Medway Hospitals ®
The way to better health

MH/ PRINT / 0075 / MRD

MRD CHECKLIST

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

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Patient Details *(Affix Label here)*
Na Mr.VENKATACHALAM P
Uh 63/Male/MHI202381271
DO 27/12/2023/IPH2023002615
DO Dr.ANBARASU MOHANRAJ
Cor

MHI/IPD/2022/002

Medway Heart Institute
every heart beat counts

ADMISSION SLIP

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

Advised Date & Time: 27/12/23 @ 12 noon

Provisional Diagnosis:

CAD-TVD / T_2 DM / HTN / Old CVA

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

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

Surgery / Procedure Name (if planned):

CABG.

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

Expected Duration of Stay: 5 to 6 days

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

Payer: ☐ Self ☑ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Admit in private ward.

Any other Instructions (if any):

—

Doctor's Signature	Name	Reg. No.	Date	Time
Reg. No: 55476	Dr. ANBARASU MOHANRAJ Reg. No: 55476	55476	27/12/23	12:00

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**
27/12/23	12-40pm	27/12/23	12:19 PM

Source:

- ☑ OPD
- ☐ ER
- ☐ Direct

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

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

Front office Staff Signature	Name	Emp. No.	Date	Time
	Soundarya	2209	27/12/23	12:19 PM

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Patient ID: Mr.VENKATACHALAM P
Name: 63/Male/MHI202381271
UHID: 27/12/2023/IPH2023002615
DOB:
DOA: Dr.ANBARASU MOHANRAJ
Consultan

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	SREE AKSHAYAM, E2, LAKSHMI NAGAR,	8056142540
Occupation	ADAMBAKKAM, CHENNAI - 600 126	
—		

Referred from	Date of Admission	Time of Admission	Date & Time of Discharge	Total No. of Days
DR. Anbarasu Mohanraj	27/12/23	@12:19 pm	2/1/24	7 days

UNIT	MLC	If Yes AR No. :
Cardiothoracic	☐ Yes ~~☐ No~~	

FINAL DIAGNOSIS	ICD Code
TRIPLE VESSEL CORONARY ARTERY DISEASE, LEFT MAIN	I25.1
DISEASE, EFFORT ANGINA, POSITIVE TMT	I20.8 / R94.3
ADEQUATE LV SYSTOLIC FUNCTION - EF: 54%	I50.1
TYPE II DIABETES MELLITUS, SYSTEMIC HYPERTENSION	E11.9 / I10
CHRONIC OBSTRUCTIVE PULMONARY DISEASE.	J44.9
OLD CEREBRO VASCULAR ACCIDENT - FEBRUARY-2023	I69.4

DATE	OPERATION / PROCEDURES	ICPM Code
28/12/23	OFF PUMP CORONARY ARTERY BYPASS GRAFTING X 4 GRAFTS	36.14

DATE	TYPE OF ANESTHESIA				
28/12/23	~~☐ GENERAL~~	☐ SPINAL	☐ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

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

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

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்
Signature of Admitting Nurse

தேதி
Date 27/12/23

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

உறவுமுறை Son
Nature of Relationship

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Patient Details (Affix Label here)
Name: Mr.VENKATACHALAM P
UHID: 63/Male/MHI202381271
DOB: 27/12/2023/(PH2023002615
DOA:
Consultant Dr.ANBARASU MOHANRAJ

MHI/IP/2022/008

Medway Heart Institute
heart beat counts

GENERAL CONSENT FOR ADMISSION

I, MR. Venkatachalam. P 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		VENKATACHALAM P	27/12/23	12:19 PM
Surrogate/Guardian (if applicable #)		MAHESH V (SON) *(Write name and relationship with patient)*	27/12/23	12:19 PM
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		MEENAKSHI V	27/12/23	12:19 PM
Interpreter (if applicable)				

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

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/ICU/2022/114

Medway Heart Institute
Every heart beat counts

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

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

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

Doctor	Signature	Name	Reg. No.	Date	Time
	S	Dr. praveen	112216	28/12/23	18.3

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

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

Doctor	Signature	Name	Reg. No.	Date	Time
	S	Dr. praveen	112216	30/12/23	10.00

MRD

DISCHARGE SUMMARY

IP No.	: IPH2023002615	**D.O.A**	: 27/12/2023
UHID	: MHI202381271	**D.O.D**	: 02/01/2024
Name	: Mr. VENKATACHALAM.P	**Room No.**	: **105**
Age / Gender	: 63Years / MALE		
Consultant	: **Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)** **Director and Clinical lead – Cardio Vascular and Thoracic Surgery**		

D.O.S: 28.12.2023

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE
LEFT MAIN DISEASE
EFFORT ANGINA
POSITIVE TMT
ADEQUATE LV SYSTOLIC FUNCTION – EF: 54%
TYPE II DIABETES MELLITUS
SYSTEMIC HYPERTENSION
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
OLD CEREBRO VASCULAR ACCIDENT – FEBRUARY 2023

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD, SVG TO OM, PDA TO PLV (SEQUENTIAL) DONE ON 28.12.2023

BRIEF HISTORY:

Mr. Venkatachalam.P, 63 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, Chronic obstructive pulmonary artery disease, Old Cerebro vascular accident – February 2023, Effort angina, Positive TMT, Left main disease + Triple vessel disease, Good LV systolic function, has come for CABG. Patient was apparently normal till 1 month ago when he developed breathlessness on exertion which progressed to NYHA class III. Initially, he went to nearby clinic where his TMT was positive for inducible ischemia. He was advised Coronary Angiogram. He went to Rela Hospital and underwent Coronary Angiogram which showed Left main disease + Triple vessel disease. He then came to Medway Heart Institute on 13.12.2023 and advised early CABG. Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, he is getting admitted for the same. No H/O Chest pain, Palpitations, Syncope or Swelling of Legs. No H/O CKD or Hypothyroidism.

NAME : Mr. VENKATACHALAM.P UHID : MHI202381271 IPNO: IPH2023002615

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP	-	97.2° F
HR	-	74bpm
BP	-	140/70mmHg
SPO_2	-	96% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft, BS (+)
CNS	-	Moves all 4 limbs, Bilateral – pupil reacting to light (+).

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	12.6	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	37.3	39-52	%
TWBC	8900	4000 - 10000	Cells/Cumm
NEUTROPHILS	74.4	40-70	%
LYMPHOCYTES	20.1	20 - 40	%
EOSINOPHILS	1.2	0 - 6	%
MONOCYTES	3.8	0 - 6	%
BASOPHILS	0.5	0 - 2	%
PLATELET	275000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Cells/Cumm
Urea	25	14 - 40	mgs/dl
Creatinine	0.81	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na+)	134	135 - 145	mmol/l
Potassium (K+)	5.50	3.4 - 5.5	mmol/l
T. Bilirubin	0.38	0.2-1.0	mg/dl
D. Bilirubin	0.17	0.00 – 0.4	mg/dl
I. Bilirubin	0.21	0.4-0.6	mg/dl
S.G.O.T	14	<38	U/L
S.G.P.T	12	<41	U/L
ALP	82	Adult: 42 - 141	U/L
GGT	13	Male : 10 - 45 Female : 5 - 32	U/L
Total Protein	6.5	6.0 - 8.0	gm/dl
S. Albumin	4.5	3.5 - 5.0	gm/dl

NAME : Mr. VENKATACHALAM.P UHID : MHI202381271 IPNO: IPH2023002615

PROTHROMBIN TIME	10.3	Normal : 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction : 2.0 - 3.0 Deep Vein Thrombosis : 2.0 - 3.0 Pulmonary Embolism : 2.0 - 3.0 Artificial Cardiac Value : 3.0 -4.5 Recur.Systmic Embolism: 3.0 - 4.5 INR	
INR	0.8		

HBA1C	6.4	Normal: Below 6.0 Good control: 6.1-7.0 Fair Control : 7.1-8.0 Unsatisfactory: 8.1-10.0 Above 10 : poor control (GHB is an index of your blood Sugar control for the past (3 months)	%
T.S.H	1.74	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	ulU/ml
T3	73	"Adult : 60 - 152 New born - 4 days : 96 - 730 1 - 11 Months : 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	10.1	"Adult : 4.6 - 9.3 New born - 4 days : 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs : 6.3 - 13.16	ug/dl

ECG: HR – 70bpm, sinus rhythm, RBBB.

ECHO: ALL CHAMBERS NORMAL SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT – BASAL INFERO SEPTUM HYPOKINETIC, ADEQUATE LV SYSTOLIC FUNCTION – EF : 54%, AORTIC GRADIENT – MAX GRADIENT – 3 MM HG, MEAN GRADIENT – 2 MM HG, GRADE I DIASTOLIC DYSFUNCTION, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 11CM/S, TAPSE: 18MM, IAS / IVS INTACT, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, IVC NORMAL IN SIZE AND COLLAPSING, NO CLOT / VEGETATION / EFFUSION.

CAROTID DOPPLER: SOFT PLAQUE NOTED IN BOTH CCA, CALCIFIC PLAQUE NOTED IN LEFT CAROTID BULB EXTENDING TO LEFT ICA ORIGIN, LEFT ICA ORIGIN SHOWS 50 % DIMENSIONAL STENOSIS, LEFT CAROTID BULB SHOWS 33 %, DIMENSIONAL STENOSIS, NORMAL BILATERAL VERTEBRAL DOPPLER STUDY.

CAROTID AND VERTEBRAL ARTERIES DOPPLER : BILATERAL INCREASED INTIMA MEDIAL THICKNESS IN COMMON CAROTID ARTERIES, NO SIGNIFICANT STENOSIS OR OCCLUSION SEEN IN CAROTID AND VERTEBRAL ARTERIES ON BOTH SIDES.

NAME : Mr. VENKATACHALAM.P UHID : MHI202381271 IPNO: IPH2023002615

MRI – BRAIN: ACUTE INFARCT MEASURING ~ 10 X 5 MM RIGHT THALAMUS, NO EVIDENCE OF HEMORRHAGE / MIDLINE SHIFT NOTED, MILD AGE RELATED ATROPHY CHANGES, MILD PERIVENTRICULAR SMALL VESSEL ISCHEMIC CHANGES, CHRONIC INFARCT SEEN IN HEAD OF RIGHT CAUDATE NUCLEUS.

CXR: PA film, lung fields clear.

COURSE IN THE HOSPITAL:

Mr. Venkatachalam.P, 63 years old male, was admitted with above mentioned complaints. He underwent **OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 4 GRAFTS: LIMA TO LAD, SVG TO OM, PDA TO PLV (SEQUENTIAL) ON 28.12.2023.** He was shifted to SICU with stable hemodynamics and nil supports. He was extubated on the next day (29/12/2023) at 8.45 am. Drains were removed on POD1 (29/12/2023). He was shifted to ward on POD 2 (30/12/2023). Suture removal was done on POD5 (02/01/2024). Patient course in the hospital was uneventful. His medications are optimized and he is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR	-	94/min	BP	-	150/70mmHg
SPO2	-	94% in room air			

POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	8.2	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	24.3	39-52	%
TWBC	9810	4000 - 10000	Cells/Cumm
NEUTROPHILS	82.5	40-70	%
LYMPHOCYTES	13.0	20 - 40	%
EOSINOPHILS	0.4	0 - 6	%
MONOCYTES	4.0	0 - 6	%
BASOPHILS	0.1	0 - 2	%
PLATELET	183000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Cells /cumm
Urea	19	14 - 40	mgs/dl
Creatinine	0.76	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na+)	128	135 - 145	mmol/l
Potassium (K+)	4.09	3.4 - 5.5	mmol/l

NAME : Mr. VENKATACHALAM.P UHID : MHI202381271 IPNO: IPH2023002615

ECG: HR – 70bpm, sinus rhythm, RBBB.

ECHO: S/P CABG, CONCENTRIC LVH, ALL CHAMBERS NORMAL IN SIZED, REGIONAL WALL MOTION ABNORMALITY PRESENT – BASAL INFERO SEPTUM HYPOKINETIC, ADEQUATE LV SYSTOLIC FUNCTION, EF: 55%, NORMAL RV SYSTOLIC FUNCTION, TAPSE: 16MM, AORTIC VALVE SCLEROSIS, OTHER VALVE STRUCTURALLY NORMAL, IAS/IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 3MMHG, MEAN GRADIENT – 2MMHG, GRADE II DIASTOLIC DYSFUNCTION, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, MODERATE LEFT, MILD RIGHT PLEURAL EFFUSION, NO CLOT/ VEGETATION/ PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, lung fields clear, no effusion.

NAME : Mr. VENKATACHALAM.P UHID : MHI202381271 IPNO: IPH2023002615

ADVICE MEDICATIONS:

Sl.. NO.	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. ROSUVAS (ROSUVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	50MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2WEEKS
5	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
6	CAP. RAZO D (DOMPERIDONE + RABEPRAZOLE)	1 CAPSULE	20MG 30MG	1	0	1	ORAL	30 MINUTES BEFORE FOOD	X 1 WEEK
7	TAB. LIVOGEN (FOLIC ACID + FERROUS FUMARATE)	1 TABLET	1500MCG + 152MG	1	0	0	ORAL	AFTER FOOD	X 30 DAYS
8	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATION)
9	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	1 MONTH
10	SYP ALEX PLUS (DEXTROMETHORPHAN HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
11	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.5MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

NAME : Mr. VENKATACHALAM.P UHID : MHI202381271 IPNO: IPH2023002615

DIABETIC MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. METFORMIN	1 TABLET	500MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. DIAMICRON XR MEX (GLICLAZIDE + METFORMIN)	1 TABLET	60MG/ 500MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. VOLIBO – R (REPAGLINIDE + VOGLIBOSE)	1 TABLET	0.3 MG/ 1.0MG	1	1	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	HIGH PROTEIN, LOW SALT LOW FAT AND DIABETIC DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	NIL
REVIEW	REVIEW WITH **DR. ANBARASUMOHANRAJ** AFTER 09/01/2024 WITH FBS, PPBS, HB, UREA, CREATININE, SODIUM, POTASSIUM, CHEST X RAY

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

Typed by: Kalai

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

"I understood the Content of the discharge summary."

Dr. ANBARASU MOHANRAJ MS, M.Ch(CTVS)
Director & Clinical Lead
Cardio Vascular and Thoracic Surgery
Medway Heart Institute, Chennai-24
Reg No: 55476

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/107

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INPATIENT INITIAL ASSESSMENT

Date: 27/12/23 **Time of arrival in ward:** 13.00.

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 74/m (beats/min) | BP: 140/70 (mmHg)
Respiration: 20/m (breaths/min) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

- Pt. came to OPD with H/o - SOB, NYHA III aggravated 1 chest pain, few days back.
- H/o - CAG - done, shows TVD, advised for CABG, PE. got admitted here for further management.

PAST MEDICAL HISTORY (with duration of illness)
Diabetes Mellitus: ☑ Yes ☐ No. If Yes, duration: 4yrs Hypertension: ☑ Yes ☐ No. If Yes, duration: 1yrs

Others: H/o - T2DM on Rx. H/o - SHTN on Rx.
H/o - CAG done, (27/12/23). N11K140 - Hypothyroidism
H/o - CVA (Acute. infarct) (20/03/23). recent.

Past Surgical History:

No H/o - previous surgical history.

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. PROLOMET	50 mg	P/o	1-0-0	27/12/23	☑ Yes ☐ No
2.	C. ROZA GOLD 20		P/o	0-0-1	23/12/23	☐ Yes ☐ No
3.	T. IMDUR 30	30 mg	P/o	1-0-0	27/12/23.	☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

—

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

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

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

Others: _____

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

—

General Physical Examination:

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

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

SYSTEMIC EXAMINATION

CVS: CVS : $S_1 S_2$ (+)

Respiratory System: RS : BAE (+)

Gastrointestinal System: P/A : Soft, BS (+)

Central Nervous System: CNS : moves all (4) limbs
B/L - pupil reacts to light (+)

Urinary / Reproductive / Locomotor System:
- Normal.

Skin / Opthalmic / ENT —

Suspected of contagious disease: ☐ Yes ☑ No Immuno compromised status: ☐ Yes ☐ No
Isolation required: ☐ Yes ☐ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:
☑ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

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

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

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

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

Provisional Diagnosis:
Triple Vessel disease | SHTN | T2DM.

Plan of Care:
CABG. Tr GA

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: _____

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

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. Mohamed Ayhan	165807	27/12	14:50
Consultant		DR. ARBARASU	55476	28/12/23	08:00
Patient Attendant		Relationship Wife Meenakshi. V	—	27/12/23	13.00

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MHI/IP/2022/041

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
27/12/23	S/B Dr. Mohamed Hydross
10pm	CAD - TVD / T2DM / HTN
	Plan: CABG ↓ GA
	tomorrow -
	Patient Conscious
	oriented.
	Vitals stable. Afebrile.
	CVS → S1 S2 (+)
	RS → BAE (+)
	P/A → soft, NT
	Adv
	- Monitor vitals
	- To follow drug chart
	- NPO from 8pm.
	- Consent obtained
	- Parts preparation
	(signature) (K...)

DATE	NOTES
28/12/2023 @ 18:30	Mr. venkatachalam 63y/m underwent opCABG x 4 grafts.
	He was shifted to SICU & following hemodynamics
	HR - 79 Bpm
	Bp - 152/46 mmHg
	CVP - 11 mmHg
	SpO_2 - 100%
	Ventilator:
	mode: VCV FIO2: 60% peep: 5 mmHg
	Supports:
	NIL
	plan:
	continue ventilation (over night)
	For Dr. Anbarasu PA. Karthika (PMH0216)

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
29/12/2023 @8.00	S/B: Dr. Anbarasu / Dr. Rajesh / Dr. Praveen
	S/P: OPCAB x 4 grafts.
POD#1	patient on ventilator: mode - ps/cpap
Hb - 10.1	O/E: conscious, oriented, Afebrile
u - 23	· BP - 176/60 mmHg
cr - 0.9	· HR - 100 BPM
na - 139	· SpO_2 - 100% on ventilator
K - 3.51	· I/O - 1595 mL / 1420 mL; Bal (+) 175 ml
	· on heath
RBS - 144 mg/dL	· Adequate urine output
ABG	· peripheries warm (+)
pH - 7.438	Supports: nil
pCO_2 - 32.7	Total drain: 290 ml
pO_2 - 221.0	Plan
HCO_2 - 22.8	· RF - 2.2 litres / day
BE - (-)0.1	· Good chest physio
	· Extubation
	· Remove drains & artery line
	· Mobilize
	· Nebulization & spirometry
	· T. ROSUVASTATIN 40mg 0-0-1
	· T. METOPROLOL 25mg 1-0-1
	· Restart OHA
	· Keep him here today.

Praveen 112236.

DATE	NOTES
30/12/2023 8.00	S/B DR Anbarasu / DR Rajesh / DR Praveen
	POD - 11
	S/P OPCAB X 4 grafts.
Hb - 9.0	Patient conscious, oriented, afebrile.
Urea - 20.4	BP : 118/70 mm Hg
crea 0.74	HR : 94 bpm
Nat - 129	SpO2 : 94 % on room air.
Ict - 4.19	I/o : 2718 ml / 2640 ml. balance +278 ml.
	Self voided.
RBS - 155 mg/dL.	Tolerating oral feeding
	Pheripheries felt warm
	Supports Nill
	Plan
	- RF 2-2 litres / day
	- Chest Physio & Spirometry
	- Mobilise
	- Nebulise
	- Remove lines
	- Shift to ward.
	Praveen 172236.

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Mr.VENKATACHALAM P
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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
30/12/23	S/B - Dr. Sri Elango (DMO)
10:30am	- pt. received in ward.
	POD - II S/P - OPCAB x(4) Grafts
	K/c/o - T2DM / SHTN.
PR - 101/min	
BP - 120/70mmHg	O/E: conscious, oriented, afebrile.
RR - 20/min	c/o - pain over Sx site.
SpO2 - 100% (RA)	S/E:
	CVS: S1 S2 (+)
	RS: BAE (+)
	P/A: soft
	Advice:
	- RF 2 ltr / day.
	- Check physio + spirometry.
	- To mobilise the pt.
	- Follow drug chart.
	Ely. / I Hours

DATE	NOTES
30.12.23	S/B Dr. Anusuya
2.30pm	S/p OPCABX 3grafts
POD - 2	patient reviewed
	c/o: mild pain in the surgical site
Temp - 100.5	O/E: patient conscious, oriented,
	S/E: CVS - S1S2 (+)
	RS - BAE (+)
	CNS - NFND
	P/A - soft, non-tender.
	L/E: Dressing intact
	no seepage
	Vitals: HR - 82b/m
	BP - 130/80mmHg
	RR - 18/min
	SpO2 - 98% RA
	Advice
	- monitor vitals
	- continue the drugs as per chart
	- W/F fever spikes / desaturation / dehydration
K.M 134559	

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Dr.ANBARASU MOHANRAJ

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
30/12/23	S/B Dr. Mohamed [illegible]
10pm	Post OP case of CABG x 3 grafts
	POD-2
	Patient conscious
	Oriented
	Afebrile
Vitals stable	CVS → S1 S2 ⊕
	RS → BAE ⊕
	P/A → Soft, NT
	Adv
	- Monitor vitals
	- To follow drug chart
	- Mobilise the patient
	- nebulisation [illegible]
	[signature]

DATE	NOTES
31.12.23 11.20 AM POD-3	S/B Dr. Anusuya S/P OPCABX 3grafts Patient recieved C/O: fever with chills & nausea O/E: Patient conscious, oriented, afebrile S/E: CVS - S1S2 (+) RS - BAE (+) CNS - NFND P/A - soft, non-tender L/E: Dressing intact no leakage Vitals: HR - 82b/M BP - 110/80mmHg RR - 18/min SPO2 - 98% RA Advice - monitor vitals - Continue the drugs as per chart - mobilise the patient - continue the chest physio & spirometry
K/D 13/1/24	

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

2/041

DOCTOR'S PROGRESS NOTES

DATE	NOTES
01/1/24	S/B Dr. Anusuya
10.00	S/P OP CAB patient reviewed
POD-4	C/O: Fever
Vitals stable	S/E: CNS-S1S2 (+) RS-BAE (+)
	H/E: Dressing Contact no Soakage
	Advice Continue the same
	Plan: SR Dn tomorrow - mobilise the patient Continue Chest Physio & Spirometry
D.M 13.01.24	

DATE	NOTES
	S/B Dr. Mohamed Yghoss
1/1/24 10pm	
	Post OP case of OPCAB x 3grafts
	POD-4.
	Patient conscious
	oriented
	Afebrile.
	CVS → S1 S2 ⊕
vitals stable.	RS → BAE ⊕
	P/A → Soft, NT
	Adv
	- Monitor vitals
	- To follow drug chart
	- To do PostOP investigation ECG, ECHO, CXR
	PA view
	Plan DC tomorrow
	168803

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Tel : 044 - 2473 4455 | Mobile No : 9962 985 985
KUMBAKONAM : No. 142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post),
Thiruvidaimarudhur (Taluk), Kumbakonam - 61 2103. (Taniore Dist). Ph: 0435 - 2412345 | Mob : 7397720491
E-mail : info@medwayhospitals.com I Website : www.medwayhospitals.com

PRE-OPERATIVE CHECKLIST

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Name | Age : 63Y Gender : M | UHID No. : 20238127 1

Ward | Bed No. : 104-A'

		B.S.	A.S.
	Clinical Diagnosis : CAD - LM. TVD.	✓	✓
	Proposed Procedure : CABG	✓	✓
	CHECKLIST		
1.	Identification Band on Hand Checked ?	✓	✓
2.	Surgical consent Signed? a. Special Consent signed if required.	✓	✓
3.	Anesthetist Consultation (If required?)	✓	✓
4.	History AND Physical Onchart? a. Height..168CM.. b. Weight..61kg..	✓	✓
5.	Allergic to drugs ? NKDA	✓	✓
6.	Surgical Preparation done ? YES	✓	surgical dressing
7.	Nill by Mouth From ..5.00..	✓	✓
8.	Blood Grouping & Rh Typing 'O' POSITIVE	✓	✓
9.	Investigation ☑ X - Ray ☑ ECG ☐ LAB	✓	✓
10.	Blood Sugar 83 mg/dl Time 10.30	✓	✓
11.	TPR Chart Pulse..77.. Temp..98.6.. BP ..120/70.. RR..20..	✓	✓
12.	Time Voided a. Retention ☐ Yes ☑ No	✓	catheterized
13.	Enema ☐ Yes ☑ No	✓	✓

14.	a. Prosthesis Removed ☐ Yes ☐ No / ☑ Not Applicable b. Plates present Removed ☐ Yes ☐ No / ☑ Not Applicable c. Contract Lenses Removed ☐ Yes ☐ No / ☑ Not Applicable d. Dentures Removed ☐ Yes ☐ No / ☑ Not Applicable	✓	✓
15.	Valuables and Jewellery Removed ☑ Yes ☐ No Secured ☑ Yes ☐ No	✓	✓
16.	Pre-Operative Medication Admistered ..... YES ..... a. Time ..... 5.00 ..... b. Nurse	✓	✓
17.	Blood Transfusion requisition Onchart	✓	✓
18.	X-Ray ..... 1 ..... CAG Report → No (1) Carotid tappler Report → (1)		
	ECG / ECHO ..... 1 ..... Screening ..... echo Report → (1)	✓	✓
	Ultra Sound ..... USG Report Doppler Study → (1)	✓	✓
	C.T. Scan.....		
	MRI Scan 1	✓	✓
	TMT		
	Medication		
	27/12/23		
	T. PAN 40MG } GIVEN T. ALPRAX 0.5MG } AT 21.00	✓	✓
	28/12/23		
	T. PAN 40MG } GIVEN Others T. ALPRAX 0.5MG } AT 21.00	✓	✓

VERIFIED BY DUTY INCHARGE SREEKUMAR

Nurse Signature

MHI/OT/2022/116

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
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MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Mr. Venkatachalam. P Age 63/M UHID MHI202381271

Diagnosis Effort angina / Positive TMT / Ct. Main + TVD / Good LV Plan CABG.

Serology Negative

EURO Score / STS Score 0.82% PRE OP DRUGS (ACE/ARB/ANTIPLATELETS): T. Rosuva gold stopped on 23/12/23

Diabetes Mellitus (HB1AC) 6.4%. Associated Illness K/C/o Acute CVA – 20/03/2023. T2DM x 8yrs.

Carotid Doppler Bulb. 33%. Rt. ICA – 50%. Ct. carotid

Thyroid Enzymes T3 73, T4 10.1, TSH 1.74.

Sr. Creatinine 0.82 Any other illness of concern –

INR. 0.8

Allen's Test Myocardial viability if needed

Varicose Veins

Pulmonologist Clearance — Nephro Clearance: —

Neurology Clearance : cleared for surgery. Dental Clearance: –

Mitral Regurgitation Assessment Trivial MR / No PAH

Nursing: Billing Clearance:

Physiotherapy Spirometry taught

Concerns from Surgical Team :

SIGNATURE :

Dr Manoj (REH20217)

CXR: PA fCm, Lung fields clear.

Mr. Venkatachalam. P 62/M a K/C/O T2DM, Old CVA - Feb 2023, Effort angina, TVD, Good LV has come for CABG. Pt. was apparently normal till 1 month ago when he developed breathlessness on exertion which progressed to NYHA Class II - IV. Initially, he went to nearby clinic where his TMT was positive for inducible ischemia. He was advised CAG. He went to Rela and underwent CAG which showed TVD. He then came to Medway Heart Institute and was advised CABG

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/OT/2022/082

Medway Heart Institute
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CONSENT FOR SURGERY

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

☑ Read

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

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

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

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

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

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

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

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

- Possible risks & complications 1. Bleeding 2. Infection 3. Stroke 4. Arrythmia 5. Prolonged ICU stay 6. Mild risk to life
- Benefits Symptom free survival
- Alternatives High risk PTCA.
- The likelihood of success of the surgery (Percentage / Other commands) 96 %.
- Possible results of non-treatment 1. Myocardial Infarction 2. Heart Failure.
- I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my sign this form.

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	VENKATACHALAM	Meenakshi V
Relationship	Self.	Wife
Signature		
Date & Time	27/12/23 @ 18.00	27/12/23 @ 18.00
Name & Signature of Doctor with Registration No.:	Dr. PRAVEEN JEYAKUMAR 112236.	

Dr. Anbarasu Mohanraj
Reg No: 55476

Doctor Seal

MHI/OT/2022/082

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

அறுவை சிகிச்சை ஒப்புதல் படிவம்

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

☐ படியுங்கள்

☐ எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.

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

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

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

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

- சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் _____

_____

_____

- நன்மைகள் _____

- மாற்றுவழிகள் _____

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

- சிகிச்சையின்றி சாத்தியமான முடிவுகள் _____

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

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

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

மருத்துவரின் முத்திரை

(50)

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ
Consultant

MHI/OT/2022/083

Medway Heart Institute
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CONSENT FOR ANAESTHESIA SERVICES

I, VENKATACHALAM. P, ☑ the patient or ☑ the representative of patient have,
(please tick the correct option above and below)

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

Operation / Procedure CORONARY ARTERY BYPASS GRAFTING.

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

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

It has been explained to me that the following may be needed as part of anaesthesia during or after surgery may be needed

☐ Central Venous catheter ☑ Arterial Line ☐ Lumbar Puncture ☐ Tracheostomy
☑ Transesophageal ☑ Blood & Blood product Transfusion ☑ ICU Admission / Recovery ☑ Others

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

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

PRENATAL / EARLY CHILDHOOD ANAESTHESIA

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	Venkatachalam	D. VENKATACHALAM.	27/12/23	13.45
Surrogate/Guardian (if applicable #)	Meena	Meenakshi. V. (Wife) *(Write name and relationship with patient)*	27/12/23	13.45
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	Pavi	Pavithra	27/12/23	13.45
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by	[signature]	Dr A. S. SYLVESTER	43570.	27/12/23	13.45

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

MH/OT/2022/083

Medway Heart Institute
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மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

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

மேலேயும் கீழேயும் சரியான விருப்பத்தைத் தேர்ந்தெடுங்கள்) படித்தல்

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

செயல்பாடு/செயல்முறை _____

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இந்த ஒப்புதல் படிவத்தின் கீழே கொடுக்கப்பட்ட செயல்பாட்டு நடைமுறையின் முழு பெயர்)

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

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

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

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

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

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

பிறப்புக்கு முந்தைய / ஆரம்பகால குழந்தை பருவ மயக்க மருந்து

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

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

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

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்	தேதி	நேரம்
பெறப்பட்ட ஒப்புதல்					

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MHI/OT/2022/094

ANAESTHESIA RECORD

Medway Heart Institute
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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Type of Surgery : ☐ Day Care ☑ Elective ☐ Emergency

Blood Group : O+ve Height : 168 cms Weight : 61 Kgs

Pre-Operative Diagnosis: CAD, TVD, EF 55%, 3M, old CVA, (L) main.

Proposed Surgery: CABG

Anaesthetic Plan: GA.

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

History of Present Illness:
- ☑ ANGINA — L/t main TVD,
- ☐ DYSPNOEA
- ☐ SYNCOPE
- ☐ MI
- ☐ CCF
- ☐ OTHERS

Previous Surgery :

COMORBIDITY
- ☐ HT
- ☑ DM 8yrs,
- ☐ ASTHMA / COPD
- ☐ HYPO THYROID
- ☐ STROKE / TIA
- ☐ EPILEPSY
- ☐ SMOKING
- ☐ ALCOHOL
- ☐ GERD
- ☐ CKD / NEPHROPATHY
- ☐ DRUG ALLERGY
- ☐

Present Medication : Metoprolol 50mg 1OD, Telma Beta

Anti Platelet Stopped on : 23/12/23 Telma stopped 15/12/23

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

SYSTEMC EXAMINATION
CVS : S1S2 CNS : Recovered CVA,
RS : Normal Others : WNL,

HR : 72/mt. NIBP : 120/70 mm Hg SPO2 : 96/1 TEMP : 98.4°F.

INVESTIGATION

HB : 12.6	T.BILIRUBIN : 0.38	T3 : 73	SEROLOGY		
PLAT : 275000	I.D. : 0.21	T4 : 10.1	Urine:		
TC : 8,900	D. 0.17	TSH : 1.74			
UREA : "	T-PROTEINS : 8.5	HBA1C : 6.4			
CREAT: 0.82	S.ALBUMIN : 4.5	RBS :	Others:		
Na+ : 138	PTT / INR 13.3/1.10	INR 0.8			
K+ : 6.38	APTT : 28.0				

ANGIO (L) main 50% LAD 90% Lesion, Mixed RCA 90-99%

ECG NSR.

CXR WNL

ECHO EF 55%
TAPSE 18mm.
RWMA +
Aortic valve sclerosis
Trivial AR/MR.

AIRWAY
- Teeth
- Mallampatti class
- Mouth Opening
- Neck Movement
- TM Distance

CAROTID DOPPLER
Soft plaque noted in dstn CCA.
Calcific plaque in (L) carotid,
extending to (L) ICA
(L) ICA - 50% stenosis & (L) carotid bulb 30% stenosis,
Normal vertebral artery study.

Other Opinions: MRI 20/3/23
Acute infarct 10x5 (R) thalamus.
NO evidence of hemorrhage / mid line shift
Mild age related atrophy changes.
Mild periventricular small vessel ischaemic changes.
Chronic infarct in head of (C) caudate nucleus.

Pre OP Instruction :

Pre Medication :

Night Before Surgery : Tab, Aflox 0.5mg + Tab. Pantop 40mg

Day of Surgery Tab, Aflox 0.5mg + Tab. Pantop 40mg at 5AM.

Special Instruction :

NPO From: ~~6hrs~~ midnight. 5AM after cup of milk and 2 slices bread.

Blood Reservation

PCV : one Platelet :

FFP : CRYO :

Whole Blood:

Remarks: Acute CVA 20/03/23. ⇒ NEUROLOGIST OPINION – (R) Thalamic syndrome ⇒ RECOVERED ⇒ fit for CABG.

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

Signature :

Date: 28/12/23 | **Anaesthetist:** DR. SYLVESTER | **Surgeon:** DR ANBARASU, DR. PRAVEEN | **Anaesthesia Technique:** ☑GA ☐Regional ☐Others

PRE INDUCTION ANAESTHESIA RECORD

Pulse: 62 BP: 135/70 RR: 16 to 20/min
Sensorium: Wnl
Sign-in Completed: ☑Yes ☐No
Equipment Checked: ☑Yes ☐No
Sign: DR. SYLVESTER Name: Dr. Sylvester
Reg. No: 43570
Time: 13:00

PATIENT SAFETY

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

MONITORS AND EQUIPMENTS

☑NIBP ☐Left ☐Right
☑ECG ☐Pulse Oximeter ☑End Tidal CO_2
☐Gas Analyzer ☑Oxygen Sensor
☑Disconnect ☐Temperature Probe
☑Foley Catheter ☐Nerve Stimulator
☐TEE ☐Others:
☑CVC Type: 8.5 Fr 8cm 4 lumen Site: Rt IJV
☑Standard Asepsis ☐USG Guidance
☐Complications: ☐Yes ☑No
If Yes, details:
☑Arterial Line - Type: 20G Thyflo 18mm Site: Lt Radial
☐PVC Type: 20G 30mm Intima Site: Rt wrist
☐PVC Type: Site:
☐Others:

GENERAL ANAESTHESIA

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

AIRWAY MANAGEMENT:
Intubation: Oral / Nasal ETT Size: 8.5 Type: Cuffed
CL Grade: I / II / III / IV Secured at: 22 cm
Any difficulties and accessories:
Throat Pack: ☐Yes ☑No ☐Removed
NG / OG Tube: ☑Yes ☐No

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

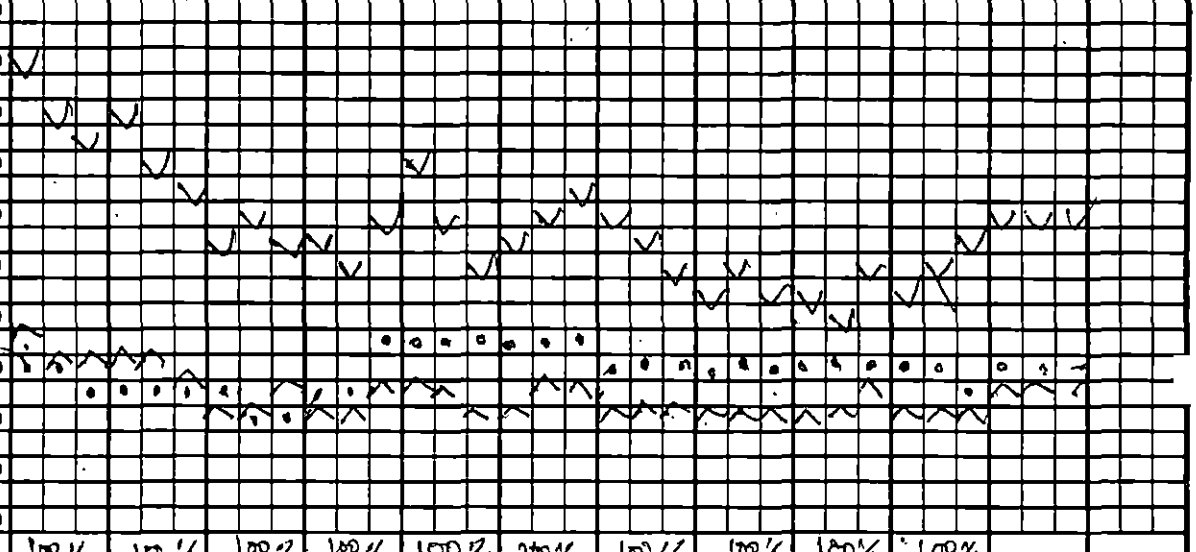
Antibiotic / Dose / Time
Inj. Cefuroxime 1.5gm @ 13.00

Reversal of Anaesthesia 2nd dose @ 17.20

DRUGS

	13:00	14:00	15:00	16:00	17:00	18:00
PROPOFOL			30	30		
MIDAZOLAM	3					
FENTANYL	125	125	75	75	50	50
MORPHINE						
VECURONIUM	6	2	1	1	1	1
ETOMIDATE						
KETAMINE						
SUXA/ROCURONIUM						
CISATRACURIUM/ATRACURIUM						
SEVO/ISOFLURANE	✓	✓	✓	✓	✓	✓
Air/N,O	✓	✓	✓	✓	✓	✓

VITAL SIGNS



MONITOR

	13:00	14:00	15:00	16:00	17:00	18:00
SPO2	100%	100%	100%	100%	100%	100%
CVP	6	5	4	4	5	5	4	5	4	5
PAP						
ETCO,	24	23	23	24	23	23	24	23	22	21
Urine Output					500 ml					

ABG

	13:00	18:00
PH	7.469	7.441
PCO_2	39.2	30.9
PO_2	85.9	296.3
Na^+	130	132
K^+	4.1	3.23
HCT	33	34
RBS	110 mg%	179 mg%
LAC	-	
BE	4.2	-3.5
HCO_3	27.9	B.G.

	START	STOP
ANAESTHESIA	13.00	18.20
PROCEDURE	13.50	18.15

CPB

AXC

CUF : MUF:

FLUID TRANFUSED		BLOOD PRODUCTS
CRYSTALOID	COLLOID	—
KABILYTE 01U	—	
02U		
03U		
04U		
05U		

HEPARIN

DOSE	TIME	ACT
125 mg	16.17	530 secs

PROTAMINE

DOSE	TIME	ACT
100 mg	17:37	183 sec

PRESSURE MONITOR

PRE OP

PA	RV	PCWP

ABP

POST OP

PA	RV	PCWP

ABP

INOTROPES & INFUSIONS

DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
NORADRENALINE (4mg/50cc)	0.02-0.05 µg/kg/min	16.15	contd.
ADRENALINE (6mg/50cc)	0.02-0.04 µg/kg/min	16.15	stopped.

DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
NITROGLYCERINE (25mg/25cc)	0.5-0.75 µg/kg/min	16.00	stopped.

REGIONAL ANAESTHESIA [YES] / NO

DETAILS : B/L ESPB

25 ml + 25 ml 0.25% ROPIVACAINE + 100 MICS DEXMEDETOMIDINE

LEFT FEMORAL NERVE BLOCK - 10ml of 0.25% ROPIVACAINE

IABP : —

ECMO: —

TEE: —

REMARKS / CRITICAL EVENTS

—

ANAESTHESIOLOGIST NAME : Dr. A. SAMUEL SYLVESTER

REG.NO. Reg. No: 43570

SIGNATURE

POST OPERATIVE PLAN

Transfer to: ☑ SICU ☐ Others, specify: _____

Arrival in Recovery / ICU Time: 18.30.

SpO_2: 100 % HR: 71 beats/min Rhythm : Reg Sinus RR: 14 breaths/min

ABP : 140/90 mmHg CVP : 9 mmHg PAP: _____ mmHg C.O : _____ L/min

Conscious state: Sedated Pain score: _____

VENTILATOR SETTINGS : Volume control; RR 14/mt; TV 550 ml; PEEP 5 mmHg. FIO_2 1:6.

IONOTROPES: N/L

POST OP ORDERS:

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

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

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

Total Score : 10

Patient fit for discharge: ☑ YES ☐ NO

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

Signature

MHI/OT/2022/081

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OPERATION NOTES

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

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

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

Operation Procedure Off Pump CABG x 4 grafts
LIMA → LAD SVG → PDA / PLB (Sequential) / OM

D.O. Operation 28/12/2023

Please tick the type of procedure :
Closed ☑ Open ☐

Operation Commenced :	Operation Completed :	Nature of Anaesthetic :
13.50	18.15	General

Surgeons Dr. Anbarasu / Dr Praveen / PA-Saikumar / PA- Karthika

Perfusionist –

Anaesthetist Dr- Sylvester

Nurse Ms- Sujatha.

Incision Midline Sternotomy

Cannulation

Arterial

Venous

Oxygenator

Total CPB Time
Total ACC Time
Total TCA Time

Findings and Relevant Details :

LIMA of good calibre and flow ~1.75mm

Lt SVG of good calibre ~4mm

Targets:-

LAD	1.5	Atherosclerosis
OM	1.5	Healthy
PLB	1.5	Healthy
PDA	1.75	Healthy

Median sternotomy – Thymus dissected – Vertical pericardotomy – Targets assessed – Lt SVG harvested endoscopically – LIMA harvested – Systemic heparinisation – LIMA divided and prepared – Myocardium stabilised with Stabiliser – SVG anastomosed to PDA (end to side), PLB (side to side) and OM (side to side) sequentially – LIMA anastomosed to LAD – Pericardial fat cleared – Dexa applied – Aortotomy with 4mm punch – Proximal anastomosis with 7-0 Prolene – Haemostasis – Protamine – Drains placed – Sternum closed with No.6 Steel wire – Wound closed in layers.

POST-BY PASS HAEMODYNAMICS

RA LA Cardiac Output

RV LA C I

SVS SYS

PA MEAN BP MEAN

DIAS DIAS

PACW

Support: Isoprin Adrenaline. Norad 0.05 μg/kg/min

Dopamine I A B P

Dobutrex Others

POST-OPERATIVE INSTRUCTIONS :

To do - ABG, ACT, Chest xray

Watch for:-

1- Bleeding

2- Hypotension

Blood loss - 300 ml

Blood transfusion - Nil

Drains: Chest -① Lt Pleural

Mediastinal - ①

Pericardial

Others

Sponge Count : Correct

Surgeon : Dr. ANBARASU MOHANRAJ **Date :** 28/12/2023

OPERATION NOTES

NAME: Mr. VENKATACHALAM.P	**AGE/GENDER:** 63Years / MALE
UHID NO: MHI202381271	**IP NO:** IPH2023002615
DOA: 27/12/2023	**DOS:** 28/12/2023
SURGEON: DR. ANBARASU MOHANRAJ	**ANESTHETIST:** DR. SYLVESTER
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	**PHYSICIAN ASSOCIATE:** MS. SAIKUMARI/MS. KARTHIKA
SCRUB NURSE: MS. SUJATHA	

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

LEFT MAIN DISEASE

ADEQUATE LEFT VENTRICULAR FUNCTION (EF – 54%)

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (CHRONIC SMOKER)

CLASS III ANGINA

SURGERY DONE:

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

LIMA TO LAD

SVG TO OM, PLV AND PDA (SEQUENTIAL)

FINDINGS:

Good myocardial contractions

No significant scarring

Emphysematous lungs with dark pigmentation (fixed to chest)

LIMA – 1.75mm, Good quality, good flow

SVG – 4mm, Endoscopic vein harvesting from left leg to mid thigh, Good quality

LAD – 1.5mm, Plaques (+)

OM – 1.5mm, Healthy target

PDA – 1.5mm, Healthy target

PLV – 2.0mm, Healthy target

Good distal run off in all the grafts

PROCEDURE:

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

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the PDA artery with 7-0 prolene suture. (SVG TO PDA)

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

Heart re-positioned and stabilized with myocardial stabilizer for OM grafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The side of the saphenous vein from the PLV graft was anastomosed to the side of the OM artery with 7-0 prolene suture. (SVG TO OM (SEQUENTIAL))

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD)

Aorta occluded partially. One 4mm hole was made on the aorta with aortic punch. Proximal anastomosis of vein graft done onto aorta with 7-0 prolene suture. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural drain tubes insitu

SUPPORTS:

He was shifted to ICU with nil support.

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

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

MHI/HOSP/2022/090

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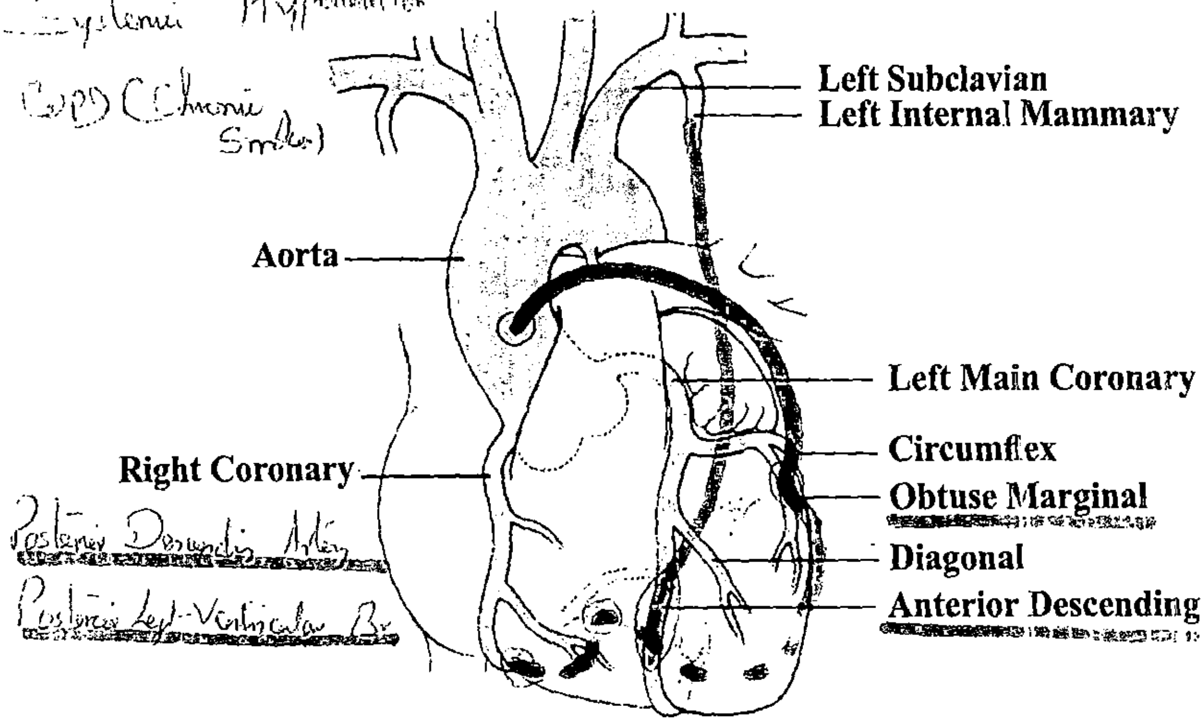
Triple Vessel Coronary Artery Disease
Left Main Disease
Adequate LV Function
Class iii Angina
Diabetes Mellitus
Systemic Hypertension
COPD (Chronic Smoker)



Good myocardial contraction
No significant scarring
Emphysematous lungs with black pigmentation (chronic smoker)

Left Internal Mammary Artery (LIMA) } Healthy,
Saphenous Vein Graft (SVG). Endoscopic harvest } Conduit

Name Mr VENKATACHALAM P 6[illegible]/M Date of Surgery 28/12/20[illegible] UHID. No. MIE [illegible]

Operation Performed OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) x 4 LIMA TO LAD; SVG TO [illegible] / PLV (SEQUENTIAL)

MHI/ICU/2022/092

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PATIENT'S INFORMATION SHEET

NAME	AGE / SEX	UHID NO
Mr.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ	63 / M	2-0238127

	SURGEON	ANAESTHETIST
Dr. ANBARASU	Dr. ANBARASU	Dr. SYLVESTER.

DIAGNOSIS (In Capital Letters)	1. CAD-TVD ((L) Main)	
	2. T_2DM / HTN.	
	3. OLD CVA (Acute infarct).	
	4.	
	5.	
	6.	
	7.	
	8.	
PRESENT PROCEDURE/ SURGERY	CABG ↓ GA	
PREVIOUS PROCEDURE/ SURGERY	–	
CONTACT NO. & RELATIONSHIP	1. (MEENACHI) 8056142540 (WIFE)	2.

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	1/8/23.	T. Prolomet	50mg	P/o	~~1-0-0~~	- continue
2	"	C- Rozagold	1 cap	P/o	~~0-0-1~~	23/12
3	"	T. Imdur	30mg	P/o	~~1-0-0~~	- continue
4						
5						
6						
7						
8						
9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	1/8/23.	T. Prolomet	50mg	P/o	1-0-0	continue
2	"	T. Imdur	30mg	P/o	1-0-0	
3						
4						
5						
6						
7						
8						
9						
10						

ANY RELEVANT INFORMATION:

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

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site: 2. Site: 3. Site:	1. Inserted Date and Time 2. Inserted Date and Time 3. Inserted Date and Time	1. Removed on : 2. Removed on : 3. Removed on :	
Neek Line : IJL / EJL	Site:	Inserted Date and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on	
Pressure Bandage	Site:	Inserted Date and Time	Removed on	
Drain Site	1. **Mediastinal :** Inserted Date and Time 2. **Pleural Right / Left :** Inserted Date and Time		Removed on Removed on	
Urinary Catheterization	Inserted Date and Time	Removed on		
Nasal / Oral Gastric Tube	Inserted Date and Time	Removed on		
Intubation Date and Time	Extubation Date And Time	Reintubation Date And Time		
Other Information	27/12/23 10 pcv Reservation done with S/N Lavanya			Qaf 27/12/23

MHI/ICU/2022/092

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PATIENT'S INFORMATION SHEET

NAME	AGE / SEX	UHID NO
Mr.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ		

SURGEON	ANAESTHETIST
DR. ANBARASU	DR. SYLVESTER

DIAGNOSIS (In Capital Letters)	1. CAD - TVD + LEFT MAIN 2. RWMA PRESENT 3. INADEQUATE LV 4. AORTIC VALVE SCLEROSIS 5. TRIVIAL AR, MR, TR 6. EF - 55 % 7. 8.
PRESENT PROCEDURE/ SURGERY	OPCAB X 4 GRAFTS LIMA → LAD SVG < PDA, PLB, OM (Sequential)
PREVIOUS PROCEDURE/ SURGERY	MRS. MEENAKSHI
CONTACT NO. & RELATIONSHIP	1. 8939330785 (WIFE) (V-C) 2.

N.No:- 35/178

INSURANCE

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	27/12/23	T. PROLOMET	50mg	PO	1-0-0	
2	"	T. IMDUR	30mg	PO	1-0-0	continue
3						
4						
5						
6						
7						
8						
9						
10						

ANTIPLATELETS STOPPED ON 23/12/23

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	29/12/2023.	SYP. SUCRALFATE SUSPENSION:	10mL	PO	1-1-0	
2	29/12/2023	INEB. LEVOSALBUTAMOL	0.63mg	RNH	Q 6HRLY.	
3	29/12/2023	T. FRUSEMIDE	40mg	PO	1-1-0.	
4	29/12/2023	T. SPIRANALACTONE	25mg	PO	1-1-0.	continue
5	29/12/2023	T. BEPLEX FORTE	1TAB	PO	1-0-0.	
6	29/12/2023	T. CLOPIDOGREL + ASPIRIN.	75/75 mg	PO	0-1-0.	
7	29/12/2023	T. PARACETAMOL	650 mg	PO	1-1-1.	
8	29/12/2023	SYP. CREMAFFIN PLUS.	15ml	PO	0-0-1.	
9	29/12/2023	T. ROSUVASTATIN	40mg	PO	0-0-1.	
10	29/12/2023	T. METOPROLOL	25mg	PO	1-0-1.	
		NEB. BUDESONIDE	0.5mg	RNH	1-1-1.	

ANY RELEVANT INFORMATION:

Admission / OT Receival **Date and Time :** 28/12/23 at 18.30 **From :** OT **To :** SICU	**Condition of the Patient :** ON VENT 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated
Transfer Out **Date and Time :** 30/12/23 **From :** SIW **To :** 104-B	**Condition of the Patient :** 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated
Transfer In **Date and Time :** **From :** **To :**	**Condition of the Patient :** 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated

	Year	Months	Days
1) Known Case of **Diabetic Mellitus**	4 YEARS		
2) Known Case of **Hypertension**	1 YEAR		
3) Known Case of **Bronchial Asthma/COPD**	—		
4) Known Case Of **Others** H/O CVA [ACUTE- INF	—		

Denture	☐ Yes ☑ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent
Allergic Reaction : Drugs/Food	☐ Yes ☑ No If you means mention about Drug / Food Name :
Pressure Ulcer Present	☐ Yes ☑ No If you means mention about **Grade :** 1 / 2 /3 / 4 & Site:

ANY RELEVANT INFORMATION:

				Sign With Date
Peripheral Cannulation	1. Site: RT CUBITAL 2. Site: 3. Site:	1. Inserted Date and Time 08/12/23 at 13:00 2. Inserted Date and Time 3. Inserted Date and Time	1. Removed on : 2/1/24 2. Removed on : 3. Removed on :	Nurse 2/1/24
Neek Line : IJL / EJL	Site: RT IJV	Inserted Date and Time 08/12/23 at 13:17	Removed on 30/12/23 @ 9.00	DOM
Arterial Line : Right/Left	Site: LT RADIAL	Inserted Date and Time 08/12/23 at 13:20	Removed on 29/12/23 AT 12:30	Dr.
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on	
Pressure Bandage	Site:	Inserted Date and Time	Removed on	
Drain Site	1. **Mediastinal :** Inserted Date and Time + 2. **Pleural Right / ~~Left~~ :** Inserted Date and Time 08/12/23 at 17:30		Removed on Removed on 29/12/23 AT 16:30	Dr.
Urinary Catheterization	Inserted Date and Time 08/12/23 at 13:05	Removed on 30/12/23 AT 04:30		Nurse
Nasal / Oral Gastric Tube	Inserted Date and Time 08/12/23 at 18:30	Removed on		
Intubation Date and Time 08/12/23 at 18:30	Extubation Date And Time 29/12/23 AT 8.45 (14HRS 15mins)	Reintubation Date And Time		
Other Information	C/O SHORTNESS OF BREATH & CHEST PAIN CAG DONE ON 07/11/23 ECHO DONE ON 13/12/23 CAROTID AND DOPPLER DONE ON 14/12/23. [SOFT PLAQUE NOTED IN BOTH CCA] ECG DONE ON 07/12/23 [HR - 74 bpm] MRI DONE ON 20/3/23			Nurse

MHI/OT/2022/086

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SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Medway Heart Institute

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Name of the Procedure : OPCAB[CLOSED HEART] Location : CTOT-OT-I Date & Time : 28/12/23@

Does the Procedure involve Procedural Sedation : ☑ Yes ☐ No ↓ N/A

SIGN IN : 13.00 Before Induction of Procedural Sedation		TIME OUT : 13.50 After procedural Sedation and before procedure		SIGN OUT : 18.25 When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure		
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	☑ Yes	Identity by two identifiers	☑ Yes	Name of the Procedure done written down ☐ Yes OPCAB[CLOSED HEART]
Procedure	☑ Yes	Procedures	☑ Yes	Name and site of all specimens / investigations ☐ Yes ☑ NA confirms labeling and sent to lab
Side	☐ Rt ☐ Lt ☑ NA chest & leg	Side Expected Blood loss 200 - 300ml	☐ Rt ☐ Lt ☑ NA chest & leg	—
Consent	☑ Yes	Position -	☑ Yes - SUPINE	Any recovery concerns : ☐ Yes ☑ None If Yes, Pls. specify :
Known Allergy	☐ Yes ☑ No / UNKNOWN If yes, plaese specify	Consent	☐ Yes	—
		Required equipment and implants available	☐ Yes ☐ NA	
Difficult airway / aspiration risk / dentures	☑ No ☐ Yes, equipment and assistance available	Essential Imaging displayed	☑ Yes ☐ NA	
		Antibiotic prophylaxis within last 60 minutes	☑ Yes ☐ NA	
Possibility of hypothermia	☐ No ☐ Yes, warmer in place	Name of the Antibiotic given INJ-CEFUROXIME 1.5M @ 13.20		Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☑ None If Yes, Pls. specify :
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☑ NA	—
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	☑ Yes	
☑ Spo2 ☑ NIBP ☐ Others pls. specify —		Anticipated blood loss briefed	☑ Yes ☐ NA	
Pre OP medication taken	☑ Yes ☐ No	Adequate fluids and blood available	☑ Yes ☐ NA	
		Team briefed on any critical or unexpected steps	☐ Yes ☑ NA	Corrective action : INSTRUMENTS, WAVERS & SPONGE & NEEDLE COUNTS ARE CORRECT
Required equipment for procedure available	☑ Yes ☐ NA	For procedural sedation cases		
		Any patient specific concerns :	☐ Yes ☑ None	
		Intra procedure glycemic control	☑ Yes ☐ NA	
		Any concerns about sterility	☐ Yes ☑ None	

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse :	Technician :	Others Please Specify :
DR.SYLVESTER	DR.ANBARASU MOHANRAJ	SASIKUMAR 0031	SATHYA MMC 9060	DR.CHARITY 0036
Date : 28/12/23	Date : 28/12/23	Date : 28/12/23	Date : 28/12/23	Date : 28/12/23
Time : 18.25	Time : 18.25	Time : 18.25	Time : 18.25	Time : 18.25

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

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CONSENT FOR BLOOD / BLOOD COMPONENTS

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

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

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

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

Witness.....
Doctor A-3570
Time 13.45
Date 27/12/23

Patients name..... P VENKATACHALAM
Patient signature..... Venkat
or Guardians name. Meenakshi. V
Guardians signature..... Meena
Relationship to patient. Wife

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

Time: Date:

Doctors signature.....

This Consent Form is valid for 72 hours from the time of signing this form

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ஒப்புதல்:இரத்தம் / இரத்தத்தின் பாகங்களை செலுத்துதல்

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

சிவப்பு அணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு
தட்டணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு
குருதிநீர்	இரத்த கனஅளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு
கிரையோபிரெஸிபிடேட்	சிறப்பு உறைவு அம்சங்களுக்காக

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

1. இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானமளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அலோஜெனிக்) அல்லது சுயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானமளிப்பிற்கு வாய்ப்புள்ளது.
2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்பட்டிருந்தாலும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்களான எய்ட்ஸ், ஹெபடைடிஸ் மற்றும் இதர வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையும் நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம், இவை, காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும்கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொள்கிறேன்.
3. இரத்தம் செலுத்துவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலைத் துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம், என்றாலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
4. இரத்தம் செலுத்துதல், மாற்று சிகிச்சை முறைகள், சிகிச்சை எடுக்காமல் இருப்பதிலுள்ள ஆபாயங்கள், பயன்படுத்தப்படவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய விவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.
5. முறையான மருத்துவப் பராமரிப்பின் பொருட்டு, இரத்தம் மற்றும் /அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முழுமையான காலகட்டத்திற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக்கொள்கிறேன்.

நோயாளியின் பெயர்.....

சாட்சி..... நோயாளியின் கையொப்பம்.....

மருத்துவர் ..... அல்லது பாதுகாவலரின் பெயர்.....

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

தேதி..... நோயாளியுடனான உறவு.....

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

நேரம்:

நோயாளியின் பெயர் மருத்துவரின் கையொப்பம் .....

தேதி:

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Patient Details *(Affix Label here)*
Name: Mr.VENKATACHALAM P
UHID: 63/Male/MHI202381271
DOB: 27/12/2023/IPH2023002615
DOA:
Consultant: Dr.ANBARASU MOHANRAJ

MHI/PHY/2022/049

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IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints: PT c/o Shortness of breath (NYHA IV) associated c̄ chest pain.

Occupation: ☐ Heavy Activity ☑ Moderate Activity ☐ Light Activity

Past Medical / Surgical History:
K/c/o T2DM (On Rx) (4 yrs)
K/c/o SHTN (On Rx) (1 yrs)
K/H/o CAG (27/12/23)
K/H/o CVA (acute infarct)

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

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

FALL RISK SCREENING Nil
Fall Risk Screening for Adults: ☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem
In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.

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

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

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

Spine Injury: ☐ Present ☑ Absent

AIS:ISNCSCI SCALE: NIL

☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx

Associated Injuries: Speech impaired: ☐ Yes ☑ No

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

ASHWORTH SCALE: NIL

☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit

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

Functional Activities

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

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

FIM Score:

Breathlessness *(If applicable)*:

Dyspnoea Grading Scale: Grade III

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

Abnormal Breathing Pattern: Abdominal breathing

Pain Assessment: Pain: ☑ Yes ☐ No

Pain Score: 6/10

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

☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC

Location: Chest Duration: – Frequency: – Character: ~

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

☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing

Aggravating Factors:	Relieving Factors:
–	~

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

☐ Range of Motion:

Normal

☐ Muscle Strength:

Normal

☐ Reflexes:

Normal

Plantar Response: ☑ Diminished ☐ Brisk ☐ Clonus

Biceps: ☐ Diminished ☐ Brisk ☐ Clonus

Triceps: ☑ Diminished ☐ Brisk ☐ Clonus

Supinators: ☑ Diminished ☐ Brisk ☐ Clonus

Knee: ☐ Diminished ☐ Brisk ☐ Clonus

Ankle: ☑ Diminished ☐ Brisk ☐ Clonus

Sensation: Good

Investigation & Findings:

TVD/ SHTN/ T2DM

Physiotherapy Management Plan:

- DBE
- Spirometry ex
- Chest percussion to B/L chest wall
- AROM to B/L UL & LL
- Mobilization

	Signature	Name	Emp. No.	Date	Time
Physiotherapist	G.B. Akash	AKASH GB	0256	28/12/23	18:09

RE-ASSESSMENT FORM

Date & Time	
30/12/23 & 10:00	**Fall Risk Score:** — **Pain Score:** 2/10 Surgical site pain. Rx - DBE's encouraged - chest expansion done to B/L chest wall - Spirometry ex encouraged - Active ex to B/L UL & LL - Mobilized to chair. - To Improve Joint ROM - To Improve ADL - To Improve lung expansion & lung clearance **Post Intervention Pain Score:** 2/10 **Treatment Care & Plan:** Post operative cardio pulmonary Rehabilitation

	Signature	Name	Emp. No.
Physiotherapist	[signature]	J. VIJAYARAGHAVAN	2102

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NABH

Patient Details *(Affix Label here)*
Name: Mr.VENKATACHALAM P
UHID: 63/Male/MHI202381271
DOB: 27/12/2023/IPH2023002615
DOA: Dr.ANBARASU MOHANRAJ
Consultant

MHI/PHY/2022/050

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CONSENT FORM - PHYSIOTHERAPY

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

☐ Read
☑ I/We have been explained the current clinical condition of me / my patient
☑ Been explained this consent form in Tamil. *(Name of language)* which I fully understand and understood the information provided about Operation / procedure POST OPERATIVE CARDIO PULMONARY REHABILITATION.

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

Brief description of the Operation / ~~Procedure~~: DBE's, Chest percussion, Spirometry Ex's, Aerom Ex's, Mobilization

I understand the intended benefits of undergoing the procedure .The intended benefits from this procedure are:
To Improve Chest Expansion, To clear out Lung Secretions, To Improve Rom & ADL

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

Pain

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

Nil.

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

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

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

Meena

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	Meena	Meenakshi · V *(Write name and relationship with patient)*	28/12/23	19:20
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		Dayatara · S.P.	28/12/23	19:20
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by	G.E Akash	AKASH G.E	0256	28/12/23	19:20
Procedure performed by	G.E Akash	AKASH · G.E	0256	28/12/23	19:20

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
28/12/23	21:00	S/B Ramanathan. P - ET / oral Suctioning done yielded thick Secretions	[signature] MH10260
29/12/23	8:45	S/B Ramanathan. P. - ET / oral / nasal suctioning done yeilded thick white secreation - Patient extubated and connected to O2 NP 4 l/min - Speech voice clear & audible. - DBE's encouraged - chest mobilisation done to B/L chest wall - Spirometry ex encouraged Ins-600cc Exp-600cc - Active ex to B/L UL & LL encouraged.	[signature] MMC-2102

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63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
29/12/23	~~6:00~~ 17:00	S/B AKASH - DBE encouraged - Spirometry Exs encouraged Ins: 600cc Exp: 600cc - Chest percussion to B/L Chest wall - AROM to B/L UL & LL - Vibrator given - PT Chair Mobilised.	G.P. Akash MHI0256
29/12/23	22:00	S/B Ramanathan.P -DBE's encouraged -Chest percussion to B/L Chest wall -AROM Ex's to B/L UL & LL -Spirometry Ex's encouraged Ins: 600cc Exp: 600cc -Vibrator Given	MHI0260
30/12/23.	6:00	S/B Ramanathan.P -DBE's encouraged -Chest percussion to B/L chest wall -AROM Ex's to B/L UL & LL - Vibrator Given -Spirometry Ex's encouraged Ins: 600cc Exp: 600cc	MHI 0260

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
30/12/23	9:00	S/B Vijayaraghavan - DBE Encouraged - Spirometry ex encouraged Ins: 600cc Exp: 600cc - Chest percussion to Bl chest wall - AROM to Bl UL - Vibrator given	G.E.Akash MH 0286
30/12/23	17:00	S/B AKASH - DBE encouraged - Spirometry ex encouraged Ins: 600cc Exp: 600cc - Chest percussion to Bl chest wall - AROM to Bl UL - PT mobilised - Vibrator given	G.E.Akash MH 0286
31/12/23	10:00	S/B J. VIJAYARAGAVAN - DBE encouraged - Chest percussion done to Bl chest wall - Stromaly ex encouraged Ins 600cc Exp 600cc - Active ex to Bl UL - PA mobilised	J.Vij MHC-2102

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
31/12/23	15:00	S/B J. VIJAYARAGHAVAN - DBCT encouraged - Chest mobilisation done to Bl chest wall - Spirometry ex encouraged Ins-600cc Exp-600cc - Active ex to Bl UL+LL - Pt mobilised	J. vij MMC-2102
01/01/24	10:00	S/B AKASH - DBCT encouraged - Spirometry ex encouraged Ins: 600cc Exp: 600cc - Chest percussion to Bl chest wall - AROM to Bl UL&LL - PT Stair climb encouraged - Mech-Vibration to Bl chest wall	G.E. Akash MH10256
01/01/24	16:00	S/B AKASH -DBCT encouraged - Spirometry ex encouraged Ins: 600cc Exp 600cc - Chest percussion to Bl chest wall - AROM to Bl UL&LL	G.E. Akash MH10256

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
		- PT Stair climb encouraged - Mech. vibration to B/L chest wall	
2/1/24.	10.00	S/B Ramanathan R - DBE's encouraged - Chest percussion to B/L chest wall - AROM Ex's to B/L UL & LL - Spirometry Ex's encouraged Insp: 600cc Exp: 600 cc - Pt mobilized	[signature] MH10266.

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

URINE ROUTINE ANALYSIS — MICROBIOLOGY SHEET

DATE	14/12/23.		
COLOUR	PALE YELLOW		
REACTION			
SPECIFIC GRAVITY	1.010		
APPEARANCE	CLEAR		
ALBUMIN	-		
SUGAR	-		
ACETONE	-		
BILE SALT	-		
BILE PIGMENT	-		
UROBILINOGEN	NORMAL		
PUS CELLS	3-5		
EPITHELIAL CELLS	1-2		
RBC	NIL		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL		

MICROBIOLOGY-CULTURE REPORTS

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

T. DIAMICRON XR MR 60/500
T. JALRA DP (1-0-0)
T. VOLIBO-R 0.3/1.0 (1-1-0)

MHI/IP/2022/065

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DIABETIC CHART

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

ACTUAL WEIGHT ..... 61 kg ..... HbA,c ..... 6.4.

PREVIOUS DIABETIC MEDICATIONS .....

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
27/12/23	13.00	136 mg/dl	—		DR. PRAVEEN
	18.30	123 mg/dl	T. metformin 500mg	20:4	Dr. Praveen
28/12	6.30.	112 mg/dl	NPO from 5Am.		
	10.30	83 mg/dl	NPO		DR. ANUSHYA

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone

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

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MHI/IP/2022/065

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DIABETIC CHART

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

ACTUAL WEIGHT ..... 61 kg ..... HbA1c ..... 6.4% .....

PREVIOUS DIABETIC MEDICATIONS ..... 1. DIAMICRON XR MEX 60/500 [1-0-0] 1. VOLIBO-R 0.3/1.0 [1-1-0] .....

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
28/12/23	18.35	184 mg/dl	Inj. ACTRAPID 8IU/hr		Dr. Sylvester
	23:00	221 mg/dl	Inj. ACTRAPID 4 IU/hr.		DR. PRAVEEN
	20:00 HH	164 mg/dl	STOPPED INJ. ACTRAPID		DR. PRAVEEN
29/12/23	8:00	144 mg/dl	T. DIAMICRON XR MEX 60/500 given AT 11.00 T. VOLIBO-R 0.3/1.0 Subs AT 11:00		DR. PRAVEEN
29/12/23	11:00	180 mg/dL	T. VOLIBO-R 0.3/1.0 PIO Inj AT 11.00		DR. PRAVEEN
29/12/23	19:30	180 mg/dL	INJ. HUMAN ACTRAPID 4IU BOLUS GIVEN AT 19:50.	meaning	DR. PRAVEEN.
30/12/23	04:30	155 mg/dl	T. DIAMICRON XR MEX 60/500 1 T. VOLIBO-R 0.3/1.0 GIVEN PIO AT 8.30		DR. PRAVEEN JEYAKUMAR
	12.30	221 mg/dl	Inj. HA 8units	13--	Dr. Praveen.
	1835	148 mg/dl	T. metformin 500mg		
31/12/23	6:30	152 mg/dl	T. Dramicron XR MEX 60/500mg T. Volibo-R 0.3/1.0		Dr. Praveen.
	12.30	153 mg/dl	T. VOLIBO-R	13.40	

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone

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

MHI/IP/2022/065

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Medway Heart Institute

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Pat
Na
UH
DO

DIABETIC CHART

T. METFORMIN 500mg 0-0-1

ACTUAL WEIGHT 61kg HbA1c 6A%

PREVIOUS DIABETIC MEDICATIONS T. DIAMICRON XR MEX 60/500mg [1-0-0] T. VOLIBO-R 0.3/1.0 [1-1-0]

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
31/12/23	18:30	138 mg/dl	T. Metformin 500mg (AF)	[illegible]	[illegible]
1/1/24	6:30	101 mg/dL	T. Diamicron XR 60/500mg given at 9:00 AM	[illegible]	[illegible]
			T. Volibo-R 0.3		
	12:30	118 mg/dl	T. Volibo	1250	[illegible]
	18:30	97 mg/dl	T. Metformin 500mg	20:30	[illegible]
2/1/24	6:30	113	T. Diamicron XR	[illegible]	[illegible]
			T. Volibo-R 0.3/1.0mg		
	12:30	193 mg/dl	T. VOLIBO-R 0.3/1.0mg	14:00	[illegible]

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone [ ]

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

MHI/IP/2022/069

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Dr.ANBARASU MOHANRAJ

BLOOD GROUP

'O' positive

INVESTIGATION SHEET

Date	14/12/23	27/12/23	28/12/23			
HAEMATOLOGY						
Hb	12.6					
P.C.V	37.3					
Platelets	275000					
TLC	8900					
Polymorphs	74.4					
Lymphocytes	20.1					
Eosinophils	1.2					
Mono / Basophils	3.8/0.5					
E.S.R						
BIO-CHEMISTRY						
Urea	18	25				
Creatinine	0.52	0.81				
Sodium	133	134				
Potassium	6.38	5.50	4.62			
Bicarbonate	24					
Chloride	96.8					
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.38					
D.Bilirubin	0.17					
I.Bilirubin	0.21					
S.G.O.T	14					
S.G.P.T	12					
ALP	82					
GGT	13					
Total Protien	6.5					
S.Albumin	4.5					
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Date	14/12/23					
COAGULATION PT / INR	10.3 / 12.0 0.8					
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						
THYROID FUNCTION T.S.H	1.74					
T.3	T3					
T.4	10.1					
SEROLORY						
HIV	negative					
HBsAg						
V.D.R.L						
COVID 19						
RT- PCR						
IgM Ig						
HBA1C	6.4					
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality **URINE**						
Osmolality						
Spot - Na						
aPTT	28.0					

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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

BLOOD GROUP

'O' POSITIVE

INVESTIGATION SHEET

Date	14|12|23	29|12|23	30|12|23	1|1|24		
HAEMATOLOGY						
Hb	12·6	10.1	9.0	8.2		
P.C.V	37·3	29.6		24.3		
Platelets	2,75000	240000		183000		
TLC	8900	14890		9810		
Polymorphs	74·4	94.5		82.5		
Lymphocytes	20·1	2.1		13.0		
Eosinophils	1·2	0.0		0.4		
Mono / Basophils	3·8|0·5	3.4|0.0		4.0|0.1		
E.S.R						
BIO-CHEMISTRY	27|12|23					
Urea	25	23.	29.	19		
Creatinine	0·81	0.91	0·74	0·76		
Sodium	134		129	128		
Potassium	5·50		4.18	4·09		
Bicarbonate						
Chloride						
Magnesium		2.1				
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0·38	0·34				
D,Bilirubin	0·17					
I.Bilirubin	0·21					
S.G.O.T	14					
S.G.P.T	12					
ALP	82					
GGT	13					
Total Protien	6·5					
S.Albumin	4·5	3.3				
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK		347				
CK - M.B. MASS		19.9				
LDH						
Ntpro bnp						

Date	14/12/23					
COAGULATION						
PT / INR	10·3 / 0·8					
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
V.L.D.V						
THYROID FUNCTION						
T.S.H	1·74					
T.3	73					
T.4	10·1					
SEROLORY						
HIV						
HBsAg	NEGATIVE					
V.D.R.L						
COVID 19						
RT- PCR						
IgM						
Ig						
HBA1C	6·4 %					
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						

MHI/IP/2022/074

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Mr.VENKATACHALAM P
63/Male/MH1202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

VITAL INFORMATION SHEET

BLOUD GROUP	"O" Positive

ON ADMISSION	
Height in CM	Weight in Kg.
168 cm	61 kg.

Diagnosis: CAD - LM + TVD

Procedure :

NO. OF DAYS	27/12/23	DAY-1									
DATE	27/12/23	28/12/23									
HOUR	2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6

Temperature scale: 40.5°, 40°, 39.5°, 39°, 38.5°, 38°, 37.5°, 37°, 36.5°, 36°

PULSE	77/m	78	77								
RESP	20/m	20	20								
B.P.	140/70	130/60	122/74								
SPO2	96%	97%	97%								
DAILY WEIGHT	61kg										
24 HRS INTAKE	900ml										
24HRS OUTPUT	1050 ml										
BALANCE	150ml										
MOTION		✓									

AP stopped on 23/12/23

DIABETIC | HYPERTENSIVE

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63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

BSA: 1·66m²

BLOOD GROUP	O Positive

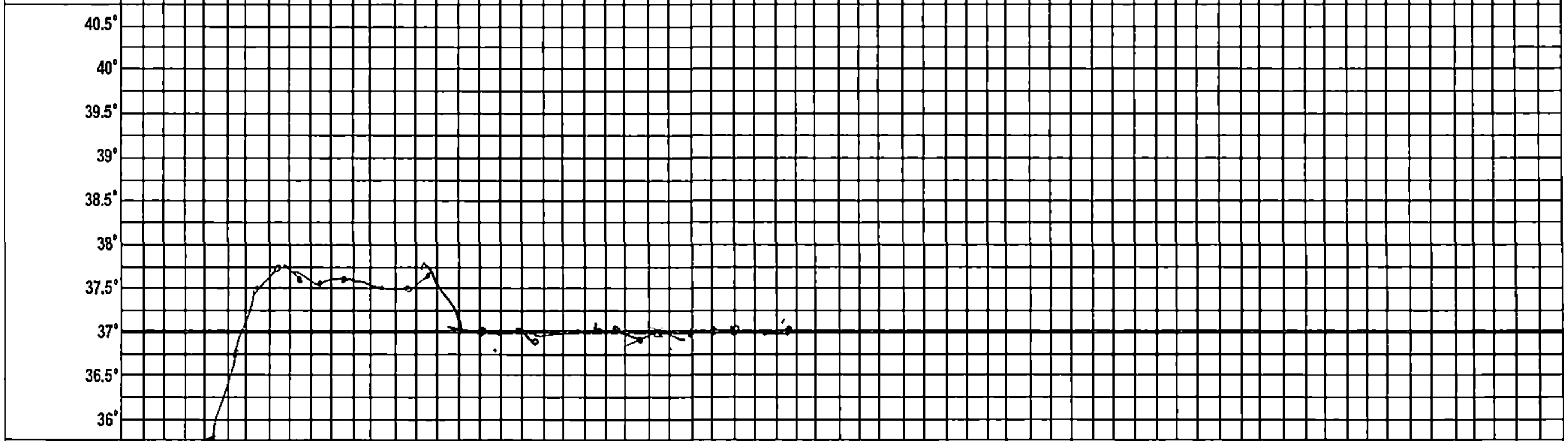
VITAL INFORMATION SHEET

ON ADMISSION	
Height in CM	Weight in Kg.
168CM	61kg

Diagnosis: CAD - TVD LVEF - 55%.

Procedure : OPCAB X 4 GRAFTS

NO. OF DAYS	DOS	I POD	POD-II	POD-III	POD-IV	POD-V
DATE	28/12/23	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10



	DOS	I POD	POD-II	POD-III	POD-IV	POD-V
PULSE	64/mt	112/mt, 102	101, 98	88, 88	76, 76	94
RESP	VC/14	16/mt, 18	20, 20	20, 20	20, 22	20
B.P	164/58	119/54, 120/54	123/73, 100/80	130/90, 130/80	140/80, 130/80	160/70
SPO2	100%	100%	100%, 98	97%, 98	97%, 98%	95
DAILY WEIGHT	BED REST	BED REST	Bed Rest	Bed Rest		
24 HRS INTAKE	1595ml	2918 mL	1665mL	1600mL	2675mL	
24HRS OUTPUT	1420ml	2640 mL	2300mL	2535mL	2125	
BALANCE	+175 ml	+278 mL.	635mL	-935mL	550mL.	
MOTION	x	x x	x	x	x	x

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63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
art beat counts

EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE / TIME	27/12 13.00	27/12 17.00	27/12 22.00	28/12 6.00	28/12 10.00								DATE / TIME
A+B Respirations Breath/ min	>25						3							>25
	21-24						2							21-24
	18-20													18-20
	15-17													15-17
	12-14													12-14
	9-11						1							9-11
	<8						3							<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96													>96
	94-95						1							94-95
	92-93						2							92-93
	<91						3							<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % in hypercapnic piratory failure only use scale 2 under the direction of qualified clinician	*>96 on oxygen*						3							>96 on oxygen
	95-96 on o2						2							95-96 on o2
	93-94 on O2						1							93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87						1							86-87
	84-85						2							84-85
	<83%						3							<83%
Air or Oxygen ?	A= Air													A= Air
	O2litre/ min						2							O2litre/ min
	Device													Device
C Blood Pressure	>220						3							>220
	201-219													201-219
	181-200						2							181-200
	161-180													*161-180*
	141-160													141-160
	121-140													121-140
	111-120													111-120
	91-100						1							91-100
	81-90						2							81-90
	71-80						3							71-80
	61-70						3							61-70
	51-60						3							51-60
	<50						3							<50
_iastolic BP	mmHg	70	76	78	74	80								mmHg
C Pulse Beats / min	>131						3							>131
	121-130						2							121-130
	111-120						2							111-120
	101-110						1							101-110
	91-100						1							91-100
	81-90													81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	41-50						1							41-50
	31-40						3							31-40
	<30						3							<30
D Consciousness Score for New onset of confusion (no score if chronic)	*Alert*													*Alert*
	Confusion						3							Confusion
	V						3							V
	P						3							P
	U						3							U
E Temperature Degree Celsius	>39.1 degree Celsius						2							>39.1 degree Celsius
	38.1-39.0						1							38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0													36.1-37.0
	35.1-36.0						1							35.1-36.0
	< 35.0						3							< 35.0
NEWS Total		0	0	0	0	0								
Monitoring Frequency		4th	4th	4th	4th	4th								
Escalation of Care Y/N		N	N	N	N	N								
Initials by RN														
Initials by Sr. RN														

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

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

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/103

Medway Heart Institute

Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE / TIME													DATE / TIME
A+B Respirations Breath/ min	>25						3							>25
	21-24						2							21-24
	18-20													18-20
	15-17													15-17
	12-14													12-14
	9-11						1							9-11
	<8						3							<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96													>96
	94-95						1							94-95
	92-93						2							92-93
	<91						3							<91
Spo2 scale 2 oxygen saturation (%) use scale 2 target range is 88-92 % in hypercapnic respiratory failure only use scale 2 under the direction of qualified clinician	>96 on oxygen						3							>96 on oxygen
	95-96 on o2						2							95-96 on o2
	93-94 on O2						1							93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87						1							86-87
	84-85						2							84-85
	<83%						3							<83%
Air or Oxygen ?	A= Air													A= Air
	O2litre/ min						2							O2litre/ min
	Device													Device
C Blood Pressure	>220						3							>220
	201-219													201-219
	181-200						2							181-200
	161-180													161-180
	141-160													141-160
	121-140													121-140
	111-120													111-120
	91-100						1							91-100
	81-90						2							81-90
	71-80						3							71-80
	61-70						3							61-70
	51-60						3							51-60
	<50						3							<50
Diastolic BP	mmHg	80	70	70	80	82	72	78	74	80	86	86	80	mmHg
C Pulse Beats / min	>131						3							>131
	121-130						2							121-130
	111-120						2							111-120
	101-110						1							101-110
	91-100						1							91-100
	81-90													81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	41-50						1							41-50
	31-40						3							31-40
	<30						3							<30
D Consciousness Score for New onset of confusion (no score if chronic)	Alert													Alert
	Confusion						3							Confusion
	V						3							V
	P						3							P
	U						3							U
E	>39.1 degree Celsius						2							>39.1 degree Celsius
Temperature Degree Celsius	38.1-39.0						1							38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0													36.1-37.0
	35.1-36.0						1							35.1-36.0
	< 35.0						3							< 35.0
NEWS Total		0	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring Frequency		4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly	4hrly
Escalation of Care Y/N		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
Initials by RN														
Initials by Sr. RN														

Note: Nurses are trained to Call Code 99 (109) when they get Score of 3 in any single parameter or aggregate score of > 5

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

MHI/IP/2022/103

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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
...rt beat counts

EARLY WARNING SCORE MONITORING CHART

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

NEWS key 0 1 2 3	DATE / TIME	2/1/24 6:00												DATE / TIME
A+B Respirations Breath/ min	>25						3							>25
	21-24						2							21-24
	18-20	•												18-20
	15-17													15-17
	12-14													12-14
	9-11						1							9-11
	<8						3							<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96	•												>96
	94-95						1							94-95
	92-93						2							92-93
	<91						3							<91
Spo2 scale 2 oxygen saturation (%) use scale 2 target range is 88-92 % in hypercapnic respiratory failure only use scale 2 under the direction of qualified clinician	>96 on oxygen						3							>96 on oxygen
	95-96 on o2						2							95-96 on o2
	93-94 on O2						1							93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87						1							86-87
	84-85						2							84-85
	<83%						3							<83%
Air or Oxygen ?	A= Air	•												A= Air
	O2litre/ min						2							O2litre/ min
	Device													Device
C Blood Pressure	>220						3							>220
	201-219													201-219
	181-200						2							181-200
	161-180													161-180
	141-160													141-160
	121-140	•												121-140
	111-120													111-120
	91-100						1							91-100
	81-90						2							81-90
	71-80						3							71-80
	61-70						3							61-70
	51-60						3							51-60
	<50						3							<50
Diastolic BP	mmHg	88												mmHg
C Pulse Beats / min	>131						3							>131
	121-130						2							121-130
	111-120						2							111-120
	101-110						1							101-110
	91-100						1							91-100
	81-90													81-90
	71-80	•												71-80
	61-70													61-70
	51-60													51-60
	41-50						1							41-50
	31-40						3							31-40
	<30						3							<30
D Consciousness Score for New onset of confusion (no score if chronic)	Alert	•												Alert
	Confusion						3							Confusion
	V						3							V
	P						3							P
	U						3							U
E Temperature Degree Celsius	>39.1 degree Celsius						2							>39.1 degree Celsius
	38.1-39.0						1							38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0	•												36.1-37.0
	35.1-36.0						1							35.1-36.0
	< 35.0						3							< 35.0
NEWS Total		0												
Monitoring Frequency		4hr												
Escalation of Care Y/N		N												
Initials by RN														
Initials by Sr. RN		Nee												

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

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

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Mr.V ATACHALAM P
63/M MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

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

Date	From: 27/12/23	To: 28/12/23	Bed No: 104
24 Hrs : Started Time :	13.00	Ended Time :	7.00
NPO Started at :		NPO Over at :	

INTAKE & OUTPUT CHART

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE		500ml	400ml	
OUTPUT		550	500ml.	

Total Intake: 900ml. Total Output: 1050ml Difference: 150ml.

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
15.00	200					200
17.00	100					300
18.30	100					500
19.20	100					600
21.00	100					700
5.00	200					900

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
15.30	200					200		
17.30	350					550		
22.00	300					850		
6.40	200					1050		

TOTAL INTAKE - 900 ml.
TOTAL OUTPUT - 1050 ml
BALANCE - 150ml

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/066

Medway Heart Institute
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Date	From: 30/12/23	To: 31/12/23	Bed No:	INTAKE & OUTPUT CHART
24 Hrs : Started Time :		Ended Time :		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	570 ml	545	550ML.	2.4 litres
OUTPUT	650ml	1050	600ML	

Total Intake: Total Output: Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
10.00	600					420
11.00	150					570
11.15	20					590
13.30	180					770
16.00	125					895
17.00	200					1095
19.00	20					1115
19.45	100					1215
20.00	100					1315
12AM	150					1465
5AM	200					1665

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
TOTAL	INTAKE - 320ML							
TOTAL	OUTPUT - 250 ML							
	TOTAL BALANCE - 470 ML							
11.00	400					650		
11.15	600					780		
11.40	400					1150		
17.00	350					1500		
18.00	200					1700		
20.00	100					1800		
1AM	200					2000		
5.35	300					2300		
		TOTAL INTAKE - 1665ML						Nag
		TOTAL OUTPUT - 2300 ML						024
		BALANCE - 635ML						

MOTION NOT PASSED

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27/12/2023/IPH2023002615
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MHI/IP/2022/066
Medway Heart Institute
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Date	From: 31/12/23	To: 1/1/2024	Bed No:	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 7:30am		Ended Time :		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	700	1175	425 ml	2.4 litters
OUTPUT	400	1,135	1000 ml	

Total Intake: Total Output: Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
7:30	225	~~200~~				225
7:40	100					325
10:20	150					475
11:45	225					700
12:30	75					775
13:15	100					875
14:8	100					975
16:25	25					1000
17:27	125					1125
18:15	50					1175
20:00	125					1300
20:30	100					1400
2am	200					1600

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
10:00	200ml					200		
11:45	200ml					400		
14:10	180					580		
15:50	280					860		
17:00	200					1060		
18:00	225					1,285		
19:00	250					1,535		
19:30	200					1735 +800		
20:30	200					2,535 ml		
21:40	300							
2AM	300							

+800

TOTAL INTAKE - 1600ML
TOTAL OUTPUT - 2535ML
BALANCE - -935ML
MOTION NOT PASSED +

24

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27/12/2023/IPH2023002(
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MHI/IP/2022/066
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Date	From: 1/1/23	To: 2/1/23	Bed No:	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 7:30		Ended Time :		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	775	375ml	575ml	2-4 litters
OUTPUT	925	300ml	900ml	

Total Intake: 2675ml Total Output: 2125ml Difference: 550ml

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
6.30	100					100	6.45	200					200		
7.00	75					175	8.00	150					350		
8.15	100					275	9.15	125					475		
9.10	300					575	11.30	100					575		
10.45	100					675	12.05	200					775		
11.35	100					775	12.25	150					925		
13.30	200					975	16.30	300					1225		
15.00	100					1075	21.10	200					1425		
17.00	25					1050	23.10	200					1625		
19.00	50					1100	2.15	500					1925		
19.30	75					1175	3.30	200		TOTAL INTAKE			2675ml		
20.00	100					1275				TOTAL OUTPUT			2125		Nae
2.30	300					2575					BALANCE		550	N	024
6.30	100					2675									

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

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INTAKE & OUTPUT CHART

Date From: 2/1/24 To: 3/1/24 Bed No: 105-'A'

24 Hrs : Started Time : 7.00 Ended Time : 7.00

NPO Started at : NPO Over at :

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	1250 ml			R.F 2 litre/day
OUTPUT	675 ml			

Total Intake: Total Output: Difference:

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
6.30	100					100	6.25	200					200		
7.00	100					200	7.10	200					400		
7.25	100					300	11.35	275					675		
8.45	200					500									
9.40	500					1000									
10.40	250					1250									

Total Intake - 1250ml

Total output - 675ml

Ncea 024

MHI/DIET/2022/147

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAD-TVD | EF-54% | DM | HTN | COPD | Old CVA | CABG (2023)			
Height: 168 cms	Weight: 61 Kgs	Food allergies: Yes/ No, if yes, specify.....	
Religious Beliefs:	☑ Vegetarian	☐ Non Vegetarian	☐ Eggetarian ☐ Jain
Diet Prescription: 1000 calorie, low fat, no salt, high protein, diabetic diet.			

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time: 27/12/23, 15:00
Maria Catherine John (24017)
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
24/12/22, 15:00	A 63 year old gentleman came c/o breathlessness on exertion was assessed to be well nourished as evident by SGA. K/C/O - DM/HTN/COPD/TVD/old CVA. Educated the patient and family on low calories, low fat, low salt, high protein, diabetic diet. Emptied on small fruit meal & low glycemic cereal.	Maria Catherine John Senior Dietitian
28/12/22 16:00	Patient shifted to OT for surgery (CABG) and kept as NBM. Patient visited to see. will initiate on diabetic, fluid diet as per doctors advice.	Maria Catherine John Senior Dietitian
29/12/22, 10:00	NBM over. Patient tolerated diabetic, fluid diet. Can initiate on diabetic, high protein, soft solid diet.	Maria Catherine John Senior Dietitian
30/12/22, 14:00	Patient visited to ward. Re-emptied on the diet instructions. Motivated to eat well.	Maria Catherine John Senior Dietitian

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/DIET/2022/148

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Department of Dietetics

(1)

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
2/1/24, 10:00	Oral intake is good. Educated the patient and family on 1500 calorie, low fat, low salt, high protein, diabetic diet on discharge. Explained small frequent meals three glucose control diet modifications and lifestyle changes done. Diet chart given on discharge	Maria Catherine John (2401) Senior Dietitian

Department of Dietetics

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE

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PSYCHOLOGICAL WELLBEING REPORT

Date: 30/12/23 Time: 12.30 pm.

Unit: 10SA

Clinical diagnosis: CAD-TVD / T_2DM / HTN / OLD-CVA.

Surgery/ Procedure:

Impression: Smoking (: 35 years) - substance dependance.

- motivation ↓ (to quit substance).
- calm affect, irritated by physical c/o, oriented, response
- sleep & appetite (N).
- resistance expressed for behavioural modification discussion to quit smoking.
- suggestions / supportive counseling provided to increase the motivation.

Employee ID: MH1027894 Signature of the Psychologist:

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INTRAOPERATIVE NURSING RECORD

Patient Details *(Affix Label here)*
Name: Mr.VENKATACHALAM P
UHID: 63/Male/MHI202381271
DOB: Sex: 27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Name of Surgery : OPCAB E closed HEART Date of Surgery : 28/12/2023

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

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

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

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

Skin preparation in OT ☑ Chlorhexidine Prep ☑ Providone Iodine ☐ Lodophor scrub 7-5-Scrub
☐ Alcohol Prep ☐ Others (specify)----------

Electrocautery : ☑ Monopolar ☑ Pad Loacation---------- ☐ Bipolar Right upper arm - Megadyne pad used

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

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

Personal : ☑ Surgeon DR. ANBARASU ☐ Asst. DR. PRAVEEN
☑ Anaesthetist DR. SYLVESTER ☐ Asst. ----------

Type of Specimen :

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

~~Packing~~ / Drains / Catheters

Type	Size	Site	Type	Size	Amount	Sign
Romson's	28Fr	mediastinum	—	—	—	SK 0031
Romson's	28Fr	left pleura	—	—	—	

Urinary catheterization had done by Mr. Asad with use 14Fr Foley's catheter

Sponge Court Record

Count	Raytex Sponges	Gauze Lined	Gauze Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	Needle	Circ. Nurse sign	Scrub Nurse Sign
Pre-op	correct	correct				correct	correct	correct	SK 0031	Sujatha 0125
Change over count	correct	correct				correct	correct	correct	SK 0031	Sujatha 0125
First closure count	correct	correct		N/A		correct	correct	correct	SK 0031	Sujatha 0125
Final closure count	correct	correct	X			correct	correct	correct	SK 0031	Sujatha 0125

☐ ~~Count~~ Correct

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

Surgeon informed

Chest Dressing / ~~Cast Immobilizer~~ done with sterile mepore, leg dressing done with sterile crepe bandage over bandage

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

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

Scrub Nurse Signature Sujatha/0125

Name : RN SUJATHA/0125

Date & Time : 28/12/2023 @ 18.25

Circulating Nurse Signature SK/0031

Name ; RN SARDKUMAR/0031

Date & Time : 28/12/2023 @ 18.25

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63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/053

Medway Heart Institute
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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 27/12/23 Time of Arrival: 12.00 Mode of Admission: ☑ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☐ Yes ☐ No If Yes, Name of the Relative: Mrs. Meenatchi.

Relationship with Patient: Wife. Contact Person's Name: — Relationship: —

Contact No.: 8939330785 Primary language spoken: ☑ Tamil ☐ English ☑ Indian ☐ International

Interpreter needed: ☐ Yes ☑ No

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

Menstrual History : LMP : — Menopause: —

Medical History : DM / HTN / Co - Morbility : 8 yrs Yes If yes specify

Drugs History : Antiplatelet Tab Rosa Gold (Specify) 28/12/23

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

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

If Yes, specify details:

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

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 74 m. (beats/min) | BP: 140/80 (mmHg)

Respiration: 20/m (breaths/min) | SpO_2: 96 (%) | CBG: 136 (mg/dl) | Height: 168 (cms) | Weight: 61 kg (kgs)

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

If Yes, specify:

Pain: ☐ Yes ☑ No. If Yes, Score: 0/10 **Pain Scale Used:** ☐ Wong-Baker FACES Pain Rating Scale (7-12 years) ☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: — Location: —

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

Nutritional Screening:

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

Last 3 months Weight: ☐ Increased ☑ Decreased ☐ No Change 10 kg

Type of Patient: ☑ Diabetic ☐ Non Diabetic Type of Diet: Diabetic Diet

Dietician Informed: ☑ Yes ☑ No. If Yes, mention the Name: Mrs. Catherine Time: 13.00.

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

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

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

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	☑ Yes ☐ No	30 yrs Reading only.	
Hearing Impairment	☐ Yes ☑ No		
Chewing Difficulty	☐ Yes ☑ No		
Walking Difficulty	☐ Yes ☑ No		

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

Total Score: 23 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT): **Final Score** 0

Tick the score obtained (✓)

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

Personal Belongings / Valuables:

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

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

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	Veena	Meenakshi. V	*Relationship* —	27/12/23	13.00
Nurse		B. Vanisri	0195	27/12/23	13.00.
Unit In-Charge		Dhanasekaran.	0005	28/12/23	08:00

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NABH

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 27/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: CAD-2VT TVD.
GCS: 15/15
NEWS / PEWS Score: 0
POD: —
Ventilator day: —
Central line days: —
Peripheral line day: Right: — Left: —
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B — BACKGROUND

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

A — ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 74/m (beats/min) | Respiration: 20/m (breaths/min)
BP: 140/70 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 Kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 30 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: SOFT Diet
Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications: 3 ml
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: TMT plan CABG

	Signature	Name	Emp. No.	Date	Time
Handover given by		B. Vania	0195	27/12/23	19.30
Handover taken by		A. Nandhini	0170	27/12/23	19.30
Document endorsed		Dhanavanti	0005	28/12/23	08:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
25/12/22	ADMISSION NOTES	
12-30	pt Admitted to 1st Floor while pt conscious and oriented, Pt vitals are checked and recorded. Assessment are done provided clean cotton and to sleep	
16-30	pt vitals are checked and recorded	
19-30	pt case file handed over to night duty S/N while pt conscious and oriented	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Divakaran	0005	26/12/22	08:00

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Mr.VENKATACHALAM P
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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

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

B

BACKGROUND

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

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 77 (beats/min) | Respiration: 20 (breaths/min)
BP: 122/74 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Diabetic diet Drains: –

R

RECOMMENDATION

Referral doctors: Nil
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: –
Pending follow-up orders: –
Special instructions if any: Tomorrow Plan : CABG, NPO from 5.00

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Nandhini	0170	28/12/23	7.30
Handover taken by			0264	28/12/23	8.00
Document endorsed			0005	28/12/23	08:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
27/12/23 @ 19.30	Night duty Notes → Patient taken over from evening duty Staff Nurse → patient Conscious & oriented → patient vital Signs checked & Recorded	
20.30	→ Medication given as per drug Chart → Tomorrow Plan CABG NPO from 5.00 Preparation done, Consent taken ... 10 pcv Reservation done → Today Potassium Correction done kt - 5.50 → Repeat kt, orders DR. praveen informed	
22.00	→ Patient Sleep well during Night time → Provide Comfortable position to the patient	
2.00	→ patient pulse & saturation Checked → I/O Chart Monitored	
6.30	→ patient vital Signs Checked & Recorded	
7.30	→ patient handing over to Morning duty Staff Nurse	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Dhanam	0005	26/12/23	08:00

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Madras Heart Institute

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp No.
	CTOT RECEIVAL REPORT	
28/12/23 @	Patient Received From CTW To CTOT With Blue Op File And Case Sheet	
12-00	ECG: \ ECHO: \ X-RAY: | ANGIO CD: with attender	
	CT FILE: MRD ® ©, CVA on 20/3/2023	
	Patient Posted For Procedure: CABG	SK
	Under Anesthesia: GA	0081
	Allergy Status: NKDA	
	Known Case Of: CAD-TVD, Effort Angina, SHTN, Type II DM, CVA - Acute infarct	
	Past Surgical History: —	
	VITAL SIGN: TEMP: 37°C HR: 80bpm SPO2: 100% BP: 122/74 mmHg	
	CTOT SHIFTING REPORT	
28/12/23 @	Patient Shifted From CTOT To SICU With Blue Op File And Case Sheet Along With	
18-25	*Surgery Safety Check List *Intra Operative Record	
	*Nurses' Record *	
	ECG: \ ECHO: \ X-RAY: | ANGIO CD: with attender	SK
	CT FILE: MRD - brain ®©	0081
	Patient Posted And Underwent For Procedure: CABG Under Anesthesia: GA	
	Procedure: OPCABG 4 arrest, LIMA → LAD, SVG → OM, PDA, PLV [sequential]	
	Drain tube size and placement: 28Fr	
	Pacing wire placement: Present/Absent Site: —	
	Implants: —	
	Cautery burn/skin peeling/towel clip mark: Present/Absent Site:	
	VITAL SIGN: TEMP: 37°C HR: 59bpm SPO2: 100% BP: 126/61 mm of Hg	
	Notes: → CAG-® Cousride report xerox only present while receiving the patient	

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	SK/0081	M. SASIKUMAR	MHR0081	28/12/23	18-25

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Mr.VENKATACHALAM P
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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

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

A — ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 77 (beats/min) | Respiration: 20 (breaths/min)

BP: 122/74 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²

Others : —

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

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

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

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

Current diet: Diabetic Diet. Drains: —

R — RECOMMENDATION

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

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

Pending follow-up orders:

Special instructions if any: TO day plan CABG, NPO from 5.00

	Signature	Name	Emp. No.	Date	Time
Handover given by	Jeni	Jenipriya.	0264	28/12/23	8.00
Handover taken by	—	Shifted to OT	—		
Document endorsed	Nil	S. Nalini	0024	28/12/23	1:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	MORNING DUTY NOTES	
28.12.23		
@ 8.00	=> pt hand over to	
	Night duty staff.	[signature]
	=> pt consious and orientation	
	=> pt vitals checked and	
	Recorded.	
8.30	=> pt due drugs are	
	given. pt Today plan CABG.	
	=> pt NPO from 5.00	[signature]
	=> provide comfortable position	
	to the patient.	
9.00	=> pt shifit to the OT	
	=> pt handing over to OT staffs	
	=> pt out side CAG.	[signature]
12.00	=> pt ~~CAG~~ CD handing over to	
	=> pt attenders.	
	pt handing over to ~~given~~ CT O T	
	staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0024	28/12/23	13:00

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ
Consultant:

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28·12·23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TVD
GCS: E cp Vct Mcp
NEWS / PEWS Score:
POD: POS
Ventilator day: 1 ONBITAL (D1)
Central line days: 1
Peripheral line day: Right: Left:
Ryle's Tube: ☑ Yes ☐ No Day: 1
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: 1
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: OP CABG x 4 GRAFTS
Date of surgery: 28/12/23
Allergies if any: NK
On room air / oxygen: VENTILATOR
IV fluids on flow: KABIKYTC
Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 95 (°F) | Pulse / HR: 70 (beats/min) | Respiration: 14 (breaths/min)
BP: 190/62 (mmHg) | SpO_2: 100 (%) | Height: 167 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²
Others : CVP :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 65 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☑ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA (OT)
Current diet: NPO
Drains: Left Pleural mediastenal

R

RECOMMENDATION

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

Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: _____
Pending follow-up orders:
Special instructions if any:
} NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		Suryakala. S.P	0232	28.12.23	19.30
Handover taken by		Sathiya Vani.M	0265	28/12/23	19.30
Document endorsed			0003	29/12/23	8.00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
28.12.23 18.30	Receiving Notes	
	patient recieved from OT, unconscious	
	on ventilator ET P size ⊖ connected	
	on VC mode FiO_2: 60% PEEP:-5 Rat: 14	
	Tidal volume 500, SpO_2: 100% maintaining	
	ABG done., advised for HCO_3 correction	
	send given, routine lab investigation	
	sent K - 3.2 10meq correction started.	
	Inj insulin 2ml/hr on flow NTG 4ml/hr	
	on flow, warmer placed, ⊖	[signature]
	IFV on flow Dr. Sylvester advised for ventilation	
19.00	x-ray done., drain take ⊖	
19.10	family member seen the patient	
	explained patient condition	[signature]
19.30	Handover given to next duty	
	staff for continue ventilation. IVF	
	on flow.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	[signature]	2003	29/12/23	9.00

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

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

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

B — BACKGROUND

Type of surgery: OPCAB X 4 GRAFTS
Allergies if any: NK
On room air / oxygen: ON Vent
Complaints / New Symptoms in last shift: –

Date of surgery: 28/12/23
IV fluids on flow: KABILYTE

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 66 (beats/min) | Respiration: VENT-IN (breaths/min)

BP: 110/74 (82) mmHg) | SpO_2: 100 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 Kg/m²

Others : BSA 1.66 m²

Pain Score: 0/8 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / ~~CPOT~~

Fall Risk Score: 65 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High

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

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

Wound Dressing done: ☐ Yes ☐ No ☑ NA

Current diet: NPO

Drains: Mediastinal + (1) Pleural

R — RECOMMENDATION

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

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

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Sathiya Vani. M	0265	29/12/23	7.30
Handover taken by		D. RANEEA	0171	29/12/23	7.30
Document endorsed			01023	27/12/23	9.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
28/12/23 19:20	Took over the patient in haemodyna- mically stable condition with Ventilator Support.	Sathya 0265
20:10	Patient got awake and moved all the limbs	
21:00	Administered Inj. Paracetamol 1gm as per orders.	
21:30	Suctioning done for patient, Nebulization given.	Sathya 0265
22:30	Provided proper position for patient.	
23:40	Administered T. Ecospirin 75mg RT	
00:00	GCS assessment done & monitored	
2:00	Provided comfortable position for patient.	
3:30	weaning started for patient.	
4:30	Blood Sample taken and send to lab.	Sathya 0265
5:00	Bed Sponge bath given for patient with wipes	
5:10	Lines care given in aseptic manner.	
5:15	U-cath care given for patient.	
5:20	Administered Inj. Cefuroxime 1.5gm as per orders.	Sathya 0265
5:30	kept on PS mode for patient.	
6:30	Monitored vitals & I/o	
7:20	Handed over the patient to morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Aruna	0003	29/12/23	9.00

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Patient Name: Mr.VENKATACHALAM P
63/Male/MHI202381271
UHID: 27/12/2023/IPH2023002615
DOB:
DOA: Dr.ANBARASU MOHANRAJ
Consul

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: CAD-TVD
GCS: E4 VET M6
NEWS / PEWS Score: –
POD: D1
Ventilator day: D2
Central line days: D2
Peripheral line day: Right: Meta Left: D2
Ryle's Tube: ☑ Yes ☐ No Day: D2
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: D2
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:.

B — BACKGROUND

Type of surgery: OPCABG 2 V GRAFTS
Date of surgery: 28/12/23
Allergies if any: NKDA
On room air / oxygen: on Ventilator
IV fluids on flow: KABUTTE
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 112/mt (beats/min) | Respiration: 18/mt (breaths/min)

BP: 124/52(74) (mmHg) | SpO_2: 100 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6kg/m²

Others : CVP - 7mmHg, BSA - 1.66m²

Pain Score: 9/8 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 65 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High

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

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

Current diet: NPO
Drains: LEFT PLEURAL + MEDIASTINAL

R — RECOMMENDATION

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

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

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		D. RANEER	0171	29/12/22	13.00
Handover taken by	Meena	Meenaselvam	0276	29/12/22	19.00
Document endorsed			00.	30/12	9.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
29/12/23 7.30	MORNING DUTY REPORT	RN RAVEENA 0171 -
	* Patient had taken over from Night duty staff. Vital signs are haemodynamically stable.	
	* PS-CPAP.	
8.45	* Patient had Extubated. Followed by Nasal prongs 4L/min.	
	* ABP - 213/104/(146) mmHg. Inj Metoprolol 3mg IV Stat had given O/B Dr. Sumathi.	[signature] dr.
9.30	* Due medications are not given due to Patient was on NPO.	
	* Neb, chest Physio & Spirometry had given. postures done.	
10.00	* Vital signs are haemodynamically stable. No complaint.	
14.00	* Due medications are given as per drug chart	
16.30	* Drain & arterial line had removed O/B Dr. Anbarasu.	
17.00	* Drain removed CXR taken & Patient had mobilized.	[signature] dr
18.00	* Neb, Chest Physio & Spirometry had given Ryle's - Ritual - postures done	
19.30	* Patient details handed over to the Night duty Staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	[signature]	0005	30/12/23	9.00

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NABH ACCREDITED

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 29/12/2023 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: CAD-TVD. GCS: 15/15
NEWS / PEWS Score: - POD: II.
Ventilator day: - Central line days: III
Peripheral line day: Right: Metacarpal D2. Left:
Ryle's Tube: ☐ Yes ☑ No Day: - VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: -

B

BACKGROUND

Type of surgery: OPCAB x 4 GRAFTS. Date of surgery: 28/12/2023.
Allergies if any: NKDA.
On room air ✓ / oxygen: IV fluids on flow: KABILYTE.
Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98.4 (°F) | Pulse / HR: 93. (beats/min) | Respiration: 20. (breaths/min)
BP: 106/64. (mmHg) | SpO_2: 99. (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²
Others: BSA - 1.66 m2.
Pain Score: 1/10. **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS ✓ / CPOT
Fall Risk Score: 50. **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☑ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ No ☐ NA Wound Dressing done: ☐ Yes ☑ No ☐ NA
Current diet: SOFT DIET. Drains: -

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	S.meena	Meena selvam	0286.	30/12/23	01:30
Handover taken by	[signature]	Suryaprakash	0282	30/12/23	07:30
Document endorsed	[signature]	[signature]	0003	30/12/23	9.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
29/12/23	Patient hand over taken.	
19:00.	Vitals Stable. on Room Air.	
	off foleys cath. on CVP line. u.cath.	
	Present.	S. meena 0226
20:00.	Dinner given.	meena 0226
20:30.	Medication given.	meena 0226
21:30.	vitals monitored.	meena 0226
22:30.	Patient is on comfortable.	
	position.	S. meena 0226
22:30.	NEB, SPIROmetry given.	
23:30.	Vitals I/O chart monitored	
00:30.	Patient is sleeping.	
02:30.	Patient is on comfortable	
	position.	
04:30.	Blood samples taken.	
05:00	u.cath removed.	S. meena 0226
05:15.	morning care given. Ryles tube	
	care given.	meena 0226
06:00.	vitals monitored.	
	Hand over given to	
	assigned staff.	S. meena 0226

	Signature	Name	Emp. No.	Date	Time
Document endorsed by			0003	30/12/23	9.00

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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 30-12-23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: CAD - TVD. GCS: 15/15
NEWS / PEWS Score: — POD: 11
Ventilator day: — Central line days: D3
Peripheral line day: Right: ☑ METACARPAL (D3) Left:
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: OPCABG 4 GRAFTS Date of surgery: 28-12-23
Allergies if any: NK.
On room air / oxygen: ON RA IV fluids on flow: —
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: ____ (°F) | Pulse / HR: 104 (beats/min) | Respiration: 14 (breaths/min)
BP: 123/72 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²
Others : ____
Pain Score: 2/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☑ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: SOFT DIET Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Suryaprabha	0232	30/12/23	9.30
Handover taken by		Pavitha	0072	30/12/23	9.35
Document endorsed			0003	30/12/23	9.40

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
30/12/23	MORNING DUTY NOTES	
7.00	Patient handovers taken from the night duty staffs. Patient is stable	PIN RANEEN 0171.
8.00	* Patient had oral diet. tolerated. Vital Signs are haemodynamically Stable. I/O chart maintained	
8.30	* Patient had bathed. Inc medications are given as per drug chart & diabetic drugs are given	
8.45	DR. ANBARASU SIR ROUNDS OVER Plan for Shifting	0088
9.00	IJV line removed. No oozing. vitals is Stable	0088
9.30	ECG leads removed & cleaned SHIFTING TO 1ST FLOOR ROOM NO. 105	0088
	TOTAL X-RAY - 4 ABG - 5	
	Receiving Notes	
9.35	- Patient received from SICU - While receiving patient is haemodynamically Stable - 2nd POD	Padlin
12.30	- Patient handed over to nursing staff	Padlin

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Linnan	2005	30/12/23	9.00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 30/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - [illegible] GCS: 15/15
NEWS / PEWS Score: — POD: 2
Ventilator day: — Central line days: —
Peripheral line day: Right: 3 Left: —
Ryle's Tube: ☐ Yes ☑ No Day: — VIP Score: 0/5
Urinary Catheter: ☐ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: OPCAB x 2 graft Date of surgery: 28/12/23
Allergies if any: not known
On room air / oxygen: on Room air IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

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

BP: 120/80 (mmHg) | SpO_2: 98 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²

Others : —

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

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

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

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

Current diet: normal diet Drains: nil

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	A. monisha.	0??	30/12/23	19:30
Handover taken by	[signature]	RN Bharathi	0271	30/12/23	19.30
Document endorsed	[signature]	S. Nalini	0024	30/12/23	20:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Evening duty note	
30/12/22		
	pt hand over taken from morning duty staff	
	pt is stable &	
12:30	conscious	
	vital sig checked & Recorded	
	pt had food	
	medication sig	
1430	given as per chart	
	pt mobilized	
1630	well	
1700	Dr. Rajesh sir visited the pt advised to mobilized well	
1800	pt mobilized well	
	vital sig checked & Recorded	
1900	pt hand over to night duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0024	30/12/22	2000

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DO Dr.ANBARASU MOHANRAJ
DO
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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 30/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

Diagnosis: CAD - TVD
GCS: 15/15
NEWS / PEWS Score:
POD: 11
Ventilator day:
Central line days: —
Peripheral line day: Right: DM Left:
Ryle's Tube: ☐ Yes ☐ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism: —

B — BACKGROUND

Type of surgery: OPCAB x 3 grafts
Date of surgery: 28/12/23
Allergies if any: NKDA
On room air / oxygen: Room air
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.2°F | Pulse / HR: 74 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 98% | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 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 Drains: NIL

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		RN Bhavitha	0271	31/12/23	7:30
Handover taken by		M. Devika	0181	31/12/23	7:30
Document endorsed		S. Nalini	0084	31/12/23	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
31/12/23	Night duty notes	
19:30	Patient heard over from evening duty staff	
20.30	Vitals Checked & recorded Vitals are stable.	
21.00	drug medication given as per	
22.00	Patient side no issue Patient stable well.	
23:00	Patient sleeping No c/o	
6am	Vitals Checked & recorded	
6:30	Monitor Intake & Output chart.	
7am	Before Bood medication given as per order	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0084	31/12/23	8:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 31/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: OPCABG x 3 graft
Date of surgery: 28/12/23
Allergies if any: NKDA
On room air / oxygen: O2 room air
IV fluids on flow:
Complaints / New Symptoms in last shift: Nil

A — ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 74 b/m (beats/min) | Respiration: 20 br (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 98 (%) | Height: 168 (cms) | Weight: 61 bm (kgs) | BMI: 21.6 kg-m2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / ~~CPOT~~
Fall Risk Score: 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: NPO Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		U. Deepika	0182	31/12/23	12:30
Handover taken by		A. monisha.	0141	31/12/23	12:20
Document endorsed		E - Nalini	0024	31/12/23	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
31/12/23 @ 7:00	Morning duty → patient head over taken from night duty staff → patient Normal diet	
7:00	→ patient is stable & vitals signs checked. recorded	
8:00	→ patient Medication given as per duty staff. → patient Hb and checked.	
9:00	→ patient mobilization given	
10:00	→ patient is well sleep → patient no complention	
11:00	→ patient Normal vital sings check	
11:30	→ patient No chest check	
12:00	→ patient head over given per evening duty	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		L. Nalini	0024	31/12/23	13:00

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Dr.ANBARASU MOHANRAJ
Consortium:

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 31/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: CAD-TVD
GCS: 15/15
NEWS / PEWS Score: —
POD: III
Ventilator day: —
Central line days: —
Peripheral line day: Right: D1 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: OPCABG x 3 graft
Date of surgery: 28/12/23
Allergies if any: Not known
On room air / oxygen: on Room air
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

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

BP: 120/80 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 64 (kgs) | BMI: 21.6 kg/m²

Others : —

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

Fall Risk Score: 60 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High

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

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

Current diet: Normal diet
Drains: nil

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	A. Mondal	0161	31/12/23	19:00
Handover taken by	[signature]	RN Bharathi	02715	31/12/23	19:30
Document endorsed	[signature]	S. Nalini	0084	31/12/23	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
31/12/23	evening duty note	
	pt hand over taken from morning duty staff	
12:30	pt is stable &	
	conscious.	
	vital sys checked & Recorded,	
1:30	pt had food medication sys given as per chart	
6:00	well pt mobilized well	
	vital sys checked & Recorded,	
8:00	pt hand over	
8:00	to night duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nalini	S. Nalini	0084	31/12/23	20:00

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 31/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

Diagnosis: CAD - TVD
GCS: 15/15
NEWS / PEWS Score:
POD: 5th
Ventilator day:
Central line days: —
Peripheral line day: Right: P4 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 015
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: OPCAB x 3 grafts
Date of surgery: 28/12/23
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: 98.2 °F | Pulse / HR: 82 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 97 (%) | Height: 158 (cms) | Weight: 61 (kgs) | BMI: 24.6 Kg/m²
Others: —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Normal diet Drains: NIL

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Bhavanthi	0271	1/1/24	7:30
Handover taken by		Pavithra	0072	1/1/24	7:30
Document endorsed		S. Nalini	0084	1/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
31/12/23	~~Morning~~ Night duty Notes	
19:30	=> Patient hand over from Evening duty Staff.	0271
20.00	Vitals checked & recorded Vitals are stable.	0271
21:00	olue medication given as per order.	0271
22.00	Continue Nebulization given.	0271
22:30	Patient Side noishuie Patient stable. patient Sleeping now.	0271
✓		
6AM	monitor Intake & output chart.	0271
7am.	Vitals checked & recorded	
7:30	Patient hand over by morning duty Staff.	0271

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

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D Dr.ANBARASU MOHANRAJ
D
C

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD-TVD
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: 4th POD
Central line days:
VIP Score: 0

B — BACKGROUND

Type of surgery: OPCAB X 3grafts
Allergies if any: NKDA
On room air / oxygen: RA
Complaints / New Symptoms in last shift: Nil

Date of surgery: 28/12/23
IV fluids on flow: —

A — ASSESSMENT

Vital Signs: Temp: 95 (°F) | Pulse / HR: 88 (beats/min) | Respiration: 20 (breaths/min)
BP: 130/80 (mmHg) | SpO_2: 98 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6 kg/m²
Others :

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

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Pavithra	0072	1/1/24	13:00
Handover taken by		A. Monisha	0161	1/1/24	13:00
Document endorsed		S. Nalini	0024	1/1/24	13:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
1/1/24 7.30	Morning Duty Notes	
	- Patient taken over from night duty staff	Poslm
	- while take over Patient is hemodynamically	
	- Tomorrow plan suture removal	Poslm
8.45	- Due medications given as per Chart	Poslm
10.00	- Nebulization given	
	- patient mobilized well	Poslm
	- patient S/B Dr. Rajesh sir advised plan suture removal tomorrow & discharge	Poslm
13.00	- patient handed over to evening duty staff	Poslm

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

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD - CVD
NEWS / PEWS Score: —
Ventilator day: —
Peripheral line day: Right: PH 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: 5p
Central line days: —
VIP Score: 0/16

B — BACKGROUND

Type of surgery: OPCAB x 3 graft
Allergies if any: Not known
On room air / oxygen: On Room air
Complaints / New Symptoms in last shift: —

Date of surgery: 28/12/23
IV fluids on flow: —

A — ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 98 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.61 kg/m²
Others : —

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

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Monisha	0841	1/1/24	19:30
Handover taken by		RN Bhargavi	0291	1/1/24	19:40
Document endorsed		S. Nalini	0584	1/1/24	20:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
1/1/24	Evening duty code	
	pt hand over taken	
12:00	from morning duty staff	
	pt is stable &	
	conscious	
	vitals were checked	
	& recorded	
14:00	pt had food	
	medication were	
	given as per chart	
	pt mobilized	
	well	
18:00	vitals are checked	
	& recorded,	
	pt hand over	
20:00	to night duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0024	1/1/24	20:00

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: CAD - TVD
GCS: 15/15
NEWS / PEWS Score: —
POD: 5
Ventilator day: —
Central line days: —
Peripheral line day: Right: D5 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —

B — BACKGROUND

Type of surgery: OPCABX3 grafts
Date of surgery: 28/12/23
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: 96.2°F | Pulse / HR: 84 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.6/M/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: NIL

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		RN Bhuvaneshwari	0241	2/1/24	7:30
Handover taken by		R. Divya	0249	2/1/24	7.30
Document endorsed		S. Nalini	0084	2/1/24	8:00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
21/1/24	Night duty Notes	
19:30	=> patient hand over from evening duty staff.	0274
		0274
20.00	due medication given as per.	
22.00	Vitals checked & recorded. Vitals are Stable.	0274
23:00	patient side no issue patient Stable well.	0274
00.00	patient sleeping now.	0274
6AM	monitor vitals checked & recorded.	0274
7am.	Monitor Intake & output. Chart	0274
7:30	patient hand over by. morning duty staff.	0274

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		E. Nalini	0084	21/1/24	8:0

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ
Consultant:

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2/1/22 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD – TVD
GCS: 15/15
NEWS / PEWS Score: –
POD: 5
Ventilator day: —
Central line days: —
Peripheral line day: Right: D5 Left:
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/4
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: —

B

BACKGROUND

Type of surgery: OPCAB x 3 grafts
Date of surgery: 28/12/23
Allergies if any: NKDA
On room air / oxygen: On room air
IV fluids on flow: –
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 86 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 61 (kgs) | BMI: 21.61 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: Nil

R

RECOMMENDATION

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

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

Pending follow-up orders: —

Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	C. Lidiya	0249	2/1/22	12.40
Handover taken by	—	Discharged	—		
Document endorsed	[signature]	S. Nalini	0084	2/1/24	13.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/4/24	Morning duty	
7.30.	pt case file taken over from night duty SN who pt conscious and oriented	
8-00	pt vitals are checked and recorded.	
9.00	Oral medication are given	
10-00	provided clean cover and to sleep	
18-30	pt case file handing over to Evening duty SN while pt conscious and oriented	
	discharge note	
18:30	pt Summary was explained to pt & pt Attender all the Report was given to pt & pt Attender all line Removed IV Band Removed pt discharged at 18:30	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0024	2/11/24	18:00

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ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 27/12/23 **Time:** 13.00 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** CAD-1M TVD

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

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

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by	[signature]	Dharanarani	0005	08/12/23	08:00

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ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 28/12/23. **Time:** 7:00 **Modified Date:** **Time:**

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☑ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt NPO 5.00 E N	
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on Room air. E N	
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt I/O chart Maintain E N	

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

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nalini	R. Nalini	0084	28/12/23	13:00

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NABH

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/112

Medway Heart Institute
Every heart beat counts

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 28/12/23 **Time:** 7.00 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:**

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☐ Comfortable Position ☐ Pain Scale ☑ Pain Score ☐ Others:	☑ Patient will have less pain	☐ Evaluate location, character, quality and severity of pain ☑ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☑ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M E Administered dolo as per orders N Maintained proper position.	 28/12 28/12/65
OXYGENATION ☐ Room Air ☐ Oxygen Hood ☐ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☐ Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☑ Check oxygen saturation ☐ Perform suctioning if needed ☑ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M E on ventilator. SpO2 : 99% maintained N Suctioning done as needed.	 28/12 28/12/65
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	☐ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M E — N —	
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☑ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E provided safe environment N Provided Safe environment.	 28/12 28/12/65

S.No. : 8

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☑ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☑ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	**M** **E** Monitored I/o chart-checked IV sites **N** Monitored I/O every hour..	 02 0265
RISK OF INFECTION ☐ Prevent Infection ☑ Others:	☑ The patient will be discharged with no hospital acquired infection	☑ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	**M** **E** used aseptic technique during care **N** followed aseptic precautions.	 0265
RISK OF FALL ☐ Giddiness ☐ Independent State ☑ Dependent State	☑ The patient will have safe, free from fall hospitalization	☑ Keep bed on low position ☑ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	**M** **E** kept bed in low position **N** followed risk fall prevention.	 02 0265
SKIN &WOUND CARE ☐ Observe REEDA ☑ Oozing ☐ Foul Smell	☑ The patient will have intact skin while staying in the hospital and on discharge	☑ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	**M** **E** Checked drains **N** All lines and tubes are insitu.	 01 0265
DIET & NUTRITION ☐ NPO ☑ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☑ Patient will have adequate nutrition with no nausea and vomiting	☑ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ *Provide high calories, high protein diet as prescribed* ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	**M** **E** patient on NPO IVF on flow **N** NPO, on IV fluids	 02 0265

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.	☐ Patient will have patent, properly maintained catheters, drains etc	☑ Check the catheters, drains etc frequently ☑ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M E Maintained I/O chart N Maintained I/O	02/65
DISTURBED BODY IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M E N NA	02/65
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☑ Monitor GCS of patient	M E Monitored vital sign N Monitored vitals & assessed for GCS.	02/65
HEALTH EDUCATION ☐ Patient ☑ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:	☑ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ Provide proper education regarding follow-up diet ☐ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☑ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M E educate the family regarding patient condition. N Educated regarding —	02/65
ANY OTHER NEEDS			M E N	

	Signature		Name		Emp. ID		Date	Time
Endorsed by					0003		29/12/25	9.00

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MHI/NUR/2022/112

Medway Heart Institute
Every heart beat counts

Patient Name	Mr.VENKATACHALAM P
UHID:	63/Male/MHI202381271
DOB:	27/12/2023/IPH2023002615
DOA:	Dr.ANBARASU MOHANRAJ
Consul	

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 29/12/23 Time: 10:00	Modified Date: – Time: –
Reason for Modification:	Diagnosis: CAD - TVD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions		Evaluation	Sign & Initials
PAIN ☐ Comfortable Position ☐ Pain Scale ☑ Pain Score ☐ Others:	☑ Patient will have less pain	☐ Evaluate location, character, quality and severity of pain ☐ Administer pain medication as prescribed and as needed ☑ Observe for any changes in vital signs ☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M	Patient had decreased level of Pain - 4/10	[signature] 014
			E	Administered drug as per order	[signature]
			N	comfortable position given	[signature] 0276
OXYGENATION ☐ Room Air ☑ Oxygen Hood ☑ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☑ Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment ☑ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M	Patient is on Nasal prongs SpO2-98%	[signature] 017
			E	patient on NP c̄ SpO2:98%	[signature] 023
			N	On Room Air.	[signature] 0276
ANXIETY ☑ Increased Pulse Rate ☑ Anxious Look	☑ Patient will cope properly with his illness and react positively to his surroundings	☐ Explain all procedures to patient or family member in simple language they understand ☑ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M	NA	[signature] 017
			E	explained the procedure to the patient	[signature]
			N	–	–
MOBILITY ☐ Mobile / Immobile ☑ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☑ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Apply Anti-Embolic stocking / SCD ☑ Evaluate the need for assistive devices ☑ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M	Patient is on Bed fast	[signature] 017
			E	provide safe environment	[signature] 023
			N	Bed is lowered & locked position,	[signature] 0276

S.No. : 8

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.	☑ Patient will have patent, properly maintained catheters, drains etc	☑ Check the catheters, drains etc frequently ☑ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M	On UBD, I/O Chart maintained	[signature] 0171
			E	I/O Chart monitor	[signature]
			N	I/O chart monitored.	[signature]
DISTURBED BODY IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image	☐ Note non verbal body language, negative attitude and self talk ☐ Note emotional reaction (grieving, depression, anger) ☐ Acknowledge and accept expression of feeling of grief and hostility	M	NA	[signature] 0171
			E	NA	[signature]
			N		
OBSERVATION ☑ Vital Signs ☑ GCS ☑ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☑ Assess physically for any abnormality ☑ Inform doctor if there is any abnormality ☑ Monitor GCS of patient	M	Vital Signs are haemodynamically Stable	[signature] 0171
			E	Vital Sign are Stable	[signature]
			N	Vitals signs monitored.	[signature] 0276
HEALTH EDUCATION ☑ Patient ☐ Family / Guardian ☐ Diet ☐ Disease process ☐ Infection control / PPE ☐ Medication ☐ Educate about TAC level and immunosuppressant ☐ Personal Safety ☐ Treatment Regimen ☐ Others:	☑ Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ Provide proper education regarding follow-up diet ☑ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about medication ☐ Provide clear, thorough, and understandable explanations regarding safety precautions. ☐ Explain to perform activities / skin care that recommended by concerned doctor ☐ Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M	Patient gained knowledge regarding Perm Exercise	[signature] 0171
			E	Patient gained knowledge regarding diet	[signature]
			N		
ANY OTHER NEEDS			M		
			E		
			N		

	Signature		Name		Emp. ID		Date	Time
Endorsed by	[signature]			[signature]	0003		30/12/21	9.00

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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.VENKATACHALAM P
63/Male/MH1202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/112

Medway Heart Institute
Every heart beat counts

ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 30/12/23	Time: 8.00	Modified Date: —	Time: —
Reason for Modification:		Diagnosis: OPCAB x 4 GRAFTS	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
PAIN ☑ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	☑ Patient will have less pain	☑ Evaluate location, character, quality and severity of pain ☐ Administer pain medication as prescribed and as needed ☐ Observe for any changes in vital signs ☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration, swelling, separation and drainage ☐ Non-Pharmacological therapy	M	PT had Mild Pain	[signature]
			E	provided comfort position	[signature]
			N	Pt was alert	[signature]
OXYGENATION ☑ Room Air ☐ Oxygen Hood ☐ Nasal Cannula ☐ Nebulizer ☐ Ventilator ☐ Others:	☑ Patient will have no shortness or difficulty of breathing	☑ Provide well ventilated environment ☐ Check oxygen saturation ☐ Perform suctioning if needed ☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed ☐ Encourage spriometry, deep breathing and coughing exercises ☐ Monitor amount, viscosity, colour and odour of sputum if present	M	SpO_2 - 95%	[signature]
			E	SpO_2 - 96%	[signature]
			N	SpO_2 - 98%	[signature]
ANXIETY ☑ Increased Pulse Rate ☐ Anxious Look	☑ Patient will cope properly with his illness and react positively to his surroundings	☑ Explain all procedures to patient or family member in simple language they understand ☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery ☐ Keep patient in comfortable position in bed to enhance sleep	M	NA	
			E	—	
			N	NA	
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M	PT Mobilized well	[signature]
			E	pt mobilized well	[signature]
			N	Pt mobilized well	[signature]

S.No. : 8

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	**M** PT is on oral fluids	0080
			E pt I/O chart was monitored	[illegible]
			N Pt I/O Chart monitoring	[illegible]
RISK OF INFECTION ☑ Prevent Infection ☐ Others:	☐ The patient will be discharged with no hospital acquired infection	☑ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	**M** No risk of Infection	0080
			E —	
			N —	
RISK OF FALL ☑ Giddiness ☐ Independent State ☐ Dependent State	☐ The patient will have safe, free from fall hospitalization	☑ Keep bed on low position ☐ Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed ☐ Remove clutter, keep items patient needs within reach ☐ Avoid movement out of bed after surgery for 46 hours ☐ Review patients' medication like narcotics and hypotensive agents ☐ Offer urinal or bedpan to the patient if needed	**M** No risk of fall	0080
			E N.R.O.F.	
			N No risk of fall	[illegible]
SKIN &WOUND CARE ☑ Observe REEDA ☐ Oozing ☐ Foul Smell	☑ The patient will have intact skin while staying in the hospital and on discharge	☑ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	**M** PT is on closed wound	0080
			E —	
			N	
DIET & NUTRITION ☐ NPO ☐ Soft Diet ☐ Semisolid Diet ☐ Solid Diet ☐ RT Feeds	☑ Patient will have adequate nutrition with no nausea and vomiting	☑ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor	**M** Pt is on NORMAL diet	0080
			E Pt feed Ⓓ diet	[illegible]
			N pt on Ⓝ diet	[illegible]

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

	Signature		Name		Emp. ID		Date	Time
Endorsed by							30/12/25	7.00

Medway Hospitals®
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ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 31/12/23 **Time:** 7:30 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:**

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt DM Diet E pt had @ diet. N pt had @ dinner	
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt roomair E spo2 - 98% N spo2 - 98%	
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt electrytes fluids E s/o chest acg monitored N I/O chart monitoring	

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

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by		E. Nalini	0024	31/12/23	18:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 1/4/2024	Time: 7:30	Modified Date:	Time:
Reason for Modification:		Diagnosis: CAD - TVD	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions		Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M	Takes normal diet	[illegible]
			E	Pt had [illegible] diet	[illegible]
			N	Pt had N diet	[illegible]
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M	Patient is on room air	[illegible]
			E	SpO_2 - 98%	[illegible]
			N	SpO_2 - 98%	[illegible]
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M	Takes adequate oral fluids	[illegible]
			E	I/O chart monitored	[illegible]
			N	I/O chart monitored	[illegible]

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

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☒ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☒ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	Effective verbal communication	[signature]
			E	Pt communicate well	[signature]
			N	Pt communicated well.	[signature] 0271
SPECIAL INTERVENTIONS ☒ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☒ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M	Medications given as per chart	[signature]
			E	medication was given	[signature]
			N	Medication given	[signature] 0271

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

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ADULT NURSING CARE PLAN

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 27/12/23	Time: 7:30	Modified Date:	Time:
Reason for Modification:		Diagnosis:	

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

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

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Vali	R. Valini	0024	2/1/24	18:00

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 27/12/23		
					Time: P	A	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	4	
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
				TOTAL SCORE	23	23	
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

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

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NABH

P Mr.VENKATACHALAM P
N 63/Male/MHI202381271
U 27/12/2023/IPH2023002615
D Dr.ANBARASU MOHANRAJ
D
C

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 28 | 12 | 23		
					Time: M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	~~4. No~~ **Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	~~4. Rarely~~ **Moist** Skin is usually dry, linen only requires changing at routine intervals	4		
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	~~4. Walks~~ **Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	~~4. No~~ **Limitation** Makes major and frequent changes in position without assistance	4		
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	~~4.~~ **Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4		
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	~~3.~~ **No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3		
				TOTAL SCORE	23		
				Initial & Emp. No. of Staff Nurse:			
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6				**Initial & Emp. No. of Sr. Staff Nurse:**			

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NABH

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

Date: 28/12/23 29/12/23
Time: 14:30 20:00 7a

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	1	1	1
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	1	1	1
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	1	1	1
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	1	1	1
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		1	1	1
				TOTAL SCORE	6	9	6
				Initial & Emp. No. of Staff Nurse:		0226	
				Initial & Emp. No. of Sr. Staff Nurse:			

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

MHI/NUR/2022/045

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Medway Heart Institute
Every heart beat counts

Patient Name:	Mr.VENKATACHALAM P
UHID:	63/Male/MHI202381271
DOB:	27/12/2023/IPH2023002615
DOA:	Dr.ANBARASU MOHANRAJ
Consult	

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 29/12	29/12	
					Time: 13:00	19:00	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	3	3	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	3	3	
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	2	2	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	2	2	
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	2	2	
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		1	1	
				TOTAL SCORE	13	13	
				Initial & Emp. No. of Staff Nurse:	[signature]	[signature]	
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6				**Initial & Emp. No. of Sr. Staff Nurse:**	[signature]	[signature]	

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NABH ACCREDITED

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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

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

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Mr.VENKATACHALAM P
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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 31	12	23
					Time: M	A	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	4
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	4	4
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	23	23	23
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:	Nee 24	Nee 24	Nee 24

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

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 1	1	24
					Time: M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	4
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	4	A
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	23	23	23
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

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

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NABH

Patient Details
Name: Mr.VENKATACHALAM P
UHID: 63/Male/MHI202381271
DOB: 27/12/2023/IPH2023002615
DOA: Dr.ANBARASU MOHANRAJ
Consultant:

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 2	1	24
					Time: M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4		
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body *or extremity position without assistance*	**2. Very Limited** Makes occasional slight changes in body *or extremity position but unable to make* frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body *or extremity position independently*	**4. No Limitation** Makes major and frequent changes in position without assistance	4		
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	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	22		
				Initial & Emp. No. of Staff Nurse:			
***Score Interpretation:** Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**			

Medway Hospitals®
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MHI/NUR/2022/052

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

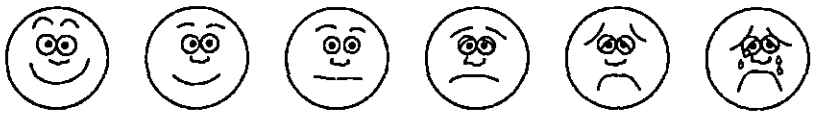
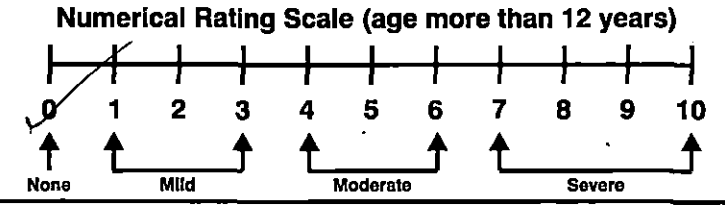
Medway Heart Institute
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
27/12/23 13.00	0/10	No pain	—	—	—	01/40	05
17.00	0/10	No pain	—	—	—		05
22.00	0/10	No pain	—	—	—	01/40	05
28/12/23 2.00	0/10	No pain	—	—	—	01/40	05
6.00	0/10	No pain	—	—	—	01/40	05
8.00	0/10	No pain	—	—	—		

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

PAIN SCALES

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

Pharmacological Interventions as per doctor's prescription

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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.
19.30	0/8	By CPOT	—	—	—		
21.30	0/8	—	—	—	CPOT		
23.30	0/8	—	—	—	CPOT		
1:30	0/8	—	—	—	CPOT		
3:30	0/8	—	—	—	CPOT		
5.30	0/8	—	—	—	CPOT		
29/12/22 7:30	0/8	—	—	—	By CPOT		
9.30	2/10	Dull Pain	10-15 Sec	Surgical Site	Non-Pharmacological Intervention a/c followed		
11.30	2/10	Achy Pain	10 Sec	Sternum	Pharmacological Intervention a/c followed.		

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
13:30	1/10	DULL PAIN	10-15 SEC	SURGICAL SITE	Pharmacological Interventions are followed	0171	
15:30	2/10	ACHY PAIN	10 SEC.	STERNUM	Non- Pharmacological Interventions are followed.	0171	
17:30	1/10	DULL PAIN	10-15 SEC	SURGICAL SITE	Pharmacological Interventions are followed.		
19:30	2/10	ACHY PAIN	10 SEC	STERNUM	Non- Pharmacological Interventions are followed		

PAIN SCALES

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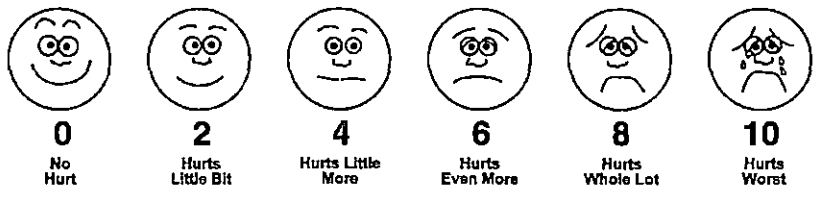
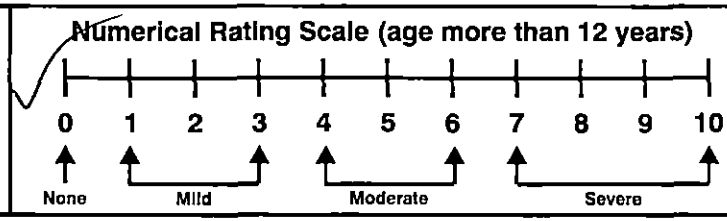
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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Dr.ANBARASU MOHANRAJ
Consultant:

MHI/NUR/2022/052

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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
29/12 21:30	1/10	Achy pain.	< 15sec	Sternum	comfortable position given,	S.mary 0276	0001
22:30	1/10	Achy pain	< 10sec	Sternum.	Comfortable position given	S.mary 0276	0001
30/12 01:30	1/10.	Achy pain.	< 15sec	Sternum.	comfortable position given.	S.mary 0276	0001
03:30	1/10	Dull pain.	< 15sec.	Sternum.	Comfortable position given,	S.mary 0276	0001
05:30.	1/10	Dull pain	< 15sec	Sternum	Comfortable position given.	Mary 0276.	0001
7.30	1/10	Dull Pain	< 15 sec	Sternum	Comfortable position given	0088	0001
9:30	2/10	ACHY PAIN	10-15 sec	SURGICAL SITE	Pharmacological Intervention on Hand	0276	0001
11:30	1/10	dull pain	on & off	surgical site	provided comfortable position	0276	Nee 024
15:30	1/10	dull pain	on & off	surgical site	provided comfortable position	0276	Nee 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.
19:00	0/10	No pain	—	—	—	[illegible] 0171	[illegible] 024
23:00	0/10	No pain	—	—	—	[illegible] 0271	[illegible] 024
3.00	0/10	NO pain	—	—	—	[illegible] 0271	[illegible] 024
7:00	0/10	NO pain	—	—	—	[illegible] 0271	[illegible] 024

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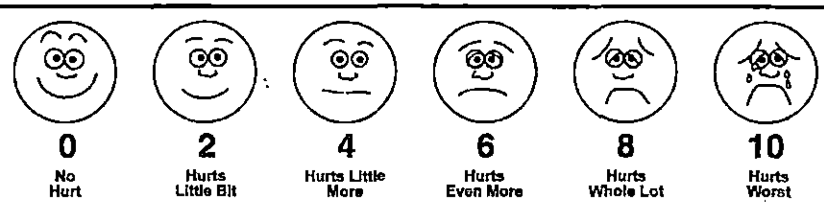
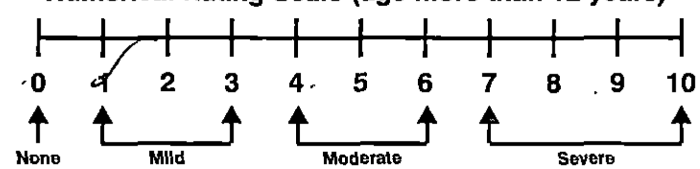


Numerical Rating Scale (age more than 12 years)



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11.00	0/10	No pain	–	–	–	[signature]	Naa 024
15.00	0/10	No pain	–	–	–	[signature]	Naa 024
19.00	0/10	No pain	–	–	–	[signature]	Naa 024
23.00	0/10	No pain	–	–	–	[signature] 0271	Naa 024
1/1/24 3.00	0/10	No pain	–	–	–	[signature] 0271	Naa 024
7.00	0/10	No pain	–	–	–	[signature] 0271	Naa 024
11.00	0/10	No pain	–	–	–	[signature]	Naa 024
15.00	0/10	No pain	–	–	–	[signature]	Naa 024
19.00	0/10	No pain	–	–	–	[signature]	Naa 024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
25/1/24 0800	0/10	No pain	—	—	—	0271	Nas 024
26/1/24 0300	0/10	No pain	—	—	—	0271	Nas 024
27/1/24 7.00	0/10	No pain	—	—	—	0271	Nas 024
10.00	0/10	No pain	—	—	—	JSH 024	Nas 024

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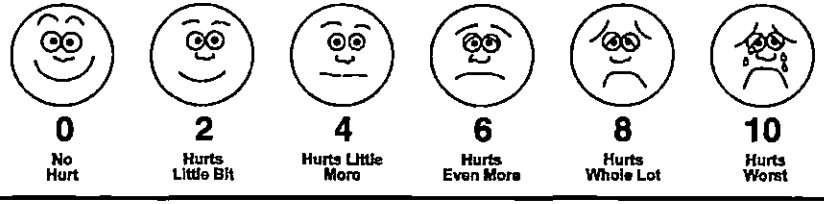
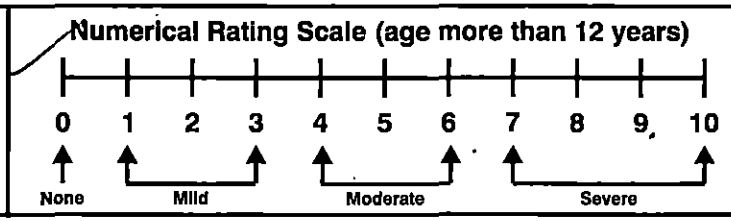
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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DVT RISK ASSESSMENT

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

	Date	27/12	28/12					
	Time	13.00	7.00					
S. No.	**PARAMETERS**							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0					
2	Bedridden recently >3 days or major surgery within four weeks	0	0					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0					
5	Entire leg swollen (Assess for both legs)	0	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0					
9	Previously documented DVT (Assess for both legs)	0	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0					
	FINAL SCORE	0	0					
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low	Low					
	DVT prophylaxis started	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

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NABH ACCREDITED

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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	28/12/23	29/12/23	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
		Time	19.00	6:00	19:00	7:00	7:00	7:00	7:00
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)		0	0	0	0	0	0	0
2	Bedridden recently >3 days or major surgery *within four weeks*		+1	+1	+1	+1	+1	+1	+1
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)		0	0	0	0	0	0	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)		0	0	0	0	0	0	0
5	Entire leg swollen (Assess for both legs)		0	0	0	0	0	0	0
6	Localized tenderness along the deep venous system (Assess for both legs)		0	0	0	0	0	0	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)		0	0	0	0	0	0	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)		0	0	0	0	0	0	0
9	Previously documented DVT (Assess for both legs)		0	0	0	0	0	0	0
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.		0	0	0	0	0	0	0
		FINAL SCORE	+1	+1	+1	+1	+1	+1	+1
		Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	MOD	MOD	MOD	MOD	MOD	MOD	MOD
		DVT prophylaxis started	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
		Signature & Emp. No. of RN	0227	0265	0270	0280	0227	0227	0227
		Signature & Emp. No. of Sr. RN	0227	0265	0270	0280	214	214	214

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MHI/NUR/2022/046

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Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	27/12/23	27/12/23	28/12/23						
	Time	13.00	20.00	6-00						
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS *Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics*	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		30	50	50						
Low Risk (0 - 24)										
Medium Risk (25 - 44)		✓								
High Risk (45 or above)			✓							
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

INTERVENTIONS *Tick as per the Risk Score*	Date	27/12	27/12	28/12					
	Time	13.00	20.00	8.00					
Low Risk Interventions (0 - 24)									
Familiarize the patient with the immediate surroundings		✓	✓	✓					
Remind the patient to use call bell before getting out of bed		✓	✓	✓					
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓					
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓					
Remove excess equipment or furniture to make a clear path		✓	✓	✓					
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓					
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓					
Bed wheels should be locked		✓	✓	✓					
Encourage family participation in the patient's care		✓	✓	✓					
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓					
Review medications for potential side effects that can promote falls		✓	✓	✓					
Use safety belts during movement in wheelchair		✓	✓	✓					
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓					
Medium risk interventions (25 - 44)									
Apply all the low risk interventions		✓	✓	✓					
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓					
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓					
Use restraints and bed monitors as ordered by the doctor		✓	✓	✓					
Allow the patient to ambulate only with assistance		✓	✓	✓					
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓					
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓					
Accompany the patient while going to bathroom		✓	✓	✓					
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓					
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓					
High-risk interventions (45 or above)									
Apply all the low and medium risk interventions			✓	✓					
Tie red fall risk tag in the bed, wheel chair and stretcher			✓	✓					
Locate the high-risk patients in a room close to the nurses' station			✓	✓					
Answer these patients call bells as quickly as possible			✓	✓					
Provide a commode at bedside (if appropriate)			✓	✓					
Urinal/bedpan should be within easy reach (if appropriate)			✓	✓					
Encourage family members or other visitors to stay with them			✓	✓					
If appropriate, consider using protection devices: safety belts			✓	✓					
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									

MHI/NUR/2022/046

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NABH ACCREDITED

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	28.12.4	28/12/23	29/12/23	29/12/23	29/12/23	30/12	30/12/23	30/12	31/12/24
	Time	19-00	21:00	8.00	134	00:00	8.00	14:00	8-00	1
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		65	65	65	50	50.	50	60	50	
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓	✓	
Signature & Emp. No. of RN		[signature]	[signature]	[signature] 0171	[signature] 017	[signature] 0276	[signature] 0083	[signature]	[signature]	
Signature & Emp. No. of Sr. RN		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature] 24	[signature] 24	

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

INTERVENTIONS *Tick as per the Risk Score*	Date	28.12.23	28/12/23	29/12/23	29/12/23	29/12/23	30/12	30/12/23	30/12	
	Time	19-00	21:00	8:00	13.00	19/00	8.00	14:00	8:00	
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings								✓	✓	
Remind the patient to use call bell before getting out of bed								✓	✓	
Keep the two side rails in the raised position at all times for all patients regardless of age								✓	✓	
Keep the call bell, bedside table, water, glasses within the patient's easy reach								✓	✓	
Remove excess equipment or furniture to make a clear path								✓	✓	
Keep the patient's bed in the low position at all times except during procedure								✓	✓	
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed								✓	✓	
Bed wheels should be locked								✓	✓	
Encourage family participation in the patient's care								✓	✓	
Ensure that floor of the bathroom is dry and not slippery								✓	✓	
Review medications for potential side effects that can promote falls								✓	✓	
Use safety belts during movement in wheelchair								✓	✓	
The patients are not ambulated by themselves. They are to be ambulated only with assistance								✓	✓	
Medium risk interventions (25 - 44)										
Apply all the low risk interventions								✓	✓	
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher								✓	✓	
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat								✓	✓	
Use restraints and bed monitors as ordered by the doctor									✓	
Allow the patient to ambulate only with assistance								✓	✓	
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care								✓	✓	
Do not leave patients unattended in diagnostic or treatment areas								✓	✓	
Accompany the patient while going to bathroom								✓	✓	
Advice the patient to use grab bars near the toilet, bathtub, and shower								✓	✓	
Make sure the family and other visitors understand the restrictions mentioned above								✓	✓	
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓	✓	✓	✓	✓	✓	✓	
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓	✓	✓	✓	✓	✓	✓	
Locate the high-risk patients in a room close to the nurses' station		NA	✓	✓	✓	✓	✓	✓	✓	
Answer these patients call bells as quickly as possible		NA	NA	NA	NA	NA	NA	✓	✓	
Provide a commode at bedside (if appropriate)		NA	NA	NA	NA	NA	NA	✓	✓	
Urinal/bedpan should be within easy reach (if appropriate)		NA	NA	NA	NA	NA	NA	✓	✓	
Encourage family members or other visitors to stay with them		NA	NA	NA	NA	NA	NA	✓	✓	
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓	✓	✓	
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/046

Medway Heart Institute
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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	27/12/23	31/12	1/1/24	1/1/24	1/1/24	2/1/24			
	Time	14:00	20:00	8:00	14:00	20:00	8:00			
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		60	70	50	60	50	50			
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓			
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

INTERVENTIONS *Tick as per the Risk Score*	Date	31/12/23	31/12/23	1/1/24	1/1/24	1/1/24	2/1/24			
	Time	8:00	20:00	8:00	14:00	20:00	8:00			
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓			
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓			
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓			
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓			
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓			
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓			
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓			
Bed wheels should be locked		✓	✓	✓	✓	✓	✓			
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓			
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓	✓	✓	✓			
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓	✓			
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓			
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓			
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓	✓	✓	✓	✓	✓			
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓	✓	✓	✓			
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓	✓	✓			
Use restraints and bed monitors as ordered by the doctor		✓	✓	✓	✓	✓	✓			
Allow the patient to ambulate only with assistance		✓	✓	✓	✓	✓	✓			
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓			
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓	✓	✓	✓			
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓			
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓	✓	✓	✓			
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓			
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓	✓	✓	✓	✓			
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓	✓	✓	✓	✓			
Locate the high-risk patients in a room close to the nurses' station		✓	✓	✓	✓	✓	✓			
Answer these patients call bells as quickly as possible		✓	✓	✓	✓	✓	✓			
Provide a commode at bedside (if appropriate)		✓	✓	✓	✓	✓	✓			
Urinal/bedpan should be within easy reach (if appropriate)		✓	✓	✓	✓	✓	✓			
Encourage family members or other visitors to stay with them		✓	✓	✓	✓	✓	✓			
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓			
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/055

Medway Heart Institute
Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

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

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

Completed By : Date 27/12/23 Time 13.00 Nurse Signature :

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	27/12/23	P	O		28/12	L	P	O		L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics		P	OD	✓		P	OD	✓					
☑ Treatment													
Medications		P	OD	✓		P	OD	✓					Doctor / Nurse
☑ Information on Safe and Effective use of medicines		P	OD	✓		P	OD	✓					
☐ Information on drug / drug and drug / food interactions		P											
☐ Discharge Medications													
Surgical Instructions													Nurse
☑ Pre - Operative Instructions		P	OD	✓		P	OD	✓					
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☑ Reporting of pain		P	OD	✓		P	OD	✓					
☑ Pain Management		P	OD	✓		P	OD	✓					
Safe and effective use of medical Equipment (if required)		P				P							Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient :_____ *Signature* :_____

Name of Discharge Nurse

Signature :

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63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/055

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Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

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

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

Completed By : Date 28.12.23 Time 19.00 Nurse Signature :

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	28/12/23	L	P	O	29/12	L	P	O	30/12/23	L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics		S	OD	V		S	OD	V		P	OD	V	
☑ Treatment		S	OD	V		S	OD	V		P	OD	V	
Medications		S	OD	V		S	OD	V		P	OD	V	Doctor / Nurse
☐ Information on Safe and Effective use of medicines													
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☑ Post - Operative Instructions (Wound / Dressing Care)		S	OD	V		S	OD	V		P	OD	V	
Pain Management													Nurse
☑ Reporting of pain		S	OD	V		S	OD	V		P	OD	V	
☑ Pain Management		S	OD	V		S	OD	V					
Safe and effective use of medical Equipment (if required)		—				—							Doctor / Nurse
Name of Equipment Rehabilitation Techniques		—				—							

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	28/12	L	P	O	29/12	L	P	O		L	P	O	
Nutritional Guidance													Dietician
☐ Diet Instruction for patients at Nutritional risk		P	OD	V		P	OD	V		RD			
☐ Diet advice for home													Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)

Nil

Reports Given :

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

Name of Attendant / Patient :_____Signature :_____

Name of Discharge Nurse Signature :

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P Mr.VENKATACHALAM P
N 63/Male/MHI202381271
UI 27/12/2023/IPH2023002615
DO Dr.ANBARASU MOHANRAJ
DO
Co

MHI/IP/2022/055

Medway Heart Institute
Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

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

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

Completed By : Date 31/12/23 Time 1420 Nurse Signature :

Learning Record

Need	Date 31/12	Visit 1 L	P	O	Date 1/1/24	Visit 2 L	P	O	Date 2/1/24	Visit 3 L	P	O	Signature
Disease													Doctor
☐ Information on Disease / Diagnostics													
☐ Treatment													
Medications													Doctor / Nurse
☐ Information on Safe and Effective use of medicines													
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☑ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☐ Reporting of pain													
☐ Pain Management													
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	8/1/12	L	P	O	8/1/12	L	P	O	2/1	L	P	O	
Nutritional Guidance													Dietician
☐ Diet Instruction for patients at Nutritional risk		P	OD	V		P	OD	V		P	OD	V	Maria Catherine John Senior Dietitian
☐ Diet advice for home		-	-	-		-	-	-		P	OD	V	Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

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

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

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

Written Material given and explained (if any)

—

Reports Given :

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

Name of Attendant / Patient : MAHESH.V. Signature :

Name of Discharge Nurse S/N Mjonghen Signature :

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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/IP/2022/054

Medway Heart Institute
Every heart beat counts

IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 30/12/23 Time: 10:00 Transferred from: SICU To: 1ST FLOOR

Diagnosis: CAD-TVD + LEFT MAIN.
C/O

Vital Signs: Temp: 97.7 (°F) | Pulse / HR: 94/mt (beats/min) | BP: 104/74 mm (mmHg) | Respiration: 18 (breaths/min)

Part B *(to be filled by Physicians)* Any Critical Investigations: _____

Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	☑ Clear ☐ Crepitation ☐ Rhonchi ☐ Others:	☑ Yes ☐ No
Abdomen	☑ Soft ☐ Tender ☐ Distended ☐ Others:	☑ Yes ☐ No
Heart Sound	☑ Normal ☐ Feeble ☐ Loud ☐ Others:	☑ Yes ☐ No
CNS	☑ Conscious ☐ Oriented GCS Score:	☑ Yes ☐ No
For Surgical Patients (if applicable)	Surgical Site: ☑ Healthy ☐ Soakage ☐ Others:	☑ Yes ☐ No

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	SYP. SUCRALFATE SUSPENSION	10mL	PO	1-1-1.	29/12/23 AT 21:00	☑ Yes ☐ No
2	NEB. LEVOSALBUTAMOL	0.63 mg	INH	8 HRLY	30/12/23 AT 04:00	☑ Yes ☐ No
3	T. FRUSEMIDE	40mg	PO	1-1-0.	30/12/23 AT 20:00	☑ Yes ☐ No
4	T. SPIRONALACTONE	25 mg	PO	1-1-0.	30/12/23 AT 10:00.	☑ Yes ☐ No
5	T-BEPLEX FORTE	1 TAB	PO	1-0-0.	30/12/23 AT 08:00.	☑ Yes ☐ No
6	T. CLOPIDOGREL + ASPIRIN.	1 TAB	PO	0-1-0.	29/12/23 AT 14:00.	☑ Yes ☐ No
7	T. PARACETAMOL	650 mg	PO	1-1-1.	30/12/23 AT 08:00	☑ Yes ☐ No
8	SYP. CREMAFFIN PLUS	15 mL	PO.	0-0-1.	29/12/23 AT 20:00.	☑ Yes ☐ No
9	T-ROSUVASTATIN.	40mg	PO	0-0-1.	29/12/23 AT 20:00.	☑ Yes ☐ No
10	T. METOPROLOL.	25mg	PO	1-0-1.	30/12/23 AT 08:00.	☑ Yes ☐ No
11	NEB. BUDESONIDE	0.5mg	INH	1-1-1-1.	30/12/23 AT 05:00	☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

—

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

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		DR. PRANEETH JEYAKUMAR	112236	30/12/23	10:00
Receiving Doctor	K.BD	Dr. K. Anusuya	134559	30/12/23	10:15

Part C *(to be filled by Nurses)*

Check for	Transferring Nurse	Receiving Nurse
Drains	☐ Chest ☐ Abdominal ☐ Others: —	☐ Yes ☐ No
Respiratory	Air Way Type: ☑ Patent ☐ Tracheostomy ☐ Others: _____ Oxygen Therapy: ☑ No ☐ Yes via: _____ Rate: _____ li/min	☐ Yes ☐ No
NG Tube / Oral	☐ Yes ☑ No ☐ For Feeding ☐ Gastric Suction ☐ Fluid Restriction	☐ Yes ☐ No
Foley's Catheter	☐ Yes ☑ No	☐ Yes ☐ No
Intravenous Access	☑ Peripheral Line ☐ Central Venous Line ☐ Others: _____	☐ Yes ☐ No
Pressure Injury	☐ Yes ☑ No If Yes, give details: _____	☐ Yes ☐ No
Score	Fall Risk: 50 . WELLS: NEWS / PEWS:	☐ Yes ☐ No
Patient Belongings	☑ Yes ☐ No If Yes, give details: FILE	☐ Yes ☐ No
Handover Details	Medication Administration Record explained: ☑ Yes ☐ No Lab & Diagnostic Reports handed over: ☑ Yes ☐ No	☐ Yes ☐ No
Patient Attendant Informed	☑ Yes ☐ No If No, give details: _____	☐ Yes ☐ No

Additional Details *(if any)*:

—

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		A. ALBINUS	0088	30/12/23	10:10
Receiving Nurse		SUSILA	208	30/12/23	10:15

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHIIP/2022/051

Medway Heart Institute
Every heart beat counts

FAMILY COUNSELLING FORM

CONSULTANT- DR. Anbarasu | DIAGNOSIS- CAD - TVD

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
28.12.23	R/A SURYA	Meenakshi	Explained the family regarding patient condition, ICU rule and visitors policy	—	Meena	R 1/2/23
29/12/23	P/N RANEEMA D	Mohash	Explained about the patient present Condition & Ward Shifting	✓		R 1/2/23

MHI/HOSP/2022/110

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Patient Details *(Affix Label here)*
Name: Venkatachaler
UHID: 20238127
DOB: 63Y M Sex:
IP 23002615

Medway Heart Institute
Every heart beat counts

WOUND ASSESSMENT CHART

DATE	2/1/23							
SITE OF WOUND								
CHEST	✓							
LEG L/R								
ABDOMEN								
SACRAL REGION								
HEEL	✓							
OTHERS								
SIZE OF THE WOUND								
SUPERFICIAL / DEEP IN NATURE								
PRESSURE *Specify system used :*								
RISK FACTORS *Specify system used :*	DM ✓	HTN	Age	Obesity				
WOUND TISSUE TYPE(S) PRESENT								
necrotic	☐	☐	☐	☐	☐	☐	☐	☐
slough	☐	☐	☐	☐	☐	☐	☐	☐
undermining	☐	☐	☐	☐	☐	☐	☐	☐
granulation	☐	☐	☐	☐	☐	☐	☐	☐
overgranulation	☐	☐	☐	☐	☐	☐	☐	☐
epithelialisation	☐	☐	☐	☐	☐	☐	☐	☐
other	☑	☐	☐	☐	☐	☐	☐	☐
SURROUNDING SKIN TISSUE TYPE(S)								
macerated	☐	☐	☐	☐	☐	☐	☐	☐
erythema	☐	☐	☐	☐	☐	☐	☐	☐
oedematous	☐	☐	☐	☐	☐	☐	☐	☐
cellulitis	☐	☐	☐	☐	☐	☐	☐	☐
blistered	☐	☐	☐	☐	☐	☐	☐	☐
bruising	☐	☐	☐	☐	☐	☐	☐	☐
dry / scaling	☐	☐	☐	☐	☐	☐	☐	☐
healthy	☑	☐	☐	☐	☐	☐	☐	☐

WOUND ASSESSMENT CHART

EXUDATE AMOUNT								
none	☑	☐	☐	☐	☐	☐	☐	☐
evidence of some moisture	☐	☐	☐	☐	☐	☐	☐	☐
evidence of significant flow	☐	☐	☐	☐	☐	☐	☐	☐
EXUDATE								
serous	☐	☐	☐	☐	☐	☐	☐	☐
sero - sanguinous	☐	☐	☐	☐	☐	☐	☐	☐
Purulent	☐	☐	☐	☐	☐	☐	☐	☐
ODOUR								
none	☑	☐	☐	☐	☐	☐	☐	☐
some evidence of odour	☐	☐	☐	☐	☐	☐	☐	☐
significantly malodorous	☐	☐	☐	☐	☐	☐	☐	☐
PAIN AT WOUND SITE (nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)								
INFECTION SUSPECTED*	☑	☐	☐	☐	☐	☐	☐	☐
SWAB SENT	☑	☐	☐	☐	☐	☐	☐	☐
ANTIBIOTIC THERAPHY	☑	☐	☐	☐	☐	☐	☐	☐
BLOOD GLUCOSE / URINE ANALYSIS	☑	☐	☐	☐	☐	☐	☐	☐
PATIENT / CARER TO DO DRESSING	☑	☐	☐	☐	☐	☐	☐	☐
SIGNATURE								

***SIGNS & SYMPTOMS OF WOUND INFECTION :**

- Pytexia
- localised pain
- erythema
- localoedema
- excess exudate
- pus
- offensive odour

***SUSPECT WOUND INFECTION IF :**

- granulation tissue bleeds easily
- fragile bridge of epithelium occurs
- odour increas
- healing is slower than anticipated
- wound breakdown

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Mr.VENKATACHALAM P
63/Male/MHI202331271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/ICU/2022/056

Medway Heart Institute
Every heart beat counts

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 27/12/23 **Time:** 13.00

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor	Elango	Dr. Dr Elango	179044	27/12/23	13.00
Nursing Staff		B. Vanitha Maria Catherine John Senior Dietitian	0195	27/12/23	13.00
Dietician			2401	27/12/23	13.00
Physiotherapist	G.E. Akash	AKASH G.E	0256	28/12/23	19:00
Patient Care Service Staff					

MHI/IP/2022/116

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Medway Heart Institute
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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

IP No. / UHID No

AGE / SEX :

Ward / Bed No. 1St Floor (10?)

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
27/12/23							
	20:00	Lt cubital	0/5	patent	flushed	followed	[illegible]

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MHI/IP/2022/116

Medway Heart Institute
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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615

IP No. / UHID No

AGE / SEX :

Dr.ANBARASU MOHANRAJ

Ward / Bed No. 105

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
28.12.23	LP.30	RIGHT CUBITAL	0/5	IV LINE PATENT	FLUSHED	NO SIGNS OF PHLEBITIS	02#
	21:00	Ⓡ CUBITAL	0/5	PATENT & HEALTHY	ON FLOW	ON OBSERVATION	02#
29/12/23	8.00	RIGHT META	0/5	IV LINE PATEN	FLUSHED	NO SIGNS OF PHLEBITIS	
	13:00	RIGHT metacarpal	0/5	IV LINE PATEN	FLUSHED	NO SIGN OF PHLEBITIS	
	19.00	RIGHT METACARPAL	0/5	IV LINE PATENT	FLUSHD	NO SIGNS OF PHLEBITIS	02#
30/12/23	8.00	RT METACARPAL	0/5	IV LINE PATENT	FLUSHED	NO SIGNS	02#
	14:00	Rt metacarpal	0/5	IV line good	Flushed	—	02#
	20.00	Rt Meta Carpal	0/5	IV line Good	Flushed	—	02#
31/12/23	8.00	Rt meta	0/5	IV line good	Flush	—	
	14:00	Rt metacarpal	0/5	IV line good	Flushed	—	02#
	20.00	Rt Meta Carpal	0/5	IV line good	Flushed	—	02#
1/1/24	8.00	Rt metacarpal	0/5	Patent	Flushed	—	
	14:00	Rt metacarpal	0/5	patent	Flushed	—	02#
	20.00	Rt Meta Carpal	0/5	Patent	Flushed	—	02#
2/1/24	8.00	Rt metacarpal	0/5	patent	Flushed	—	
				IV line Removed			

New drug chart changed.

MHI/PHARM/2022/028

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Medway Heart Institute
Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1 Height (cms): 168 cm Weight (kg): 61 kg

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

Drug Details	Description of Allergy	Doctor's Sign:
- NKDA -	-	Dr. Sri Elayol Kannan Name: Reg. No. 179044

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
27/12	6:55 pm	Inj. IV bolus [19ml 25% D T6HA]		IV	[signature]	179044	[signature]	0072	19.00
27/12	21.00	T. ALPRAX	0.5mg	P/o	[signature]	165301	[signature]	0170	21.00
27/12	21.00	T. PANTOCID	40mg	P/o	[signature]	165302	[signature]	0170	21.00
28/12	5.00	T. ALPRAX	0.5mg	P/o	[signature]	165302	[signature]	0170	5.00
28/12	5.00	T. PANTOCID	40mg	P/o	[signature]	165302	[signature]	0170	5.00

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given
Time ↓	28/12/2.

DRUG NAME T. PROLOMET — 8:00 am — NPO

Dose	Route	Frequency
50mg	P/O	1-0-0

Dr. Sign & Reg. No. / Seal: Elyo 179004

Start Date & Time: 27/12/23 at 14:00

Stop Date & Time:

Additional Info:

DRUG NAME T- IMIDUR — 8:00 am — NPO

Dose	Route	Frequency
30mg	P/O	1-0-0

Dr. Sign & Reg. No. / Seal: Elyo 179004

Start Date & Time: 27/12/23 at 14:00

Stop Date & Time:

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge Nurse Signature:

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

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

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
28/12	5 AM	NPO from 5 AM		165307					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
27/12/23	Evening	A. Nandhini	0170			Evening			
28/12/23	Night	A. Nandhini	0170			Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

LOS

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NABH

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/PHARM/2022/028

Medway Heart Institute
Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug Chart: 02 of 01 Height (cms): 168 cms Weight (kg): 61 kg

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

Drug Details	Description of Allergy	Doctor's Sign:
NKDA	—	Name: DR. PRAVEEN Jeyakumar Reg. No. 112236

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered			
					Sign.	Reg. No.	Sign.	Emp. No.	Time	
28.12.23	18:45	INJ- SODIUM BICARBONATE	50ml	IV		112236		0131	18:45	
28.12.23	18:50	INJ- PROTAMINE	25mg	IV		112236		0131	18:50	
28/12/23	20:50	INJ. FENTANYL	50mics	IV		112236		0265	20:50	0000
28/12/23	23:40	T. ECOSPIRIN	75mg	RT		112236		0265	23:40	
29/12/23	8:55	INJ METAPROLOL	3mg	IV		112236		0171	8:55	0503
29/12/23	9:30	TAB. METOPROLOL	50mg	PO		112236		0171	9:30	
29/12/23	9:30	BUPRENORPHINE	10mg	ID		112236		0171	9:30	0003
31/12/23	13:30	INJ. EMESET	4mg	IV		134779		0141	13:30	

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

DRUG NAME
INJ. PARACETAMOL

Dose	Route	Frequency
1gm	IV	Q 8th hourly

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 28/12/23 at 21:00
Stop Date & Time: 29/12/23 at 10.00

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME
SYP. SUCRALFATE SUSPENSION

Dose	Route	Frequency
10ml	PO	1-1-1

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 28/12/23 at 20:00
Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME
NEB: LEVOSALBUTAMOL

Dose	Route	Frequency
0.63mg	PNH	Q 6th hourly

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 28/12/23 at 22:00
Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME
TAB. FRUSEMIDE

Dose	Route	Frequency
40mg	PO	1-1-0

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 29/12/23 AT 10.00
Stop Date & Time: 1/1/24 @ 8.00

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME
TAB. SPIRONOLACTONE

Dose	Route	Frequency
25mg	PO	1-1-0

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No:112236

Start Date & Time: 29/12/23 AT 11:00
Stop Date & Time: 1/1/24 @ 8:00

Additional Info:

Clinical Pharmacist Medway Heart Institute

Area In-charge Nurse Signature:

Date → / Time ↓	To be filled by Nursing Staff only. Sign and time given							
	28/12	29/12	30/12	31/12	1/1/24	2/1/24		
5:00	→	5.00						
13:00	→			Stop				
21:00	21.00							
7:30	→	7.30	7.30	7.30	7.30	7.30		
13:30	→	13.30	13.00	13.00	13.00			
19:30	20.00	19.30	19.30	19.30	19.30			
4:00	→	4.00	04:00	5.00	5.00	5.00		
10:00	→	10.00	10.00	10.00	10.00	10.00		
16:00	→	16.00	16.00	16.00	16.00			
22:00	22.00	28:00	22:00	02:00				
8:00		NPO 10.00	8.00	9.0				
					Dose change			
16:00		(A)	16.00	16.00				
10:00		NPO 11.00	10.00	10.00				
					Dose change			
17:00		17.00	17.00	17.00				

REGULAR PRESCRIPTIONS

To be filled in by Doctors only ↓

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

DRUG NAME
TAB. REPLEX FORTE

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

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No: 112236
Start Date & Time: 29/12/23 AT
Stop Date & Time:
Additional Info:

DRUG NAME
TAB. CLOPIDOGREL + ASPIRIN

Dose	Route	Frequency
75/75mg	P/O	0-1-0

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No: 112236
Start Date & Time: 29/12/23 AT 14.00
Stop Date & Time:
Additional Info:

DRUG NAME
TAB. ATORVASTATIN

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

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No: 112236
Start Date & Time: 29/12/23 AT 21.00
Stop Date & Time: 29/12/23 AT 8 [illegible]
Additional Info:

DRUG NAME
TAB. PARACETAMOL

Dose	Route	Frequency
650mg	P/O	1-1-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No: 112236
Start Date & Time: 29/12/23 AT 14.00
Stop Date & Time:
Additional Info:

DRUG NAME
SYP. CREMAFFIN PLUS

Dose	Route	Frequency
15mL	P/O	0-0-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEY[illegible] Reg. No: [illegible]
Start Date & Time: 29/12/23 AT 21.0
Stop Date & Time:
Additional Info:

Area In-charge Nurse Signature:

Nursing administration record

Drug	Time ↓ / Date →	29/12	30/12/23	31/12	1/1	2/1/24
Tab. Replex Forte	8:00	NPO 10.00	8.00	9.00	9.00	9.05
Tab. Clopidogrel + Aspirin	14:00	14.00	14.00	14.00	14.00	14.00
Tab. Atorvastatin	21:00			Stop		
Tab. Paracetamol	8:00	→	8.00	9.00	9.00	9.10
	14:00		14.00	14.00	14.00	14.30
	20:00	20.00	20.00	[illegible]	20.30	
Syp. Cremaffin Plus	21:00	21.00	21.00	21.00	[illegible]	

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date → / Time ↓ — To be filled by Nursing Staff only. Sign and time given

Clinical Pharmacist
Medway Heart Institute

DRUG NAME: T. ROSUVASTATIN

Dose	Route	Frequency
40mg	PO	0-0-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No:112236

Start Date & Time: 29/12/23 21.00

Stop Date & Time:

Additional Info:

Time	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
21.00	21:00	21:00	21.00	21:00	

Clinical Pharmacist
Medway Heart Institute

DRUG NAME: T. METOPROLOL (BETALOC)

Dose	Route	Frequency
25mg	PO	1-0-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No:112236

Start Date & Time: 29/12/23 21.00.

Stop Date & Time:

Additional Info:

Time	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
9.00	→	9.00	9.00	9.00	9.10
21.00	21:00	21:00	21.30	21:00	

Clinical Pharmacist
Medway Heart Institute

DRUG NAME: BUDESONIDE

Dose	Route	Frequency
0.5mg	INH	1-1-1-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No:112236

Start Date & Time: 29/12/23. at 9.00.

Stop Date & Time:

Additional Info:

Time	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
5.00	→	05:00	6:00	5:00	5:30
11.00	9.00	11.15	11.00	11:00	stop
17.00	17.00	17.00	17.00	17:00	
23.00	23:00	22:00	22:00	23:00	

Clinical Pharmacist
Medway Heart Institute

DRUG NAME: SALT CAPSULES

Dose	Route	Frequency
1 Cap	P/O	1-1-1

Dr. Sign & Reg. No. / Seal: Dr. PRAVEEN JEYAKUMAR Reg. No:112236

Start Date & Time: 30/12/23 at

Stop Date & Time:

Additional Info:

Time	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
8.00	→	8.15	9.00	9.00	
14.00	→	14.00	14.00	14.00	stop
20.00	→	20.00	20.00	20:00	

Clinical Pharmacist
Medway Heart Institute

DRUG NAME: SYP. ALEX PLUS

Dose	Route	Frequency
10ml	PO	1-0-1

Dr. Sign & Reg. No. / Seal: 112236

Start Date & Time: 31/12/23 9.00

Stop Date & Time:

Additional Info:

Time	29/12/23	30/12/23	31/12/23	1/1/24	2/1/24
8.00	→	→	→	9.15	9.10
20.00	→	→	21.00	20:00	

Area In-charge Nurse Signature: 2003 | 2003 | 024 | 024 | 024

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

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

Prescription	Time ↓	31/12	1/1/2	2/1/24.
DRUG NAME T. RAZOD Dose: 1 tab · Route: PO · Frequency: 1-0-1 Dr. Sign & Reg. No. / Seal: 112236 Start Date & Time: 31/12/23 9.00 Stop Date & Time: Additional Info:	7.00	→	7.00	7.00
	19.00	19.30	19.00	
DRUG NAME T. ANXIT Dose: 0.5mg · Route: PO · Frequency: 0-0-1 Dr. Sign & Reg. No. / Seal: Start Date & Time: 1/1/24 @ 8.00 Stop Date & Time: Additional Info:	21.00	→	21.00	
DRUG NAME T. FRUSEMIDE Dose: 40mg · Route: PO · Frequency: 1-0-0 Dr. Sign & Reg. No. / Seal: 112236 Start Date & Time: 1/1/24 9.00 Stop Date & Time: Additional Info:	8.00	→	9.00	9.00
DRUG NAME T. SPIRONOLACTONE Dose: 25mg · Route: PO · Frequency: 1-0-0 Dr. Sign & Reg. No. / Seal: 112236 Start Date & Time: 1/1/24 9.00 Stop Date & Time: Additional Info:	10.00	→	10.00	10.00
DRUG NAME T. LIVOGEN Dose: 1 tab · Route: PO · Frequency: 0-1-0 Dr. Sign & Reg. No. / Seal: 112236 Start Date & Time: 1/1/24 9.00 Stop Date & Time: Additional Info:	14.00	→	14.00	
Area In-charge Nurse Signature:				

Clinical Pharmacist Medway Heart Institute

ANTIMICROBIALS

To be filled in by Doctors only

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

Time ↓ 29/12/23

DRUG NAME

Inj. CEFUROXIME SODIUM

Dose	Route	Frequency
1.5gm	IV	Q12th hrly

Dr. Sign & Reg. No. / Seal
Dr. PRAVEEN JEYAKUMAR
Reg. No: 112236

Start Date & Time: 28/12/23 at 18:20

Stop Date & Time: 29/12/23 at 18.20.

Additional Info:

Time	29/12/23
5:20	5:20
17:20	17.20

Stop

Clinical Pharmacist
Medway Heart Institute

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge Nurse Signature:

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
28-12	19:00	KABILYTE	500ml	100ml/hr	IV	—	—	—	[illegible]	112236	19:00	21:30	[illegible]
28/12/23	21:30	KABILYTE	500 ml	100ml/hr	IV	—	—	—	[illegible]	112236	21:30	2:30	[illegible]
29/12/23	2:30	KABILYTE	500 ml	100ml/hr	IV	—	—	—	[illegible]	112236	2:30	7:30	[illegible]
29/12/23	23:00	KABILYTE	500 mL	100mL/HR	IV	—	—	—	[illegible]	12236	23:00	04:30	new [illegible]

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
28-12-23	18.30	0.9% NS	40ml	2ml/hr	IV	Inj. HUMAN ACTRAPID	40IU	–	[illegible]	112236	18.30	3.30	[illegible]
28-12-23	18.30	0.9% NS	25ml	4ml/hr	IV	Inj. NITROGLYCERIN	2.5mg	–	[illegible]	112236	18.30	5.30	[illegible]
28-12-23	18.45	0.9% NS	50ml	21ml/hr	IV	Inj. POTASSIUM CHLORIDE	40mg	–	[illegible]	112236	18.45	20.45	[illegible]
29/12/23	6.30	NS 0.9%	50ml	25ml/hr	IM	Inj POTASSIUM CHLORIDE	20meq	–	[illegible]	112231	6.30	8.30	[illegible]

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

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
29.12.23	19:00	NPO	[illegible]	112236	2/1/24	8:00	Normal diet	K.Bo	134559
29/12/23	9.00	LIQUID DIET	[illegible]	112236					
29/12/23	20:00	SOFT DIET	[illegible]	112236					
30/12/23	8:00	soft diet	K.Bo	134559					
31/12/23	8:00	soft diet	K.Bo	134559					
1/1/24	8:00	Normal diet	K.Bo	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning				1/1/24	Morning	Pavithra	0072	[illegible]
28.12.23	Evening	Suryakala. S.P	0232	[illegible]	1/1/24	Evening	M. Devika	016	[illegible]
28/12/23	Night	Sathiya Vani. M	0265	[illegible]	1/1/24	Night	A. Nandhini	0170	[illegible]
29/12/23	Morning	D. RANEEVA	0171.		2/1/24	Morning	[illegible]	0240	[illegible]
29.12.23	Evening	RAVEENA / SURYAKALA	0232/0171	[illegible]	2/1/23	Evening	Parameswari	2333	[illegible]
29/12/23	Night	SUGANYA. G / MEENA	0223/0274	[illegible]		Night			
30/12/23	Morning	D. RANEEVA	0171	[illegible]		Morning			
30/12/23	Evening	M. Devika	016	[illegible]		Evening			
30/12/23	Night	RN Bharathi	0271	[illegible]		Night			
31/12/23	Morning	M. Devika	016	[illegible]		Morning			
	Evening					Evening			
31/12/23	Night	RN Bharathi	0271	[illegible]		Night			

① P CAB × 4 GRAFTS
LIMA → LAD
SVG — PDA
— PLB (sequential)
— OM

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Medway Heart Institute
Every heart beat counts

Mr.VENKATACHALAM P
63/Male/MHI202381271
Name 27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ
UHID No.

MHI/ICU/2022/076

Blood Group	Height	Weight	BSA	Age	Sex	Sheet No.
O+VE	168cm	61kg	1.66m²			1 / A

SURGICAL PROCEDURE: DATE OF SURGERY: 28/12/23 POST-OP DAY: POD 3

DATE	TIME	VENTILATORS PARAMETERS										BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
28/12/23	18.30	VCV	14		21.0	5.0	9.0	7.1	500	495	60%		7.48A	30.1	266.A	19.7	99.6	-4.5
29/12	3:30	SIMV	12.0	20.0	22.0	5.0	10.1	8.1	500	496	50%							

CRITICAL CARE FLOWCHART

PATIENT RECIEVED AT 18.30

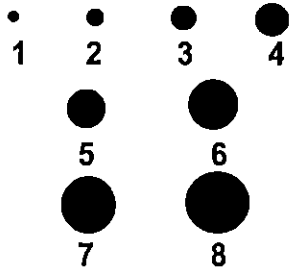
NEURO

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

VERBAL
Oriented-5
Confused/Disoriented-4
Inappropriate words-3
Sounds-2
No response-1

MOTOR
Obey commands-6
Localise pain-5
Non-localising-4
Abn.Flexion-3
Abn.Extension-2
No response/flacid-1

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

PUPILS SCALE (mm)


PUPILS REACTION
Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL
Br-Brisk
Sl-Sluggish
O-Absent

EDEMA
D-Dependent
G-Generalised
O-Absent

HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS
JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER
Valve Replaced / Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING
Ab-Abdominal
TA-Thoraco-abdomial
L-Laboured

SUCTION
ET-Endotracheal
N-Nasal
Or-Oral

BREATH SOUNDS
CL-Clear
Ro-Ronchi
Wh-Wheezes
CR-Crackles
BECL-Bilat equal & clear

SECRETIONS
COLOUR
CL-Clear
Y-Yellow
W-White
Pk-Pink

CHARACTER
M-Moderate
Sc-Scanty
Th-Thin
Tk-Thick
Cs-Copious
R-Red

GASTROINTESTINAL

BOWEL SOUNDS
+Present
O-Absent

NGT POSITION
Air injected
+Heard in Abd
O-Absent
GA-Gastric contents aspirated
Dr-Dependent Drainage

ABDOMINAL TONE
So-Soft
F-Firm
Tn-Tender
Ob-Obese
D-Distented

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

LIVERSIZE
N-Normal
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OpCABG x 4 GRAFTS
LIMA → LAD
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OM

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MHI/ICU/2022/076

Name	Mr.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615		Sheet No. 2
UHID No.	Dr.ANBARASU MOHANRAJ	Age / Sex	
Blood Group	O+VE	Weight 61kg / BSA 1.66m²	A

SURGICAL PROCEDURE:

DATE OF SURGERY: 28/12/23

POST-OP DAY: 1

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
29/12/23	4:30	SIMV	10.0	16.0	21.0	5.0	7.0	7.4	500	495	50%							
	5:30	SIMV	8.0	12.0	21.0	5.0	8.0	7.1	500	501	50%							
	5:50	PC SIMV		10.0		5.0					50%		7.43	32.7	221.0	22.8	99.5	-2.6

CRITICAL CARE FLOWCHART

NEURO

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

VERBAL
Oriented-5
Confused/Disoriented-4
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MOTOR ARMS/LEGS
S-Strong
Wk-Weak
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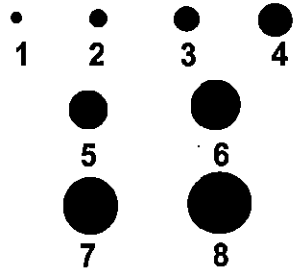
PUPILS SCALE (mm)


PUPILS REACTION
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CARDIOVASCULAR

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D-Dependent
G-Generalised
O-Absent

HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS
JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER
Valve Replaced / Shunt
+Present
O-Absent

PULMONARY

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Ab-Abdominal
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SUCTION
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MHI/ICU/2022/076

Name	Mr.VENKATACHALAM P		Sheet No.
UHID No.	63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ	Age / Sex	3
Blood Group	O+VE / 168CM	Weight: 61kg / BSA: 1.66m²	A

SURGICAL PROCEDURE: DATE OF SURGERY: 28/12/23 POST-OP DAY: 1

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO_2		pH	PCO_2	PO_2	HCO_2	SAT%	BE
29/12/23	7.30	PS		10.0		5.0					50%							
	8.45		PATIENT		HAD		EXTUBATED											
	9.00		ON		NASAL		PRONGS				2litres	9.52	7.406	40.8	128.6	25.1	98.6	0.4
	16.30			ON	Room		Air											

CRITICAL CARE FLOWCHART

NEURO

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

VERBAL
Oriented-5
Confused/Disoriented-4
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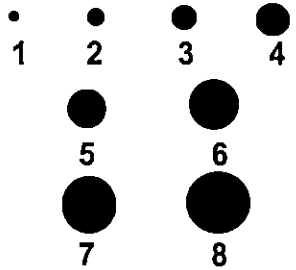
PUPILS SCALE (mm)


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GASTRIC RESIDUAL
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LIVERSIZE
N-Normal
E-Enlarged

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Sheet No.	Name			
1	UHID No.		Age	Sex
B	Blood Group O+VE	Height 168cm	Weight 81kg	BSA 1.66m²

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MHI/ICU/2022/076

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CRITICAL CARE FLOWCHART

DATE	TIME	BIOCHEMISTRY						VITAL PARAMETERS								CARDIAC ASSIST DEVICE			
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	TIME	IABP RATIO	IABP DURATION	PACEMAKER SETTING RATE	PACEMAKER SETTING MODE
28/12	18.35	10.4	132	3.20	1.0A / 18A		18.30		cl	100%	VC 1A		93°F						
							19.30		cl	100%	VCV 14								
							20.30		cl	100%	VCV 14		92°F						
							21.30		cl	100%	VCV 14								
	23.00				221		22.30		cl	100%	VCV 14		95.1°F						
							23.30		cl	100%	VCV 14								
							00.30		cl	100%	VCV 14								
							1.30		cl	100%	VCV 14		96°F						
	2.00				166		2.30		cl	100%	VCV 14								
							3.30		cl	100%	VCV 14								

PATIENT FULLY AWAKE : 20:10

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME			18:30	20:00	00:00	
	EYES			1	2	4	
	VERBAL			ET	ET	ET	
	MOTOR			CP	CP	6	
	ARMS R/L			CP	CP	St	
	LEGS R/L			CP	CP	St	
PUPILS	R.SIZE/REACTIION			CP	3/Bs	3/Bs	
	L.SIZE/REACTION			CP	3/Bs	3/Bs	
CARDIO-VASCULAR	HEART SOUNDS			S1S2	S1S2	S1S2	
	VALVE CLICK			–			
	CAPILLARY REFILL			Br	Bs	Bs	
	EDEMA			0	0	0	
	NECK VEINS			N	N	N	
PULMONARY	WORK OF BREATHING			TP	TP	TP	
	SUCTION			–	ET/O/N	ET/O/N	
	SECREATIONS			–	mild	mild	
GASTRO INTESTINAL	BOWEL SOUNDS			+	+	+	
	ABDOMINAL TONE			S	Soft	Soft	
	N/G POSITION			INSITU	Insitu	Insitu	
	GASTRIC RESIDUAL			–	cl	cl	
	LIVER			N	N	N	

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE			cl	cl	cl	
	PD - FUNCTION			–			
	DRAINAGE			–			
	PD - SITE			–			
SKN	COLOUR			–			
	Sx WOUND-CHEST			cl	cl	cl	
	LEG			cl	cl	cl	
	DRESSING			DI	DI	DI	
	PRESSURE SORE-SITE			Nil	Nil	Nil	
	AREA			–			
	DRESSING CONDITION			–			
MISCELL	POSITION CHANGE			Q4H	Q2H	Q2H	
	CHEST-PHYSIO			[illegible]	Neb Suction	Neb Suction	
	ACTIVITY			CP	CP	RE	
				ABD CVP	ABP CP	ABP CP	
	S/N NAME			[illegible]	Satya	Satya	
	TIME			18:30	20:00	00:00	
	SIGNATURE			[signature]	[signature]	[signature]	

MHI/ICU/2022/076

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Sheet No.	Name			
2	UHID No		Age	Sex
B	Blood Group O+VE	Height 168cm	Weight 61kg	BSA 1.66m²

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Every heart beat counts

CRITICAL CARE FLOWCHART

DATE	TIME	BIOCHEMISTRY						VITAL PARAMETERS								CARDIAC ASSIST DEVICE			
																IABP		PACEMAKER SETTING	
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	TIME	RATIO	DURATION	RATE	MODE
29/12/23							4:30		cl	100%	16/mt								
	5:00				144		5:30		cl	100%	14/mt		99°F						
	6:16	9.8	139	3.51	0.97		6:30		cl	100%	20/mt								

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME						24:00
	EYES						4
	VERBAL						ET
	MOTOR						6
	ARMS R/L						St
	LEGS R/L						St
PUPILS	R.SIZE/REACTIION						3/Brr
	L.SIZE/REACTION						3/Brr
CARDIO-VASCULAR	HEART SOUNDS						S1S2
	VALVE CLICK						
	CAPILLARY REFILL						Brr
	EDEMA						0
	NECK VEINS						N
PULMONARY	WORK OF BREATHING						FA
	SUCTION						Et/d/N
	SECREATIONS						mild
GASTRO INTESTINAL	BOWEL SOUNDS						+
	ABDOMINAL TONE						Soft
	N/G POSITION						Insitu
	GASTRIC RESIDUAL						Cl
	LIVER						N

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE						Cl
	PD - FUNCTION						
	DRAINAGE						
	PD - SITE						
SKN	COLOUR						
	Sx WOUND-CHEST						Cl
	LEG						Cl
	DRESSING						OT
	PRESSURE SORE-SITE						Nil
	AREA						
	DRESSING CONDITION						
MISCELL	POSITION CHANGE						Q2H
	CHEST-PHYSIO						Neb Suct
	ACTIVITY						PE
							ASP CAP
	S/N NAME						Sathya
	TIME						24:00
	SIGNATURE						

MHI/ICU/2022/076

Sheet No.	Name	Age	Sex
3	Mr.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ UHID No		
B	Blood Group: B+ VE	Height: 168CM	Weight: 61kg / BSA: 1.66m²

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DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE			
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	$ETCO_2$	BREATH SOUNDS	Sao_2	RR/MT	N,BP	TEMP°F	Abd^{cm}G	IABP RATIO	IABP DURATION	PACEMAKER SETTING RATE	PACEMAKER SETTING MODE
29/12/23							7.30		CL	100%	PS 18/mt		97F					
							8.30		CL	100%	PS 20/mt							
	9.52	10.4	135	4.59	0.97		9.30		CL	100%	18/mt							
							10.30		CL	100%	20/mt		97F					
							11.30		CL	100%	22/mt							
							12.30		CL	100%	18/mt							
							1.30		CL	100%	16/mt		97.8°F					
							4.30		CL	100%	18/mt							
							5.30		CL	100%	20/mt	PS/CVP 10 mm						
							6.30		CL	98%	22/mt	120/70 by m.	97F					

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME	8:00	12:00	16:00			
	EYES	4	4	4			
	VERBAL	VET	5	5			
	MOTOR	6	6	6			
	ARMS R/L	ST	ST	ST			
	LEGS R/L	ST	ST	ST			
PUPILS	R.SIZE/REACTIION	3/BR	3/BR	3/BR			
	L.SIZE/REACTION	3/BR	3/BR	3/BR			
CARDIO-VASCULAR	HEART SOUNDS	S_1S_2	S_1S_2	S_1S_2			
	VALVE CLICK	—	—	—			
	CAPILLARY REFILL	BR	BR	BR			
	EDEMA	0	0	0			
	NECK VEINS	N	N	N			
PULMONARY	WORK OF BREATHING	TA	TA	TA			
	SUCTION	✓	—	—			
	SECREATIONS	✓	—	—			
GASTRO INTESTINAL	BOWEL SOUNDS	+	+	+			
	ABDOMINAL TONE	Sft	Sft	Sft			
	N/G POSITION	INSITU	—	—			
	GASTRIC RESIDUAL	—	—	—			
	LIVER	N	N	N			

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE	cl	cl	cl			
	PD - FUNCTION	—	—	—			
	DRAINAGE	—	—	—			
	PD - SITE	—	—	—			
SKN	COLOUR	—	—	—			
	Sx WOUND-CHEST	cl	cl	cl			
	LEG	cl	cl	cl			
	DRESSING	OT	OT	OT			
	PRESSURE SORE-SITE	—	—	—			
	AREA	—	—	—			
	DRESSING CONDITION	cl	cl	cl			
MISCELL	POSITION CHANGE	Q2H	Q2H	Q2H			
	CHEST-PHYSIO	NEB ET/O/N	NEB SHE	NEB SI			
	ACTIVITY	PE	PE	PE			
		ABP CVP	NIBP	NIBP			
	S/N NAME	Danny	Danny	Danny			
	TIME	8:00	12:00	16:00			
	SIGNATURE	Danny	Danny	Danny			

OT URINE OUTPUT 500ml

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Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

MHI/ICU/2022/076

Name			Sheet No.
UHID No.	Age	Sex	1
Blood Group O+VE	Height 168cm	Weight 61kg	BSA 1.66m² C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	D/I	NORAD 4/50	NTG 25/5	ACTRA 40/40	
28/12/23	18.30																0.1	1.0	0.0	KCL 20/50
	19.30	170	170			60		60	60			5.0	5.0	235	KABI 100	HTE 100	—	4.0	2.0	25.0
	20.30	100	270			40		40	100				5.0	375	100+100	300		2.0	2.0	25.0
	21.30	80	350			50		50	150				5.0	505	100+100	500		1.0	2.0	
	22.30	60	410			10		10	160				5.0	575	100	600		—	—	
	23.30	80	490						160				5.0	655	100+100	800			4.0	
29/12/23	00.30	120	610			30		30	190				5.0	805	100	900			4.0	
	1.30	80	690						190				5.0	885	100	1000			4.0	
	2.30	70	760			10		10	200				5.0	965	100	1100			4.0	
	3.30	100	860			20		20	220				5.0	1085	100	1200			4.0	

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

ACT: 164 Qtee at 18.50

GENITOURINARY (GU)

PD

URINE

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

SITE

C-Clean
R-Redness
BD-Block discoloration

DRAINAGE

CL-Clear
BS-Blood

MISCELLANEOUS

OISITION CHANGE

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

V-Vibrator
CP-Chest percussion
DC-Deep breath & cough
N-Nebulizer

TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

SKIN

COLOUR

Pk-Pink
F-Flushed
P-Pale
Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

DRESSING

B-Betadine
Al-Antibiotic
Irrigation

PRESSURE SORE

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

R-Redness
BD-Black discoloration
BL-Blister
SP-Skin Peeling
D-Deep

DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air
R-Redness at site
Sw-Swelling at site
Dr-Draining
D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

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MHI/ICU/2022/076

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Name			Sheet No.
UHID No.	Age	Sex	2
Blood Group O+VE	Height 168cm	Weight 61kg	BSA 1.66m²

C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	TOT				
29/12/23	4:30	100	960			10		10	230				5.0	1190	100	1300				
	5:30	90	1050			50		50	280			5.0	10.0	1340	100	1400				
	6:30	70	1120			10		10	290				10.0	1420	100	1500				

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)

PD

URINE

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BS-Blood

MISCELLANEOUS

OISITION CHANGE

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

V-Vibrator
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TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
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SKIN

COLOUR

Pk-Pink
F-Flushed
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Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

DRESSING

B-Betadine
Al-Antibiotic
Irrigation

PRESSURE SORE

SITE

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

R-Redness
BD-Black discoloration
BL-Blister
SP-Skin Peeling
D-Deep

DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air
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MHI/ICU/2022/076

Name	Mr.VENKATACHALAM P 63/Male/MHI202381271 27/12/2023/IPH2023002615 Dr.ANBARASU MOHANRAJ		Sheet No. 3
UHID No		Age / Sex	
Blood Group O+VE	168cm	Weight 61kg	BSA 1.66m² C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME INFUSIONS					
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	NOR	KCL 20/50			
29/12/23	7.30	75	75			10		10	10					85	KABUITE 100	100	25.0			
	8.30	75	150						10					160	100	200	25.0			
	9.30	100	250			30		30	40			1.0	1.0	290	100	300	-			
	10.30	90	340			20		20	60				1.0	400		300				
	11.30	90	430						60				1.0	490		300				
	12.30	80	510			40		40	100				1.0	580		300				
	13.30	150	660			10		10	110				1.0	740		300				
	14.30	150	810			20		20	130				1.0	890		300				
	15.30	150	960			10		10	140				1.0	1050		300				
	16.30	150	1110			R			140				1.0	1200		300				

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME	
29/12/23	11.30	– LEFT RADIAL ARTERIAL LINE REMOVED O/B DR. ANBARAI.
	16.30	– LEFT PLEURAL + MEDIASTINAL REMOVED O/B DR. ANBARA.

CRITICAL CARE FLOWCHART

GENITOURINARY (GU)

PD

URINE

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B-Blocked

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Name			Sheet No.
UHID No.	Age	Sex	1
Blood Group	Weight	BSA	D
O+VE	168CM 61kg	1.66M²	

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MHI/ICU/2022/076

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FLUID ASSESSMENT (contd.) **HAEMODYNAMICS** **Blood Group:** O+VE

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
						URINE		AMT.	TOTAL														
28/12	18:30					2.0						73	SINUS	0.07	153/86	94	11		COOL	FF			
	19:30					2.0	8.0			108	+129	64	SINUS	0.07	125/54	74	4		COOL	++			
	20:30					2.0	6.0			314	-61	94	SINUS	0.05	151/85	95	8		COOL	++			
	21:30					2.0	55.0			569	+64	66	SINUS	0.03	104/40	61	3		WARM	++			
	22:30					2.0	2.0			671	+96	77	SINUS	0.02	99/36	53	3		WARM	++			
	23:30					2.0	6.0			873	+218	80	SINUS	0.01	98/46	53	4		WARM	++			
29/12/23	00.30					2.0	6.0			975	+190	94	SINUS	0.02	94/38	58	4		WARM	++			
	1:30					2.0	6.0			1077	+192	100	SINUS	000	128/47	72	3		WARM	++			
	2:30					2.0	6.0			1183	+218	99	SINUS	0.01	136/50	78	4		WARM	++			
	3:20					2.0	6.0			1289	+204	101	SINUS	0.06	144/63	93	3		WARM	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

18-45 Inj. SODIUM BICARBONATE 50ml IV stat given c/o DR. PRAVEEN
18-50 Inj. PROTAMINE 25mg IV STAT
~~18-55~~ Inj. ECOSPRIN
20:50 Inj. FENTANYL 50mics IV STAT GIVEN c/o DR. SYLVESTER
23:40 T. ECOSPIRIN 75mg RT STAT GIVEN c/o DR. PRAVEEN

PREVIOUS DAY ..... HRS

DRAINAGE:
URINE :

TOTAL INTAKE:
TOTAL OUTPUT:
TOTAL BALANCE:

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE			
B.P.			

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
ET TUBE	at 21cm 8.5	28/12/23	1			P	P
IJV	RT IJV	28/12/23	1			P	P
ART.LINE	LT RAD	28/12/23	1			P	P
PERI.LINE	RT	28/12/23	1			P	P
MEDIASTINAL						P	P
PLEURAL	RT	28/12/23	1			P	P
IR DOME		28/12/23	1			P	P
IVCATH		28/12/23	1			P	P
O2 TUBING		28/12/23	1			P	P
S.TUBING		28/12/23	1			P	P
V.TUBING		28/12/23	1			P	P
U.CATH		28/12/23	1			P	P
MAMMET		28/12/23	1			P	P

Mr.VENKATACHALAM P
63/Male/MHI202381271
Name 27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ
UHID No.

			Age	Sex	Sheet No.
Blood Group	O+VE	Height 168CM	Weight 61kg	BSA 1.66m²	D

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MHI/ICU/2022/076

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

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
						MISC		AMT.	TOTAL														
29/12/23	4:30					2.0	2.0			1391	+201	104	SINUS	0.02	140/52	83	4		warm	+++			
	5:30					2.0	2.0			1493	+153	108	SINUS	0.01	149/51	84	4		warm	++			
	6:30					2.0	2.0			1595	+175	106	SINUS	0.02	158/55	89	4		warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

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

DRAINAGE: **TOTAL INTAKE:**

URINE : **TOTAL OUTPUT:**

TOTAL BALANCE:

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			✓
EYE CARE			✓
BACK CARE			✓
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			✓
TUBINGS			
HUMIDIFIER H2O			✓
ELECTRODES			✓
ALARMS VERIFIED			
VENT - HUMIDIFIER			✓
-SETTINGS			✓
HRT.RATE			105/mt
B.P.			114/52(81)

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
E-T TUBE		28/12/23	2				P
IJV	Rt	28/12/23	2				P
ART. LINE	Lt	28/12/23	2				P
PCRL. LINE.	Rt	28/12/23	2				P
MEDIASTENAL		28/12/23	2				P
PLEURAL		28/12/23	2				P
IR DRAIN		28/12/23	2				P
IV CATH		28/12/23	2				P
O2 TUBING		28/12/23	2				P
S. TUBING		28/12/23	2				P
V. TUBING		28/12/23	2				P
U. CATH		28/12/23	2				P

Mr.VENKATACHALAM P
63/Male/MHI202351271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

Name				Sheet No.	
UHID No.		Age	Sex		9
Blood Group	O+VE	Height 168cm	Weight 61kg	BSA 1.66m²	D

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MHI/ICU/2022/076

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FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: O+VE

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
						HISR		AMT.	TOTAL														
29/12/23	7.30					2.0	27.0			127	+42.	107	SINU	0.01	168/63	74	3		warm	++			
	8.30					2.0	2.0			254	+84	103	SINU	0.01	101/62	80	4		warm	++			
	9.30					2.0	2.0	Syp		356	+66	104	SINU	0.01	153/57	87	4		warm	++			
	10.30					2.0	2.0	50	50	408	+8	87	SINU	0.01	129/64	88	8		warm	++			
	11.30					2.0	2.0	100	150	510	+20	82	SINU	0.01	116/67	76	10		warm	++			
	12.30					2.0	2.0	200	350	712	+132	78	SINU	0.01	128/71	84	9		warm	++			
	13.30					2-0	2-0	200	550	914	+174	82	SINUS	0.01	125/60	80	12		WARM	++			
	14.30					2.0	2.0	200	750	1116	+226	78	SINU	0.01	129/61	88	10		warm	++			
	15.30					2.0	2.0		750	1118	+68	86	SINU	0.01	R	R	R		warm	++			
	16.30						-	100	850	1018	+18	90	SINUS	0.01					warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

PREVIOUS DAY .....12..... HRS

DRAINAGE: 290 ml TOTAL INTAKE: 1595 ml

URINE : 1120 ml TOTAL OUTPUT: 1420 ml

TOTAL BALANCE: (+) 175 ml

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE	✓	✓	
EYE CARE	✓		
BACK CARE	✓	✓	
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE	84/mt	110/mt	
B.P.	160/mm	160/67-1 mm	

DATE	TIME	REMARKS / PLAN

INFUSION PUMPS							
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
IVV	RT IJV	28/12/23	2		P	P	
ART. LINE	LT RAD	28/12/23	2		P	P	
ART. LINE	RT FEM	28/12/23	2		P	P	
MEDIASTINAL		28/12/23	2		P	P	
PLEURAL	LT	28/12/23	2		P	P	
IR DOME		28/12/23	2		P	P	
IV EXTN		28/12/23	2		P	P	
O, TUBING		28/12/23	2		P	P	

MHI/ICU/2022/064

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

NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Medway Heart Institute
Every heart beat counts

Mr.VENKATACHALAM P
63/Male/MHI202381271
27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

RMEDIATE CARE FLOWCHART

A

NAME :   **UHID NO :**   **AGE :**   **SEX :**

SURGICAL PROCEDURE : OPCAB x 4 GRAFTS
LIMA→LAD
SVG→PDA
PLB ISEM
OM

POSTOP DAY : POD-IV   **FLUID REQUIREMENT :** 2.4 litres /day.

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
30/12/23 7.30												70	70	70	+ 70
8.30	150	150					150					150	220	220	+ 70
9.30	100	250										100	320	320	+ 70

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS

MHI/ICU/2022/064

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27/12/2023/IPH2023002615
Dr.ANBARASU MOHANRAJ

:RMEDIATE CARE FLOWCHART

A

NAME : **UHID NO :** **AGE :** **SEX :**

SURGICAL PROCEDURE : OPCAB x 4 GRAFTS
LIMA → LAD
SVG ← PDA PLB OM (SEQ)

POSTOP DAY : POD-I

FLUID REQUIREMENT : 2.4 Litres / day.

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS LABILATE			H.T.	ORAL/ R.T. H.T.	G.T.	TOTAL INTEKE	TOTAL BALANCE
29/12/23 4 17:30	120	1230				140	1320					100	952	1318	-2.
18.3.	100	1330				140	1420					200	1152	1518	+98
19:30	200	1530				140.	1620					100	1252	1618	-2
20:30	120	1650				140	1740					50	1252	1668	-72
21:30	150	1800				140	1890						1252	1668	222
22:30	100	1900				140	1990					100	1352	1768	-222
22:30	150	2050.				140	2140	100.			100	100.	1452	1968	-172
00:30	100	2150.				140	2240	100			200	100	1552	2168	-72
01:30	150	2300				140	2390	100			300	50	1602	2318	-72
02:30	150	2450				140	2540	100			400	50	1652	2468	-72
03:30	100	2550				140	2640	100			500	50	1702	2618	-22
04:30	R.	2550				140	2640	100.			600.	50	1752	2768	+128
05:30		2550				140	2640	100			700	50	1802	2918	+278
06:30		2550				140	2640.				700	.	1802	2918	+278

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS

MHI/ICU/2022/064

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:RMEDIATE CARE FLOWCHART

B

NAME : **UHID NO :** **AGE :** **SEX :**

BLOOD GROUP : O POSITIVE

HEIGHT : 168cm **WEIGHT :** 61Kgs **B.S.A :** 1.66m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
97°F	106	SINU	0:01	124/74	86	Warm	++	20	CL	98%.	ON Room air
98°F	96	SINU	0.02	127/78	86	Warm	++	20	CL	96%.	ON ROOM AIR
97.5°F	86	SINUS	0.02	132/76	87	WARM	++	22	CL	94%	ON ROOM AIR

PREVIOUS DAY - 24 HOURS

DRAINAGE 140 mL.
URINE 2550 mL

TOTAL INTAKE 2918 mL
TOTAL OUTPUT 2640 mL.
BALANCE +278 mL.

MHI/ICU/2022/064

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Dr.ANBARASU MOHANRAJ

:RMEDIATE CARE FLOWCHART

B

NAME :

UHID NO :

AGE :

SEX :

BLOOD GROUP : O POSITIVE

HEIGHT : 168cm

WEIGHT : 61kgs

B.S.A : 1.66m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
97F	88	SINU	-0.01	127/74	92	Warm	++	22	CL	98%	ON Room Air
	96	SINU	-0.02	134/84	96	Warm	++	20	CL	99%	
	99	Sinus	-0.01	114/60	78	Warm	++	20	CL	99%	on Room Air.
	98	Sinus	-0.01	110/64	78	Warm	++	20	CL	98%	
	99	Sinus	-0.01	106/64	74	Warm	++	20	CL	99%	
	96	Sinus	-0.00	104/64	74	Warm	++	18	CL	98%	Room Air.
	96	Sinus	-0.01	103/62	74	Warm	++	20	CL	98%	
	94	Sinus	-0.02	110/64	78	Warm	++	20	CL	99%	
	95	Sinus	-0.01	126/70	76	Warm	++	18	CL	99%	
	95	Sinus	-0.01	126/74	78	Warm	++	18	CL	98%	Room Air.
	96	Sinus	-0.01	128/76	76	Warm	++	18	CL	99%	
	95	Sinus	-0.00	126/74	74	Warm	++	16	CL	98%	
	95	Sinus	-0.01	126/78	76	Warm	++	18	CL	99%	Room Air.
	96	Sinus	-0.02	130/77	76	Warm	++	18	CL	99%	

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE