR, CHENNAI - 600 95. (NEXT TO SAREE AMBUDJA AGRO FOODS LTD.)		EMERGENCY Telephone Number 96000 62131
Occupation G			
Referred from Dr. Jaishankar	Date of Time of Admission 2/1/24 - 3.35 PM	Date & Time of Discharge 4/1/24	Total No. of Days 3 days
UNIT Cardiology	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
PSVT - AVNRT			I49.1
REVERTED WITH INJ. AMIODARONE ON 18.12.2021			
NORMAL LV FUNCTION			I50.1
ANEMIA			D64.9
DATE	OPERATION / PROCEDURES		ICPM Code
3/1/24	CORONARY ANGIOGRAM		88.50
3/1/24	ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION		
DATE	TYPE OF ANESTHESIA		
3/1/24	<input checked="" type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL		
DISCHARGE STATUS			
<input checked="" type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Signature of the Consultant K. Jaishankar 49448		Signature of Medical Records Officer N. S. S. S. 2568	

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

How

செவிலியர் கையொப்பம்

Signature of Admitting Nurse

02/01/2024

தேதி

Date

[Signature]

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Guardian

உறவுமுறை husband.

Nature of Relationship



GENERAL CONSENT FOR ADMISSION



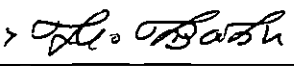
I, D. SHARON RUTH the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ 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 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.
- 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 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 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		MRS. D. SHARON RUTH	2/1/24	3:35 PM
Surrogate/Guardian (if applicable #) ATTENDANT		D. TEPHILLAH SHERYL SHAMMAH (DAUGHTER) (Write name and relationship with patient)	2/1/24	3:35 PM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		MR. DANIEL BABU (Husband)	2/1/24	3:35 PM
Interpreter (if applicable)				

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



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DISCHARGE SUMMARY

IP No.	IPH2024000016	D.O.A	: 02/01/2024
UHID	MHI202381499	D.O.P	: 03/01/2024
Name	Mrs. SHARON RUTH. D	Room No.	: 205
Age / Gender	48Years / FEMALE		
Consultant	: Dr. JAISHANKAR.K MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology	D.O.D	: 04/01/2024

DIAGNOSIS:

PSVT – AVNRT

REVERTED WITH INJ.AMIODARONE ON 18.12.2021

NORMAL LV FUNCTION

ANEMIA

PROCEDURE:

1. CORONARY ANGIOGRAM DONE ON 03.01.2024 – NORMAL EPICARDIAL CORONARIES.
2. SUCCESSFUL ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE FOR TYPICAL AVNRT - SLOW PATHWAY MODIFICATION DONE ON 03.01.2024.

BRIEF HISTORY:

Mrs. Sharon Ruth. D, 48 years/Female, Presented with complaints of palpitation lasting for half a day on and off. Complaints of breathlessness on exertion. History of SVT – reverted with Inj. Amiodarone on 18.12.2021. She was referred to Medway heart institute on 26.12.2023, evaluated in OPD and diagnosed as PSVT – AVNRT. She was advised for Coronary angiogram + Electrophysiology study + radiofrequency ablation using 3D ensite for which she has been admitted.

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

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

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

HR	-	100bpm
BP	-	110/70mmHg
SPO ₂	-	96% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft, NT

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NAME: MRS SHARON RUTH. D

UHID: MHI202381499

IP.NO: IPH/2024/00016

**Every heart beat counts**
(A Unit of United Alliance Healthcare Pvt Ltd)**INVESTIGATIONS:****BLOOD(23.12.2023)** : Hb – 8.7gm/dl, TC- 7200 cells/cumm, PLT – 396000 lacs/cumm, Urea – 31mg/dl, Creatinine- 0.7 mg/dl, INR – 1.02.**BASAL ECG:** NSR, HR – 86BPM, within normal limits.**TACHYCARDIA ECG** : SVT @ 160BPM, NARROW QRS COMPLEX. SHORT RP, S/O AVNRT.**CXR:** No cardiomegaly, BVM+, B/L lung fields clear.**SCREENING ECHO(02.01.2024):** S/P ASD patch closure. ASD path intact. No residual shunt. All chambers normal sized. No RWMA. Normal LV systolic function. EF – 62%. Grade I diastolic dysfunction. IVS intact. All valves are structurally normal. Trivial MR. Trivial TR. No PAH. IVC normal in size and collapsing. No clot vegetation / effusion.**POST RFA INVESTIGATIONS:****ECG:** sinus rhythm, HR – 76bpm, Within Normal Limits.**SCREENING ECHO:** S/P ASD patch closure + EP + RFA. ASD patch intact, No residual shunt. All chambers normal sized. No RWMA. Normal LV function. EF – 65%. Normal RV function. All valves structurally normal. IAS / IVS intact. Trivial MR. Mild TR. No PAH. IVC normal in size and collapsing. No clot / vegetation / effusion.**COURSE IN THE HOSPITAL:**

Mrs. Sharon Ruth. D, 48 years/Female, was admitted with above mentioned complaints. Basic investigation was done. She underwent Coronary Angiogram by Right radial access which revealed Normal epicardial coronaries followed by **SUCCESSFUL ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE FOR TYPICAL AVNRT - SLOW PATHWAY MODIFICATION DONE ON 03.01.2024.** Her post procedure period was uneventful and shifted to CCU. Right femoral access site normal, peripheral pulses well felt, no hematoma/soakage. Post RFA ECG showed normal sinus rhythm and ECHO showed no pericardial effusion. She was observed in ICU and shifted to ward. Her medications are optimized and she is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS - 15/15

Temp - 98.6°F

PR - 82/min

BP - 120/80mmHg

SPO2 - 97% in room air

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NAME: Mrs. SPHARON RUTH. D

UHID: MHI202381499

IP.NO: IPH2024004016



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ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. LIVOGEN (FERROUS FUMARATE AND FOLIC ACID)	1 TAB	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
3.	TAB. DOLO (PARACETAMOL)	650 MG	1	1	1	ORAL	AFTER FOOD	X 3 DAYS

DISCHARGE ADVICE

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

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



Typed by: Ezhilarasi.

CONSULTANT SIGNATURE

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

Dr. K. JAISHANKAR
Reg. No: 49448

"I understood the Content of the discharge summary."

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CORONARY ANGIOGRAM REPORT

PATIENT NAME : Mrs.SHARON RUTH.D	UHID : MH202381499
AGE/GENDER : 49YEARS / FEMALE	IP NO : IPH2024000016
CONSULTANT : Dr. Jaishankar. K MD., DM., FIAMS	D.O.A : 02.01.2024
Director and Clinical Lead	D.O.P : 03.01.2024
Cardiology and Electrophysiology	

CATH DATE	03.01.2024	DONE BY	DR. JAISHANKAR
CATH NO	3520	ASSISTED BY	SN. SANDHYA
CATH DURATION	5 MINS	TECHNICIAN	MR. RAM
HEIGHT WEIGHT	159CMS 75KGS	PHYSICIAN ASSISTANT	MS. SHALINI

CLINICAL DIAGNOSIS: PSVT – AVNRT, REVERTED WITH INJ.AMIODARONE ON 18.12.2021, NORMAL LV FUNCTION.

CATHETERIZATION PROCEDURE: AFTER OBTAINING INFORMED CONSENT, PATIENT WAS BROUGHT TO THE CATH LAB. UNDER SAP, PROCEDURE DONE BY USING 2% XYLOCAINE AS LOCAL ANAESTHESIA AND SELDINGER TECHNIQUE.

APPROACH : RIGHT RADIAL ARTERY
SHEATH : 5FR
CATHETER : 5FR TIG
CONTRAST MATERIAL : NON- IONIC, CONTRAPAQUE
MEDICATIONS : Inj. Heparin 2500 IU

COMMENTS:

LMCA - NORMAL. BIFURCATES INTO LAD AND LCX.

LAD - TYPE III VESSEL AND GIVES RISE TO DIAGONALS AND SEPTALS. LAD AND BRANCHES ARE FREE OF DISEASE.

LCX - NON-DOMINANT AND GIVES RISE TO OM_s. LCX AND BRANCHES ARE FREE OF DISEASE.

RCA - DOMINANT AND GIVES RISE TO PDA AND PLV BRANCHES. RCA AND BRANCHES ARE FREE OF DISEASE.

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IMPRESSION:

NORMAL EPICARDIAL CORONARIES
GOOD LV FUNCTION
RIGHT DOMINANT SYSTEM

ADVICE:

MEDICAL MANAGEMENT

PLAN:

ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE.

CONSULTANT SIGNATURE

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

To visit at www.medwayhospitals.com

Dr. K. JAISHANKAR

Reg. No: 49448

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Pa Mrs. SHARON RUTH D
N: 49/Female/MHI202381499
UI: 02/01/2024/IPH2024000016
D Dr. K. JAISHANKAR
D
Continuum...

MHI/IP/2022/107
Medway Heart Institute
Every heart beat counts

INPATIENT INITIAL ASSESSMENT

Date: 2/1/24 Time of arrival in ward: 17.00

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 100 (beats/min) | BP: 110/70 (mmHg)

Respiration: 22 (breaths/min) | SpO₂: 98 (%) | Height: 59 (cms) | Weight: 75 (kgs) | BMI: 24.2 g/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

49 yrs old female came with complaints of
Palpitation on & off at 18/12/2021, C/O Breathlessness
while walking occasionally, H/o SVT reverted with
Inj Amiodarone on 18/12/2021
- no H/o fever, vomiting, loose stools
- no H/o Constipation, or urine output

PAST MEDICAL HISTORY (with duration of illness):

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

Others: N/K/C/O Bronchial Asthma / COPD / CKD / epilepsy / PTB.

Past Surgical History: S/p ASD surgical closure at 2013 Southern railway hospital.

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. Calaptin SR	12mg	P/b	0-01	29/12/23	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2.	T. Livogen	1tab	P/b	1-01	1/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History:

Nil

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):

Obstetric code: P, A0.

ILSCS done at 2003.

General Physical Examination:

Pallor: ☐ Yes ☒ No

Icterus: ☐ Yes ☒ No

Clubbing: ☐ Yes ☒ No

Edema: ☐ Yes ☒ No

Lymphadenopathy: ☐ Yes ☒ No

SYSTEMIC EXAMINATION

CVS:

S₁ S₂ ⊕

Respiratory System:

BAC ⊕, no added sounds

Gastrointestinal System:

Sft, NT

Central Nervous System:

No focal neurological deficit

Urinary / Reproductive / Locomotor System:

(N)

Skin / Ophthalmic / 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:

PSVT - ? AVNRT - Reverted with inj. Amiodarone
? AI / Anemia / Fibroid Uterus.

Plan of Care:

- Plan: CAG + EP study + RFA using onsite 3D mapping.
- Monitor vitals
- NPO from 4am
- Inj. ~~propofol~~ Sulfagreat 1gm IV before shifting cath lab at 8am
- Consent / Parts Preparation

Investigations Advised:

Reports enclosed

Diet Advice:

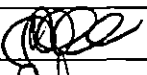
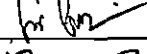

- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: low salt, low fat

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

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. Mohamed Lythons	65807	2/1/24	17:50
Consultant		DR. Jacob Mathias	49445	03/01/24	08:30
Patient Attendant		Relationship <u>Mr. Daniel Babu</u> <u>Husband</u>	—	2/1/24	19:00



DOCTOR'S PROGRESS NOTES

DATE	NOTES
02/1/24	S/B Dr. Anusuya
9.00 PM	<p>10' chest pain on a 100</p> <p>0/5' patient conscious, oriented, afebrile.</p> <p>S/B: CMS - 6/62 ⊕</p> <p>AS - BAS ⊕</p> <p>CMS - N/AID</p> <p>P/A - soft, non-tender.</p> <p>Vitals: HR - 100b/m</p> <p>BP - 110/70 mmHg</p> <p>RR - 20/min</p> <p>SpO2 - 96% RA</p> <p>Advice</p> <ul style="list-style-type: none"> - monitor vitals - continue the drugs as per chart <p>Plan: CABG + EPS + RFA tomorrow 8.15 AM</p> <ul style="list-style-type: none"> - NPO from 4 AM tomorrow - consent - ports preparation - before shifting, to give, 2mg morphine <p>1gm IV</p> <p>- shift to Cath lab on call.</p>

Wfn
Bunha

DATE	NOTES
03/01/24	CIDB Dr. K. Jaisankar
11:30 AM	
Cath no.	Procedure: Coronary Angiogram + Electrophysiology study + Radio frequency ablation using 3D Ensite
35/20/21/22	
	↓ SAP, using 2-1. Xylocaine as local anesthesia.
	Approach: RFR & RRA
	Sheath: 5Fr / 6Fr.
	Catheter: RA, RV, HRA, RF ablation, Tiq
	<u>Coronary Angiogram:</u>
	LMCA: Normal. Bifurcates into LAD & LCX.
	LAD: Type III Vessel. LAD & Branches appear Normal.
	LCX: Non Dominant. LCX & Branches appear Normal.
	RCA: Dominant. RCA & Branches appear Normal.
	<u>Impression:</u>
	Normal epicardial coronaries.
	Right dominant system.
	<u>Advice:</u>
	Medical management.

DOCTOR'S PROGRESS NOTES

DATE	NOTES
03/01/24 11:30 AM.	Electrophysiology study + Radio frequency ablation using 3D ablate.
	A regular narrow QRS tachycardia was induced with programmed atrial & ventricular stimulation protocols.
	Jump was noted before initiation of Tachycardia.
	Tachycardia cycle length - 380ms.
	His synchrony pre would not pulling subsequent atrial signals.
	VDD, would enhance the Tachycardia, TCL - PPI = (560 - 380) = 180ms, with V-A-H-V response.
	AH - 320ms with same activation pattern.
	Thus, the Tachycardia defined as typical AVNRT with slow pathway modification.
	RFA using 3D ablate:
	Using 3D ablate, RA geometry was created, CS OS was mapped for slow pathway signal & site was targeted. Using (50°, 60°, 60-120 sec) energy was delivered, resulted in stable functional rhythm.
	Post RFA:
	VAW - 270ms.
	No Tachycardia was induced with or without Pex & Programmed 'A' & 'V' protocols.
	Invariant jump & echo noted.

DATE	NOTES
9/1/24 9:40 AM	<p>SB - Dr. Sujith B. (Dmo)</p> <hr/>
	<p>CP reviewed.</p> <p>- NO complaints</p>
Input 1350ml Output 1600ml	<p>of R - H. common,</p> <p>oriented,</p> <p>Able</p>
BP - 120/80 mmHg HR - 82 bpm SpO2 - 97% on RA	<p>HR - 82-92 (P)</p> <p>RR - BAE (P)</p> <p>PA - soft.</p>
	<p>Adm</p> <ul style="list-style-type: none"> - critical monitoring. - Elyer sed - w/E deactivation. - Follow dy chnt - (P) plan today <p>APL</p> <p>183375</p>

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



Mrs. Sharon Ruth
49y1F 20238149916
202400016

MHI/IP/2022/041
Medway Heart Institute
every heart beat counts



DOCTOR'S PROGRESS NOTES

DATE	NOTES
4/1/24 9:30 AM	<u>S/R Dr. Jalshankar team -</u> - pt reexamined - no fresh complaints - O/E = Conscious, oriented RR - 24/min, BP - 120/80 SpO ₂ 97% RA Cm = 2, 4, ⑤ R = B A B ⑤ <u>Adv</u> - Cont the same - Plan d/c today for exam

Mrs.SHARON RUTH D
49/Female/MH1202381+99
02/01/2024/1PH202+000016
Dr.K.JAISHANKAR



Date & Time	Screening Echo Report	
10/1/29		
1:22 pm		
	S/p ASD patch closure + EP + RFA	
	ASD patch Intact, No Residual Shunt	
	- All chambers normal sized	
	- No RWMA	LVIDD: 45mm
		LVIDS: 29mm
	- Normal LV function	EF: 65%
	- Normal RV function	RVTDI: 9mm/s
		TAPSE: 18mm
	- All valves structurally normal	
	- TAs / Ix Intact	TR 4+ 22mmHg
		Rvsp: 32mmHg
	- Trivial MR	
	- Mild TR, no PAH	
	- IVC normal in size and collapsing	
	- No clot / Vegetation / Effusions	
	HR: 82 bpm	
	Done By	
	- Ms. Lokeshwari K	
	(Cardiac tech)	
	MH/10/30	

O + ve

MHI/IP/2022/069



Every heart beat counts

Mrs. SHARON RUTH D
49/Female/MHI202381499
02/01/2024/UPH2024000016
Dr. K. JAISHANKAR

BLOOD GROUP

O + ve

INVESTIGATION SHEET

Date	23/12/23					
HAEMATOLOGY						
Hb	8.7					
P.C.V	27					
Platelets	396000					
TLC	7200					
Polymorphs	67					
Lymphocytes	26					
Eosinophils	05					
Mono / Basophils	01 / 01					
E.S.R						
BIO-CHEMISTRY						
Urea	31					
Creatinine	0.7					
Sodium						
Potassium						
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]

Date	From: 3/1/24	To: 4/1/24	Bed No:													
24 Hrs : Started Time :		7:00		Ended Time :		7:00		INTAKE & OUTPUT CHART								
NPO Started at :				NPO Over at :												
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)									
INTAKE			275 ml		400 ml											
OUTPUT					850 ml											
Total Intake:			1350 ml			Total Output:			650 ml			Difference: - 300 ml				
INTAKE (ml)							OUTPUT (ml)									
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by	
			Type of Fluid	Additions	Amount											
							10:00	200 ml					200 ml			
	Total intake ccu.				200 ml	200 ml										
	Total intake ccu				690 ml	690 ml	Total output ccu.				800 ml					
17:40	125					815										
18:00	150					965	19:45	350 ml					1150 ml			
22:30	150 ml					1100 ml	23:30	200 ml					1350 ml			
2:00	100 ml					1200 ml	4:45	300 ml					1650 ml			
5:45	150 ml					1350 ml										
							TOTAL INTAKE			-			1350 ml			
							TOTAL OUTPUT			-			1650 ml			
															MR	
															24	



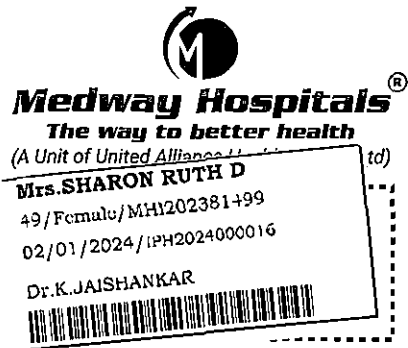
M HARON RUTH D
49/Female/MH1202381+99
02/01/2024/IPH2024000016
Dr.K.JAISHANKAR

MHI/IP/2022/066



Every heart beat counts

[illegible]



MHI/P/2022/074



VITAL INFORMATION SHEET

BLOOD GROUP - O' *Positive*

ON ADMISSION

Height in CM

Weight in Kg.

159 cm.

75.10g

Diagnosis: PSVT - AVNRT - ANEMIA.

Procedure :

[illegible]

EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex: _____

Patient Id No: _____

NEWS key	DATE	TIME	DATE	TIME
0	21/01/24	16:30	21/01/24	16:00
1	21/01/24	18:30	21/01/24	18:00
2	21/01/24	20:30	21/01/24	20:00
3	21/01/24	22:30	21/01/24	22:00
4	21/01/24	00:30	21/01/24	00:00
5	21/01/24	02:30	21/01/24	02:00
6	21/01/24	04:30	21/01/24	04:00
7	21/01/24	06:30	21/01/24	06:00
8	21/01/24	08:30	21/01/24	08:00
9	21/01/24	10:30	21/01/24	10:00
10	21/01/24	12:30	21/01/24	12:00
11	21/01/24	14:30	21/01/24	14:00
12	21/01/24	16:30	21/01/24	16:00
13	21/01/24	18:30	21/01/24	18:00
14	21/01/24	20:30	21/01/24	20:00
15	21/01/24	22:30	21/01/24	22:00
16	21/01/24	00:30	21/01/24	00:00
17	21/01/24	02:30	21/01/24	02:00
18	21/01/24	04:30	21/01/24	04:00
19	21/01/24	06:30	21/01/24	06:00
20	21/01/24	08:30	21/01/24	08:00
21	21/01/24	10:30	21/01/24	10:00
22	21/01/24	12:30	21/01/24	12:00
23	21/01/24	14:30	21/01/24	14:00
24	21/01/24	16:30	21/01/24	16:00
25	21/01/24	18:30	21/01/24	18:00
26	21/01/24	20:30	21/01/24	20:00
27	21/01/24	22:30	21/01/24	22:00
28	21/01/24	00:30	21/01/24	00:00
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30	21/01/24	04:30	21/01/24	04:00
31	21/01/24	06:30	21/01/24	06:00
32	21/01/24	08:30	21/01/24	08:00
33	21/01/24	10:30	21/01/24	10:00
34	21/01/24	12:30	21/01/24	12:00
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37	21/01/24	18:30	21/01/24	18:00
38	21/01/24	20:30	21/01/24	20:00
39	21/01/24	22:30	21/01/24	22:00
40	21/01/24	00:30	21/01/24	00:00
41	21/01/24	02:30	21/01/24	02:00
42	21/01/24	04:30	21/01/24	04:00
43	21/01/24	06:30	21/01/24	06:00
44	21/01/24	08:30	21/01/24	08:00
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87	21/01/24	22:30	21/01/24	22:00
88	21/01/24	00:30	21/01/24	00:00
89	21/01/24	02:30	21/01/24	02:00
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112	21/01/24	00:30	21/01/24	00:00
113	21/01/24	02:30	21/01/24	02:00
114	21/01/24	04:30	21/01/24	04:00
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116	21/01/24	08:30	21/01/24	08:00
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137	21/01/24	02:30	21/01/24	02:00
138	21/01/24	04:30	21/01/24	04:00
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143	21/01/24	14:30	21/01/24	14:00
144	21/01/24	16:30	21/01/24	16:00
145	21/01/24	18:30	21/01/24	18:00
146	21/01/24	20:30	21/01/24	20:00
147	21/01/24	22:30	21/01/24	22:00
148	21/01/24	00:30	21/01/24	00:00
149	21/01/24	02:30	21/01/24	02:00
150	21/01/24	04:30	21/01/24	04:00
151	21/01/24	06:30	21/01/24	06:00
152	21/01/24	08:30	21/01/24	08:00
153	21/01/24	10:30	21/01/24	10:00
154	21/01/24	12:30	21/01/24	12:00
155	21/01/24	14:30	21/01/24	14:00
156	21/01/24	16:30	21/01/24	16:00
157	21/01/24	18:30	21/01/24	18:00
158	21/01/24	20:30	21/01/24	20:00
159	21/01/24	22:30	21/01/24	22:00
160	21/01/24	00:30	21/01/24	00:00
161	21/01/24	02:30	21/01/24	02:00
162	21/01/24	04:30	21/01/24	04:00
163	21/01/24	06:30	21/01/24	06:00
164	21/01/24	08:30	21/01/24	08:00
165	21/01/24	10:30	21/01/24	10:00
166	21/01/24	12:30	21/01/24	12:00
167	21/01/24	14:30	21/01/24	14:00
168	21/01/24	16:30	21/01/24	16:00
169	21/01/24	18:30	21/01/24	18:00
170	21/01/24	20:30	21/01/24	20:00
171	21/01/24	22:30	21/01/24	22:00
172	21/01/24	00:30	21/01/24	00:00
173	21/01/24	02:30	21/01/24	02:00
174	21/01/24	04:30	21/01/24	04:00
175	21/01/24	06:30	21/01/24	06:00
176	21/01/24	08:30	21/01/24	08:00
177	21/01/24	10:30	21/01/24	10:00
178	21/01/24	12:30	21/01/24	12:00
179	21/01/24</			



PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: PSVT - AVNRT

Allergies if any: NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
<u>IInd FLOOR</u>	<u>CATH LAB</u>	<u>3/1/24</u>	<u>8:20</u>	<u>CATH + EPS + DCA</u>

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

ASSESSMENT OF PATIENT:

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

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

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
<u>97.6</u>	<u>20</u>	<u>82</u>	<u>97</u>	<u>110/70</u>	<u>0/10</u>

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

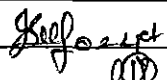

☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)

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

Any pre-medication given: INJ - SULFA 1 cone given

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
		<u>Dr. Daniel Babu</u>	<u>0249</u>	<u>3/1/24</u>	<u>8:20</u>
Handed over to		<u>Dr. Jaishankar</u>	<u>0176</u>	<u>3/1/24</u>	<u>8:20</u>

After Procedure:

Procedure completed: ☒ Yes ☐ No | Any critical information: N/A

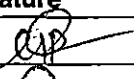

Vital Signs (to be documented at the time of shifting):

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
<u>98.5</u>	<u>22 bt/min</u>	<u>82 bt/min</u>	<u>100</u>	<u>138/90 (1/3)</u>	<u>0/60</u>

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


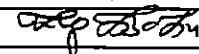

☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)

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

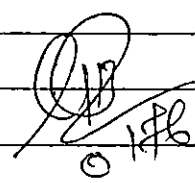
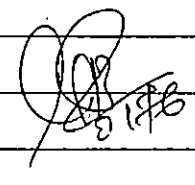
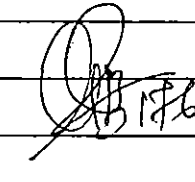
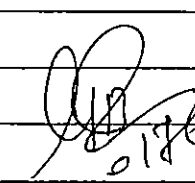
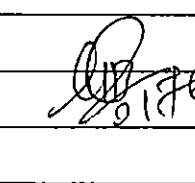
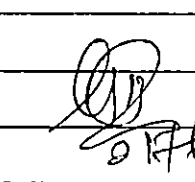
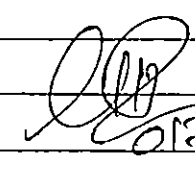
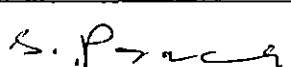
Handover by	Signature	Name	Emp. No.	Date	Time
		<u>Dr. Jaishankar</u>	<u>0176</u>	<u>3/1/24</u>	<u>12:05</u>
Handed over to		<u>Dr. Daniel Babu</u>	<u>0249</u>	<u>3/1/24</u>	<u>12:10</u>

my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition
On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		<u>Mrs. D. SHARON RUTH</u>	<u>2/1/24</u>	<u>12:00</u>
witness		<u>M. DANIEL BABU</u>	<u>2/1/24</u>	<u>12:00</u>
Doctor		<u>Dr. Saijai Sudhan</u>	<u>2/1/24</u>	<u>12:00</u>
Interpreter				

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
31/12/24	Cath Lab				
8.20	⇒ Pt Received from 1 st floor to Cath Lab. conscious and oriented.				
8.30	⇒ vitals stable. IV line Rt and left side patent. V/P score 0/5	 0176			
10.10	⇒ GVE: NS 30ml/hr IV started. sterile drapping done. CAG + EPS + RFA 3D started.	 0176			
10.20	⇒ Rt Radial Arterial approach under local anaesthesia.	 0176			
10.25	⇒ GH: ATG 100mcg IV given				
10.25	⇒ GH: Heparin 2500 ^{IU} IV given O/B Dr. JS (Sir).				
10.30	⇒ BP: 133/83 (98) mmHg, HR: 82 bt/min SpO2: 100%. vitals stable.	 0176			
10.35	⇒ CAG procedure done. Successfully followed by. EPS + RFA 3D.				
10.35	⇒ Rt femoral venous approach under local anaesthesia.	 0176			
10.45	⇒ BP: 126/70 (96) mmHg, HR: 78 bt/min SpO2: 100%. vitals stable.				
10.50	⇒ GH: Eptanyl 25 mcg + GH: emeset 4mg IV given O/B Dr. JS (Sir) O2 & little started.	 0176			
11.30	⇒ BP: 138/90 (113) mmHg, HR: 82 bt/min SpO2: 100%. vitals stable.				
11.45	⇒ Procedure EPS + RFA 3D done. Rt Radial arterial sheath removed. Rt femoral venous sheath removed. Right plaster bandage removed.	 0176			
Document endorsed by	Signature	Name	Emp. No.	Date	Time
		A. P. S. Chavara	0020	31/12/24	11.45

NURSES PROGRESS NOTES[illegible]

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086



Every heart beat counts

Mrs. SHARON RUTH D
49 / Female / MHI202381+99
02/01/2024 / IPH2024000016

Dr. K. JAISHANKAR



Name of the Procedure : CAG + EPS + RFA 3D Location : Cath Lab. Date & Time : 31/124

Does the Procedure involve Procedural Sedation : ☐ Yes ☐ No

SIGN IN <u>10:10</u> Before Induction of Procedural Sedation		TIME OUT <u>10:20</u> After procedural Sedation and before procedure		SIGN OUT <u>11:45</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <input checked="" type="checkbox"/> Yes <u>CAG + EPS + RFA 3D</u>	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>CAG + EPS + RFA 3D</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA confirms labeling and sent to lab	
Side	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt Radial arterial approach</u> <u>Rt femoral venous approach</u>	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		
Consent	<input checked="" type="checkbox"/> Yes	Position <u>Supine.</u>	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None If Yes, Pls. specify :	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes		
		Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None If Yes, Pls. specify :	
		Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
All concerned anaesthesia equipment and medication check complete		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
<input type="checkbox"/> Spo2 <input checked="" type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes	Corrective action :	
Required equipment for procedure available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	For procedural sedation cases	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Intra procedure glycemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : <u>R.N. Sandhiya</u>	Technician : <u>Mr. Pandeyan</u>	Others Please Specify :
Date : <u>31/124</u>	Date : <u>31/124</u>	Date : <u>31/124</u>	Date : <u>31/124</u>	Date : <u>31/124</u>
Time : <u>12:55</u>	Time : <u>12:55</u>	Time : <u>12:55</u>	Time : <u>12:50</u>	Time : <u>12:50</u>


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 (A Unit of United Alliance Healthcare Pvt Ltd)


Every heart beat counts

Procedure Monitoring Sheet (Cath Lab)

 Patient Name : **Mrs. SHARON RUTH D**
 97 Female / MHI202381+99
 UHID / IP : 02/01/2024 / IPH2024000016
 Consultant : Dr. K. JAISHANKAR

 Age / Sex : 49Y / M
 Ward Unit : 11ND FLOOR
 Diagnosis : PSVT - Atrial

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 110/70 Temp: 97 Pulse: 82 RR: 20 SPO2: 97	✓		
Urine voided	✓		
Bowel preparation			✓
Pre-procedure medication administered	✓		
Procedure site marked	✓		
Skin preparation done	✓		
NPO FROM 4.00	✓		
Loose Tooth removed			✓
Contact lenses / Eye glasses removed			✓
Prosthesis present			✓
Jewellery/Nail polish removed			✓
Checked for Allergies (Drug / food)			✓
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse : <i>[Signature]</i>	Date & Time : 2/1/23 @ <i>[Signature]</i> 8-20		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
10.10	80 b/min	22 b/min	146/88 mmHg	100%	-	<i>[Signature]</i>
10.25	82 b/min	22 b/min	133/83 (98)	100%	-	<i>[Signature]</i>
10.45	78 b/min	22 b/min	136/70 (96)	100%	-	<i>[Signature]</i>
11.00	82 b/min	22 b/min	150/72 (90)	100%	-	<i>[Signature]</i>
11.15	80 b/min	22 b/min	153/73 (98)	100%	-	<i>[Signature]</i>
11.45	82 b/min	22 b/min	138/90 (113)	100%	-	<i>[Signature]</i>
			Procedure got over			

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

Time : 12.00 Route : Rt Radial arterial approach
 Complication : Nil Rt femoral venous approach
 BP : 138/90/113 mmHg, HR : 82 bt/min, RR : 20 bt/min, SpO2 : 100%
 Brachial
 Distal Pulse: felt, Puncture Site: no oozing & hematoma

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt Radial artery.
- ◆ Diet Normal
- ◆ Inform Duty Medical Officer SOS
 - a) If patient complains of any Discomfort
 - b) If dressing is Loose or Socked with Blood
 - c) If limbs are Cold / Absent Pulse
- ◆ Remove Rt Radial arterial and Rt femoral venous dressing on 4/1/24 at 10.00 AM /PM after informing to the consultant.
- ◆ Special instruction if any: Nil


 Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes :

Procedure CAG+ EPS+ RFA BD done. Rt Radial arterial sheath removed. Rt femoral venous sheath removed. Tight plaster bandage applied. No oozing & hematoma

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time : 3/1/24
@ 12.05



Mrs. SHARON RUTH D
49/Female/MHI202381499
02/01/2024/UPH2024000016

Dr. K. JAISHANKAR

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: EF-62%, P3VT-?AVNRT, Rhoid Uremy, Anaemia, DM, CAPT+EPSTRA.

Height: 155 cms Weight: 55 Kgs Food allergies: Yes/ No/ If yes, specify: None

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

Diet Prescription: 1500 calories, low fat, low salt, low rich, diabetic diet.

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(A)	Patient's related Medical History				
1)	Weight Change (overall change in past 6 months)				
	<input checked="" type="checkbox"/> 1 No weight change/ gain	<input type="checkbox"/> 2 <5%	<input type="checkbox"/> 3 5 - 10%	<input type="checkbox"/> 4 10 - 15%	<input type="checkbox"/> 5 >15%
2)	Dietary Intake				
	<input checked="" type="checkbox"/> 1 No change	<input type="checkbox"/> 2 Sub-optimal solid diet	<input type="checkbox"/> 3 Full liquid diet/ moderate overall decrease	<input type="checkbox"/> 4 Hypo-caloric liquid diet	<input type="checkbox"/> 5 Starvation
	<input type="checkbox"/> 1 Adequate/ Excessive	<input type="checkbox"/> 2 Sub-optimal	<input type="checkbox"/> 3 Inadequate	<input type="checkbox"/> 4 Typo-caloric feeds	<input type="checkbox"/> 5 Starvation
3)	Gastrointestinal Symptoms Duration:				
	<input checked="" type="checkbox"/> 1 No symptoms	<input type="checkbox"/> 2 Nausea	<input type="checkbox"/> 3 Vomiting/ moderate GI symptoms	<input type="checkbox"/> 4 Diarrhoea	<input type="checkbox"/> 5 severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration:				
	<input checked="" type="checkbox"/> 1 None /improved	<input type="checkbox"/> 2 Difficulty with ambulation	<input type="checkbox"/> 3 Difficulty with normal activity	<input type="checkbox"/> 4 Light activity	<input type="checkbox"/> 5 Bed / chair - ridden with no or little activity
5)	Co-morbidity (Disease and its relationship to nutrition requirements)				
	<input checked="" type="checkbox"/> 1 Healthy	<input type="checkbox"/> 2 Mild co- morbidity	<input type="checkbox"/> 3 Moderate co- morbidity/ age >75 years	<input type="checkbox"/> 4 severe co- morbidity	<input type="checkbox"/> 5 Very severe multiple co- morbidity
(B)	Physical examination				
1)	Decreased fat stores or loss of subcutaneous fat				
	<input checked="" type="checkbox"/> 1 Normal	<input type="checkbox"/> 2 Mild	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 Severe	<input type="checkbox"/> 5 Severe
2)	Sign of muscle wasting				
	<input checked="" type="checkbox"/> 1 Normal	<input type="checkbox"/> 2 Mild	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 Severe	<input type="checkbox"/> 5 Severe
Total Score = Sum of above 7 components					
Nutritional Status : Based on this patient is					
	<input checked="" type="checkbox"/> Well Nourished (17 to 24)				
	<input type="checkbox"/> Moderately Malnourished (15 to 18)				
	<input type="checkbox"/> Severely Malnourished (19 to 35)				
Nutrition Intervention:					
	<input checked="" type="checkbox"/> Oral <input type="checkbox"/> Enteral <input type="checkbox"/> Parenteral				
Diet counselling provided:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Frequency of re-assessment:	<input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly				
Enteral / Parenteral	<input type="checkbox"/> Daily <input type="checkbox"/> Fort - night <input type="checkbox"/> Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				

Dietitian Signature / Name / Date / Time:

Padma 24/12/24, 17:00
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>2/1/24, 17:00</p>	<p>A 49 year old female came to do palpitation (on & off) & breathlessness was assumed to be well nourished & enriched by S4A.</p> <p>Klebs - DM / Anaemia / Rhinoid Ulcers</p> <p>Examined the patient and found on 1000 calories, low fat, low salt, diabetic diet. Empfind on small fruit meal & low glucose control.</p>	<p><i>Catharine</i> Maria Catherine John Senior Dietitian</p>
<p>3/1/24, 15:00</p>	<p>Patient shifted to Cathlab for procedure (CPR + EPS + RFA) and kept on ASA. Patient moved to CCU. ASA over. Patient examined diabetic; lipid diet. Can initiate a diabetic, soft solid diet</p>	<p><i>Catharine</i> Maria Catherine John Senior Dietitian</p>
<p>4/1/24, 10:00</p>	<p>Patient moved to ward. Oral intake is good. Examined the patient and found on 1000 calories, low fat, low salt, diabetic diet on discharge. Empfind on small fruit meal & low glucose control. Diet modification and clarification done. Diet chart given on discharge.</p>	<p><i>Catharine</i> Maria Catherine John Senior Dietitian</p>



Mrs. SHARON RUTH D
49/Female/MHI202381+99
02/01/2024/1PH2024000016
Dr. K. JAISHANKAR

(re)

**PSYCHOLOGICAL WELLBEING REPORT**

Date: 04/1/24

Time: 11.30 am.

Unit: 203B.

Clinical diagnosis: S/P EPS + RFA

Surgery/ Procedure:

Impression: Functioning well

- calm affect, oriented, responsive
- sleep & appetite ⊕
- no psychological distress reported.

Employee ID: MHI0215PSY

Signature of the Psychologist:

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 21/1/24 Time of Arrival: 16:30 Mode of Admission: ☐ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: Mrs. Mr. Balen.

Relationship with Patient: YES Contact Person's Name: Mrs. Balen. Relationship: Husband.

Contact No.: 96 000 62131 Primary language spoken: ☒ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☐ Yes ☒ No

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

Menstrual History / LMP: --- Menopause: ---

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

Drugs History: Antiplatelet --- (Specify)

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

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

If Yes, specify details: ---

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

Vital Signs: Temp: 98.6 (F) | Pulse / HR: 79 (beats/min) | BP: 100/79 mmHg

Respiration: 22 (breaths/min) | SpO₂: 96 (%) | CBG: 102 (mg/dl) | Height: 160 (cms) | Weight: 62 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☒ No ☐ Medication ☐ Blood Transfusion ☐ Food ☐ Not known

If Yes, specify: ---

Pain: ☐ Yes ☒ No, If Yes, Score: 0 Pain Scale Used: ☐ Wong-Baker FACES Pain Rating Scale (7-12 years)

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

Duration: --- Location: ---

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

Nutritional Screening:

Last 3 months Appetite: ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight: ☐ Increased ☐ Decreased ☒ No Change

Type of Patient: ☐ Diabetic ☒ Non Diabetic Type of Diet: Normal diet.

Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: Mrs. Catherine Time: 11:00

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

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

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

Total Score: 21 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

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

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

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT):

Final Score

Tick the score obtained (✓)

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

Personal Belongings / Valuables:

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

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

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
	<i>[Signature]</i>	M. DANIEL BABU	Relationship	21/12/24	17:00
Nurse	<i>[Signature]</i>	<i>[Signature]</i>	0116	21/12/24	17:00
Unit In-Charge	<i>[Signature]</i>	<i>[Signature]</i>	0005	03/01/24	08:20

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: DM ? AYNRT
NEWS / PEWS Score: 15/15
Ventilator day: 15
Peripheral line day: Right: 15 Left: 15
Ryle's Tube: ☐ Yes ☒ No Day: 15
Urinary Catheter: ☐ Yes ☒ No Day: 15
Barrier nursing: ☐ Yes ☒ No MDR: ☐ Yes ☒ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: UKDA
Allergies if any: KA
On room air / oxygen: KA
Complaints / New Symptoms in last shift: KA
Date of surgery: 15
IV fluids on flow: KA

A

ASSESSMENT

Vital Signs: Temp: 97.7 (°F) | Pulse / HR: 84 (beats/min) | Respiration: 18 (breaths/min)
BP: 130/80 (mmHg) | SpO₂: 97 (%) | Height: 160 (cms) | Weight: 62 (kgs) | BMI: 24.2 kg/m²
Others: KA
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: KA

R

RECOMMENDATION

Referral doctors: KA
Pending medications: KA
Pending medication indent: KA
Pending lab reports / Investigations: KA
Critical value alert and its corrections: KA
Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: 2/1/24
Pending follow-up orders: KA
Special instructions if any: KA

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>KA</u>	<u>R. Sushma</u>	<u>0081</u>	<u>2/1/24</u>	<u>12.00</u>
Handover taken by	<u>KA</u>	<u>A. ALBINUS</u>	<u>0088</u>	<u>2/1/24</u>	<u>12.00</u>
Document endorsed	<u>KA</u>	<u>A. ALBINUS</u>	<u>0088</u>	<u>2/1/24</u>	<u>12.00</u>

[illegible]

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:

3/1/24

Shift:



Morning



Evening



Night

S

SITUATION

Diagnosis: PSUT - AURRT

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: —

Date of surgery: —

Allergies if any: N/A

On room air / oxygen: on room air

IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp 97.4 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 98 (%) | Height: 160 (cms) | Weight: 62 (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: Today CA4 + EPS + RFA NPO - 4.00.

	Signature	Name	Emp. No.	Date	Time
Handover given by		<u>W. Lidegi</u>	<u>0249</u>	<u>3/1/24</u>	<u>9.00</u>
Handover taken by		<u>① Navabani</u>	<u>0176</u>	<u>3/1/24</u>	<u>8.20</u>
Document endorsed		<u>S. Nalini</u>	<u>0084</u>	<u>3/1/24</u>	<u>9.00</u>

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
3/1/24	Morning Duty	
7-30	pt case file taken over from night duty str while pt conscious and oriented	
8-00	pt vitals are checked and recorded	Jalee
8-00 8-15	pt vitals are checked and recorded	
6-00 6-30	Preparation all given	Jalee form
	SHIFED NOTES. <u>= =</u>	
8-20-	pt case file handing over to Cath Lab Str, started for CAG, Epi + PEA, preparation are done psychological support given	Jalee form 9249.
	2 x rays (Chest), 2 EcG and old abd big EcG, Echo, old Blood Reports given	
Document endorsed by	Signature Nae	Name S. Nalim
		Emp. No. 0024
		Date 3/1/24
		Time 920



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 3/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: PSVT - ? Atrial / ? AP / Anemia
NEWS / PEWS Score: -
Ventilator day: -
Peripheral line day: Right: heathal Left: Anesthetic
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: EAG + EP + RFA
Allergies if any: N/A
On room air / oxygen: on room air
Complaints / New Symptoms in last shift: -
Date of surgery: 3/1/24
IV fluids on flow: DVF NS - 30cc/hr

A


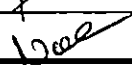
ASSESSMENT

Vital Signs: Temp: 97.5 (°F) | Pulse / HR: 81 (beats/min) | Respiration: 20 (breaths/min)
BP: 117/79 (mmHg) | SpO₂: 98 (%) | Height: 159 (cms) | Weight: 75 (kgs) | BMI: 24.269 / m²
Others: -
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 35 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☒ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: N diet Drains: -

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Madhumitha	0244	3/1/24	16:05
Handover taken by	S. Di	S. Dandhachari	0211	3/1/24	16:30
Document endorsed		S. Nallini	0024	3/1/24	2:00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 3/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: PSVT - AUNRT

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: BRACHIAL 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: -

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

BP: 130/70 (mmHg) | SpO₂: 96 (%) | Height: 159 (cms) | Weight: 75 (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: 35 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: NORMAL Diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: PLAN DISCHARGE TMRW

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0088	4/1/24	7:00
Handover taken by		Agastya	006	4/1/24	7:50
Document endorsed		S. Nalini	0024	4/1/24	8:40

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S	<p>SITUATION Diagnosis: DM1 - AVNPT NEWS / PEWS Score: 0 Ventilator day: Peripheral line day: Right: Bowel Left: Ryle's Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Day: Urinary Catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No Day: Barrier nursing: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No MDR: <input type="checkbox"/> Yes <input type="checkbox"/> No, If Yes, specify organism: nil GCS: 15/15 POD: - Central line days: - VIP Score: 0</p>				
B	<p>BACKGROUND Type of surgery: N/A Allergies if any: ON NO NO NO On room air / oxygen: 0 Complaints / New Symptoms in last shift: Date of surgery: - IV fluids on flow: -</p>				
A	<p>ASSESSMENT Vital Signs: Temp 98.6 (F) Pulse / HR: 79 (beats/min) Respiration: 22 (breaths/min) BP: 130/90 (mmHg) SpO₂: 96 (%) Height: 159 (cms) Weight: 75 (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: 35 Fall Risk Protocol: <input type="checkbox"/> Low <input checked="" type="checkbox"/> Medium <input type="checkbox"/> High Braden Score: <input type="checkbox"/> Minimal Risk: 23-19 <input type="checkbox"/> At Risk-Mild Risk: 18-15 <input type="checkbox"/> Moderate Risk: 14-13 <input type="checkbox"/> High Risk: 12-10 <input type="checkbox"/> Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA Wound Dressing done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA Current diet: Normal diet Drains: nil</p>				
R	<p>RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No, If Yes, modified care plan date: - Pending follow-up orders: Special instructions if any: Plan discharge today</p>				
Handover given by	Signature	Name	Emp. No.	Date	Time
Handover taken by	5. D.	S. Dhandhanshi	0212	4/1/24	12:00
Document endorsed	[Signature]	S. Nalin	0024	4/1/24	3:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Morning duty starts	
4/1/24	pt taking over from the Night duty staff	
4.50	pt conscious & oriented	Shu
	pt had on normal diet medication administration	
10.30	as per drug chart.	
	pt had no complaints.	
	right radial arterial pressure bandage removed.	Shu
	today plan discharge.	
	pt had no complaints	
11.30	vital signs checked & monitored	Shu
	2nd chest monitored	
12.00	pt handing over to the Evening duty staff	Shu
	<u>Discharge notes</u>	
4/1/24	pt handing today plan Discharge	
	pt conscious & oriented	
	pt ID Band Removed	
18.00	pt IV line removed	Shu
	pt handing over given to Night duty staff all reports pt & pt attended.	
Document endorsed by	Signature Nee	Name S Nadeem
		Emp. No. 0084
		Date 4/1/24
		Time 20:00

ADULT NURSING CARE PLAN

Mrs. SHARON RUTH D
49 / Female / MH1202381+99
02/01/2024 / IPH2024000016
Dr. K. JAISHANKAR



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 21/12/24 Time: 18:20		Modified Date: Time:		
Reason for Modification:		Diagnosis: PSVT ? Atrial		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input checked="" type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Ept had @ diet N pt had @ diet	Per. 21/12/24
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M E N	Pt SpO ₂ 99% SpO ₂ - 95%
FLUID & ELECTROLYTES <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input checked="" type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M E N	Pt I/O chart monitored 21/12/24

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input checked="" type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Encourage regular ambulation ROM exercise <input checked="" type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M	
			E pt well Mobilized	dy 06/11
			N pt well Mobilized	dy 06/11
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input checked="" type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input checked="" type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as toley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemeses as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M	
			E pt @ pattern	dy 06/11
			N pt @ pattern	dy 06/11
SKIN INTEGRITY <input type="checkbox"/> Maintain normal skin integrity <input checked="" type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input checked="" type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M	
			E pt skin Integrity	dy 06/11
			N skin is Intact	dy 06/11

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input checked="" type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M E pt well communication N pt well communication	[Signature] [Signature]
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M E RA due drugs due given N Due drugs are given	[Signature] [Signature]
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	Thamara	0005	03/01/24	08:00

ADULT NURSING CARE PLAN

Registered (Nursing) (Lohal hapa)
Mrs. SHARON RUTH D
49 / Female / MHI202381499
02/01/2024 / IPH2024000016
Dr. K. JAISHANKAR

Initial Date: 3/1/24 Time: 8.00		Modified Date: Time:		
Reason for Modification:		Diagnosis:		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M pt is on NPO E Pt had @ diet N PT had @ diet	Jsef 02/01/24 Jsef
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BIPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M on room air E Pt on room air N SpO ₂ - 95%	Jsef 02/01/24 Jsef
FLUID & ELECTROLYTES <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M pt takes oral fluid E Pt RWF-NS-3000/h N pt is on ORAL FLUIDS	Jsef 02/01/24 Jsef

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign. & Initials
HYGIENE <input type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M pt takes Self Bath	Ref
			E P+ clean & well groomed	02/11/17
			N pt well mobilized	Ref 00/85
SAFETY <input type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M ID Band ⊕	Ref
			E P+ ID band ⊕	02/11/17
			N ID Band ⊕	Ref 00/85
COMFORT AND SLEEP <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M P+ Slept well	Ref
			E P+ comfortable position	02/11/17
			N P+ ON COMFORTABLE POSITION	Ref 00/85
OBSERVATION <input type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M Vital Signs + recorded ⊕	Ref
			E P+ V/S are checked and recorded	02/11/17
			N Vital signs is checked	Ref 00/85
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M —	
			E —	—
			N —	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input checked="" type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt verbal communication good E Pt well communication N Pt well communication	Self 02HH 00HR
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M Dose medication are given E Pt medication given as per drug chart N medications are given	Self 02HH 00HR
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Nas	S. Nalini	0024	3/1/24	18:00

ADULT NURSING CARE PLAN

Mrs. SHARON RUTH D
49 / Female / MHI202331+99
02/01/2024 / IPH2024000016
Dr. K. JAISHANKAR



MHI/NUR/2022/044..



Every heart beat counts

Initial Date: 4/1/24 Time: 7.00		Modified Date: Time:		
Reason for Modification:		Diagnosis: P801 - AUA1T		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M <i>pt had on hospital diet</i> E N	<i>Sub</i>
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M <i>pt on room air</i> E N	<i>Sub</i>
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input checked="" type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M <i>monitored</i> E N	<i>Sub</i>

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M <i>pt well communication</i> E N	<i>Plus</i>
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input checked="" type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M <i>due drug for van</i> E N	<i>So us</i>
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>Nee</i>	<i>S. Nalini</i>	<i>0024</i>	<i>4/1/24</i>	<i>13:00</i>

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		9	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
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		4	4
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation		4	4
FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair			3	3
					TOTAL SCORE	23	23
					Initial & Emp. No. of Staff Nurse:	Dr. K. Jaishankar	008
					Initial & Emp. No. of Sr. Staff Nurse:	Dr. K. Jaishankar	008

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



Date: 3/1/24
Time: 10:00 AM

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	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	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	4	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 dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4	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	23	18	23
					Initial & Emp. No. of Staff Nurse:	Sharon Ruth D	02/01/2024	2024
					Initial & Emp. No. of Sr. Staff Nurse:	Neeraj	Neeraj	Neeraj

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



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	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	3		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	3		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	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		
					TOTAL SCORE	19	
					Initial & Emp. No. of Staff Nurse:	22	
					Initial & Emp. No. of Sr. Staff Nurse:	22	

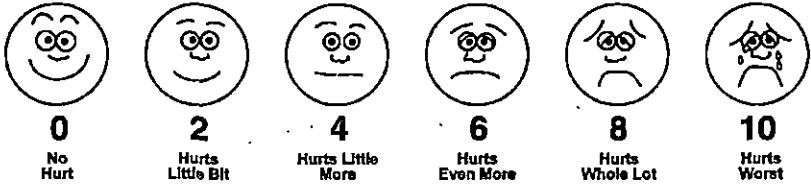
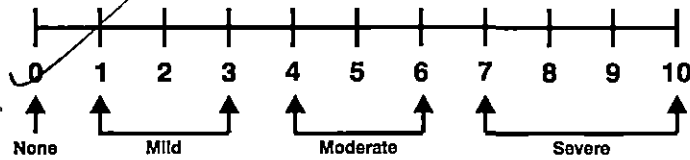
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
11:00	0/10	No pain	-	-	-	[Signature]	[Signature]
21:00	0/10	No Pain	-	-	-	[Signature]	[Signature]
1:00	0/10	No Pain	-	-	-	[Signature]	[Signature]
5:00	0/10	No Pain	-	-	-	[Signature]	[Signature]
9:00	0/10	no pain	-	-	-	[Signature]	Nae 024
		Pt received from Cath lab @ 12:10					
12:10	0/10	NO Pain	-	-	-	[Signature]	Nae 024
13:10	0/10	NO Pain	-	-	-	[Signature]	Nae 024
14:10	0/10	no pain	-	-	-	[Signature]	Nae 024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
21/12/15 12:45	0/10	No Pain	—	—	—	021141	Nae 021
19:30	0/10	No Pain	—	—	—	0088	Nae 021
23:30	0/10	No Pain	—	—	—	0088	Nae 021
3:30	0/10	No Pain	—	—	—	0088	Nae 021

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention
CRIES (38 weeks - 2 months)	The CRIES scale is used for Infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 <div> <p>Numerical Rating Scale (age more than 12 years)</p>  </div>
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

[illegible]

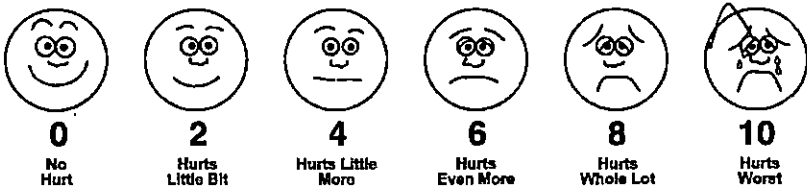
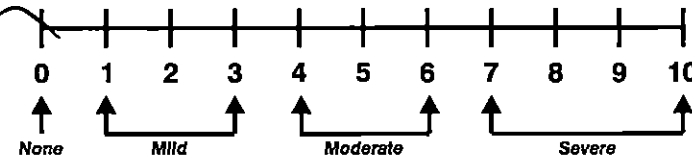
Medway
Heart
Institute

PAIN RE-ASSESSMENT & MONITORING CHART

[illegible]

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



PAIN SCALES

PIPPS (28 weeks to \leq 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention					
CRIS (38 weeks - 2 months)	The CRIS scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIS 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)	 <div> <p>0 No Hurt</p> <p>2 Hurts Little Bit</p> <p>4 Hurts Little More</p> <p>6 Hurts Even More</p> <p>8 Hurts Whole Lot</p> <p>10 Hurts Worst</p> </div>					Numerical Rating Scale (age more than 12 years) 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain					
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counseling: K - Individual Counseling; L - Family counseling					

Pharmacological interventions as per doctor's prescription

DVT RISK ASSESSMENT

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

		Date	2/1	3/1	23/1	23				
		Time	14:00	08:00	6:00					
S. No.	PARAMETERS									
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0						
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0						
5	Entire leg swollen (Assess for both legs)	0	0	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0						
9	Previously documented DVT (Assess for both legs)	0	0	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0						
FINAL SCORE		0	0	0						
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8			LOW	LOW						
DVT prophylaxis started		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										



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



MHI/NUR/2022/046

Mrs. SHARON RUTH D

49 / Female / MHI202381+99

02/01/2024 / IPH2024000016

Dr. K. JAISHANKAR



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	2/1	2/1/23	2/1/24	3/1	3/1/24	3/1/24			
		Time	14:00	22:00	8:00	14:00	22:00	8:00		
History of falling (Immediate or within 6 months)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	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		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	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		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		0	0	0	35	35	35			
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

[illegible]

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

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

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

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

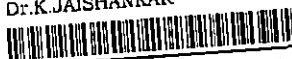
Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : Tepillah Sheryl Shammah Signature : [Signature]

Name of Discharge Nurse : A. N. Anthony Signature : [Signature]

**Medway Hospitals**The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)Mrs. SHARON RUTH D
49 / Female / MHI202381+99
02/01/2024 / IPH2024000016
Dr. K. JAISHANKAR

Consultant:

MHI/ICU/2022/056



Every heart beat counts

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 21/1/24 Time: 17:30

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		Dr. Anusuya	134777	21/1/24	17:30
Nursing Staff		R. Sushma	0801	21/1/24	17:30
Dietician		Diana Catherine John Senior Dietitian	2401	21/1/24	18:00
Physiotherapist					
Patient Care Service Staff					

[illegible]

Additional Details (if any):

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

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	<i>[Signature]</i>	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	3/1/24	16.15
Receiving Doctor	<i>[Signature]</i>	Dr. Anish Nelson	16882	3/1/24	17.00

Part C (to be filled by Nurses)

Check for	Transferring Nurse	Receiving Nurse
Drains	<input type="checkbox"/> Chest <input type="checkbox"/> Abdominal <input type="checkbox"/> Others: <i>NIL</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	Air Way Type: <input type="checkbox"/> Patent <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others: <i>NIL</i> Oxygen Therapy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes via: _____ Rate: _____ li/min	<input type="checkbox"/> Yes <input type="checkbox"/> No
NG Tube / Oral	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> For Feeding <input type="checkbox"/> Gastric Suction <input type="checkbox"/> Fluid Restriction	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Foley's Catheter	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Intravenous Access	<input checked="" type="checkbox"/> Peripheral Line <input type="checkbox"/> Central Venous Line <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pressure Injury	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Score	Fall Risk: <i>35</i> WELLS: _____ NEWS / PEWS: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Belongings	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Handover Details	Medication Administration Record explained: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Lab & Diagnostic Reports handed over: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Attendant Informed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	<i>[Signature]</i>	Maathumitha	0244	3/1/24	16.15
Receiving Nurse	<i>[Signature]</i>	A. Nambini	0170	3/1/24	16.15



Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

MHI/IP/2022/116



Every heart beat counts

AL INFUSION PHLEBITIS)

PATIENT NAME :

Mrs. SHARON RUTH D
49/Female/MHI202381+99
02/01/2024/IPH2024000016

IP No. / UHID No

AGE / SEX :

Dr. K. JAISHANKAR

Ward / Bed No.

ANY SCORE > 0 SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
3/1/24	7.00	Brachial	0/5	patent	Flushed	Healthy	Def 2100
	14.00	Brachial	0/5	patent	Flushed	followed	Def 021111
	22.00	Brachial	0/5	Patent	flushed	followed	Def 021111
4/1/24	7.20	Brachial	0/5	patent	flushed	followed	Def 021111
3/1/24	7.00	Anesthetic	0/5	patent	Flushed	Healthy	Def 2100
	14.00	Anesthetic	0/5	patent	flushed	followed	Def 021111
				Removed			



Medway Hospitals®

way to better health

Mrs. SHARON RUTH D

49/Female/MH1202381+99

02/01/2024/1PH2024000016

Dr. K. JAISHANKAR



3/1/24.

- 1) T. Pan 40 mg - 10
- 2) T. Dolo 650 mg - 10
- 3) ECG leads - 10
- 4) bed Pan - 1
- 5) Dosi flow - 1
- 6) D/S gloves - 10 Pair

Q
0244

f @MedwayHospitals @medwayhospitals in @medway-hospitals @medwayhospitals



94457 94457
1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4451

MH/PRINT /0123/ NRS

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

21/3/11 11/24

DRUG NAME

T. LIVONEN

8.00

Dose

1 tab

Route

P/O

Frequency

1-1

Dr. Sign & Reg. No. / Seal

165308

Start Date & Time

21/12/24 @ 18.00

Stop Date & Time

20.00

20.00 20.30

Additional Info:

DRUG NAME

T. Par

4.00

Dose

4mg

Route

P/O

Frequency

1-1

Dr. Sign & Reg. No. / Seal

91810

Start Date & Time

21/12/24 @ 18.10

Stop Date & Time

Additional Info:

DRUG NAME

T. Doro X 3 day

8.00

Dose

650 mg

Route

P/O

Frequency

1-1

Dr. Sign & Reg. No. / Seal

91810

Start Date & Time

21/12/24 @ 12.10

Stop Date & Time

20.00

20.30

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:

21/12/24

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

[illegible][illegible]

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
02/1/24	6 PM	Low salt, Low fat	<i>[Signature]</i>	134777					
02/1/24	8 PM	NPD	<i>[Signature]</i>	134777					
4/1/24	8:00	Soft solid diet	<i>[Signature]</i>	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
2/1/24	Evening	Agasthya	0146	<i>[Initials]</i>		Evening			
2/1/24	Night	B. Kanish	0195	<i>[Initials]</i>		Night			
3/1/24	Morning					Morning			
3/1/24	Evening	Maathumitha	0244	<i>[Initials]</i>		Evening			
3/1/24	Night	B. Kanish	0195	<i>[Initials]</i>		Night			
4/1/24	Morning	Davidha	0072	<i>[Initials]</i>		Morning			
4/1/24	Evening	Jenipriya	0081	<i>[Initials]</i>		Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

2AT A

MHI/ICU/2022/065



Every heart beat counts

Mrs.SHARON RUTH D

49/Female/MH1202381+99

02/01/2024/IPH2024000016

NAME : Dr.K.JAISHANKAR

UHID NO :

AGE: 493

SEX : F

SURGICAL PROCEDURE :

EAGH + EP + RFA 202381A99

POSTOP DAY: 03

FLUID REQUIREMENT :

3112A - ①

[illegible]

MHI/ICU/2022/064



MEDIATE CARE FLOWCHART

Dr.K.JAISHANKAR

AGE: 49 SEX: F

20281499

BLOOD GROUP :

HEIGHT: 159cm

WEIGHT: 45 kg.

B.S.A :

$$3/1/2A \rightarrow (1)$$
[illegible]