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 Name:	Mr.ANANTHA KRISHNAN.P.N
UHID:	79/Male/MHI202381290
DOB:	
DOA:	15/12/2023/IPH202302516
Consultant:	Dr.K.JAISHANKAR

1HI/IPD/2022/002

Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

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

Advised Date & Time: 15/12/23 @ 12.19pm

Provisional Diagnosis:
Severe Aortic Stenosis / ? UTI / CCF.

Reason for Admission: [x] Medical Management [ ] Surgical Management
[ ] Others (please specify details) ______

Admission Type: [ ] Day Care [ ] ER [ ] Ward
[x] ICU ______ (Specify details)

Surgery / Procedure Name (if planned):
Medical management.

Blood Product Requirement: [x] No [ ] Yes *(Kindly specify details of components required in space below)*

Expected Duration of Stay: 3-4 days.

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

Payer: [ ] Self [x] Insurance [ ] Others: ______

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

Any other Instructions (if any):

Doctor's Signature	Name	Reg. No.	Date	Time
[signature]	Dr. Jaishankar	44448	15/12/23	12.20

For admission desk staff only:

Room Category:

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

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
18/12/23	12.21	15/12/23	12:15 PM

Source:

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

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

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

Front office Staff Signature	Name	Emp. No.	Date	Time
[signature]	Soundarya	2209	15/12/23	12:15

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Patient Details
Name: Mr.ANANTHA KRISHNAN.P.N
UHID: 79/Male/MHI202381290
DOB: 15/12/2023/IPH202302516
DOA:
Consultant: Dr.K.JAISHANKAR

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	AS, SHANTHINIKETAN, NEW 93, OLD 42, BAZULLAH ROAD, T.NAGAR, CHENNAI- 600017	9884684892
Occupation: —		

Referred from	Date & Time of Admission	Date & Time of Discharge	Total No. of Days
Dr. Jaishankar	15/12/23 @ 12:15 pm	23/12/23	9 Days.

UNIT: cardiology

MLC ☐ Yes ☑ No If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
HEPATOMEGALY ASCITES ? CHRONIC	
LIVER DISEASE, SEVERE CALCIFIC AORTIC	
STENOSIS, ACUTE KIDNEY INJURY - RECOVERED	—
THROMBOCYTOPENIA, NORMAL LV FUNCTION	
TYPE II DIABETES MELLITUS, SYSTEMIC	
HYPERTENSION, BENIGN PROSTATIC HYPERPLASIA.	

DATE	OPERATION / PROCEDURES	ICPM Code
—	—	

DATE	TYPE OF ANESTHESIA
—	☑ GENERAL ☐ SPINAL ☐ LOCAL ☐ REGIONAL ☐ EPIDURAL

DISCHARGE STATUS

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

[signature] Signature of the Consultant

S. Alamdas 2538 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 P.N. ANANTHAKRISHNAN who is my SON .... (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 15/12/2023

A. Narayanan

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

A.NARAYANAN

உறவுமுறை

Nature of Relationship SON

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Patient Details (Affix Label here)
Name: Mr.ANANTHA KRISHNAN.P.N
UHID: 79/Male/MHI202381290
DOB: 15/12/2023/IPH202302516
DOA:
Consultant: Dr.K.JAISHANKAR

MHI/IP/2022/008

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GENERAL CONSENT FOR ADMISSION

I, Mr. Anantha Krishnan. P.N the ☐ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

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

- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.

- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

- I also consent to receive communication on treatment related information via text messages and e-mail as per the details provided at the time of registration.

- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	[signature]	P.N. ANANTHAKRISHNAN	15/12/23	12:15 PM
Surrogate/Guardian (if applicable #)	FOR PATIENT A NARAYANAN (SON)	A NARAYANAN (SON) (Write name and relationship with patient)	15/12/23	12:15 PM
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	[signature]	A NARAYANAN (SON)	15/12/23	12:15 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.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/114

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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	

	Signature	Name	Reg. No.	Date	Time
Doctor	[signature]	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	15/12/22	12:30

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	

	Signature	Name	Reg. No.	Date	Time
Doctor	[signature]	Dr. Anila	982	18/12/22	11:0

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MRD

DISCHARGE SUMMARY

IP No.	IPH202302516	**D.O.A**	: 15/12/2023
UHID	MHI202381290	**D.O.D**	: 23/12/2023
Name	Mr. ANANTHA KRISHNAN.P.N	**Room No.**	: 110.
Age / Gender	79Years / MALE		
Consultant	: **Dr.JAISHANKAR.K** MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology		

AGNOSIS:

:PATOMEGALY ASCITES - ? CHRONIC LIVER DISEASE
SEVERE CALCIFIC AORTIC STENOSIS
ACUTE KIDNEY INJURY - RECOVERED
THROMBOCYTOPENIA
NORMAL LV FUNCTION
TYPE II DIABETES MELLITUS
SYSTEMIC HYPERTENSION
BENIGN PROSTATIC HYPERPLASIA

BRIEF HISTORY:

Mr. Anantha Krishnan. P.N, 79 years / Male, Presented with complaints of shortness of breath on and off for 2 days.h/o bilateral lower limb swelling and mild abdominal pain ,h/o loss of appetite and generalized tiredness. He came to Medway heart institute ER on 15.12.2023 and he was advised to admit for evaluation and further management.

No H/O Syncope or presyncope.
Known case of Type II diabetic mellitus, systemic hypertension on medication.

N/K/C/O Hypothyroidism, CVA, BA, seizure disorder.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

HR	-	104pm
BP	-	140/80mmHg
SPO_2	-	94%
CVS	-	S1S2 (+) A2 elevated

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RS - B/L AE B/L Basal crepts
Abdomen - distension+, Liver & spleen palpable +
CNS - NFND

INVESTIGATIONS:

BLOOD(14.12.2023): Hb- 11.6gm/dl, TWC- 4690cells/cumm, PLT – 100000 cells/cumm, Urea – 28 mg/dl, Creatinine – 1.78 mg/dl, Na+ – 130Meq/l, K+ - 4.09meq/l, SGOT – 88U/L, SGPT – 35U/L.

BLOOD(15.12.2023): TWC- 75,000cells/cumm, Urea – 33 mg/dl, Creatinine – 1.63 mg/dl, NT pro BNP – 102, PT – 15.4secs, INR – 1.2 secs.

BLOOD(16.12.2023): Hb- 10.7gm/dl, TWC- 4700cells/cumm, PLT – 80000cells/cumm, Urea – 31 mg/dl, Creatinine – 1.61mg/dl, Na+ – 130Meq/l, K+ - 3.71meq/l, SGOT – 66U/L, SGPT – 34U/L. Alpha feto protein – 2.26IU/mL. ammonia – 60, albumin(ascitic fluid) – 1.8g/dL, proteins (ascitic fluid) – 4.5

BLOOD(17.12.2023): PLT - 85,000cells/cumm, TWC– 13950cells/cumm, Albumin – 3.5g/dL

BLOOD(18.12.2023): Hb- 10.4gm/dl, PLT – 90000 cells/cumm, Urea – 56 mg/dl, Creatinine – 2.07mg/dl, Na+ – 135Meq/l, K+ - 3.62meq/l, SGOT – 74U/L, SGPT – 27U/L.

BLOOD(20.12.2023): Hb- 11.9gm/dl, PLT – 151000 cells/cumm, TWBC – 7450 cells/cumm, Urea – 87 mg/dl, Creatinine – 1.83mg/dl, Na+ – 136Meq/l, K+ - 3.69meq/l.

BLOOD(21.12.2023): Hb- 12.8gm/dl, TWBC – 7180 cells/cumm, Urea – 84 mg/dl, Creatinine – 1.59 mg/dl, Na+ – 137Meq/l, K+ - 3.67meq/l, aPTT – 79.7 secs, INR – 1.5 secs.

BLOOD(21.12.2023): Hb- 12.1gm/dl, Urea – 88 mg/dl, Creatinine – 1.45 mg/dl, Na+ – 134Meq/l, K+ - 3.64meq/l.

ECG: HR – 65bpm, long QT interval

CXR(14.12.2023): Mild cardiomegaly. Bilateral mildly increased bronchovascular markings.

SCREENING ECHO (14.12.2023): Thickened and calcified aortic valve. Severe AS. Max gradient – 70mmHg, mean gradient – 41mmHg. AV Vmax – 4.1m/sec. No AR. Trivial MR. Trivial TR. Mild PAH. Concentric LVH. No RWMA. Normal LV systolic function. EF – 60%. Normal RV systolic function. No clot / vegetation / effusion.

USG abdomen(14.12.2023): Liver parenchymal disease. Splenomegaly. Prostatomegaly. Moderate ascites. Minimal right pleural effusion.

Peripheral smear(15.12.2023) – Thrombocytopenia

Urine culture & sensitivity(15.12.2023): Few pus cells and no bacteria seen. no growth in culture.

Stool-occult blood(19.12.2023)- Negative

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COURSE IN THE HOSPITAL:

Mr. Anantha Krishnan.P.N, 79 years / Male, admitted with above mentioned complaints in CCU. Baseline investigations were done which showed increased total counts and Creatinine level. Peripheral smear sample sent which revealed thrombocytopenia. USG abdomen showed splenomegaly, prostatomegaly, minimal bilateral pleural effusion, moderate ascites, liver parenchymal disease. Echo showed normal LV function. Due to abdominal pain & splenomegaly Dr. Karthik (medical gastroenterologist) opinion was obtained & he adviced for ODG scopy. Ascitic tapping was done & sample sent for ascitic fluid analysis. Patient improved symptomatically & shifted to ward on 18.12.2023 with CBD insitu (+). Due to complaints of black coloured stools, stools occult blood sample sent which showed negative. Patient voided freely & CBD removal. Due to breathlessness, drowsy, disorentation to place & time patient shifted to ICU on 20.12.2023. ABG done. Due to severe bilateral crepts, nebulisation started. Then patient symptomatically improved. Patient was treated with IV fluids, IV diuretics , IV antibioties, analgesics, anti-pyretics, beta blockers & other supportive measures. He symptomatically improved with above line of treatment. His medications were optimized and discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile
General condition Stable

GCS	-	15/15			
Temp	-	98.6°F	BP	-	100/84mmHg
PR	-	82/min	SPO2	-	96% in room air

ADVICE MEDICATIONS

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	**TAB. ALDACTONE** (SPIRONOLACTONE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
2.	**TAB. DYTOR** (TORASEMIDE)	10 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3.	**TAB. INDERAL** (PROPRANOLOL)	20 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	**TAB. SILODAL**	8 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	**TAB. UDILIV** (URSODEOXYCHOLIC ACID)	30 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE

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6.	TAB. NUSAM	200 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. NAC	600 MG	1	0	1	ORAL	AFTER FOOD	X 3 DAYS
8.	TAB. UDILIV (URSODEOXYCHOLIC ACID)	30 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
9.	SYP. LACTIHEP	15 ML	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10.	TAB. RCIFAX (RIFAXIMIN)	550 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11.	TAB. PROSTAGARD	8 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
12.	INHALER.LEVOLIN	0.63 MG	1	1	1	P/N	TO CONTINUE	
13.	INHALER.FORACORT	0.5MG	1	0	1	P/N	TO CONTINUE	
14.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE

DIABETIC MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
15.	TAB. TENEGLIP M	20/50 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT , SALT & DIABETIC DIET.
PHYSICAL ACTIVITIES	AS TOLERATED
REVIEW	REVIEW WITH **DR. JAISHANKAR.K AFTER 2 WEEKS WITH BLOOD SUGARS, CBC, RFT, LFT REPORTS.**

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

"I understood the Content of the discharge summary."

CONSULTANT SIGNATURE

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

Typed by: Ezhilarasi.

Dr. K. JAISHANKAR
Reg. No: 49448

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NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/IP/2022/107

Medway Heart Institute
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INPATIENT INITIAL ASSESSMENT

Date: 15/12/23. **Time of arrival in ward:** 12.15.

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others —

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 104 (beats/min) | BP: 140/80 (mmHg)
Respiration: 30 (breaths/min) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 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

Fatigue and shortness of breath on exertion x 1/12 [illegible]
increased over the last week
came for MHC – detected breathlessness – so shifted here
for further Mx.
Newly diagnosed aortic stenosis. (severe)

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

Others: BPH

Past 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	GLIMER 2		PO	1-0-0	[illegible]	☑ Yes ☐ No
2	TONICEA M		PO	0-0-1	[illegible]	☑ Yes ☐ No
3	PROSITRAMD	4mg	PO	0-0-1	"	☑ Yes ☐ No
4	URMAAX	0.4mg	PO	0-0-1	"	☑ Yes ☐ No
5	VIT-D CAPSULE		PO		"	☑ 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)*:

N/A

General Physical Examination:

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

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

MILD ASCITES

MILD PEDAL EDEMA

SYSTEMIC EXAMINATION

CVS:

S1S2

Respiratory System:

Occ wheeze / BS minimal

Gastrointestinal System:

~~Soft~~ Distended

Central Nervous System:

NFND

Urinary / Reproductive / Locomotor System:

NAD

Skin / Opthalmic / ENT

NAD

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:

Severe aortic stenosis / ? CAD

DM / HTN / BPH

Plan of Care:

Stabilize

Plan for TAVI if willing

Insulin ~~CBS~~ as per CBS

Investigations Advised:

NTPROBNP / PCT

PLEASE CORRECT CXR.

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	[signature]	~~Dr. Anish Nelson~~ Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	15/12/23	12.25
Consultant	[signature]	DR. JAISHANKAR	45448	15/12/23	12.26
Patient Attendant	[signature]	Relationship SON	—	15/12/22	12.25

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/036

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CONSENT FORM FOR CRITICAL CARE (ICU)

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

☑ Read

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

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

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

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

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

Intended benefits:

Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

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

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

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	A. Narayanan (signature)	A. NARAYANAN (SON) *(Write name and relationship with patient)*	15/12/23.	12.30
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	P.B. Subbalakshmi (signature)	P.B. Subbalakshmi (Wife)	15/12/23	12.30
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Doctor	(signature)	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	15/12/23	12.30.

MHI/ICU/2022/036

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

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உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

☐ வாசித்திருக்கிறேன்

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

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

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

மைய சிரையில் கதீட்டர் உட்செருகல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அனுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

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

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

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

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

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

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/HOSP/2022/205

Medway Heart Institute
Every heart beat counts

PROCEDURAL CONSENT FORM

I acknowledge that :

The treating doctor has explained my medical condition and the proposed procedure(s) ____________

(name of procedure(s) Ascitic Tapping.

I understand the risks / complications of the procedure, including the risks / complications that arre specific to me, which are as follows ____________

- ✓ The doctor has explained the benefits, probable outcomes and reasons for the procedure.
- ✓ The doctor has explained other alternative treatment options and their associated risks. The doctor has also explained my prognosis and the risks of not having the procedure performed.
- ✓ I was able to ask questions and raise concerns with the doctor about my condition, the procedure, the associated risks, and my treatment options. My questions and concerns have been considered and answered to the fullest of my satisfaction.
- ✓ The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly, and I hereby consent for the same.
- ✓ I have informed the Doctor of all my previous illness, drug reactions, surgical procedure and all other facts relevant to my treatment. I shall not hold the hospital or the Doctor responsible for the consequence, which may arise from the non-disclosure of the same.

KINDLY FILL EITHER:

Consent of Patient, OR

Consent of patient representative / surrogate

CONSENT OF PATIENT

On the basis of above statements,

I hereby authorize Dr. KARTHIK RAJ and those that he/she may designate as associates or assistants to perform upon me the stated diagnostic / therapeutic procedure.

	Signature	Name	Date	Time
Patient				
Witness / Interpreter	[signature]	A. NARAYANAN (Son)	16/12/23.	16.50
Doctor	[signature]	Dr. Karthik	16/12/23	16.50

ANAESTHESIA / SEDATION requirement

☐ Required ☐ Not Required

I give consent and agree to the administration of anaesthesia / sedation by Dr. ______________________

______________________ *for the performance of this procedure. I am aware of the risks of the* sedation and also consent supplementation with any other mode of anaesthesia if necessary.

	Signature	Name	Date	Time
Patient				
Witness / Interpreter				
Doctor				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because ______________________ and I, ______________________ (name / relationship to the patient), therefore consent for the patient. I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor / doctor's designee and hereby *consent to this procedure.*

	Signature	Name	Date	Time
Patient				
Witness / Interpreter				
Doctor				

The patient is unable to consent because ______________________ ______________________ and I, (name / relationship to the patient), therefore consent for the patient. I acknowledge that I have had an opportunity to discuss anaesthesia / sedation, with the doctor / doctor's designee and hereby consent to anaesthesia / sedation

	Signature	Name	Date	Time
Patient				
Witness / Interpreter				
Doctor				

MHI/HOSP/2022/205

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மருத்துவ செயல்முறைக்கான ஒப்புதல் படிவம்

கீழ்க்கண்டவாறு நான் உறுதிமொழி அளிக்கிறேன்:
சிகிச்சையளிக்கும் மருத்துவர் எனது மருத்துவ நிலை குறித்தும் மற்றும் செய்ய திட்டமிடப்பட்டிருக்கும் மருத்துவ செயல்முறைகள் குறித்தும்

____ (மருத்துவ செயல்முறைகளின் பெயர்) குறித்தும் விளக்கிக் கூறியிருக்கிறார். கீழே குறிப்பிடப்பட்டுள்ளவாறு எனக்கு குறிப்பாக, பொருந்துகின்ற இடர்கள் / சிக்கல்கள் உட்பட, இந்த மருத்துவ செயல்முறையில் எழக்கூடிய இடர்கள் / சிக்கல்களை நான் புரிந்து கொண்டுள்ளேன்.

- ✓ இந்த மருத்துவ செயல்முறையின் பலன்கள், சாத்தியமுள்ள விளைவுகள் மற்றும் இதை செய்வதற்கான காரணங்களை மருத்துவர் விளக்கிக் கூறியிருக்கிறார்.
- ✓ பிற மாற்று சிகிச்சை விருப்பத்தேர்வுகள் மற்றும் அவைகளோடு தொடர்புடைய இடர்கள் பற்றியும் மருத்துவர் விளக்கியிருக்கிறார். இந்த மருத்துவ செயல்முறையை மேற்கொள்ளாவிட்டால் ஏற்படக்கூடிய இடர்கள் குறித்தும் மற்றும் எனது நோய் நிலைமை பற்றியும் மருத்துவர் என்னிடம் விளக்கிக் கூறியிருக்கிறார்.
- ✓ எனது நோய் நிலை, சிகிச்சைமுறை மற்றும் அதன் இடர்கள் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்து மருத்துவரிடம் என்னால் கேள்விகள் கேட்கவும் மற்றும் கவலைகளை தெரிவிக்கவும் முடிந்தது. எனது கேள்விகள் மற்றும் கவலைகள் மருத்துவரால் பரிசீலிக்கப்பட்டன மற்றும் எனக்கு முழு திருப்தியளிக்குமாறு அவைகளுக்கு பதிலளிக்கப்பட்டது.
- ✓ மருத்துவ செயல்முறையின்போது உயிருக்கு அச்சுறுத்தலான உடனடி நிகழ்வுகள் ஏதும் நிகழுமானால், அவைகளுக்கு அதற்கேற்றாற்போல சிகிச்சையளிக்கப்படும் என்று மருத்துவர் என்னிடம் விளங்கிக் கூறியிருக்கிறார் மற்றும் இதன் வழியாக அவ்வாறு செய்வதற்கு நான் சம்மதிக்கிறேன்.
- ✓ என்னுடைய முந்தைய உடல்நலமின்மை, மருந்து எதிர்வினைகள், அறுவைசிகிச்சை நடைமுறை மற்றும் என்னுடைய சிகிச்சைக்கு தொடர்பான அனைத்து பிற உண்மைகளையும் நான் மருத்துவரிடம் தெரிவித்துள்ளேன். இவற்றை நான் வெளிப்படுத்தாமலிருந்தால் அதனால் ஏற்படக்கூடிய விளைவுகளுக்கு மருத்துவமனையையும் மற்றும் மருத்துவரையும் நான் பொறுப்பாக்க மாட்டேன்.

தயவுசெய்து இவற்றுள் ஒன்றை நிரப்பவும்:
நோயாளியின் ஒப்புதல் அல்லது
நோயாளியின் பிரதிநிதி / பதிலாளின் ஒப்புதல்

நோயாளியின் ஒப்புதல்
மேற்கண்ட அறிக்கைகள் / தகவல்களின் அடிப்படையில்

இங்கு குறிப்பிடப்பட்டுள்ள நோயறிதலுக்கான / சிகிச்சைக்கான மருத்துவ செயல்முறையை எனக்கு செய்ய டாக்டர். ______________________ மற்றும் அவர் / அவள் பணி ஒதுக்கீடு செய்யக்கூடிய இணை மருத்துவர்கள் அல்லது உதவியாளர்களுக்கு நான் இதன் வழியாக அங்கீகாரம் அளிக்கிறேன்.

	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி				
சாட்சி / மொழிபெயர்ப்பாளர்				
மருத்துவர்				

மயக்கமருந்து / உணர்விழப்பிற்கான தேவைப்பாடு

☐ தேவைப்படுகிறது ☐ தேவைப்படாது

இந்த மருத்துவ செயல்முறை மேற்கொள்ளப்படுவதற்கு டாக்டர். ______________________________ அவர்களால் எனக்கு மயக்க மருந்து / உணர்விழப்பு மருந்து தரப்படுவதற்கு நான் சம்மதிக்கிறேன் மற்றும் ஒப்புதலை வழங்குகிறேன். மயக்க மருந்து / உணர்விழப்பு மருந்தின் இடர்கள் பற்றி நான் அறிந்திருக்கிறேன். அவசியமானால், மயக்க மருந்திற்கான ஏதும் வேறுபிற வழிமுறைகளின் மூலம் ஆதரவு வழங்கப்படுவதற்கும் நான் சம்மதிக்கிறேன்.

	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி				
சாட்சி / மொழிபெயர்ப்பாளர்				
மருத்துவர்				

<u>நோயாளி பிரதிநிதியின் / பதிலாளின் ஒப்புதல்</u>

.... என்ற காரணத்தால் நோயாளியால் ஒப்புதலை வழங்க இயலவில்லை. எனவே, ... (பெயர் / நோயாளிக்கு உறவுமுறை) என்ற நான், நோயாளிக்காக ஒப்புதலை வழங்குகிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறை குறித்து மருத்துவருடன் / மருத்துவரால் நியமனம் செய்யப்பட்ட நபரோடு கலந்து பேசுவதற்கு எனக்கு வாய்ப்பு இருந்தது என்று நான் ஒப்புக்கொள்கிறேன் மற்றும் இதன் வழியாக இம்மருத்துவ செயல்முறைக்கு ஒப்புதலை வழங்குகிறேன்.

	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி				
சாட்சி / மொழிபெயர்ப்பாளர்				
மருத்துவர்				

.... என்ற காரணத்தால் நோயாளியால் ஒப்புதலை வழங்க இயலவில்லை. எனவே, ... (பெயர் / நோயாளிக்கு உறவுமுறை) என்ற நான், நோயாளிக்காக ஒப்புதலை வழங்குகிறேன். மேலே குறிப்பிடப்பட்டுள்ள மயக்க மருந்து / உணர்விழப்பு மருந்து வழங்குவது பற்றி மருத்துவருடன் / மருத்துவரால் நியமனம் செய்யப்பட்ட நபரோடு கலந்து பேசுவதற்கு எனக்கு வாய்ப்பு இருந்தது என்று நான் ஒப்புக்கொள்கிறேன் மற்றும் இதன் வழியாக மயக்க மருந்து / உணர்விழப்பு மருந்து தரப்படுவதற்கு ஒப்புதலை வழங்குகிறேன்.

	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி				
சாட்சி / மொழிபெயர்ப்பாளர்				
மருத்துவர்				

MHI/IP/2022/102

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

INFORMED CONSENT FOR PHYSICAL RESTRAINT

I, MR. NARAYANAN. 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 English, which I fully understand and understood the information provided about procedure

Physical Restraint

Indications for Restraint : ______

Types of Restraint : ☑ Extremity (Ankle or Wrist) ☐ Boxer ☐ Elbow restraint ☐ others : ______

BRIEF OFTHE PROCEDURE

"Physical restraints " means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that the individual cannot remove easily which restricts freedom of moment or normal access to one's body

Intended Benefits : 1, Prevention of injury to self 2, Prevention of injury to others 3, others (if any specify): ______

Potential Risks & Complications :

1, Increase incidence of falls 2, skin breakdown 3, Loss of muscle tone 4, Loss of Balance 5, Loss of decline independent mobility or ability to ambulance increased afitation or delirium 6, Loss of independence, dignity and self-respect 7, Depression, anxiety, aggression, panic 8, Reduced social contact 9, Others (if any specify) : ______

Potential Alternatives

The patient may require chemical restraint,kindly discuss with your doctor

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.

For the above mentioned procedure(s) that I been made aware of, I give my consent voluntarily for carrying out the said procedure my above named patient being fully aware of the nature, potential risks and complication, intended benefits and possible altenatives,

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	[signature]			
Surrogate/Guardian (if applicable #)	[signature]	A NARAYANAN (SON) *(Write name and relationship with patient)*	17/12/23	13.40
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	P.B. Subbu [signature]	P. B. Subbalakshmi (wife)	17/12/23.	13.40.
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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Patient Details *(Affix Label here)*
Name:
UHID:
DOB: Sex:

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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					

	PHYSICAL RESTRAINT			VITAL SIGNS						
Date & Time	In right position	CRT <3 Sec yes/No	Skin intact	Temp (f)	Pulses (rate/ min)	Resp (rate/ min)	BP (mm/ Hg)	SpO2	Releasing of restraint 2nd hourly	Sign
17/12/23/14:00			-	98 F	74	28	141/66	94	2nd hour	[signature]
15:00				98.F	76	20	138/59	96	2nd hourl	[signature]
16.00				97.8	68	26	130/56	96%.	2nd hour	[signature]
17.00				97.8	70	27	128/59	97%.	2nd hourly	[signature]
18.00				97.8	71	26	124/57	97	2nd hourl	[signature]
19.00				97.6	72	24	155/65	97	2nd hour	[signature]
20:00.				98°F	82	20	135/56	98	2nd hourly	[signature]
21:00				98°.	78	28	142/60	99	2nd hourly	[signature]
22:00				98°F	80	29	139/58	100%.	2nd hourly	[signature]
23:00				98°F	82	28	140/59	99%.	2nd hourly	[signature]
00:00				98°F	72	26	138/60	100%	2nd hourly	[signature]

Note : vital signs for ICU patients will be monitored in the ICU flow chart

Complications: ☐ yes ☐ No (If yes, specify the symptoms)

	Impaired Skin integrity		Cyanosis		Pallor
	Cold and clammy skin		Tingling sensation		Numbness
	Injury or fall due to restraint		Increased confusion / Agitation / Disorientation		
	Others				

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

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உடல் சார்ந்த தடுப்புக்காப்புகளுக்கு தகவலறிந்து வழங்கும் ஒப்புதல்

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

☐ வாசித்திருக்கிறேன்
☐ எனது / எனது நோயாளியின் தற்போதைய மருத்துவ நிலைமை பற்றி எனக்கு / எங்களுக்கு விளக்கிக் கூறப்பட்டிருக்கிறது.
☐ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் செய்யப்படவுள்ள மருத்துவ செயல்முறை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

உடல்சார்ந்த தடுப்புக்காப்பு

தடுப்புக்காப்புக்கான நோய் சுட்டிக்காட்டல்கள்: ______________________

தடுப்புக்காப்பின் வகைகள்: ☐ கால் கை முனைகள் (கணுக்கால் அல்லது மணிக்கட்டு) ☐ பாக்ஸர் ☐ முழங்கை தடுப்புக்காப்பு ☐ பிற : ______________

செயல்முறையின் விளக்கம்
“உடல் சார்ந்த தடுப்புக்காப்புகள்” என்பது, நகர்விற்கான சுதந்திரத்தை அல்லது ஒருவரது உடலிற்கான இயல்பான அணுகுவசதியை கட்டுப்படுத்துகின்ற மற்றும் ஒரு நபரால் எளிதாக அகற்ற இயலாதவாறு நோயாளியின் உடலோடு அல்லது உடலுக்கு அருகே இணைக்கப்படும் எந்தவொரு கைத்திறன் சார்ந்த வழிமுறை அல்லது பொருள் சார்ந்த அல்லது பொறியியல் சார்ந்த கருவி, பொருள் அல்லது சாதனத்தைக் குறிக்கும்.

உத்தேசிக்கப்படும் பலன்கள்: 1, சுயகாயம் ஏற்படாமல் தடுப்பது 2, பிறருக்கு காயம் ஏற்படாமல் தடுப்பது 3, மற்றவை (ஏதும் இருக்குமானால் குறிப்பிடுக):

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:
1, கீழே விழும் நிகழ்வுகளை அதிகரிக்கும் 2, சருமத்தில் சிராய்ப்பு / கிழிசல் 3, தசையின் வலுயிழப்பு 4, சமநிலைத்திறன் இழப்பு 5, தனியாக நகரும் அல்லது நடமாடும் திறன் குறைதல் & அதிகரிக்கும் பிதற்றல் 6, சுதந்திரம், கண்ணியம் மற்றும் சுயமரியாதை இழப்பு 7, மனச்சோர்வு, சஞ்சலம், தாக்கும் உணர்வு, பீதி 8, குறைந்திருக்கும் சமூகத்தொடர்பு 9, மற்றவை (ஏதும் இருக்குமானால், குறிப்பிடுக): ______________________

சாத்தியமுள்ள மாற்று வழிமுறைகள்
வேதிப்பொருள் சார்ந்த தடுப்புக்காப்பு தேவைப்படலாம்; உங்களது மருத்துவரோடு இது பற்றி தயவுசெய்து கலந்து பேசவும்.
இந்த ஒத்திசைவு படிவத்தில் கொடுக்கப்பட்டுள்ள தகவலை நான் கிடைக்கப்பெற்றேன் & முற்றிலும் புரிந்துகொண்டேன் என்றும், எனது நோய் பாதிப்பு, செய்யப்படுகின்ற அறுவைசிகிச்சை / மருத்துவ செயல்முறை, அதன் இடர்வாய்ப்புகள், பின்விளைவுகள், மாற்று வழிமுறைகள், சாத்தியமுள்ள சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் பலன்கள் மற்றும் மீண்டு குணமடைதல் தொடர்பான கேள்விகள் கேட்பதற்கு எனக்கு ஒரு வாய்ப்பு கொடுக்கப்பட்டது என்றும் மற்றும் நான் முழு திருப்தியடையும் வகையில் என்னுடைய அனைத்து கேள்விகளுக்கும் பதிலளிக்கப்பட்டது என்றும் மற்றும் என்னுடைய மனதில் தவறான அபிப்பிராயங்கள் அல்லது பொய்யான நம்பிக்கைகள் இல்லை என்றும் நான் உறுதிமொழி கூறுகிறேன். மேலும் இந்த படிவத்தில் நான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளும் எனது முன்னிலையிலேயே பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமொழி கூறுகிறேன்.

நான் அறியுமாறு விளக்கப்பட்ட, மேலே குறிப்பிடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான நான், இந்த மருத்துவ செயல்முறையை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்கள் மற்றும் சிக்கல்கள், உத்தேசிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முழுமையாக அறிந்திருக்கிறேன்.

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

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

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

MHI/IP/2022/102

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

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கீழே கையொப்பமிட்டுள்ள மருத்துவராகிய நான், திட்டமிடப்பட்டுள்ள அறுவைசிகிச்சை / மருத்துவ செயல்முறையின் தன்மை, சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், உத்தேசிக்கப்படும் பலன்கள், செயல்முறைக்குப் பிறகு எதிர்பார்க்கப்படும் போக்கு மற்றும் செயல்முறைக்கு சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் விளக்கியுள்ளேன். மேலும் இந்த ஆவணத்தில் விவரிக்கப்பட்டுள்ள தகவலை அவர் / அவள் முழுமையாக புரிந்துகொண்டுள்ளார் என்று நான் உறுதியாக நம்புகிறேன்.

	கையொப்பம்			பெயர்			பதிவு எண்.		தேதி	நேரம்
ஒப்புதலை பெற்ற நபர்										
	உடல் சார்ந்த தடுப்புக்காப்பு			இன்றியமையாத அறிகுறிகள்						
தேதி & நேரம்	வலது பக்கத்தில்	CRT <3 Sec ஆம் / இல்லை	சருமம் சிதையா நிலை	வெப்ப நிலை (f)	நாடித் துடிப்பு (விகிதம் / நிமிடம்)	சுவாசம் (விகிதம்/ நிமிடம்)	இரத்த அழுத்தம் (mm/ Hg)	SpO 2	தடுப்புக்காப்ப ிலிருந்து விடுவிப்பது 2வது மணி நேரத்தில்	கையொப்ப ம்

குறிப்பு: ஐசியு நோயாளிகளுக்கு இன்றியமையா அம்ச அறிகுறிகள், ஐசியு ∴புளோசார்ட்டில் கண்காணிக்கப்படும்
சிக்கல்கள்: □ ஆம் □ இல்லை (ஆம் எனில், அறிகுறிகளை குறிப்பிடுக)

	பாதிப்படைந்த சரும முழுமை நிலை		நீலம்பூரித்தல்		தோல் வெளுப்பு
	குளிர்ச்சியான மற்றும் பசை போன்ற சருமம்		சிலிப்பு உணர்வு		உணர்வின்மை/மரத்துப்போதல்
	தடுப்புக்காப்பினால் காயம் அல்லது கீழே விழுதல்		அதிகரித்திருக்கும் குழப்பம் / பதற்றம் / சூழல் உணர்வின்மை		
	மற்றவைகள்				

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/040

Medway Heart Institute
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Date : 15/12/23
Time : 12.30
Doctor's Name : Dr. Anisha.

ICU PROGRESS NOTES

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

ICU Day **Background** Severe AS BPH / ? Acued DM / HTN ? UTI / ? Viral Pneumonitis	**Issues last 24 hours** Normal UO - 60%.
Central nervous system Conscious / oriented / sedated with Sedation score GCS - E V M Pupils Pain score Drains	**Cardiovascular system** HR - 80 Rhythm - Cardiac Output - BP - 140/70 CVP - Cardiac Medications:
Respiratory system Oxygen supplementation – 1L 97%. Saturation / PaO2- Min crepts Ventilator : Spontaneous / Controlled Occ wheezing Last C x R - Drains -	**GIT** P/A Distended Bowels – Y / N Loose stools / Melena Drains NG tube : Y / N Day NGA- USG CT
Nutrition & Fluids Oral feeds / NG feeds TPN – formula used Supplements Calories / Proteins achieved : IV fluids - 24 hour Urine output Fluid balance Creatinine clearance Acidosis Lactate RRT – SLED / IHD / CRRT	**Microbiology** Invasive lines 1. 2. Foley's Yes / No ET Tube / Tracheostomy tube - Y / N Day Culture reports Antimicrobials with days 1. Magnex 2. Azee 3. Tamiflu
Labs Hb 11.6 TC 4690 Platelets 1L Urea 28 Creatinine 1.24 Na 130 K ALB - 3.2 Bilirubin AST ALT INR Others ESR - 80 / Procalcitonin - 4.6	DVT prophylaxis – Y/N Drugs : Mechanical – TEDS / SCD Stress Ulcer Prophylaxis – Y/N Drugs Pressure sore Y / N Alpha bed Y / N

Plan for the day

- NEBS / ABx !
- Follow up of / URINE / CREAT / PLTS / [illegible]
- Monitor [illegible]
- Continue - drug [illegible]
- UROLOGIST OPINION - SOS FOR BPH
- [illegible] I/O

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	08/12/23	12-30

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

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MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
	S/3 Dr Jaishankar Team
16/12/23	
14.00	
	problems Hepatosplenomegaly c Ascites
	Severe AS / Ⓝ WIR.
	ok
	CVTS — To do
	BMR read to carotids — peripheral smear
	— MGE (Dr. Aravind) opinion.
	(Inj lanx 40mg - Not given) — Anti HCV, HbsAg.
	— Ascitic Tapping by MGE.
	— PT INR
	— Inj lasix 20mg IV
	— CXR
	— Fluid 1L/day

Signature

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHJ202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

40 / NRS

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
15/12/23	URINE CULTURE - NO GROWTH

MHI/ICU/2022/040

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

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ICU PROGRESS NOTES

Date: 15/12/2023
Time: 3:40 PM
Doctor's Name: Dr. Velmurugan P.

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

ICU Day – 1
Background
- C/o Severe Aortic stenosis / CCF / ?Liver cirrhosis / DM / HTN
- Liver parenchymal disease

Issues last 24 hours
- H/o SOB x 1 day
- Thrombocytopenia
- Elevated ESR / ↑ pus cells in urine
- Altered LFT / Borderline RFT / Low Nat

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E4 V5 M6 Pupils – 2mm BR
Pain score – Drains –

Cardiovascular system
HR - 81/min Rhythm - NSR Cardiac Output -
BP - 120/70mmHg CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – Nil
Saturation / PaO2- — 99% RA
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

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

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

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

Antimicrobials with days
1. Inj. Meropenem
2. Tab. Azee
3. Tab. Tamiflu
Day 1

Labs
Hb 11.6 TC 4690 Platelets 1L
Urea 28 Creatinine 1.78
Na 130 K 4.09
Bilirubin 0.44 AST 88 ALT 35
INR
Others ESR - 80 / U. pus cells - 4-6

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

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

Plan for the day

- I/O charting
- Medical gastro opinion
- Diagnostic Tapping SOS
- Continue Rani infusion
- R Send HCV / HBeAg / PT / INR / CXR
- Rpt CBC / LFT / RFT @ 5am tomorrow
- Arrange for Ascitic tapping
- Fluid restriction 1.5 ltr / days.
- Attender updated.

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. ...	95418	15/12/25	4 PM

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/IP/2022/041

DOCTOR'S PROGRESS NOTES

DATE	NOTES
16/12/23 @8.00	S/B: Dr Jaishankar + team.
	pt feeling better.
	No SOB.
	No Chest pain.
	No dizziness/syncope.
	CVS: S1S2 (+), ESM (+), EDM (+)
	BP: 120/60 RS: B/L NVBS B/L Basal crepts Re
	PR: 74/min (x) MGE-opinion
Hb: 10.7 g/dl	SpO2: 96%
Plat: 80,000	RR: 24/min
TC: 4,700	
	Inj Dytor 20 mg IV bd
	CBC RFT on Monday
	49648

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/HOSP/2022/115
Medway Heart Institute
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CONSULTATION REFERRAL FORM

Referred to: Dr-karthik
Speciality: Gastro Entrology

Primary Diagnosis: CLD, ? CKD Ascities

Referral: ☑ Urgent (within 3 hrs.) ☐ Routine (within 24 hrs.)

Reason for Referral :
Abdomen distension. Breathlessness

	Signature	Name	Reg.No.	Date	Time
Doctor	[signature]	Dr Karthik .N	160038	15/12/23	4:30 pm

Seen On: Date: 16/12/23. Time: 16:36.

CLINICAL NOTES:
S/B Dr Karthik

thank you sir.

CLD +/- P.HTN / ? CKD ?? AKI/HRS.
Clinically Ascites + Encephalopathy
T/O R/O SBP

Sugg

- TAB RCIFAX 550 mg 1—0—1
A/F

- SYP HACTIHEP 20ml

0—0—1

Aff.

Target 3 B/o (day)

= Duphalac Enema (SOS)

= I/V MONOCEF 1g. 1—0—1

Ascitic tap

L protein

L Albumin

L TC

L DC

- I/V ALBUMIN 20%

100ml

~ 6-8 hrs

x 3 days

Sugg

- S-AFP

- anti HCV Ab.

Plan scopy for variceal screening once stable

160035

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NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/040

Medway Heart Institute
Every heart beat counts

Date : 16/12/23
Time : 8-00
Doctor's Name : Dr. Karthik

ICU PROGRESS NOTES

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

ICU Day Background
Severe Aortic Stenosis.
~~CLD~~.
? Congestive Liver failure
T2DM | AKI - ? AOCKD
HTN. | ? Hepatorenal.

Issues last 24 hours
– Thrombocytopenia
–

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M 15/15 Pupils
Pain score Drains

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

Respiratory system
Oxygen supplementation – BAB (+).
Saturation / PaO2- Spo2: 95%
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

GIT
P/A Distension (+).
Bowels (Y)/N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds Oral feeds.
TPN – formula used
Supplements
Calories / Proteins achieved I/O 684 / 2500
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

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

Antimicrobials with days
1. AZEE
2. Tamiflu.
3.

Labs
Hb TC Platelets
Urea Creatinine
Na K
Bilirubin AST ALT
INR
Others INR: 1.2 (15/12).

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

Stress Ulcer Prophylaxis (Y)/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

Cont.

- Stool for occult blood.
- APTT
- Ascites tapping
  - Ascitic fluid analysis.
- Cont. lasix infusion
- oral feeds - soft solid diet / Diabetic diet
- MGB - consult.
- Drugs as charted
- F/U peripheral smear and other reports
- I/O chart.
- Monitor vitals

[signature]

85851

Pt. reviewed

Drowsy Disorientation (+)

Adv

- Lactulose enema stat
- MGB consult
- Ascitic tapping
- or as required
- RT SOS
- CBD

[signature]

85851.

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. Karthikeyan	85851	16/12/23	2000

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date : 16/12/23
Time : 11PM
Doctor's Name : Dr. Velmurugan P

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

ICU Day — 2
Background
- Severe Aortic Stenosis
- congestive liver failure
- DM / HTN / AKI / ?Hepatorenal synd

Issues last 24 hours
- Altered sensorium
- post Ascitic tapping
- Thrombocytopenia / febrile episodes

Central nervous system ? Hepatic encephalopathy
Conscious / oriented / sedated with
Sedation score
GCS - E4 V4 M6 Pupils - ammonia
Pain score — Drains —

Cardiovascular system
HR - 72/mt Rhythm - NSR Cardiac Output -
BP - 110/50 mmHg CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – 2l/h O2
Saturation / PaO2- 99%
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

GIT
P/A soft
Bowels – Y / N Loose stools / Melena (on lactulose enema)
Drains -
NG tube : Y / N Day NGA- —
USG —
CT —

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved : Adequate
IV fluids -
24 hour Urine output – Negative balance
Fluid balance -1816ml
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

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

Antimicrobials with days
1. Inj - Ace
2. Tab - Tamiflu
3.

Labs
Hb 10.7 TC 4700 Platelets 80000
Urea 31 Creatinine 1.61
Na 130 K 3.71
Bilirubin 0.87 AST 66 ALT 34
INR 1.2
Others

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

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

Plan for the day

- I/O charting
- Rpt TC / ~~RFT~~ / ~~LFT~~ / ~~PT/INR~~ ~~platelet count~~
- S. Ammonia / platelet count
- collect Ascitic tap report
- S-APP / Anti HCV report
- continue O_2 support
- Nebulisation

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. Nel	95468	26/12/2	10 am

MHI/IP/2022/041

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
17/12/23 9:00	S/B: Dr Jaishankar team
	pt drowsy
	No obvious GI - Bleed
	No H/o LOC / seizure
	passed stool twice yesterday
	once today.
	Sytd
BP: 150/70	WS: S1S2 ⊕
PR: 81/m	R - B/L AE ⊕ ; ⓟ Syp. Lactulose 20ml tds
	Bowel sounds ⊕ ; target of 4-5 stools/day.
	ⓟ MGB - Review
	ⓟ Rpt CBC & RFT tomorrow.
I/O 1050 / 1680	93000.

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/040
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ICU PROGRESS NOTES

Date : 17/12/23
Time : 8:10am
Doctor's Name : Dr. G. Alastan

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

ICU Day D3
Background
- Severe AS
- Congestive Liver fault
- T2DM / SHT / AKI
Hepatorenal Syndrome / ? Hepatic encephalopathy

Issues last 24 hours
- No fever episode today Morning.

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

Cardiovascular system
HR - 78 Rhythm - NR Cardiac Output -
BP - 136/50 CVP -
Cardiac Medications: S1 S2 (+)

Respiratory system
Oxygen supplementation –
Saturation / PaO2- 94% c̄ 2l O2.
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -
BAE (+).

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

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

I / 1057ml
O / 1680ml
-623ml

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

Antimicrobials with days
1. T. Azee 500mg 1-0-0.
2. T. Tamiflu 75mg 1-0-1.
3. Inj. Monocef 1g IV bd.

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

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

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

Plan for the day

- Drugs on per chart.
- I/O chart.
- Vitals Monitoring.
- Collect Morning labs.

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. G. Akshaya	91810	17/12/23	8:20 hrs

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Mr.ANANTHA KRISHNAN.P.N
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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date : 17/12/23
Time : 11PM
Doctor's Name : Dr. Velmurugan P.

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

ICU Day – 3
Background
- Severe Aortic stenosis
- Congestive liver failure
- DM/HTN/ACI/Hypertensive ...

Issues last 24 hours
- Altered sensorium +
- post Aortic tapping
- Thrombocytopenia

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E4 V_ M6 Pupils – 2mm
Pain score Drains

Cardiovascular system
HR - 79/mt Rhythm - NSR Cardiac Output -
BP - 110/80 CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – 2l/hr
Saturation / PaO2- 99
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

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

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

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

Antimicrobials with days
1.
2.
3.

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

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

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

Plan for the day

- I/O charting
- Rpt CBC/RFT/LFT tomorrow
- Continue Ortosupport
- Mobilisation
- Drugs as per chart

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. Nel	90466	[illegible]/12/	10am

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date : 18/12/23
Dr. Ameesh

Time : 8.00.

Doctor's Name : Dr. Aneesh

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

ICU Day 4.
Background
Severe AS
Congestive heart failure
DM / HTN / AR / hepatorenal syndrome

Issues last 24 hours
? Encephalopathy / ICU psychosis.
? H/o. Melena
AG reversal
Thrombocytopenia

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - $E_4V_5M_6$ Pupils
Pain score Drains

Cardiovascular system
HR - 76 Rhythm sin Cardiac Output -
BP - 110/70 CVP - [illegible]
Cardiac Medications:

Respiratory system
Oxygen supplementation – 2L O2
Saturation / PaO2- RA - 94%
Ventilator : Spontaneous / Controlled

Last C x R -
Drains -

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

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

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

Antimicrobials with days
1. Monocef
2. Rcifax
3.

Labs
Hb 10.4 TC 9820 ↓ Platelets 80000
Urea 62↑ Creatinine 2.07↑
Na K Alb - 3.4
Bilirubin 1.2 AST 74 ALT 27
INR
Others INR - 0.7

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

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

NH_3 - 60 AFP - 2.26 (N)

Plan for the day

Anti HBE - (NR)
HCV - NEGATIVE (0.236/0.025)

- SHIFT TO WARD
- MGE OPINION IN WARD - DR. KARTHIK N.
- PR - 800 - 1000 ml/Brs
- FOLLOW UP ASCITIC FLUID ANALYSIS - TC/DC/~~[illegible]~~
- ALB - 1.8 PROTEIN - 4.5
- SAAG - 3.1/1.8 - 1.3 g/dl - TRANSUDATIVE ~~TRANSUDATE~~
- CONTINUE DRUG CHART

- ? CIRRHOSIS / PORTAL HYPERTENSION < ASCITES, THROMBOCYTOPENIA
- ? HEPATORENAL - AKI
- AS (SEVERE)
- SPLENOMEGALY
- BPH

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	18/12/23	8.00

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MHI/IP/2022/041

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
18/12/23 9AM	S/B Dr. Jaishankar & team.
	— Pt reviewed
	O/E = Conscious, oriented.
	PR - 62/min, BP - 135/64 (88)
I 980 / O 1250	SpO_2 97% on $2LO_2$
	CVS = S1S2 ⊕ LMO
	RS: BAE ⊕
TC - 9800	B/S Bowel sounds ⊕
Hb - 10.4	Adv
Plt - 90,000	— Cont the same
	— ↓ Inj. Dytor 20 — 10 — 0.
	— Shift to room today.
	— Gastro review Dr. Karthik (MGE) 9724

DATE	NOTES
18.12.23	S/B Dr. Anusuya
11.50pm	Patient reviewed.
	C/O: Chestpain on & off
	O/E: patient conscious
vitals stable	S/E: CVS - S1S2 ⊕
	RS - BAE ⊕
	Advice
	- monitor vitals
	- continue the drugs as per
K.Sh 134579	chart.
	- W/F feverspikes / desaturation
	- Glaston review.

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

DOCTOR'S PROGRESS NOTES

DATE	NOTES
19/12/23	S/B: Dr. Jaishankar & team.
	H/o Black coloured stools
	No fever, No chest pain, No SOB
	Passed stools 3 X yesterday.
	O/E: Conscious
	Disoriented to Place, Person, Time
	No flapping tremor
BP: 100/70	CVS: S1S2 ⊕
PR: 80/m	RS: B/L AE.
	Inj Optor 40mg
(— 850 ml Meg hol)	S.Na - 127
	K - 5.6
	T. Optor 40mg 1-0-1 9:30am.
	— Stool occult blood
	MGE/ Review
	→ CBC, RFT Reports

DATE	NOTES
19.12.23.	S/B Dr. S. Sridevi DMO.
4:20 Pm	
	pt reviewed
	o/e pt conscious
	oriented
	afebrile.
	CVS - S_1S_2 ⊕
	RS - BAE ⊕
	Adv
	- monitor vitals
	- follow drug chart
	- W/F fever spike,
	Desaturation
	S/B Dr. Mohamed Hydroos
19/12/23	
10pm.	Δ: Severe Aortic Stenosis)
	Congestive liver failure/ T2DM/
	HTN/ AKI
	? Hepato renal Syndrome
	? Hepato encephalopathy
vitals	Patient disoriented to Place
Stable	time
	Afebrile Person.
	CVS→ S_1S_2 ⊕
	RS→ BAE ⊕ Adv
	P/A→ Soft, NT - Repeat CBC, RFT

follow drug chart - MGE Review
- Monitor vitals

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MHI/IP/2022/041
Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

DOCTOR'S PROGRESS NOTES

DATE	NOTES
20/12/23	S/B Dr. Jaishankar & team
	- pt reviewed
	- O/E conscious, oriented
	PR - 82/min, BP - 140/84
	SpO2 - 96% RA
	CVS - S1S2 (+)
	RS - BAE (+)
	Adv
	- MGE review
To do	- Remove uro catheter
CBC	- plan d/c today after MGE review
- RFT	
	[signature]
20/12/23	S/B Dr. Anusuya
	A case of severe AS / CHF / T2DM / HTN / AKI / hepatic encephalopathy
2:40PM	Patient reviewed responding to
	O/E drowsy, [illegible] painful stimuli
HR - 67 b/m	S/E: CVS - S1S2 (+)
BP - 110/70 mmHg	RS - BAE (+)
RR - 20/min	Advice
CBG - 195 mg/dL	- Inform Dr. Jaishankar
SPO2 - 96% RA	(Cardio)

DATE	NOTES
20/12/23	S/B Dr. Jaishankar (Cardio)
3.20PM	Patient reviewed.
	O/E: drowsy.
	Advice.
	- Stop discharge process
	- Start IVF 30cc/hr
for K'80 134779	After shifting to ICU.
	- DO ABG.
	- inform ICU.
	- Medical gastro review.
20/12/23	Orders by Dr. Kritiga mam (ICU)
4.00PM	- To do ABG & electrolytes now (immediately)
for K'80 134779	- W/F desaturation/fever spikes.

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
	S/B Dr. Ihartha
20/10/23 16.30	pt drowsy
	arousable.
	confused.
	CVS: S1S2 ⊕ RR: 90/min
	SpO2: 90% on RA
	B/L wheeze ⊕
	B/L creps ⊕ R<L
	Labs
	TC 7450. Alb: 3.5
I 285 O 800	plt 1,51,000 CBG 182
Cpositive balance	Urea: 87. Na: 136
	Creat: 1.83. K: 3.69.
	ABG ⇒ .. 7.507/36/65/28.5/
Imp	Encephalopathy ? uremic ? met.
	Hypoxia ⊕.
	Severe AS
	T2DM
	HTN

DATE	NOTES
	Adv
	Neb. Levolin 1rsp Q4th hrly
	Neb Foracort 1rsp Q4th hrly
	BiPAP – SOS
	Nasal O2. 2-4 lit Nasal Prong.
	[illegible] –
	[illegible] 1-1-1.
	Nephro consult.
	[illegible]
	consider [illegible]
	Shift to [illegible].
	[illegible]
	8585

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

P/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
20/12/23 @ 11pm	S/B Dr Harish
	- patient reviewed.
	- Arousable, confused at times Obeys Commands.
	K/c/o - Severe AS Congestive liver failure DM / HTN / ⊕
	RA - SpO2 - 85% 4LO2 - 94%
	RS - B/L AE ⊕ Basal crepts ⊕ mild wheeze.
	Adv → Inj: Dytor 20-0-10-0. IV. → O2 As required → Drugs as charted. → Lactihep - 15ml bd. – Send urine R/E
[signature] 22:00	

DATE	NOTES
	~~S/B Dr~~
22/12/2023 12 noon.	S/B Dr. KIRTHIKA.N
	Case reviewed.
	Clinically better
	oxygenation better.
	UOP – good.
RFC tolerated.	HD stable. Sensorium – good.
	Afebrile. Hb – holding.
	Plan: ① ABG normalised.
	② MGF opinion
	③ physio
	④ Mobilization
	⑤ Can consider ward shift.
	(Dr. V. KIRTHIKA.N) 87455

MH/ PRINT / 0040 / NRS

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

DOCTOR'S PROGRESS NOTES

DATE	NOTES
22/12/23 10.00PM	S/B Dr. Anusuya
	patient reviewed.
	C/O:
	O/E: patient conscious, oriented.
To do ABG tomorrow	S/B: CVS - S1S2 (+)
	RS - BAE (+)
	Vitals: HR - 84b/m
	BP - 120/80mmHg
	RR - 18/min
	Advice.
	- continue the drugs as per chart
	- MGE opinion
	- chest physio, mobilisation
K180 134609	

DATE	NOTES
23.12.23 11.00 AM	Course in the hospital
	A 79y/m came with H/O shortness of breath on exertion for 1 1/2 days. H/O B/L lower limb swelling (+), H/O mild abdominal pain (+), H/O loss of appetite (+). H/O generalised tiredness. Patient got admitted under Dr. Jaishankar (cardio) in CCU. Baseline investigation increased total count, increased creatinine level.
Peripheral smear sample sent	USG abdomen showed splenomegaly, prostatomegaly, minimal B/L pleural effusion, moderate ascites, liver parenchymal disease. Echo done EF-60%.
	Due to abdominal pain & splenomegaly, Dr. Karthik (medical gastro) opinion obtained & he adviced for OGD scopy. Stool occult blood showed negative. Ascitic tapping done & samples sent for culture & ascitic fluid analysis. Patient improved symptomatically & hence being shifted to ward on 18.12.23 with CBD in situ (+). Due to complaints of black coloured stools, stool occult blood sample sent showed negative. Voided freely & CBD removed. Due to drowsy, disorientation to place, time, breathlessness patient shifted to ICU on 20.12.23. ABG done. Due to severe B/L crepts nebulisation started. Then, patient improved symptomatically & hence being shifted to ward on 22.12.23. Dr. Jaishankar (cardio) reviewed the patient periodically & adviced followed. Patient was treated with IV fluids, antibiotics, analgesics, anti-pyretics & other supportive measures. Patient improved symptomatically & feeling better & hence being discharged with advice medication.
K. 13411	

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
	S/b Dr Jaishankar (?)
23/12/23	
10:00	passed stools / No Malena
	Mild drowsiness (?)
	o/e drowsy
	BP 120/80
	P - 68/m
	SpO2 - 97%
	22/12/23 · c/o Nrs (?) · Plan
	S.Cr - 1.1 · U - 88 · Na - 134 · K - 3.64
	← MGE consultation
	← watch for aspirations
	D/S today by evening
	1900 / 2000
	(signature)

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79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/PHY/CON/012

CONSENT FORM - PHYSIOTHERAPY

I, Anantha krishnan. 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

Physiotherapy

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

Brief description of the ~~Operation~~ / Procedure: AROM Ex's, Mobilisation, Chest percussion.

I understand the intended benefits of undergoing the procedure .The intended benefits from this procedure are:
To improve Muscle strength, To improve lung clearance. To improve ADL

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

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

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)*:

For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to Dr. Surya P *(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

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 #)		*(Write name and relationship with patient)*		
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness				
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]	Surya P.	264	22/12/23	11:30:00
Procedure performed by	[signature]	Surya P	264	22/12/23	11:30am

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

South Asia
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PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
22/12/23	11:30am	S/B Surya. R K/H/o BPH DM. HTN. D Severe AS. congestive liver failure AKI Hepatic encephalopathy. Hepatorenal syndrome. Rx AROM to B/L UL & LL + chair mobilized. + chest percussion to B/L chest wall	[signature] .R 26cm.

MHI/HOSP/2022/089

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(A Unit of United Alliance Healthcare Pvt Ltd)

Medway Heart Institute
Every heart beat counts

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MICROBIOLOGY SHEET

URINE ROUTINE ANALYSIS

DATE	14/12/23		
COLOUR	PALE YELLOW		
REACTION			
SPECIFIC GRAVITY			
APPEARANCE	SLIGHTLY TURBID.		
ALBUMIN			
SUGAR	NIL.		
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	4-6		
EPITHELIAL CELLS	6-8		
RBC	NIL		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	BACTERIA PRESENT.		

MICROBIOLOGY-CULTURE REPORTS

DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY
15/12/23	Urine C/S	No growth	

MHI/IP/2022/065

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

DIABETIC CHART

ACTUAL WEIGHT ±60 HbA1c 7.6 [14/12/23]

PREVIOUS DIABETIC MEDICATIONS Don't give Tab. Metformin

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
15/12/22	12.30	140 mg/dl	-	[illegible]	DR. ANISH.
15/12/23	18:45	196 mg/dl.	* 4U HA S/C. 20.10	[illegible]	Dr. Velmurugan.
16/12/23	6:30.	143 mg/dl.	-	[illegible]	Dr. Velmurugan
	12.40	196 mg/dl	6 units H.A S/C *	[illegible]	DR Karthik
	18.50	207 mg/dl	* Inj. HA 8 units S/C 20.10	[illegible]	DR. Karthik
17/12/23	6.30	203 mg/dl.	Inj H.A 8U S/C 8.30am	[illegible]	DR. ARUN
17/12/22	12.10	193 mg/dl	Inj. HA 10U S/C	[illegible]	DR. ARUN.
17/12/23	19.00	157 mg/dl.	Inj H.A 2 units S/C @8.00	[illegible]	DR. Velmurugan.
18/12/22	6.30	156 mg/dl.	-	[illegible]	DR. Velmurugan.
	12.30	202 mg/dl.	Inj. HA 4U	[illegible]	Dr. Salai.
	18.00	171 mg/dl	-	[illegible]	Dr. Salai
19/12/23	6:30	171 mg/dl	Inj. HA - 4U	[illegible]	K. [illegible] 134559

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/2022/065

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Dr.K.JAISHANKAR

DIABETIC CHART

ACTUAL WEIGHT ...... 60 Kg ...... HbA1c 7.6 (14/12/23

PREVIOUS DIABETIC MEDICATIONS ...... TAB. TENEGLIP-M 20/500mg 1-0-0

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
-/12/23	12.00	197 mg/dl	Inj. HA 4U	0088	K.M
	18.30	171 mg/dl	—	0088	
20/12/23	6.30	200 mg/dL	Inj. HA 5U	S/c Stat given at 8.30	Dr. Karthik.
	12.00	191 mg/dl	inj H.A - 4 Units.	W.H	Dr. Solai Sir

INSTRUCTIONS FOR INSULIN INFUSIONS

Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)

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

Urine Acetone

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

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DIABETIC CHART

MH/DC/IP/2023/038

PATIENT DETAILS: Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

ACTUAL WEIGHT ______ SERUM CREATININE CLEARENCE ______

TSH ______

PREVIOUS DIABETIC MEDICATIONS ______

DATE	TIME	BLOOD SUGAR VALUE	DIABETIC DRUGS	DOCTOR SIGNATURE	STAFF SIGNATURE	CHARGE NURSE SIGNATURE
/12/23	6.30pm	161mg/dl	–	Dr. Karthik	[signature]	[signature]
21/12/23	6.30Am	168mg/dl	–	Dr. Kirthika	[signature]	[signature]
	12.30pm	219mg/dl	–	Dr. Kirthika	[signature]	[signature]
	6.30pm	160mg/dl	–	Dr. Harish	[signature]	[signature]
22/12/23	6.30am	192mg/dl	–	Dr. Harish	[signature]	[signature]
	12.30pm	302mg/dl	HA - 12unit	Dr. Kirthika	[signature]	[signature]
	6.30pm	180mg/dl	–	[signature]	[signature]	[signature]
23/12/23	6.30	203mg/dl	Inj. HA 6U	Dr. Siva	[signature]	[signature]
	12.30	191mg/dl				

MHI/IP/2022/069

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

BLOOD GROUP

'O' POSITIVE.

INVESTIGATION SHEET

Date	14/12/23	15/12/23	16/12/23	17/12/23	18/12/23	20/12/23	
HAEMATOLOGY							
Hb	11.6		10.7		10.4	11.9	
P.C.V	34.0		28.1↓			36.8	
Platelets	100000	75,000	80000↓	85000	90000	151000	
TLC	4690		4700	13950		7450	
Polymorphs	64.1		65.8		78.4	69.1	
Lymphocytes	19.4		29.6		15.8	18.4	
Eosinophils	5.6		1.7		1.1	4.6	
Mono / Basophils	10.5/0.4.		4.9/0.0		4.7/0.0	7.5/0.4.	
E.S.R	80						
BIO-CHEMISTRY							
Urea	28	33	31		56	37	
Creatinine	1.78	1.63	1.61		2.07	1.83	
Sodium	130		130		135	136	136
Potassium	4.09		3.71		3.62	3.69	3.68
Bicarbonate	19		20		25	22	21
Chloride	95.4		92		93.6	92.1	89
Magnesium							
Calcium	8.6		8.8		8.6	9.6	
Phosphorus	3.7		3.0		4.1	3.4	
LFT Uric Acid			7.0	18/12/23			
T.Bilirubin	0.95		0.87	1.20		0.98	
D,Bilirubin	0.44		0.39	0.65		0.24	
I.Bilirubin	0.51		0.48	0.55		0.74	
S.G.O.T	88		66	74		62	
S.G.P.T	85		34	27		13	
ALP	134		123	80		81	
GGT	65		68	52		46	
Total Protien	8.4		8.1	8.1		9.0	
S.Albumin	3.2.		3.1	3.4		3.2	
CARDIAC ENZYMES							
Troponin I							
CKNAC - CPK							
CK - M.B. MASS							
LDH							
Ntpro bnp		102.					

Date	14/12/23.	15/12/23.				
COAGULATION						
PT / INR INR.		1.2				
Fibrinogen Test		15.4				
D Dimer control		12.1				
LIPID PROFILE						
Total Cholesterol	95					
Triglyceride	97					
H.D.L	27					
L.D.L	49					
V.L.D.V	19.					
THYROID FUNCTION						
T.S.H						
T.3						
T.4						
SEROLORY						
HIV						
HBsAg						
V.D.R.L						
COVID 19						
RT- PCR						
IgM						
Ig						
HBA1C						
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN		0.26.				
DDIMER						
S.Osmolality						
URINE						
Osmolality						
Spot - Na						
Motion occult Blood		Negative				
Sr. ALBUMN. Globules	22					

MH/IS/IP/2023/031

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

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

BLOOD GROUP

O+VE

INVESTIGATION SHEET

Date	18/12/23	19/12/23	20/12/23	21/12/23	22/12/23	
HAEMATOLOGY			(Evening)			
Hb	10.4	11.9		12.8	12.1	
P.C.V		36.8				
Platelets	90000	151000				
TLC		7450		7180		
Polymorphs	78.4	69.1				
Lymphocytes	15.8	18.4				
Eosinophils	1.1	4.6				
Mono / Basophils	4.7/0.0	7.5/0.4				
E.S.R						
BIO-CHEMISTRY						
Urea	56	87		84	88	
Creatinine	2.07	1.83		1.59	1.45	
Sodium	135	136	136	137	134	
Potassium	3.62	3.69	3.68	3.6	3.64	
Bicarbonate	25	22	21			
Chloride	93.6	92.1	89			
Magnesium						
Calcium	8.6	9.6				
Phosphorus	4.1	3.4				
LFT						
T.Bilirubin		0.98				
D.Bilirubin		0.24				
I.Bilirubin		0.74				
S.G.O.T		62				
S.G.P.T		13				
ALP		81				
GGT		46				
Total Protien		9.0				
S.Albumin		3.2				
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

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

Mr.ANANTHA KRISHNAN.P.N
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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/PRINT /0064/ NRS

I P INSTRUCTION AND MONITORING CHART

Room No. : 203

Dr. Name : DR. K. JAISHANKAR

Name : MR. Ananthakrishnan IPNO: 2516.

		21/12/23	22/12/23	23/12/23					
PR	BP	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day
		12 4 8 12 4 8 / 6 8 12 4 6 8	6 8 12 4 6 8	6 8 12 4 6 8					Temp.
									106°
									105°
									104°
									103°
									102°
									101°
									100°
									99°
									98.6° 98°
					68 120/70				97°
Hb/plt		96%		20 95%					
Urea / Creat									
CBG				203					
Inv		Na⁺, K⁺ Hb, PC UREA, CREA ABG.	Na⁺, K⁺ CREA.						
ABX									
Culture									
Misc									

Medway Hospitals® HTN/T2DM.

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Every ...

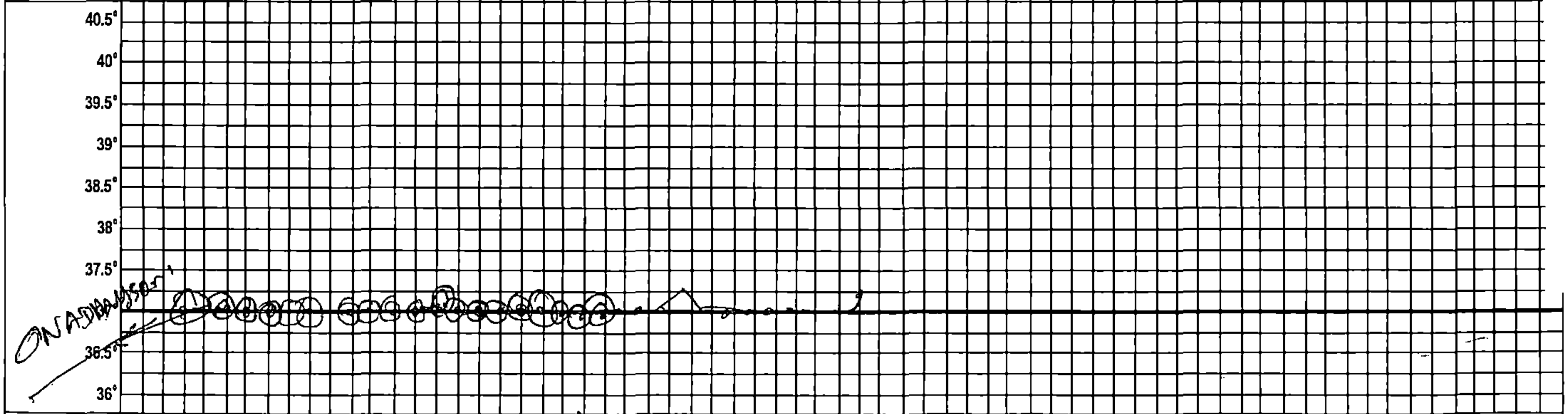
BLOOD GROUP	
ON ADMISSION	
Height in CM	Weight i...
± 168	± 60.

VITAL INFORMATION SHEET

Diagnosis: T2DM / HTN / SEVERE CALCIFIC AORTIC STENOSIS / ?UTI / CCF.

Procedure :

NO. OF DAYS	DOA	Day-2	Day-3	Day-4	Day-5	Day-6
DATE	15/12/23	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23
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



	DOA	Day-2	Day-3	Day-4	Day-5	Day-6
PULSE	107 / 82	66 / 78	80 / 70	67 / 68	70 / m / 80b/m	82 / m / 89
RESP	27 / 26	26 / 28	28 / 26	28 / 24	20 / m / 22b/m	22 / m / 21
B.P.	140/40 / 126/57	128/64 / 137/58	128/58 / 119/56	132/67 / 130/80	100/90 / 110/70	100/84 / 110/70
SPO2	96% / 98%	95% / 96%	96% / 98%	99% / 98%	99% / 98%	96% / 98%
DAILY WEIGHT	±60. ±60	±60kg	±60kg ±60kg	±60kg		
24 HRS INTAKE	684 ml	1057 ml	980 ml	1190 ml	1000 ML	
24HRS OUTPUT	2500 ml	1680 ml	1250 ml	2050 ml	1600 ML	
BALANCE	-1816 ml	-623 ml	-270 ml	-860 ml	600 ML	
MOTION	×	✓✓	✓✓✓	✓	✓	✓

MHI/IP/2022/103

Medway Hospital
The way to better h[...]
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EARLY WARNING SCORE MONITORING CHART

Name: ____________ **Age/Sex:** ________ **Patient Id No:** ____________

NEWS key: 0 1 2 3

Parameter	Range	Score	Range
A+B Respirations Breath/ min	>25	3	>25
	21-24	2	21-24
	18-20		18-20
	15-17		15-17
	12-14		12-14
	9-11	1	9-11
	<8	3	<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96		>96
	94-95	1	94-95
	92-93	2	92-93
	<91	3	<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % eg: in hypercapnic respiratory failure only [redacted] ale 2 under the [redacted] on of qualified [redacted] n	>96 on oxygen	3	>96 on oxygen
	95-96 on o2	2	95-96 on o2
	93-94 on O2	1	93-94 on O2
	>93 on air		>93 on air
	88-92		88-92
	86-87	1	86-87
	84-85	2	84-85
	<83%	3	<83%
Air or Oxygen ?	A= Air		A= Air
	O2litre/ min	2	O2litre/ min
	Device		Device
C Blood Pressure	>220	3	>220
	201-219		201-219
	181-200	2	181-200
	161-180		161-180
	141-160		141-160
	121-140		121-140
	111-120		111-120
	91-100	1	91-100
	81-90	2	81-90
	71-80	3	71-80
	61-70	3	61-70
	51-60	3	51-60
	<50	3	<50
Diastolic BP	mmHg		mmHg
[redacted] e [redacted] ts / 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			
Monitoring Frequency			
Escalation of Care Y/N			
Initials by RN			
Initials by Sr. RN			

Handwritten entries:

	1	2	3	4	5	6	7	8	9	10	11	12	13
DATE	18/12	18/12	18/12	19/12	19/12	19/12	19/12	19/12	20/12	20/12	20/12	20/12	
TIME	14.00	18.00	22.00	6.00	10.00	14.00	18.00	22.00	6.00	10.00	14.00	12.00	
Diastolic BP mmHg	62	66	70	66	70	78	82	80	86	82	89	70	
NEWS Total	0	0	0	0	0	0	0	0	0	0	[illegible]	4	
Monitoring Frequency	4th	4th	4th	4th	4th	4th	[illegible]	4th	4th	4th	[illegible]	2	
Escalation of Care Y/N	No	No	N	N	No	N	N	N	N	N	[illegible]	No	
Initials by RN	[illegible]	[illegible]	[illegible]	[illegible]	DC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Initials by Sr. RN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

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

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

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IP/2022/066

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Dr.K.JAISHANKAR

INTAKE & OUTPUT CHART

Date From: 18/12/23	To: 19/12/23	Bed No: 111	
24 Hrs : Started Time : 7.00	Ended Time : 7am		
NPO Started at :	NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE				
OUTPUT				

Total Intake: 1190ml Total Output: 2050ml Difference: −860ml

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
18/12/23															
@ 10.40															
	TOTAL INTAKE →					230	ml.		TOTAL	OUTPUT →			280 ml		
12.30	100ml					330									
14.00	150ml					480	18.00	600ml					880ml		
17.00	75ml					505	23.00	370					1250		
18.30	100ml					665	7.00	800ml					2050		
19.45	125ml					790									
21.00	150					940									
22.00	150					1090			Total intake →		1190 ml				
6.00	100					1190			Total output —		2050 ml				
														[signature]	
															[signature]

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Dr.K.JAISHANKAR

INTAKE & OUTPUT CHART

Date	From: 19/12/23	To: 20/12/23	Bed No: 716
24 Hrs : Started Time : 7.00		Ended Time : 5 am	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE		400 ml	300 ml	
OUTPUT		600 ml	500 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
7.20	100					100	8.00	200					200		
8.00	50					150	10.00	300					500		
9.00	50					300	14.00	300 ml					800		
9.20	50					350	18.00	300 ml					1100	[signature]	
11.00	50					400	6.30	500					1600	[signature]	
13.30	150					550									
14.30	150					700									
18.15	100					800			total	intake	→	1000ml			
20.00	100					1000			total	output	→	1600 ml			
5.30	200								Bal	ance	→	600 ml	[signature]		
															Neeo

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79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

INTAKE & OUTPUT CHART

Date From: 20/12/23 To: 21/12/23 Bed No: 111

24 Hrs : Started Time : 7.00 Ended Time : 7am

NPO Started at : NPO Over at : 7.00

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

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
7.30	150					150	7.45	300					300		
8.45	100					250	16.30	200					500		
10.10	50					300									
13.10	50					350									
16.10	50					400						F-Cath 0207		Nel 0224	

MH/ PRINT / 0061 / NRS

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CHART

Date :	Mr.ANANTHA KRISHNAN 79/Male/MHJ202381290 15/12/2023/IPH202302516
Name :	Dr.K.JAISHANKAR
Operation Performed :	
IP No. :	
Age :	Sex :
Date :	

	TEMP	RESP	PUL	BP	SP02	IV FLUID 1	ORAL	TOTAL	URINE	NGT	DRAIN	OTHER	DRUGS & MEDICATIONS TIME	DRUG	DOSE	RTE.
9.00 a.m.																
10.00 a.m.																
11.00 a.m.																
12.00 Noon																
1.00 p.m.																
2.00 p.m.																
3.00 p.m.																
4.00 p.m.																
5.00 p.m.																
6.00 p.m.						IVF 400		400	500ml			500ml				
7.00 p.m.	98.2	16	72	130/90	96%	30	H2O 50	480								
8.00 p.m.	98.6°	16	70	120/70	92%	30		510								
9.00 p.m.	98.0°	22	68	130/70	96%	30		540								
10.00 p.m.	98.6°	20	66	120/80	98%	30		570								
11.00 p.m.	98.8	18	76	120/70	92%	30		600								
12.00 MN	98.2°	20	68	120/70	93%	30		630	DIAPER CHANGED			500ml				
1.00 a.m.	98.4°	22	60	130/60	92%	30		660								
2.00 a.m.	98.6°	16	70	120/50	93%	30		690								
3.00 a.m.	98.8	16	68	130/100	92%	30		720								
4.00 a.m.	98.6°	22	66	120/70	93%	30		750	B.							
5.00 a.m.	98.0°	20	64	130/70	92%	30		780	BED WETTING			400ml				
6.00 a.m.	98.2	18	68	140/70	92%	30	H2O 100	910								
7.00 a.m.	98.2	20	72	120/70	93%	30		940								
8.00 a.m.																
SUB TOTAL																

24 HOURS INTAKE = 940ml   OUTPUT = 1,400ml

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I/O RT MH/ PRINT / 0061 / NRS

Date : IP No. :

Name : Age : Sex :

Operation Performed : Date : 20/12/23

	TEMP	RESP	PUL	BP	SP02	IV FLUID 1	ORAL	TOTAL	URINE	NGT	DRAIN	OTHER	TIME	DRUG	DOSE	RTE.
9.00 a.m.	98.6F	20	70	120/70	96%	30		30								
10.00 a.m.	98.4F	22	68	130/80	97%	30	100	160						24-HRS I/O CHART!		
11.00 a.m.	98.6F	20	74	120/60	95%	30	50	240								
12.00 Noon	98.2F	22	72	120/70	96%	30		270						INTAKE!		
1.00 p.m.	98.6	22	74	120/80	96%	30	100 50	300	Bed wet		(3rd	300ml				
2.00 p.m.	98.4	20	68	130/80	95%	30		380						IVF- 390ML		
3.00 p.m.	98.6	22	60	120/80	98%	30		410								
4.00 p.m.	98.4	20	74	130/80	98%	30	Tea	440						MED-		
5.00 p.m.	98.6	18	78	120/70	94%	Stop	50	490								
6.00 p.m.	98.4	20	72	130/80	97%									ORAL - 530ML		
7.00 p.m.	98.6	20	72	120/72	98%											
8.00 p.m.	98.6	18	72	120/70	96%	H2O	H2O 100	590						TOTAL INTAKE!	940ML	
9.00 p.m.	98.8	18	76	120/60	98%											
10.00 p.m.	98.6	18	78	130/70	97%		H2O 100	690						OUTPUT!		
11.00 p.m.	98.8	16	76	130/60	96%				400			700 ml				
12.00 MN	98.8	18	72	120/50	98%									URINE - 1,400ML		
1.00 a.m.	98.6	16	74	130/60	97%											
2.00 a.m.	98.8	18	72	120/70	97%									MOTION NOT PASSED		
3.00 a.m.	98.6	18	70	130/60	96%											
4.00 a.m.	98.6	16	72	120/60	98%				BEDWIDE →			400 ml		TOTAL OUTPUT: 1,400ML.		
5.00 a.m.	98.8	18	72	120/50	96%											
6.00 a.m.	98.6	18	76	140/80												
7.00 a.m.	98.8	20	72	120/80					DIAPPER changed →			200 ml		NEGATIVE BALA-	460ML	
8.00 a.m.																
SUB TOTAL																

24 HOURS INTAKE = OUTPUT = 1,300ML

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.. CHART

MH/ PRINT / 0061 / NRS

Date : Mr.ANANTHA KRISHNAN.P
79/Male/MH1202381290
Name : 15/12/2023/IPH202302516
Dr.K.JAISHANKAR
Operation Performed :

IP No. :
Age : Sex :
Date : 21/12/23

	TEMP	RESP	PUL	BP	SP02	IV FLUID 1	ORAL	TOTAL	URINE	NGT	DRAIN	OTHER
9.00 a.m.	98.6	20	72	110/70	98%		1000 286ml	200				
10.00 a.m.	98.4	18	76	130/80	97%							
11.00 a.m.	98.6	16	72	130/70	92%							
12.00 Noon	98.4	18	74	120/80	98%		H_2O		bed	Well		Moon
1.00 p.m.	98.6	16	80	110/60	95%		100	300				
2.00 p.m.	98.4	18	82	110/70	92%							
3.00 p.m.	98.4	16	90	130/70	95%							
4.00 p.m.												
5.00 p.m.												
6.00 p.m.												
7.00 p.m.												
8.00 p.m.												
9.00 p.m.												
10.00 p.m.												
11.00 p.m.												
12.00 MN												
1.00 a.m.												
2.00 a.m.												
3.00 a.m.												
4.00 a.m.												
5.00 a.m.												
6.00 a.m.												
7.00 a.m.												
8.00 a.m.												
SUB TOTAL												

24 HOURS INTAKE = OUTPUT =

DRUGS & MEDICATIONS

TIME	DRUG	DOSE	RTE.
	INTAKE		
	ORAL →	450ML	
	Inf →	240ML	
	MED →		
	TOTAL INTAKE :	690ML	
	OUTPUT :		
	URINE →	1,300ML	
	MOTION →	PASSED	
	TOTAL OUTPUT :	1,300ML	
	NEGATIVE BALA -	610ML	

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I/O C RT

MH/ PRINT / 0061 / NRS

Date : 22/12/23
Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Na[me]
Op[eration]
Per[iod]

IP No. :
Age : Sex :
Date : 23/12/23

	TEMP	RESP	PUL	BP	SPO2	IV FLUID 1				NUT	DRAIN	OTHER	TIME	DRUG	DOSE	RTE.
9.00 a.m.							100	100								
10.00 a.m.									500			500				
11.00 a.m.							100	200								
12.00 Noon							100	300								
1.00 p.m.																
2.00 p.m.							100	400	500			1000		TOTAL INTAKE :		
3.00 p.m.																
4.00 p.m.							100	500						1900 ml		
5.00 p.m.																
6.00 p.m.							200	700	400			1400		TOTAL OUTPUT:		
7.00 p.m.							300	1000						2000 ml		
8.00 p.m.																
9.00 p.m.	—						300	1300	300			1700				
10.00 p.m.	—						200	1500								
11.00 p.m.																
12.00 MN																
1.00 a.m.																
2.00 a.m.							200	1700								
3.00 a.m.																
4.00 a.m.																
5.00 a.m.																
6.00 a.m.							200	1900	300			2000				
7.00 a.m.																
8.00 a.m.																
SUB TOTAL																

DRUGS & MEDICATIONS

24 HOURS INTAKE = 1900 ml OUTPUT = 2000 ml

MHI/DIET/2022/147

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Medway Heart Institute
Every heart beat counts

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: DM/HTN / ?UTI / CKD / Anaemia (10.7gm%) / BPH. EF - 60%				
Height: 168 cms	Weight: 60 Kgs	Food allergies: Yes/ No, If yes, specify........................		
Religious Beliefs:	☑ Vegetarian	☐ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1800 calories, low fat, low salt, diabetic, soft solid diet.				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A)	Patient's related Medical History				
	1)	Weight Change (overall change in past 6 months)				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Oral	No change	Sub - optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric feeds	Starvation
3)	Gastrointestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration: Since (10 days)					
		☐ 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)	12
	Moderately Malnourished	☐ (15 to 18)	
	Severely Malnourished	☐ (19 to 35)	

Nutrition Intervention:				
	☑ Oral	☐ Enteral	☐ Parenteral	
Diet counselling provided:	☑ Yes	☐ No		
Frequency of re-assessment:	☑ Weekly		☐ Fort - night	☐ Monthly
Enteral / Parenteral	☐ Daily		Calorie count: ☐ Yes	☑ No

Dietitian Signature / Name / Date / Time: [signature] 15/12/23, 1400

Maria Catherine John
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
15/12/21 14:00	A [illegible] year old gentleman came c/o shortness of breath on exertion since [illegible]. Assessed to be well nourished as evident by SGA. K/c/o - DM/HTN/CKD/Anaemia. Patient [illegible] to [illegible]. Educated the patient and family on 1500 calories, low fat, low salt, diabetic, soft solid diet. Emphasized on small frequent meals with glycemic control.	[signature] (2/?/21) Maria Catherine John Senior Dietitian
16/12/21 10:00	Diet modification and clarification done. Motivated to eat well.	[signature] (2/?/21) Maria Catherine John Senior Dietitian
19/12/21 10:00	Motivated to eat well. Oral intake is good.	[signature] (2/?/21) [illegible] Catherine John Senior Dietitian
[illegible]/12/21 10:00	Oral intake is good. Educated the patient and family on 1500 calories, low fat, low salt, diabetic diet on discharge. Emphasized on small frequent meals with low glycemic control.	[signature] Maria Catherine [illegible] Senior Dietitian

control. Diet chart given on discharge.

MHI/HOSP/2023/223

Medway Heart Institute
Every heart beat counts

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

re)

PSYCHOLOGICAL WELLBEING REPORT

Date: 19/12/23 Time: 1.15pm.

Unit: III

Clinical diagnosis: Severe aortic stenosis.

Surgery/ Procedure:

Impression: Memory decline, ↑ sleep (∵ im), low interest.

- calm affect, responsive, no eye contact
- ↑ sleep & appetite (N)
- multiple physical c/o & family health - stressors.
- memory decline (∵ 7 years).
- Memory registering have been suggested for family, encouraged to provide positive affirmations.

Employee ID: MH10275PS4

Signature of the Psychologist:

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NABH

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/053

Medway Heart Institute
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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 15.12.23 Time of Arrival: 12.15 Mode of Admission: [ ] Walking [x] Wheelchair [ ] Stretcher

Accompanied by Relative: [x] Yes [ ] No If Yes, Name of the Relative: MR. NARAYANAN.

Relationship with Patient: FATHER Contact Person's Name: MR. NARAYANAN Relationship: SON.

Contact No.: ________ Primary language spoken: [x] Tamil [ ] English [ ] Indian [ ] International

Interpreter needed: [ ] Yes [x] No

Patient status: [x] Conscious [ ] Unconscious [ ] Disoriented | Patient Vulnerable: [x] Yes [ ] No

Menstrual History : LMP : — Menopause: —

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

Drugs History : Antiplatelet — (Specify)

Psychological Status: [x] Calm [ ] Anxious [ ] Withdrawn [ ] Agitated [ ] Depressed [ ] Sleeping Difficulty

Do you have any special religious, spiritual or cultural needs to be considered? [ ] Yes [x] No

If Yes, specify details: ________

Socio Economic Status: [ ] Employed [ ] Retired [ ] Own Business [ ] Home-Maker [x] Others: ________

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 104 (beats/min) | BP: 120/62 (mmHg)

Respiration: 29 (breaths/min) | SpO_2: 98% (%) | CBG: 140 (mg/dl) | Height: 160 (cms) | Weight: 60 (kgs)

Allergies / Adverse Reaction: [ ] Yes [x] No [ ] Medication [ ] Blood Transfusion [ ] Food [ ] Not known

If Yes, specify: ________

Pain: [ ] Yes [x] No. If Yes, Score: 0/10 **Pain Scale Used:** [ ] Wong-Baker FACES Pain Rating Scale (7-12 years) [x] 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 [x] No Change

Last 3 months Weight: [ ] Increased [ ] Decreased [x] No Change

Type of Patient: [ ] Diabetic [ ] Non Diabetic Type of Diet: DM diet

Dietician Informed: [x] Yes [ ] No. If Yes, mention the Name: Mrs. Catherine. Time: 12.15.

Orient Patient if: [x] Conscious **Orient Patient Attendant if:** [ ] Unconscious [ ] Disoriented

[x] Room [x] Side Rails [x] Toilet Bell [x] Patient Information Board [x] Bathroom [x] Bed Controls

[x] Use of Footstool [x] Grab Bars [ ] Nurses Call Bell [ ] Television [ ] Light Controls [ ] Telephone

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	[ ] Yes [x] No		
Hearing Impairment	[ ] Yes [x] No		
Chewing Difficulty	[ ] Yes [x] No		
Walking Difficulty	[ ] Yes [x] 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: 17 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**		45

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

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

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**	✓		15/12/23	12.30.
Moderate Risk	**1 to 2**				
High Risk	**3 to 8**				

Personal Belongings / Valuables:

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

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

____

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	[signature]	A-NARAYANAN	Relationship Son	15/12/23	12.20
Nurse	[signature]	S. Alley [illegible]	0162	15/12/23	12.30.
Unit In-Charge	[signature]	JAYADEVI T	0002	15/12/23	12.30

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NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048
Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: T2DM / HTN / severe calcific Aortic stenosis, ?UTI, CKF GCS: 15/15
NEWS / PEWS Score: — POD: —
Ventilator day: — Central line days: —
Peripheral line day: Right: — Left: Cephalic
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: Unknown
On room air / oxygen: 2 L on FM 2 litre IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 99 (beats/min) | Respiration: 27 (breaths/min)
BP: 143/74 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²
Others:
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS ✓ / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains: —

R

RECOMMENDATION

Referral doctors: Gastro Opinion.
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Serum ammonia, HCV, HbeAg, PT/INR, urine C/S
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date:
Pending follow-up orders: Gastro
Special instructions if any: To do CBC, RFT, LFT, Tommrow.

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	S. Abinaya [illegible]	0262	15/12/23	19.20
Handover taken by	[signature]	madhumitha.	0244	15/12/23	19.20
Document endorsed	[signature] 002	JAYADEVI T	0002	15/12/23	19.20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
15/12/23		
13.00	⇒ pt for admission in CCU. Pt was c/o breathless. pt was haemodynamically stable. pt stat ECG and CBG. pt Neb. stat given and Inj. Lasix 40 mg give.	[signature]
13.30	⇒ Dr. Jaishankar visit the pt Advice to investigation taken send to lab.	[signature]
15.00	⇒ Inj. Lasix infussion stat 2mg/hr onflow	[signature]
16.00	⇒ pt was stable hourly urine passed.	[signature]
17.00	⇒ monitor vital signs No other complaints.	
~~17.35~~	⇒ Dr. Siva Advice to infussion Pan 8ml/hr stat.	[signature]
17.50	⇒ IV line instead corrected	
18.00	the Inf. Pan 8ml/hr onflow.	
19.00	⇒ pt Round platelet 2 U reservation done. Request send to Blood bank.	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature] 0002	JAYADEVI J	0002	15/12/23	19.30

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NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 15/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

Diagnosis: T2DM | HTN | Severe Calcific Aortic stenosis
GCS: 15/15
NEWS / PEWS Score: –
POD:
Ventilator day: –
Central line days: –
Peripheral line day: Right: cephalic Left: cephalic
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: 97.2(°F) | Pulse / HR: 84 (beats/min) | Respiration: 24 (breaths/min)

BP: 111/44 (mmHg) | SpO_2: 92 (%) | Height: ±168 (cms) | Weight: ±60 (kgs) | BMI: 21.3 kg/m²

Others : –

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

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

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

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

Current diet: DM diet
Drains: –

R — RECOMMENDATION

Referral doctors: Dr. Gastro opinion
Pending medications: –
Pending medication indent: –
Pending lab reports / Investigations: CBC, LFT, RFT, HBsAg,
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: –
Pending follow-up orders:
Special instructions if any: Plan for Tapping.

	Signature	Name	Emp. No:	Date	Time
Handover given by	[signature]	Madhumitha	02AH	16/12/23	7.30
Handover taken by	[signature]	R. Udhaya	2352	16/12/23	7.30
Document endorsed	[signature]	JAYADEVI	0002	16/12/23	7.30am

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
15/12/23 @ 19.45	Pt hand over taken from evening duty staff. Pt on room air. Pt was hemodynamically stable. Pt Inj. Pan - 4ml/hr - and Inj. lasix - 2ml/hr on flow. Fluid restriction 1-1.5 litre/day	0244.
20.10.	Inj. H.A - 4U S/C given.	
20.30	Pt medication oral dinner taken.	
20.40	Pt medication given as per drug chart.	0244.
21.00	Pt V/S are checked and recorded.	
22.00	Pt was sleeping.	0244
00.00	Pt V/S are checked and recorded.	
4.00	Morning sample taken.	
5.00	Morning care given	0244
6.00	ECG and CBG taken	
7.00	Pt V/S are checked and recorded. Pt voided motion.	0244
7.30	Pt hand over to morning duty staff.	0244.

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	JAYADEVI J	0002	16/12/23	7:30

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Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 16/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: T2DM, HTN, Severe Calcific Aortic Stenosis, ? CTD, CKD GCS: 15/15

NEWS / PEWS Score: POD: –

Ventilator day: Central line days: –

Peripheral line day: Right: cephalic Left: cephalic

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: AIR ROOM ON IV fluids on flow: –

Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 68/mt (beats/min) | Respiration: 20/mt (breaths/min)

BP: 123/60 (mmHg) | SpO_2: 95 (%) | Height: 168 (cms) | Weight: 60 kg (kgs) | BMI: 21.3 kg/m²

Others :

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

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

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

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

Current diet: DM diet Drains: –

R

RECOMMENDATION

Referral doctors: MGE opinion.

Pending medications:

Pending medication indent:

Pending lab reports / Investigations: Gm

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: Ab BEAE, urine C/S, Ⓡ due, To send Br. ammonia

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	R. Mohany	2352	16/12/23	14.30
Handover taken by	[signature]	S. Alliyanayani	0462	16/12/23	14.00
Document endorsed	[signature]	JAYANDHI	0042	16/12/23	14.30

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
16/12/23 @ 8.00	pt taken over from Night duty staff. pt consious oriented => pt V/S Noted & Recorded. Inj Lasix 40/40 2mg/hr on flow => Inj - Pan 8/40 - 4ml/hr on flow CBC / RFT, LFT Report collted => pt oral taken fluids No Gastric compleints	Nee 286
9.00	pt Had a diet. administered the medication as per drug chart - Nebs given.	Nee 286
10.00	Dr. Jaishankar visit to the patient. T. Aldacton added & Nep opinion to do.	Nee 286
12pm	pt Continous cardiac monitoring & record it	Nee 286

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	Jay	JAYASRI	00	16/12/23	13.00

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Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 16/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: T2DM / HTN / Severe calcification aortic stenosis / ? UTI.

GCS: 15/15

NEWS / PEWS Score:

POD:

Ventilator day:

Central line days: —

Peripheral line day: Right: cephalic 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: Air Room.

IV fluids on flow: —

Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 88 (beats/min) | Respiration: 27 (breaths/min)

BP: 165/66 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²

Others :

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

Fall Risk Score: 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: DM diet.

Drains:

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations: Urine C/S, Sr. Ammonia, Ascitic fluid. Protein, Albumin, TC, DC. Sr. AFB.

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]	S. Alliyammal	0161	16/12/23	19.30
Handover taken by	[signature]	Premalatha	0211	16/12/23	19.30
Document endorsed	[signature]	Jayashree	0002	16/12/23	19.30

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
16/12/23		
14.00	⇒ patient took handed over from morning duty staff pt haemodynamically stable pt concious and oriented pt had semi diet given.	[signature]
14.20	⇒ medication as per dr chart. Inj. Lasix 2ml/hr on flow.	[signature]
15.30	⇒ pt was haemodynamically stable.	
16.30	⇒ Dr. Karthik. N visit the pt Advice to Ascitic taping and send to protein, albumin, TC, DC.	[signature]
17.00	⇒ pt tapping done 2000ml removal of fluid. patient motion passed.	
18.10	⇒ pt catheterization done ⇒ pt suddenly temperature increase Inform to Dr. Karthik advice to inj. Paracetamol 1gm given.	[signature]
18.30	⇒ inj. Oxytor 20mg SC given as per dr chart.	[signature]
19.00	⇒ Infusion Lasix stopped as per dr chart. ⇒ Inj. Pan 40mg given as per order.	[signature]
19.10	⇒ Inj. albumin.	[signature]
19:30	→ pt handing over to Night duty staff Nurse.	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	JAYASRI J	0930	16/12/23	2020

MHI/NUR/2022/048

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Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 16/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: T2DM / HTN / Severe Calcific for aortic stenosis GCS: 15/15

NEWS / PEWS Score: – POD: –

Ventilator day: Central line days: –

Peripheral line day: Right: cephalic Left: cephalic

Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/5

Urinary Catheter: ☑ Yes ☐ No Day: D1

Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism: –

B

BACKGROUND

Type of surgery: – Date of surgery: –

Allergies if any: NKDA

On room air / oxygen: O2 4 L via fm IV fluids on flow: IVF Inj. Albumin 15 ml/hr.

Complaints / New Symptoms in last shift: –

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 30 (breaths/min)

BP: 113/54 (mmHg) | SpO_2: 95 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²

Others : –

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

Fall Risk Score: 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: Diabetic diet. Drains: –

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations: Urine C&S, Sr Amonia, Ascitic fluid, Protein, Albumin, TC, DC

Critical value alert and its corrections: Sr AFB, Platelet count.

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

Pending follow-up orders: } Nil

Special instructions if any: } Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	S. Premalatha	0211	17/12/23	7.30
Handover taken by	[signature]	Aarthi	0282	17/12/23	7.30
Document endorsed	[signature]	Jayapriya	0002	17/12/23	7.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
16/12/23	Night duty notes	
@ 19:30	⇒ Pt taken over from evening duty staff. Pt is conscious & oriented. Pt haemodynamically stable & recorded.	021
19:40	⇒ T-98F, P-68 b/mt, R-20 b/mt, BP-138/62 (92) mmHg, SPO2-98%.	021
19:50	⇒ Pt FMO2 4 litres onflow.	
20:00	⇒ Pt CBD present Day-1	021
20:10	⇒ Pt had diet no other complaints	
20:30	⇒ Pt medication given as per drug chart. Inj. albumin 50ml/hr onflow.	021
20:45	⇒ Neb. foracort given as per drug chart	
21:45	⇒ Pt hourly I/O chart maintained & recorded.	021
23:00	⇒ Pt provide comfortable position sleeping well no other complaints	021
17/12/23 00:00	⇒ Pt V/S stable & recorded.	
04:30	⇒ Pt blood investigation TC, S.Ammonia & platelet count send to lab.	021
05:00	⇒ Pt morning care is given.	
06:00	⇒ Pt ECG given. CBG checked & recorded. Pt hourly I/O chart maintained	021
07:00	⇒ Pt Inj. Pan 40mg given as per drug chart	021
07:30	⇒ Pt hand over to morning duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jeyn	JAYA DEVI J	0021	17/12/23	9.45

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Pat Mr.ANANTHA KRISHNAN.P.N
Na 79/Male/MHI202381290
UH 15/12/2023/IPH202302516
DC Dr.K.JAISHANKAR
DI
Cı

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 17/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: DM, HTN, SEVERE CALCIFIC FOR AORTIC STENOSIS GCS: 15/15
NEWS / PEWS Score: — POD: —
Ventilator day: — Central line days: —
Peripheral line day: Right: Cephalic Left: cephalic
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: 2lit O2 Fm IV fluids on flow: —
Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp 98.4 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 32 (breaths/min)
BP: 130/62 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: ______ **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains: —

R

RECOMMENDATION

Referral doctors: — MGE.
Pending medications: —
Pending medication indent: —
Pending lab reports / Investigations: Urine c/s Report, ~~Sr Amonia~~, Ascitic Fluid Protein, ~~Albumin TC+DC~~, Sr. AFB.
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]	Anithi	0282	17/12/23	13.00
Handover taken by	[signature]	S. Allwinprangrace	0162	17/12/23	13.00
Document endorsed	[signature]	JAYADEVI	0 00	17/12/23	13.00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
17/12/23	MORNING DUTY REPORT	
7.30	pt Report taken from night duty S/N, pt is conscious & oriented pt vitals are monitoring.	Abhi 0282
8.30	pt take diet & morning drugs are given he have complaint of [illegible].	Abhi 0282
12.00	pt on continuous cardiac monitoring. there is no any issues.	Abhi 0282
13.00	patient Report h/o to afternoon duty S/N.	Abhi 0282

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	Jay	JAYASRI J	0002	17/12/23	14:00

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 17/12/23. Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: T2DM / HTN / Severe Calcific for Aortic Stenosis, GCS: 15/15

NEWS / PEWS Score: POD: —

Ventilator day: Central line days: —

Peripheral line day: Right: Cephalic Left: Cephalic

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: 2 litre O2 FM IV fluids on flow: —

Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 97.8 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 19 (breaths/min)

BP: 143/54 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²

Others :

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

Fall Risk Score: 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: DM diet Drains: —

R

RECOMMENDATION

Referral doctors: MGE

Pending medications:

Pending medication indent:

Pending lab reports / Investigations: Urine c/s, TC, DC, Sr. Albumine.

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any: To do CBC, RFT Tommorow.

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	S. Alleviz gnanapraw	0162	17/12/23	19.30.
Handover taken by	[signature]	S. Premalatha	021	17/12/23	19:30
Document endorsed	Jay	JAYAGEN	002	17/12/23	19:35

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
17/12/22		
13.00	⇒ patient took hand over taken from morning duty staff pt conscious and oriented pt was haemodynamically stable. pt on face mask O2 2litres Onflow.	[signature] 0162
13.00	⇒ CBG checked and recorded informed to Dr. Akbar advice to inj. H.A 10U H.A s/c given.	[signature] 0162
13.20	⇒ pt had Dm diet given diet	
14.00	⇒ Medication as per drug chart.	
14.30	⇒ Nebulisation given as per drug chart	[signature] 0162
14.30	⇒ pt Not Cooperative informed to Attender consent taken for Physical Restraint 2nd hourly Released.	[signature]
15.00	⇒ hourly I/O and V/S checked and Recorded.	
16.20	⇒ Inj. Septor 20 mg IV given as per drug chart.	[signature]
18.00	⇒ Inj. Albumin 20% stat 20ml/hr onflow. D2	
19.00	⇒ Inj. Pan 40mg given as per drug chart.	[signature]
19.30	⇒ pt hand over given to night duty staff.	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay[signature]	JAYADEVI	00[illegible]	17/12/22	20.00

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(A Unit of United Alliance Healthcare Pvt Ltd)

NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 17/12/23. Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: T2DM / HTN / SEVERE CALCIFIC AORTIC STENOSIS. GCS: 15/15
NEWS / PEWS Score: POD: —
Ventilator day: Central line days: —
Peripheral line day: Right: Cephalic Left: Cephalic
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: 2 litres FMO2. IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 69. (beats/min) | Respiration: 27. (breaths/min)
BP: 143/68. (mmHg) | SpO_2: 99. (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m^2.
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 05 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications: Nil
Pending medication indent: Nil
Pending lab reports / Investigations: urine C/S, TC, DC, ESR, RFT, LFT (R) due
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: ______
Pending follow-up orders: Nil
Special instructions if any: Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature] 0211	S. Premalatha	0211	18/12/23	07:30
Handover taken by	[signature]	Daya	0159	18/12/23	7-30
Document endorsed	Jaya	JAYAPRIYA	0001	18/12/23	7-30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
17/6/23	Night duty Notes	
@ 19:30	⇒ Pt taken over from evening duty staff. Pt is Conscious & Oriented. Pt haemodynamically stable & recorded.	024
19:40	⇒ T-98°F, P-68 b/mt, R-22 b/mt, BP-90/68 mmHg, SpO2-98%.	0211
19:50	⇒ Pt FMO2 2litres onflow & CBD Present Day-2.	024
20:00	⇒ Pt Inj. Human Atrapid 2 units given as per DM chart. Pt had diet no other complaints	024
20:30	⇒ Pt medication given as per drug chart.	024
	⇒ Neb. levolin & foracort given as per drug chart	024
20:45	⇒ Pt antibiotic monocef 1g IV given as per drug chart	024
22:00	⇒ Pt hourly I/O chart maintained & recorded.	024
23:00	⇒ Pt Provide comfortable position sleeping well no other complaints	
18/6/23 00:00	⇒ Pt V/S stable & recorded.	024
04:30	⇒ Pt blood investigation CBC, RFT send to lab.	
05:00	⇒ Pt morning care is given.	024
06:00	⇒ Pt ECG given & CBG checked & recorded	
07:00	⇒ Pt inj. Pan 40mg given as per drug chart	024
07:30	⇒ Pt hand over to morning duty staff	

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	Jay	JAYASREE	0002	18/12/23	9.45

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79/Male/MH1202381290
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Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 18/12/23 . Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION
Diagnosis: T2DM / SHTN / SEVERE CALCIFIC FOR AORTIC STENOSIS
GCS: 15/15
NEWS / PEWS Score:
POD: —
Ventilator day:
Central line days: —
Peripheral line day: Right: cephalic Left: cephalic
Ryle's Tube: ☐ Yes ☐ No Day:
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: D 3
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: 2 Ltr FMD ON FLOW
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT
Vital Signs: Temp: 97.7°F) | Pulse / HR: 64 (beats/min) | Respiration: 24 (breaths/min)
BP: 130/73 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT
Fall Risk Score: 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: DM DIET
Drains: —

R

RECOMMENDATION
Referral doctors: Dr. Ananth
Pending medications: NIL
Pending medication indent: NIL
Pending lab reports / Investigations: TC, DC, urine c/s @ due
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modif —
Pending follow-up orders:
Special instructions if any: plan

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Ramya. R	0152	18/12/23	11.00
Handover taken by	[signature]	M. Dasle	08	18/12/23	1100
Document endorsed	[signature]	S. Nalini	0024	18/12/23	13:00

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
18/10/23	MORNING DUTY NOTES	
@ 7.30		
	→ pt on taken over from night duty staff, pt on conscious & oriented, v/s checked & recorded, 2 lit/ O2 face Mask, CBD ⊕ D3 back clear no complaints	[signature]
8.30	→ pt had break fast done Medication given as per daily chart	
	→ CBC RFT, LFT ⓢ collected.	[signature]
9.30	→ DR. JASHANKAR bid order to pt ward shifted plan, T. Tamiflu T. Abee Stoped. T. INDERAL 20 mg pt BD Start as per drug chart pt on Mobilised to chair	[signature]
10.00	→ wheels, Tc, DC ⓢ due → pt no complaints → pt on 2 lit /NP shifted	
11.00	→ pt handing over to ward staff	[signature]
	Received notes	
11.30	pt received from CCU pt came c̄ phlebitis Both hand c/o Brachial, hand over given by S/N Ramya.	[signature]
12.10	→ patient hand over given as evening duty staff	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	C. Nalini	0024	18/12/23	13:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 18/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

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

B

BACKGROUND

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

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 18 (breaths/min)
BP: 140/80 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²
Others : —

Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 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: DM diet Drains: —

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	R. Sushma	0201	18/12/23	19:00
Handover taken by	[signature]	A. Anitha	0222	18/12/23	19:00
Document endorsed	[signature]	S. Nalini	0024	18/12/23	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
18/12/23 @	Evening duty Notes	
12.00	⇒ patient handing over taken from evening duty staff	[signature]
12.00	⇒ pt Consious & Recorded.	
13.30	⇒ pt due drugs are given.	
14.00	⇒ pt had @ diet	[signature]
16.00	⇒ pt well Mobilized.	
18.30	⇒ pt I/o chart Monitered	[signature]
19.00	⇒ pt v/s checked & Recorded.	
19.00	⇒ pt handing over given by Night duty Staff	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0024	18/12/23	2:00

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Pat Mr.ANANTHA KRISHNAN.P.N
Nat 79/Male/MHI202381290
UHI 15/12/2023/IPH202302516
DOI Dr.K.JAISHANKAR
DOA
Con:

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 18/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: severe calcific for aortic stenosis GCS: 15/15
NEWS / PEWS Score: POD: —
Ventilator day: Central line days: —
Peripheral line day: Right: — Left: cephalic
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: Room air IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 64 (beats/min) | Respiration: 24 (breaths/min)
BP: 180/70 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 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: Drains:

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	A. Anitha	0222	19/12/23	7.30
Handover taken by	E. Cat	E-Cathrine	0207	19/12/23	7.30
Document endorsed	[signature]	C. Nalini	0084	19/12/23	8.0

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	NIGHT DUTY notes	
18/12/23 19.30	→ patient hand over taken from evening duty staffs	Ai/0222
	→ patient conscious and oriented	
20.00	→ medication given as per drug chart	Ai/0222
21.00	→ nebulization given to the pt	
23.00	patient sleep well	
	→ patient hemodynamically stable	Ai/0222
5.00	→ pt vital signs checked & recorded	
6.00	→ I/O chart monitored	
	→ CBD DAY - 5	
7.30	→ pt hand over given to morning duty staffs	Ai/0222

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nale	S. Nalesi	0024	19/12/23	8:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 19/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: Severe calcific for aortic stenosis GCS: 15/15
NEWS / PEWS Score: POD: –
Ventilator day: Central line days: –
Peripheral line day: Right: – Left: cephalic
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: NKD
On room air / oxygen: Room air IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 97.8 (°F) | Pulse / HR: 64 (beats/min) | Respiration: 22 (breaths/min)
BP: 130/70 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m^2
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS ✓ / CPOT
Fall Risk Score: 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: Drains:

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Jeni Priya	0284	19/12/23	8.00
Handover taken by	[signature]	A. Anitha	0222	19/12/23	19.00
Document endorsed	[signature]	S. Nalini	0024	19/12/23	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	MORNING DUTY NOTES	
19/12/23		
@	=> pt handing over	Jen
7.30	taken from night duty staff.	
	=> pt vitals are checked	
8.30	=> pt had break fast done	Jen
	=> Medication given as	
	per drug chart.	
9.30	=> pt Neubulization was	
	given.	
	=> pt sleep well	Jen.
	=> pt consious and orientation	
10.30	=> pt had normal diet.	
	=> pt drug given.	
	=> pt vitals are checked	Jen
11.30	=> pt Mobilized well	
	=> Neubulization given to	
	the patient.	
12.30	=> pt I/O chart Maintain	Jen
	=> pt handing over given	
	to evening duty staff.	
14.00	=> pt had diet, patient due drugs	E-Cati 0207
	are given	
16.00	=> pt V/S checked & recorded	E-Cati 0207
18.30	=> pt V/S checked & recorded	
	=> pt I/O chart maintained	E.C 0207
	=> pt well mobilized	
19.30	=> pt handed over to Night duty	E.C 0207
	staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0024	19/12/23	20.L

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Dr.K.JAISHANKAR

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: severe calcific aortic stenosis GCS: 15/15
NEWS / PEWS Score: 0 POD: —
Ventilator day: — Central line days: —
Peripheral line day: Right: — Left: cephalic
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: Room air IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 64 (beats/min) | Respiration: 22 (breaths/min)
BP: 130/70 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 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: Drains:

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
(all above: 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. Anitha	0222	20/12/23	7.30
Handover taken by	[signature]	A. Nandhini	0170	20/12/23	7.30
Document endorsed	[signature]	S. Nalini	0084	20/12/23	8.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	NIGHT DUTY notes	
19/12/23 19:30	→ patient hand over taken from Evening duty staffs	Ai 0222
	→ Patient conscious and oriented	
20:00	→ medication given as per drug chart	
21:00	→ Nebulization given to the pt	Ai 0222
22:00	→ Patient hemodynamically stable	
23:00	→ pt sleep well	Ai 0222
5:00	→ pt vital signs checked & recorded	
6:00	→ I/O chart monitored	
7:30	→ pt hand over given to morning duty staffs	Ai 0222

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0084	20/12/23	8:00

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Patient Name: Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: severe calcific aortic stenosis GCS: 15/15

NEWS / PEWS Score: 0 POD: —

Ventilator day: — Central line days: —

Peripheral line day: Right: — Left: cephalic

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: Room air IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 84 (beats/min) | Respiration: 22 (breaths/min)

BP: 130/90 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²

Others : —

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

Fall Risk Score: 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: Drains:

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
(above) 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]	Jenipriya	0284	20/12/23	8.00
Handover taken by	[signature]	Amony Lex	0141	20/12/23	12.20
Document endorsed	[signature]	R. Nalini	0084	20/12/23	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
20/12/23 @ 8.00	MORNING DUTY NOTES	
	=> Pt handing over taken from night duty staff.	Jen
8.30	=> Pt vitals are checked	
	=> Pt conscious and orientation	
	=> Pt due drugs are given.	Jen
9.30	=> Pt Mobilized well	Jen
	=> Pt sleep well	
10.00	=> Pt Neubulisation was given.	
	=> Pt had Normal diet.	
10.30	=> Pt vitals checked and Recorded.	Jen
	=> Pt had Normal diet and Medication given.	
11.30	=> Pt I/O chart Monitored	Jen
	=> Pt had Normaldiet.	
	=> Pt vitals are stable.	
12.3-	-> patient handing over to Evening duty Staff Nurse	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0084	20/12/23	13:00

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79/Male/MH1202381290
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Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

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

B

BACKGROUND

Type of surgery: — Date of surgery: —
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: 100/60 (mmHg) | SpO_2: 98 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: [illegible] **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. Monika	0161	20/12/23	07:30
Handover taken by	— Shifted to CCU				
Document endorsed	[signature]	Dhanalakshmi	005	20/12/23	19:30

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
20/12/23	Evening duty note	
12:30	pt hand over taken from morning duty staff pt is stable & conscious. vital signs checked & recorded. pt sleep well	[signature]
1:00	pt complaint for sleepy. vital signs checked & recorded T- 98.6, P - 60 b/m SpO₂ - 96 %. but pt is [illegible] informed to Dr. Krishnan sir advised to start [illegible] & shifted to CCU	[signature]
[illegible]:30		[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Dharmarani	0005	20/12/23	19:30

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/SBAR/IP/2022/029

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/12/23 Shift: ☐ Morning ☐ Evening ☐ Night RECEIVING NOTES.

S

SITUATION

Diagnosis: BPH, DM, HTN
GCS: 15/15
NEWS / PEWS Score: 0/6
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:
? hepatic encephalopathy

B

BACKGROUND

Type of surgery: –
Date of surgery: INTA 400ML OUTPUT → 500ML
Allergies if any: –
On room air / oxygen: (FM) 2LITRE
IV fluids on flow: FR / LITRE. IVF 30ML/HR
Complaints / New Symptoms in last shift: –

A

ASSESSMENT

Vital Signs: Temp: 98.9 (°F) | Pulse / HR: 70 (beats/min) | Respiration: 18 (breaths/min)

BP: 130/90 (mmHg) | SpO_2: 96 (%) | Height: – (cms) | Weight: – (kgs) | BMI: –

Others : –

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

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

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

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

Current diet: SOFT DIET
Drains:

R

RECOMMENDATION

Referral doctors: NEPHRO CONSULTANT, MGIE OPINION, DROWSE, DISORIENTED,
ONCOLOGIST OPINION NONE.
Pending medications: NOT CONTINUED
PAIN ATTEND NOT CALLING
Pending medication indent: –
ASCITIC TAPPING DONE
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: SEND U/R.
Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	S/N K. VIJAYAN	2351	21/12	7AM
Handover taken by	[signature]	G. Jancy	2009	21/12/23	8AM
Document endorsed	[signature]	S/N K. VIJAYAN	2351	21/12	7AM

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
20/12/23	RECEIVING NOTES:	
7:00PM	PATIENT RECEIVED FROM MH1 1ST FLOOR TO ICU (MAIN) C/O DROWSINESS AND BREATHLESSNESS AND (FM) 4 LITRE SPO2-97% AND VITALS CHECKED AND CBG 161NG/DL	330
8:30PM	PATIENT INJ: DYTOR 20MG IV GIVEN	
9:30PM	PATIENT JELLY GIVEN INTAKE IS VERY POOR	330
10:00PM	PATIENT ALL MEDICINES GIVEN AS PER DRUG CHART.	
12:00AM	PATIENT VITALS CHECKED AND IVF-30 ML/HR ON FLOW.	330
2:00AM	PATIENT HE WAS SLEEPED NO OTHER COMPLAINTS IN BEDSIDE	330
4:00AM	PATIENT HE WAS COMFORTABLE POSITION	
5:00AM	PATIENT MORNING ROUTINE BLOOD SAMPLE SENT TO MH LAB	
5:45AM	PATIENT MORNING CARE IS GIVEN BACK CARE, MOUTH CARE IS GIVEN	330
6:30AM	PATIENT VITALS CHECKED AND CBG CHECKED 109 IVF 30ML/HR ON FLOW	
7:30AM	PATIENT HANDING OVER TO MORNING DUTY S/N	330

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S/N K VIJAYAN	330	21/12	7AM

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79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/SBAR/IP/2022/029

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 21/12/23 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: nil Date of surgery: Nil
Allergies if any: nil
On room air / oxygen: NP (2 litres) IV fluids on flow: 50ml/hr
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 70 (beats/min) | Respiration: 20 (breaths/min)
BP: 130/80 (mmHg) | SpO_2: 97 (%) | Height: – (cms) | Weight: – (kgs) | BMI: –
Others : –
Pain Score: – **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☑ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: Normal diet Drains: –

R — RECOMMENDATION

Referral doctors: – ⇒ Urologist opinion (2023)
⇒ TAVI Attender not willing
⇒ (More pending)
Pending medications: –
Pending medication indent: –
Pending lab reports / Investigations: Stool for occult Blood (R) due.
Critical value alert and its corrections: –
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date:
Pending follow-up orders: Urine RE.
Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	U. Samuel	2008	21/12/23	1pm.
Handover taken by	[signature]	Sri Pavan	2057	21/12/23	2pm
Document endorsed	[signature]	[signature]	683	21/12/23	2pm

MH/SBAR/IP/2022/029

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Morning duty on NOTES 21/12/23	
8am	patient taken over Night duty staff. continuous cardiac monitoring conscious oriented. patient vitals signs checked by recorded patient morning due medication given. patient Normal diet given. patient IVF - NS 30ml/Hr	G. Jancy 2042
10:00 am	→ patient right hand peripheral IV line present. patient NP 2 litres O2 supports on flow. patient urine c/s No Growth. patient self void. motion passed. Negative balance.	
	→ patient urine R/E due to be follow	G. Jancy 2042
12.30 pm.	patient vitals signs checked by recorded continuous cardiac monitoring. conscious oriented. patient CBG checked by recorded. pt handing over evening duty staff	G. Jancy 2042

Document endorsed by	Signature	Name	Emp. No.	Date	Time

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Dr.K.JAISHANKAR

MH/SBAR/IP/2022/029

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 21/12/23 Shift: ☑ Morning ☑ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: — Date of surgery: —
Allergies if any: —
On room air / oxygen: N/p 2 litr (or) IV fluids on flow: stopped
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 72 (beats/min) | Respiration: 20 (breaths/min)

BP: 140/70 (mmHg) | SpO_2: 98 (%) | Height: — (cms) | Weight: — (kgs) | BMI: —

Others : —

Pain Score: ______ **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: Normal diet Drains: Nil

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	S/N: Sri Priyal	2053	21/12	8pm
Handover taken by	[signature]	S/N K VIJAYAN	2301	21/12	8PM
Document endorsed	Gowri	Gowri	685	21/12	8pm

MH/SBAR/IP/2022/029

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	(21/12/22) Evening duty Notes	
1pm	Patient Received Over Take From Morning duty Staff. Patient in O_2 Support [illegible] (O_2 2 litre) Patient Was Comfortable Position	
2pm	Patient due Medicine all Given Patient Was Normal diet Given Patient I/O Chart Monitoring Properly Patient Was Self [illegible]	[signature] 2053
4pm	Patient Continue Cardiac Monitoring Patient vitals are Stable. Inj [illegible] Stopped [Order Dr. HARISH]	Sr [signature] 2053
6pm	Patient Inj Dyclox 1gm IV Started Patient CBG Was Checked.	
7pm	Patient Handed Over to the Night duty Staff	SRI [signature] 2053

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Sr. SRI [illegible]	2053	21/12/22	8pm

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Dr.K.JAISHANKAR

MH/SBAR/IP/2022/029

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 21/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: BPH, DM, HTN. GCS 15/15
NEWS / PEWS Score: 0/6 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: –
On room air / oxygen: NP-2L/RE SpO2-96 IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A

ASSESSMENT

Vital Signs: Temp 97.8 (°F) | Pulse / HR: 70 (beats/min) | Respiration: 18 (breaths/min)
BP: 120/70 (mmHg) | SpO_2: 96 (%) | Height: – (cms) | Weight: – (kgs) | BMI:
Others :
Pain Score: 0 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 2 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☑ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Drains: –

R

RECOMMENDATION

Referral doctors: MOTE OPINION
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: U/R

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	JS/N K Vijayan	2301	22/12	7AM
Handover taken by	[signature]	S/N - Sr Pramod	2053		
Document endorsed	JS/N K [signature]	JS/N K Vijayan	2301	22/12	7AM

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
22/12/23	NIGHT DUTY NOTES S/N KVIJAYAN	
7:45PM	PATIENT HANDING OVER TAKEN FROM EVENING DUTY S/N. PATIENT CONSCIOUS AND ORIENTED, AND O2-NP 2LITRE SPO2-96% AND VITALS CHECKED AND CBG 220MG/DL	230
9:00PM	PATIENT NIGHT DINNER IS GIVEN INTAKE IS POOR	
9:30PM	PATIENT NIGHT DINNER GIVEN AND DUE MEDICINES GIVEN AS PER DRUG CHART.	
10:30PM	PATIENT VITALS CHECKED AND PATIENT O2-2LITRE SPO2-96%	230
11:40PM	PATIENT URINE ROUTINE SAMPLE SEND TO MH LAB.	230
12:45AM	PATIENT VITALS CHECKED AND CONTINUE O2-NP-2LITRE.	230
2:00AM	PATIENT HE WAS COMFORTABLE POSITION	
4:00AM	PATIENT HE WAS SLEEPED NO OTHER COMPLAINTS IN BED SIDE.	
5:00AM	PATIENT ROUTINE BLOOD SAMPLE SEND TO MH LAB.	230
5:30AM	PATIENT MORNING CARE IS GIVEN, BACK CARE, MOUTH CARE IS GIVEN.	
6:30AM	PATIENT VITALS CHECKED AND NP-2LITRE SPO2-96%	230

Document endorsed by.	Signature	Name	Emp. No.	Date	Time
	[signature]	S/N K.VIJAYAN	230	22/12	7AM

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Dr.K.JAISHANKAR

MH/SBAR/IP/2022/029

PATIENT CLINICAL HANDOVER RECORD FOR NUSRSES

Date: 22/12/23 Shift: ☑ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: BPH
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: –
On room air / oxygen: –
IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 72 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO_2: 96 (%) | Height: – (cms) | Weight: – (kgs) | BMI: –

Others : –

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

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

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

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

Current diet: Normal diet
Drains: Nil

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Shri Sai Prasad	2003	22/12/23	3pm
Handover taken by	[signature]	Dharanamani	005	22/12/23	16:00
Document endorsed	1008	1008	681	22/12/23	8pm

MH/SBAR/IP/2022/029

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
22/12/23	Morning Notes Staff	
7AM	Patient Received Over Note from Night duty Staff	
	Patient on Room air Support	
	Patient Was Comfortable Doctor	
8AM	Patient due Medicine all Given	
	Patient Was Self Void	
	Patient Was planned diet	[illegible] 203
	Patient I/O chart Monitoring	
10AM	Patient Continue Cardiac Monitor	
	Patient Vital see Staff	
11AM	Patient Can Was Checked (202)	
	[illegible] Dr. KRANIKAR Order by	
	H.A Received S/c [illegible]	
3PM	Patient Shifted to Ward Room	[illegible] 203
3pm	Patient Shifted to Ward (207)	
	(HI) 22/12/23 at 3:20pm	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	[signature]	203	22/12	8PM

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MHI/NUR/2022/048

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 22/12/23 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: RHD severe calcific aortic stenosis
GCS: —
NEWS / PEWS Score: 6
POD: —
Ventilator day: —
Central line days: 5
Peripheral line day: Right: cephalic Left: cephalic
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: ~~2 liters~~ /day —
IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 32 (breaths/min)

BP: 180/52 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m²

Others : —

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

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

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

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

Current diet: DM diet
Drains: —

R — RECOMMENDATION

Referral doctors: nil
Pending medications: nil
Pending medication indent: nil
Pending lab reports / Investigations: nil
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]	A. Anitha	0222	22/12/23	19.00
Handover taken by	[signature]	M. Revathi	0225	22/12/23	19.30
Document endorsed	[signature]	Nalini	0024	22/12/23	10.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Evening duty notes	
22/12/23 19.30	→ patient hand over given taken from morning duty staffs	Ai / 0222
15.00	→ patient conscious and oriented	
	→ medication given as per drug chart	
16.00	→ patient vital signs checked & recorded	Ai / 0222
17.00	→ I/O chart monitoring	
19.00	→ Pt hand over given to Night duty staffs	Ai / 0222

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	[signature]	Nalini	0024	22/12/23	1010

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79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 22/12/23 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: RHD severe calcific aortic stenosis GCS: 15/15

NEWS / PEWS Score: 0 POD: –

Ventilator day: – Central line days: –

Peripheral line day: Right: – Left:

Ryle's Tube: ☐ Yes ☑ No Day:

Urinary Catheter: ☐ Yes ☑ No Day:

VIP Score: 0/5

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: 96.4 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/60 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 60 (kgs) | BMI: 21.3 kg/m2

Others : –

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

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

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

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

Current diet: Diabetic diet Drains: –

R

RECOMMENDATION

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

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

Pending follow-up orders: –

Special instructions if any: –

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	M. Revathi	0225	23/12/23	7:30
Handover taken by	[signature]	Dhanasree	005	23/12/23	07:40
Document endorsed	[signature]	Nalini	0029	23/12/23	10:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
22/12/23 at	Night duty Note.	
19.30	→ pt hand over taken to the evening duty staff.	[signature] 0278
	→ Conscious & Oriented.	
	→ vitals checked & recorded.	
20.00	→ patient had a Diabetic diet	
	→ Medication given as per as drug chart.	
21.00	→ pt was stable & No have complaints	[signature] 0278
23.00	→ patient sleeping good.	
1.00	→ pt is on deep sleep.	
4.00	→ patient was stable & No have complaints	
6.30	→ vital signs checked & recorded	[signature] 0278
	→ I/O chart monitored.	
7.30	→ patient hand over given to the morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Nalini	0024	22/12/23	10 am

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

SITUATION

Diagnosis: Post D - same day 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: —

Urinary Catheter: ☐ Yes ☐ No Day:

Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: — Date of surgery: —

Allergies if any: not known

On room air / oxygen: 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: 110/70 (mmHg) | SpO_2: 98 (%) | Height: 161 (cms) | Weight: 60 (kgs) | BMI: 23.14 kg/m2

Others: Nil

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

Fall Risk Score: 6 **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	0161	23/12/23	12.30
Handover taken by	[signature]	Sruthi	1208	23/12/23	12.30
Document endorsed	[signature]	Nalini	0024	23/12/23	10.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
23/12/23	Morning duty note	
9:30	pt hand over taken from night duty staff pt is stable & conscious. vital was checked & Recorded	[illegible]
8:30	pt feed food medication was given as per chart	[illegible]
10:30	pt mobilised well vital was checked & Recorded	[illegible]
[illegible]	pt feed food medication was given as per chart	[illegible]
23/12/23	Discharge notes	
	patient heamodynamically stable pt conscious & Oriented. pt was checked & recorded. vitals are stable. Temp: 98.4°F. pulse: 80/mt, BP: 120/80 mmHg. SpO2: 98%. D/c summary. All lab reports & old Rx given to pt attender	[illegible]

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	[illegible]	Nalini	0021	23/12/23	10.0

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 15/12/23	Time: 18.00	Modified Date:	Time:
Reason for Modification:		Diagnosis: T2DM / HTN / SEVERE AORTIC STENOSIS / 2UTI / CKF	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M	
			E pt had DM diet.	[signature]
			N patient had dinner	[signature] 0158
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 O2 2 litre [illegible]	[signature]
			N patient SpO2 maintained 99%.	[signature] 0158
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M ↑	
			E pt take oral fluids.	[signature]
			N patient fluid status was balanced	[signature] 0158

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 Bed mobilize **N** patient was bed mobilized	M: E: [illegible] N: [illegible] 0158.
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 / consistent / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	**M** **E** pt (N) elimination pattern **N** patient elimination pattern was normal.	M: E: [illegible] N: [illegible] 0158.
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☑ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	**M** **E** pt maintain (N) skin integrity **N** patient skin integrity (N).	M: E: [illegible] N: [illegible] 0158.

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 cleanly hygiene N patient stay cleaned.	 [signature] 0158
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 cleanly hygiene. N patient ID band ⊕ checked	 [signature] 0158
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 pt comfort position. N provided comfortable position	 [signature] 0158
OBSERVATION ☑ Vital Signs ☑ GCS ☑ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M E pt Haemodynamical stable & Recordil N Pateent vitals stable.	 [signature] 0158
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 pt good psychological support N provided psychological support	 [signature] 0158

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 good verbal communication.	[illegible]
			N maintained good therapeutic relationship	[illegible] 0158.
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 Administered the medication as per dr's order	[illegible]
			N patient medication given as per chart	[illegible] 0158

Endorsed by	Signature	Name	Emp. ID	Date	Time
	Jay [illegible]	Jay Boris J	0002	15/12/23	21:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 18/12/23 Time: 8:00	Modified Date: Time:
Reason for Modification:	Diagnosis: T2DM / HTN / Severe Aortic Stenosis

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had a DM diet	[signature]
			E Pt had a DM diet	[signature]
			N patient had dinner.	[signature]
OXYGENATION ☑ Room Air ☑ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on Air Room Suppt SpO2-95%	[signature]
			E Pt on Room Air.	[signature]
			N Patient SPO2 maintained 98%.	[signature]
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt take oral fluid	[signature]
			E Pt taken oral fluid	[signature]
			N Patient fluid status was balanced	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☑ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	**M** pt mobilized on Bed **E** Pt mobilized on Bed **N** Patient was bed mobilized.	[signature] 23m [signature] [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** pt bedpan voiding **E** Pt Bed pan voiding **N** CBD (+)	[signature] 23m [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** maintain Normal Skin Integrity **E** Maintain (N) skin Integrity **N** maintained (N) Skin integrity	[signature] 23m [signature] [signature]

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 will stay clean groomed E Pt will stay clean groomed N Pt stay clean & well groomed.	[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) (R) Hand E ID band (P) [illegible] N Pt ID band (E)	[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 pt with comfortable Bed E Pt with comfortable N Pt had comforte sleep	[illegible]
OBSERVATION ☐ Vital Signs ☑ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M pt V/S monitoring hourly E Pt V/S montany N pt V/S monitored	[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 Pt psycological support (P) E Psychological support (P) N Psychological support given	[illegible]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	pt well good communication effection	[illegible]
			E	Pt will good communication	[illegible]
			N	maintained good rapport	[illegible] 0211
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	[illegible]
			E	Pt medication given as per	[illegible]
			N	patients medication given as per	[illegible] 0211

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jaye	JAYADEVI. J	00[illegible]	17/12/21	9.45

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ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 15/12/23	Time: 8.00	Modified Date:	Time:
Reason for Modification:		Diagnosis: T2DM / HTN / SEVERE CALCIFIC AORTIC STENOSIS / ?OTT	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
☑ NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt had diet	[signature] 0282
			E Pt had Om diet.	[signature]
			N Pt had Om diet	[signature] 0211
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 Fm with 2lit-O2	[signature] 0282
			E Fm O2 2 litter.	[signature] 0162
			N Pt FM O2 2 litres onflow	[signature] 0211
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 maintain on balanced electrolytes.	[signature] 0282
			E Pt maintain on fluid restricted	[signature]
			N Pt Maintain fluid restricted	[signature] 0211

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 on bed.	0262
			E Pt mobilized on bed	
			N Pt on bed mobilized	014
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 maintain on normal elimination pattern.	0262
			E Pt on CBD D2	
			N Pt on CBD Present Day-2	024
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 on normal skin integrity	0262
			E Maintained on (N) Skin Integrt	
			N Pt Maintain (N) Skin integrity	024

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 Well groomed E Well Stay Clean N Pt clean & well groomed	[signature] 0282 [signature] [signature]
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 (R) is hand E Pt ID (R) hand N Pt ID band present	[signature] 0282 [signature] [signature]
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 well comfort E Pt well comfortable N Pt provide comfortable position	[signature] 0282 [signature] [signature]
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 monitoring E Monitor vitalsigns N Monitored V/S checked & recorded	[signature] 0282 [signature] [signature]
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 Psychological support given E Psychological support N Pt provide psychological support	[signature] 0282 [signature] [signature]

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 maintain good communication	[signature]
			E maintained good communication	[signature]
			N Pt maintain good communication well	[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 Drug followed as per chart	[signature]
			E Medication as per drug chart.	[signature]
			N Pt medication given as per drug chart.	[signature]

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jay	JAYASRI	00[illegible]	18/12/23	9.45

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 18/12/23	Time: 8:00	Modified Date:	Time:
Reason for Modification:		Diagnosis: T2DM/HTN/SEVERE CALCIFIC AORTIC STENOSIS/?UTI/CCF	

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	[signature]
			E	Pt on DM diet	[signature]
			N	pt had DM diet	[signature]
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☑ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M	Pt on RA(2Lt)/onflow	[signature]
			E	Pt SpO2 99%.	[signature]
			N	Pt is on Room Air	[signature]
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M	Pt on I/O chart maintained	[signature]
			E	Pt I/O chart Maintained	[signature]
			N	I/O chart monitored	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☑ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	**M** → pt on 4 hrly Mobilized **E** pt well Mobilized **N** pt well mobilized	[illegible] [illegible] 024 [illegible] 022
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 on CBD ⊕ - D3 **E** pt Ⓝ pattern **N** pt on CBD ⊕ D3 ~~pt self voided~~	[illegible] [illegible] 021 [illegible] 022
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 on Maintain Ⓝ skin integrity **E** pt Ⓝ skin Integrity **N** maintain normal skin integrity	[illegible] [illegible] 024 [illegible] 022

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 on stay clean & well groomed	[illegible]
			E	pt well groomed	[illegible]
			N	pt well groomed	[illegible]
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☑ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M	pt on check ID band (+)	[illegible]
			E	pt ID band check	[illegible]
			N	ID band present	[illegible]
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M	—	
			E	—	
			N	—	
OBSERVATION ☐ Vital Signs ☑ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☑ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M	pt on v/s checked & recorded	[illegible]
			E	pt v/s checked	[illegible]
			N	pt v/s checked & recorded	[illegible]
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M	—	
			E	—	
			N	—	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☑ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	**M** pt on Good communication **E** pt well communication **N** pt good communicated	[illegible] [illegible] Ai 0222
SPECIAL INTERVENTIONS ☑ Medication ☑ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	**M** medication given as per drug chart **E** medication due given **N** medication given as per drug chart	[illegible] [illegible] Ai 0222

Endorsed by	Signature	Name	Emp. ID	Date	Time
	[signature]	S. Nalini	0024	18/12/23	14:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 19/12/23 Time: 8:00	Modified Date: Time:
Reason for Modification:	Diagnosis: sev calcific aortic stenosis

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had Normal diet. E Pt had Normal diet N pt had Ⓝ diet	Ser [illegible] 00/86 Ai 0222
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 SPO_2 - 95% N pt is on Room Air	Ser [illegible] 00/86 Ai 0222
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt I/O Chart Monitored. E I/O chart Monitored N I/O chart monitored	Ser [illegible] 00/86 Ai 0222

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.	Jey
			E Pt well mobilized	EC 0207
			N pt well mobilized	Ai 0222
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 / consistent / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M pt in U cath.	Jey
			E Pt is U- cath	EC 0207
			N U-cath	Ai 0222
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.	Je
			E Pt maintain normal skin integrity	EC 0207
			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.	[illegible]
			E Pt well groomed	[illegible] 0207
			N Pt well groomed	[illegible] 0222
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.	[illegible]
			E Pt ID Band (+)	[illegible] 0207
			N Pt ID band (+)	[illegible] 0222
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** Vitals are checked.	[illegible]
			E V/S checked & recorded	[illegible] 0207
			N Pt V/S checked & recorded	[illegible] 0222
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	**M** —	
			E —	
			N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	**M** Pt communication well	Jes
			E Pt well communicated	☑ C 0207
			N Pt good communicated	A 0221
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	**M** Pt due drugs are given.	Jes
			E Pt due drugs are given	☑ C 0207
			N due drugs are given	A 0221

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Na	S. Nalini	0024	19/12/23	18:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.K
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR
Consultant

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 20/12/22 Time: 8.00	Modified Date: Time:
Reason for Modification:	Diagnosis: severe calcific for aortic stenosis

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had normal diet.	Jen
			E pt is fed ⓝ	[illegible]
			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.	Jen.
			E [illegible]	[illegible]
			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.	Jen
			E I/O chart monitored	[illegible]
			N	

<table>
<tr><th>Patient Specific Problems / Needs</th><th>Measurable Goals</th><th>Nursing Interventions</th><th colspan="2">Evaluation</th><th>Sign & Initials</th></tr>
<tr><td rowspan="3">MOBILITY
☑ Mobile / Immobile
☐ Walk with assistance
☐ Physiotherapy
☐ Others:</td><td rowspan="3">☐ 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</td><td rowspan="3">☑ 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)</td><td>M</td><td>Pt mobilized well.</td><td>[signature]</td></tr>
<tr><td>E</td><td>Pt mobilized well</td><td>[signature]</td></tr>
<tr><td>N</td><td></td><td></td></tr>
<tr><td rowspan="3">ELIMINATION
☐ Catheter, bedpan, urinal
☐ Nasogastric tube
☐ Bowel movement
☑ Urination
☐ Others:</td><td rowspan="3">☑ Patient will have normal elimination pattern
☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns</td><td rowspan="3">☑ 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 / consistent / volume / Hemetemesis as per doctors order and follow proper protocol
☐ Check for malena / constipation / urinary retention</td><td>M</td><td>Pt Normal elimination pattern</td><td>[signature]</td></tr>
<tr><td>E</td><td>elimination pattern [illegible]</td><td>[signature]</td></tr>
<tr><td>N</td><td></td><td></td></tr>
<tr><td rowspan="3">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:</td><td rowspan="3">☑ Patient will maintain normal healing status
☐ Patient will discharge with intact skin integrity</td><td rowspan="3">☑ 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</td><td>M</td><td>Pt maintain Normal skin Integrity.</td><td>[signature]</td></tr>
<tr><td>E</td><td>—</td><td></td></tr>
<tr><td>N</td><td></td><td></td></tr>
</table>

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 I.D band checked. **E** ID band ⊕ **N**	[illegible]
COMFORT AND SLEEP ☑ Pain Control ☐ Sleep Patterns ☐ Others:	☑ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	**M** — **E** **N**	
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	**M** Pt vitals are stable. **E** [illegible] stable **N**	[illegible] [illegible]
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	**M** — **E** — **N**	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	**M** pt communication well.	Jan
			E Pt communicating well	[illegible]
			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** pt due drugs are given.	Jan
			E	
			N	

Endorsed by	Signature	Name	Emp. ID	Date	Time
	[signature]	S. Nalini	0024	20/12/23	16:00

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(A Unit of United Alliance Healthcare Pvt Ltd)

NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Patient Details
Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

				Date:	16	12	23
				Time:		E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals		3	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours		1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance		3	3
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		3	3
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair			3	3
				TOTAL SCORE		17	17
				Initial & Emp. No. of Staff Nurse:		[signature]	[signature] 0118
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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79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR
Consultant

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 16 / 12 / 23
Time: M | E | N

					M	E	N
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				TOTAL SCORE	17	17	17
				Initial & Emp. No. of Staff Nurse:	[illegible]	[illegible]	[illegible]
Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**	[illegible]	[illegible]	[illegible]

MHI/NUR/2022/045

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NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 17 | 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	4	4
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				TOTAL SCORE	15	15	15
				Initial & Emp. No. of Staff Nurse:	[illegible] 0282	[illegible]	[illegible]
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6				**Initial & Emp. No. of Sr. Staff Nurse:**	[illegible]	[illegible]	[illegible]

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 18 | 12 | 22
Time: M | E | N

					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
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				TOTAL SCORE	19	19	19
				Initial & Emp. No. of Staff Nurse:	[illegible]	[illegible]	[illegible]
				Initial & Emp. No. of Sr. Staff Nurse:	[illegible]	[illegible]	[illegible]

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

MHI/NUR/2022/045

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Na 79/Male/MH1202381290
UH 15/12/2023/IPH202302516
DO Dr.K.JAISHANKAR
DO
Con

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 19 12 23
Time: M E N

					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
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MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	✓ **4. No Limitation** Makes major and frequent changes in position without assistance	4	4	4
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				TOTAL SCORE	23	23	23
				Initial & Emp. No. of Staff Nurse:	P.C 0207	P.C 0207	Ai 0211
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:**	Ne 24	Ne 24	Ne 24

MHI/NUR/2022/045

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NABH

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 20	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	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:	[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]		

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79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/BS/IP/2022/027

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 20/12/23
Time: 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			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
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours			3
MOBILITY ability to change and control body *position*	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance			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
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			15
				Initial & Emp. No. of Staff Nurse:			[illegible]
Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**			[illegible]

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

	1	2	3	4	Date: 21	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	3	3	3
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ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	3	3
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	2	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	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		3	3	3
				TOTAL SCORE	15	15	15
				Initial & Emp. No. of Staff Nurse:	[illegible]	[illegible]	[illegible]
				Initial & Emp. No. of Sr. Staff Nurse:	[illegible]	[illegible]	[illegible]

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

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 22	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	3	3	3
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ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	3	3
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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	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		3	3	3
				TOTAL SCORE	15	15	15
				Initial & Emp. No. of Staff Nurse:	[illegible]	[illegible]	[illegible]
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6				**Initial & Emp. No. of Sr. Staff Nurse:**	[illegible]	[illegible] 05	[illegible] 05

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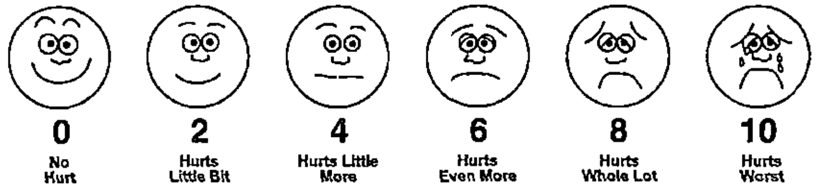
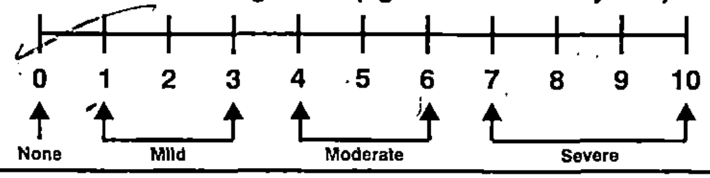
PAIN RE-ASSESSMENT & MONITORING CHART

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.
15/12/23 12.15	0/10	No pain	—	—	—	[signature]	Jay [signature]
13.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
14.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
15.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
16.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
17.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
18.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
19.00	0/10	No pain	—	—	—	[signature]	Jay [signature]
20.00	0/10	No pain	—	—	—	[signature]	Jay [signature]

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.
15/12/23 21:00	0/10	No pain	–	–	–	[signature] 0244	[signature]
22:00	0/10	No pain	–	–	–	[signature] 0244	[signature]
23:00	0/10	No Pain	–	–	–	[signature] 0244	[signature]
16/12/23 00:00	0/10	No Pain	–	–	–	[signature] 0244	[signature]

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)	 **Numerical Rating Scale (age more than 12 years)** 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling

Pharmacological Interventions as per doctor's prescription

MHI/NUR/2022/052

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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.
16/12/23 1.00	0/10	No Pain	–	–	–	02AH	Jay 002
2.00	0/10	No Pain	–	–	–	02AH	Jay 002
3.00	0/10	No Pain	–	–	–	02AH	Jay 002
4.00	0/10	No Pain	–	–	–	02AH	Jay 002
5.00	0/10	No Pain	–	–	–	02AH	Jay 002
6.00	0/10	No Pain	·	–	–	02AH	Jay 002
7.00	0/10	No Pain	–	–	–	02AH	Jay 002
8.00	0/10	No pain	–	–	–	23	Jay 002
9.00	0/10	no pain	–	–	–	23	Jay 002

16/11/23

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10.00	0/10	No pain	—	—	—	[illegible]	[illegible]
11.00	0/10	No pain	—	—	—	[illegible]	[illegible]
12.00	0/10	No pain	—	—	—	[illegible]	[illegible]
13.00	0/10	No pain	—	—	—	[illegible]	[illegible]

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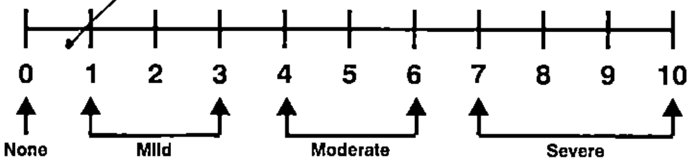
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	**Numerical Rating Scale (age more than 12 years)** 
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Pharmacological Interventions as per doctor's prescription

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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.
18/12/23 1400	0/10	No pain	—	—	—	[signature]	[signature]
15.00	0/10	No pain	—	—	—	[signature]	[signature]
1600	0/10	No pain	—	—	—	[signature]	
17.00	0/10	No pain	—	—	—	[signature]	
18.00	0/10	No pain	—	—	—	[signature]	
1900	0/10	No pain	—	—	—	[signature]	
20.00	0/10	No pain	—	—	—	[signature] 0211	
21.00	0/10	No pain	—	—	—	[signature] 0211	
22.00	0/10	No pain	—	—	—	[signature] 0211	

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.
16/12/22 23:00	0/10	No Pain	—	—	—	[signature] 0241	[signature]
17/12/22 00:00	0/10	No Pain	—	—	—	[signature] 0241	[signature]
01:00	0/10	No Pain	—	—	—	[signature] 0241	[signature]
02:00	0/10	No Pain	—	—	—	[signature] 0241	[signature]

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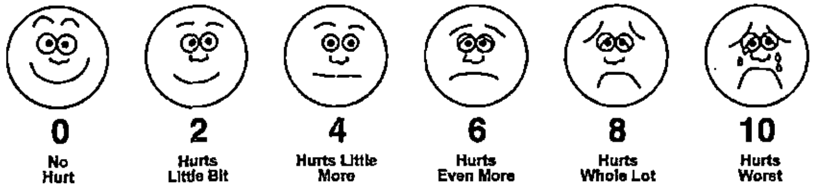
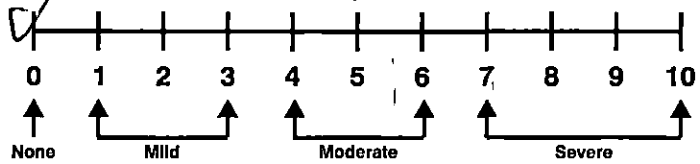
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months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

Pharmacological Interventions as per doctor's prescription

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

MHI/NUR/2022/052

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

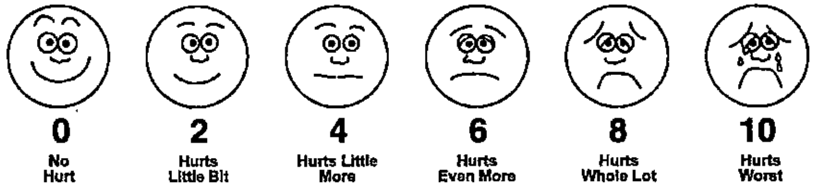
Medway Heart Institute
Every heart beat counts

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.
17/12/23 03:00	0/10	No Pain	—	—	—	0211	Jay 002
04:00	0/10	No Pain	—	—	—	0211	Jay 002
05:00	0/10	No Pain	—	—	—	0211	Jay 002
06:00	0/10	No Pain	—	—	—	0211	Jay 002
07:00	0/10	No Pain	—	—	—	0211	Jay 002
8.00	0/10	No pain	—	—	—	Abi 0282	Jay 002
9.00	0/10	No pain	—	—	—	Abi 0282	Jay 002
10.00	0/10	No pain	—	—	—	Abi 0282	Jay 002
11.00	0/10	No pain	—	—	—	Abi 0282	Jay 002

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.
17/1/23 12.00	0/10	No Pain	–	–	–	[signature] 0282	[signature]
13.00	0/10	No Pain	–	–	–	[signature] 0282	[signature]
1400	0/10	No pain	–	–	–	[signature]	[signature]
1500	0/10	No pain	–	–	–	[signature]	[signature]

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
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Numerical Rating Scale (age more than 12 years)

0 1 2 3 4 5 6 7 8 9 10 (0 ticked)

None (0) | Mild (1–3) | Moderate (4–6) | Severe (7–10)

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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.
17/12/23 16.00	0/10	No pain	—	—	—	0162	
17.00	0/10	No pain	—	—	—	0162	
18.00	0/10	NO pain	—	—	—	0162	
19.00	0/10	NO pain	—	—	—		
20:00	0/10	No Pain	—	—	—	0241	
21:00	0/10	NO Pain	—	—	—	0241	
22:00	0/10	No Pain	—	—	—	0241	
23:00	0/10	No Pain	—	—	—	0241	
18/12/23 00:00	0/10	No Pain	—	—	—	0241	

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.
18/12/23 01:00	0/10	No Pain	–	–	–	0241	[illegible]
02:00	0/10	No Pain	–	–	–	0241	[illegible]
03:00	0/10	No Pain	–	–	–	0241	[illegible]
04:00	0/10	No Pain	–	–	–	0241	[illegible]

PAIN SCALES

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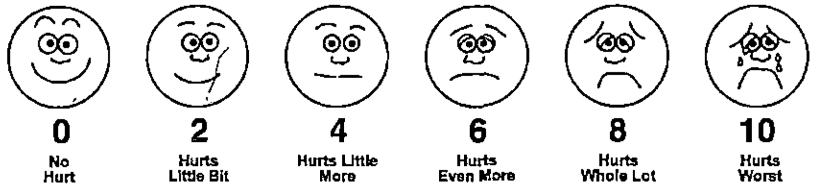
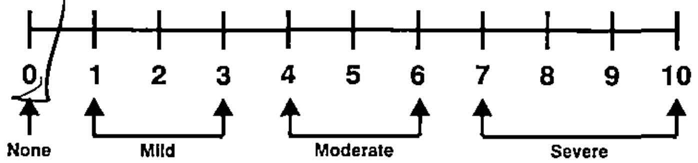
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 **Numerical Rating Scale (age more than 12 years)** 
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PAIN RE-ASSESSMENT & MONITORING CHART

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.
18/12/23 05:00	0/10	No Pain	–	–	–	0241	Jay 0001
06:00	0/10	No Pain	–	–	–	0241	Jay 0001
07:00	0/10	No Pain	–	–	–	0241	Jay 0001
8.00	0/10	NO pain	–	–	–	[illegible]	Jay 0001
9.00	0/10	NO pain	–	–	–	[illegible]	Jay 0001
10.00	0/10	NO pain	–	–	–	[illegible]	[illegible]
11.00	0/10	NO pain	–	–	–	[illegible]	[illegible]
12.00	0/10	No pain	–	–	–	0262	Nao 024
13:00	0/10	No pain	–	–	–	024	Nao 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.
17.00	0/10	No Pain	—	—	—	[illegible] 0221	[illegible] 024
23.00	0/10	No pain	—	—	—	[illegible] 0222	[illegible] 024
19/12/23 3.00	0/10	No pain	—	—	—	[illegible] 0222	[illegible] 024
7.00	0/10	No pain	—	—	—	[illegible] 0222	[illegible] 024

PAIN SCALES

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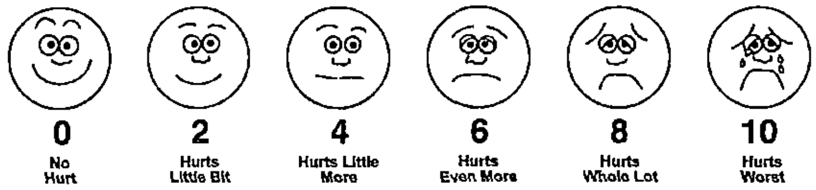
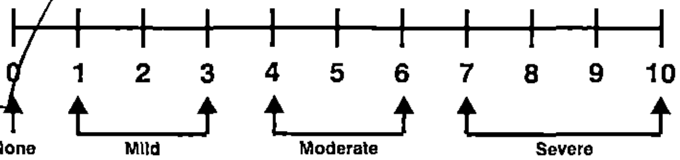
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 **Numerical Rating Scale (age more than 12 years)** 
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Pharmacological Interventions as per doctor's prescription	

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Dr.K.JAISHANKAR

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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.
19/12/23 8.30	0/10	No Pain	—	—	—	[signature]	Naa 024
12.30	0/10	No pain	—	—	—	[signature] 0207	Naa 024
16.30	0/10	No pain	—	—	—	[signature] 0207	Naa 024
20.30	0/10	No pain	—	—	—	[signature] 0222	Naa 024
20/12/23 00.30	0/10	No pain	—	—	—	[signature] 0222	Naa 024
4.30	0/10	No pain	—	—	—	[signature] 0222	Naa 024
8.00	0/10	No pain	—	—	—	[signature]	Naa 024
10.00	0/10	No pain	—	—	—	[signature] 0222	Naa 024
12.00	0/10	no pain	—	—	—	[signature] [illegible]	[signature] 0029

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
12:00	0/10	no pain	–	–	–	[illegible]	[illegible] 0021

PAIN SCALES

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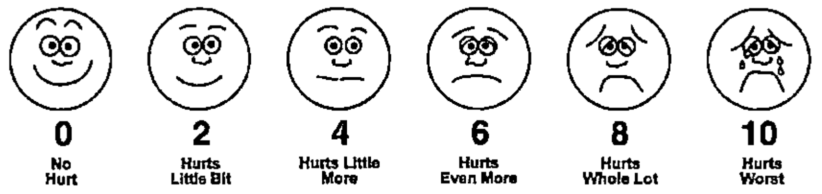
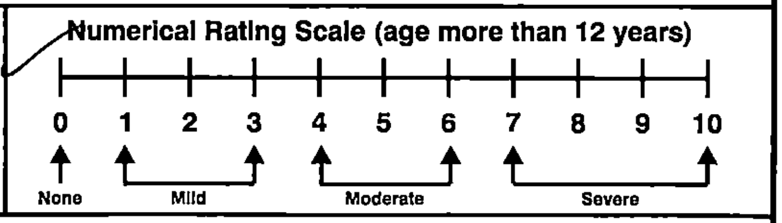
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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MHI/NUR/2022/047

Medway Heart Institute
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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

S. No.	PARAMETERS							
	Date	15/12/23	16/12	17/12/23	18/12/23	19/12/23	20/12/23	
	Time	12.0	8.00	6:00	6:00	6:00	6:00	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	0	0	0	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0	0	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	0	0	0	0	0	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	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	
9	Previously documented DVT (Assess for both legs)	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	
	FINAL SCORE	0	0	0	0	0	0	
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low	Low	Low	Low	Low	Low	
	DVT prophylaxis started	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	
	Signature & Emp. No. of Sr. RN	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MH/DVT/IP/2022/028

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	20/12 8pm	21/12 8am	21/12 2pm	21/12 8pm	22/12 8am	22/12 [illegible]	22/12 8pm
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	0	0	0	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0	0	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	0	0	0	0	0	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	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	
9	Previously documented DVT (Assess for both legs)	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.	N	-2	-2	-2	-2	-2	
	FINAL SCORE	N	-2	-2	-2	-2	-2	
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	low	low	low	low	low	low	
	DVT prophylaxis started	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	Signature & Emp. No. of Sr. RN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

MHI/NUR/2022/046

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NABH ACCREDITED

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Dr.K.JAISHANKAR

Medway Heart Institute
Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	15/12/23	15/12	16/12	16/12/23	16/12/23	17/12/23	17/12/23	17/12/23	18/12/23
	Time	13:00	20:00	8:00	1400	20:00	8:00	13.00	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		65	65	65	66	65	65	65.	65	65
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Signature & Emp. No. of Sr. RN		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]

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

INTERVENTIONS *Tick as per the Risk Score*									
Date	15/12/23	15/12/23	16/12	16/12	16/12/23	17/12	17/12/23	17/12/23	18/12/23
Time	12·00	20:00	8:00	14:00	20:00	8:00	18:00	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	NA	NA	NA	NA	NA	NA	NA	NA	NA
Make sure the family and other visitors understand the restrictions mentioned above	✓	✓	✓	✓	✓	✓	✓	✓	✓
High-risk interventions (45 or above)									
Apply all the low and medium risk interventions	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tie red fall risk tag in the bed, wheel chair and stretcher	✓	✓	✓	✓	✓	✓	✓	✓	✓
Locate the high-risk patients in a room close to the nurses' station	✓	✓	✓	✓	✓	✓	✓	✓	✓
Answer these patients call bells as quickly as possible	✓	✓	✓	✓	✓	✓	✓	✓	✓
Provide a commode at bedside (if appropriate)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urinal/bedpan should be within easy reach (if appropriate)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage family members or other visitors to stay with them	NA	NA	NA	NA	NA	NA	NA	NA	NA
If appropriate, consider using protection devices: safety belts	✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Signature & Emp. No. of Sr. RN	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]

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

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/NUR/2022/046

Medway Heart Institute
Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	18/12	18/12/23	19/12	19/12	19/12/23	20/12/23	20/12/23		
	Time	14.00	20.00	8.00	14.00	20.00	8.00	14.00		
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		65	65	65	65	65	65	65		
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓		
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

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

INTERVENTIONS *Tick as per the Risk Score*	Date	18/12	18/12/23	19/12	19/12	19/12/23	20/12/23	20/12/23		
	Time	14:00	20:00	8:00	14:00	20:00	8:00	14:00		
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓	✓		
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓	✓		
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓	✓		
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓	✓		
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓	✓		
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓	✓		
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓	✓		
Bed wheels should be locked		✓	✓	✓	✓	✓	✓	✓		
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓	✓		
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓	✓	✓	✓	✓		
Review medications for potential side effects that can promote falls			✓	✓	✓	✓	✓	✓		
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓	✓		
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓	✓		
Medium risk interventions (25 - 44)										
Apply all the low risk interventions			✓	✓	✓	✓	✓	✓		
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓	✓	✓	✓	✓		
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓	✓	✓	✓		
Use restraints and bed monitors as ordered by the doctor		✓	✓	✓	✓	✓	✓	✓		
Allow the patient to ambulate only with assistance			✓	✓	✓	✓	✓	✓		
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓	✓		
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓	✓	✓	✓	✓		
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓	✓		
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓		✓	✓	✓	✓	✓		
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓	✓		
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓	✓	✓	✓	✓	✓		
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓	✓	✓	✓	✓	✓		
Locate the high-risk patients in a room close to the nurses' station		✓	✓	✓	✓	✓	✓	✓		
Answer these patients call bells as quickly as possible		✓	✓	✓	✓	✓	✓	✓		
Provide a commode at bedside (if appropriate)		✓	✓	✓	✓	✓	✓	✓		
Urinal/bedpan should be within easy reach (if appropriate)		✓	✓	✓	✓	✓	✓	✓		
Encourage family members or other visitors to stay with them		✓	✓	✓	✓	✓	✓	✓		
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓	✓		
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
Signature & Emp. No. of Sr. RN										

Nas 24 Nas 24 Nas 24 Nas 24 Nas 24 Nas 24 Nas 24

MH/MMF/IP/026

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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	20/12	21/12/23			22/12/23		22/12.		
	Time	8pm	M	E	N.	M	E	N.		
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
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
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
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	60	60	60	60	60	60		
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (above 45)		✓	✓	✓	✓	✓	✓	✓		
Signature & Emp. No. of RN		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]		
Signature & Emp. No. of Sr. RN		[signature]	[signature]	[signature] 651	[signature]	[signature]	[signature]	[signature]		

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

INTERVENTIONS *Tick as per the Risk Score*										
	Date	20/12	20/12	/12	22	12	12	23		
	Time	7:00 pm	M	E	N	M	E	N		
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		✓	✓	✓	✓	✓	✓	✓		
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

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DRUG CHART

MH/ PRINT / 0042 / NRS

Name of the Patient: Mr.ANANTHA KRISHNAN.P.N .... Age............... Sex............... Bed No. ....
79/Male/MH1202381290
15/12/2023/IPH202302516
Clinical Diagnosis: Dr.K.JAISHANKAR ....IP No...........................Ht............Wt............
Primary Consultant Name ....PID No. ....

Name of the Medicine	Dose	Route	Frequency	20/12/23	21/12/23	22/12/23	23/12/23
Inj. Dyfor	[illegible]	IV	10-0-10-0		4 pm	Stop	
Inj. Rantac	50g	IV	1-0-1	9 pm	8 AM, 9 PM	7 AM, 7 pm	7 Am
T. Aldactone	25g	P/o	1-0-0.		8 AM	8 AM	8.00 AM
T. Silodal	8g	P/o	0-0-1.	9 PM	8 PM	8 pm	2000
T. Udiliv	300g	P/o	1-0-1.	9 PM	8 AM, 8 PM	8 AM, 8 pm	2000
T. Nusam	20g	P/o	0-1-0.		2 PM	2 pm	1400
T. NAC	600g	P/o	1-0-1.	9 PM	8 AM, 8 PM	8 AM, 8 pm	800, 2000
Syp. Lactimep	20ml	P/o	1-1-1.	9 PM	8 AM, 2 PM, 8 PM	8 AM, 2 pm, 8 pm	8.00, 1400, 2000
T. Inderal	20g	P/o	1-0-1.	9 PM	8 AM, 8 PM	8 AM, 8 pm	8.00, 2000
T. Rcifax	550g	P/o	1-0-1.	9 PM	8 AM, 8 PM	8 AM, 8 pm	8.00, 2000
Administered by (Nurse Signature) :							
Verified by (DMO Signature) :							

Nurse Signature : [signature]
Nurse Name : S/N K Vijayan
Date & Time : 20/12/22 @ 8:00PM.

DMO Signature : for [signature] 103208
DMO Name : DR. HARISH.
Date & Time : 20/12/22 @ 8:00pm

Primary Consultant Signature : for [signature] 103208
Primary Consultant Name : DR. J. JAISHANKAR
Date & Time : 20/12/22 @ 8:00pm
Reg No. : 49448

Allergic to ....Nil..........Adverse Reaction, if any ....Nil..........

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SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				
20/12/22	9L30PM	INJ LOYTOK	20MG	IV	DR HARISH	[illegible]				

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				

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DRUG CHART

MH/ PRINT / 0042 / NRS

Name of the Patient : .. Mr.ANANTHA KRISHNAN.P.N 79/Male/MH202381290 .... Age........ Sex........ Bed No. ....

Clinical Diagnosis : .. 15/12/2023/IPH202302516 ....IP No........Ht........Wt........

Primary Consultant Name : .. Dr.K.JAISHANKAR ....PID No. ....

Name of the Medicine	Dose	Route	Frequency	21/12/23	22/12/23	23/12/23
C. AUAY TOX	1	P/O	1-1-1	8 PM	8 AM, 2 pm, 8 PM	800, 1400, 2000
T. DYTOR	10mg	P/O	8Am 4pm 1-0-1-0		8 AM, 4 PM	800, 1600
D-Pan	40mg	PO	1-0-0			

Administered by (Nurse Signature) : [signatures]

Verified by (DMO Signature) : [signatures]

Nurse Signature : [signature]	DMO Signature : [signature] 85851	Primary Consultant Signature : [signature]
Nurse Name : Sln. Sri Priyanka	DMO Name : Dr. Karthik	Primary Consultant Name : Dr. K. Jaishankar
Date & Time : 21/12/23 @ 8am	Date & Time : 21/12/23 @ 8PM	Date & Time : 21/12/23 @ 8Am
		Reg No. : 49448

Allergic to ....Nil........ Adverse Reaction, if any ....No........

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SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS				

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

Mr.ANANTHA KRISHNAN.P.N
79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

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 15/12/23 Time 12:20 Nurse Signature : [signature]		

Learning Record

Need	Date 15/12	Visit 1 L	Visit 1 P	Visit 1 O	Date 16/12	Visit 2 L	Visit 2 P	Visit 2 O	Date 17/12	Visit 3 L	Visit 3 P	Visit 3 O	Signature
Disease													Doctor
☐ Information on Disease / Diagnostics		P	OD	VD		P	OD	VU		P	OD	V	Dr. Anish Nelson Reg. No: 88434 [signature]
☑ Treatment						P	OD	VU		P	OD	V	
Medications		P	OD	VD		P	OD	VU		P	OD	V	Doctor / Nurse
☑ Information on Safe and Effective use of medicines		P	OD	VD		P	OD	V		P	OD	V	[signature]
☑ 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		P	OD	V		P	OD	V		P	OD	V	[signature]
☑ Pain Management		P	OD	V		P	OD	V		P	OD	V	
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☐ Diet Instruction for patients at Nutritional risk		P	OD	V		P	OD	V					Maria Catherine John Senior Dietitian
☐ 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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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/IP/2022/055

Medway Heart Institute
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PATIENT AND FAMILY EDUCATION RECORD

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

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

Completed By : Date 18/12/23 Time 8.00 Nurse Signature : [signature]

Learning Record

Need	Date 18/12/23	Visit 1 L	P	O	Date 19/12/23	Visit 2 L	P	O	Date 20/12/23	Visit 3 L	P	O	Signature
Disease													Doctor
☑ Information on Disease / Diagnostics										P	OD	✓	K. [signature] 134555
☐ Treatment		P	OD	✓		P	OD	✓					
Medications		P	OD	✓		P	OD	✓		P	OD	✓	Doctor / Nurse
☐ Information on Safe and Effective use of medicines													[signature]
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions										P	OD	✓	Nurse
☐ Pre - Operative Instructions													[signature]
☐ Post - Operative Instructions (Wound / Dressing Care)													0809
Pain Management													Nurse
☑ Reporting of pain		P	OD	✓		P	OD	✓		P	OD	✓	[signature]
☑ Pain Management		P	OD	✓		P	OD	✓		P	OD	✓	0224
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☐ Diet Instruction for patients at Nutritional risk		nan				nan				nan			Maria Catherine John Senior Dietitian
☐ Diet advice for home		—				—				nan			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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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/IP/2022/054

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IN-HOUSE TRANSFER FORM

Part A (to be filled by Nurses)

Date of Transfer: 18/12/23 Time: 11.00 Transferred from: CCU To: [illegible]

Diagnosis: ? UTI / Severe calcific aortic stenosis / T2 DM

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 56 (beats/min) | BP: 120/80 (mmHg) | Respiration: 20 (breaths/min)

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

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

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. PROSTRAM[illegible]	80mg	PO	0-0-1	18/12/23 @ 10.30	☑ Yes ☐ No
2	NEBS. LEVOLIN	0.63g	PO	1-1-1		☑ Yes ☐ No
3	NEBS. BUDECORT	0.5g	PO	1-0-1		☑ Yes ☐ No
4	T. NUSAM	200mg	PO	OD		☑ Yes ☐ No
5	T. WOLIN	300g	PO	1-0-1		☑ Yes ☐ No
6	T. NAC	600g	PO	1-0-1		☑ Yes ☐ No
7	T. [illegible]	1mg	PO	1-0-0		☑ Yes ☐ No
8	INJ. PAN	40g	PO	1-0-1		☑ Yes ☐ No
9	INJ. [illegible]		IV	20-0-10-0		☑ Yes ☐ No
10	SYP. [illegible]	20ml	PO	1-1-1		☑ Yes ☐ No
11	T. INDERAL	20g	PO	1-0-1		☑ Yes ☐ No
12	INJ. MONOCEF	1gm	IV	1-0-1		☑ Yes ☐ No
13	T. RCIFAX	550g	PO	1-0-1		☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

Patient Condition: [x] Stable [ ] Sick-need urgent care [ ] Others: ____________

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	(signature)	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	18/12/23	11.30
Receiving Doctor	(signature)	Dr. Mohamed [illegible]	165307	18/12/23	11.30

Part C *(to be filled by Nurses)*

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

Additional Details *(if any)*: NIL

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	(signature)	Roopa R	0159	18/12/23	11.00
Receiving Nurse	E. Cathrine	E. Cathrine	0207	18/12/23	11.15

MHI/ICU/2022/056

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

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Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 15/12/23 Time: 12:15.

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor	[signature]	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	15/12/23	12.30
Nursing Staff	[signature]	JAYADEVI J	0002	15/12/23	12.30
Dietician	[signature]	Maria Catherine John Senior Dietitian	2107	15/12/23	14:20
Physiotherapist	[signature]	AKASH-G-K	0256	15/12/23	14:00
Patient Care Service Staff					

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r.ANANTHA KRISHNAN.P.N
)/Male/MHI202381290
5/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/IP/2022/051

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FAMILY COUNSELLING FORM

CONSULTANT- DR. JAISHANKAR.			DIAGNOSIS- T2DM / HTN / SEVERE CALCIFIC AORTIC STENOSIS			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
15/12/23	DOCTOR.	SON.	Patient condition updated to family		[signature]	[signature] Dr. Anish Nelson Reg. No: 83434
16/12/23	Doctor	Son	PATIENT UPDATED TO ATTENDER.		[signature]	[signature]
17/12/23	Doctor	Son	Pt condition updated to family		[signature]	[signature] 91010
18/12/23	DOCTOR.	Son	Pt. condition updated to family		[signature]	[signature]

MHI/IP/2022/116

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
AGE / SEX : Dr.K.JAISHANKAR

IP No. / UHID No

Ward / Bed No. II CCU.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
15/12/22	13.00	(Rt) Cephalic	0/5	patten	flush	followed	[signature]
	20:00	(L) cephalic	0/5	Patent	flushed	followed	[signature] 0244
				~~pn~~	~~flush~~	~~followed~~	
16/12/23	8.00	(Rt) cephalic	0/5	PATENT	flush	followed	[signature]
	14.00	(Rt) Cephalic	0/5	Patent	flush	followed	[signature]
	20:00	(L) cephalic	0/5	Patent	flushed	followed	[signature] 0211
17/12/23	8:00	Lt cephalic	0/5	pattent	flushed	followed	[signature] 0222
	13.00	(Rt) Cephalic	0/5	Patent	flushed	followed	[signature]
	20:00	(Lt) cephalic	0/5	Pattent	Flushed	followed	[signature] 0211
15/12/23	18.00	(Rt) Cephalic	0/5	pattern	flush	followed	[signature]
	20:00	(R) cephalic	0/5	patent	flushed	followed.	[signature] 0244
16/12/23	8.00	Rt cephalic	0/5	PATENT	flush	followed	[signature]
	14.00	(Rt) Cephalic	0/5	Patent	flushed	followed.	[signature]
	20:00	(R) cephalic	0/5	Patent	flushed	followed	[signature] 0211
17/12/23	8:00	R cephalic	0/5	Pattent	flushed	followed.	[signature] 0222
	18.00	(Rt) Cephalic	0/5.	patent	flushed	followed	[signature]
	20:00	(R) cephalic	0/5	patent	flushed	followed	[signature]
18/12/23	8.00	(Rt) cephalic	0/5	patent	flushed	followed	[signature]
	14.00	Rt cephalic	0/5	patent	flushed	followed	[signature]
	20.00	Rt cephalic	0/5	patent	flushed	followed	[signature]

MHI/IP/2022/116

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Medway Heart Institute
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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME: Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516

AGE / SEX : Dr.K.JAISHANKAR

IP No. / UHID No

Ward / Bed No.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
19/12/23	8:00	Rt cephalic	0/5	patent	flushed	–	[illegible] 0207
	14:00	Rt cephalic	0/5	patent	flushed	—	[illegible] 0207
	20:00	Rt cephalic	0/5	patent	flushed	–	[illegible] 0722
20/12/23	8.00	Rt cephalic	0/5	patent	flushed	–	[illegible] 0274.
	14:00	Rt cephalic	0/5	patent	flushed	—	[illegible]

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MH/VIP/IP/2023/035

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516

IP No. / UHID No

AGE / SEX : Dr.K.JAISHANKAR

Ward / Bed No. ICU

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
20/12/23							
	8:00 am	(R) Hand	0/5	–	FLUSH	-	[illegible]
21/12/23	8am	(R) hand peripheral	0/5	–	Flush	-	[illegible]
	2pm	(R) hand peripheral	0/5	–	Flush	–	[illegible]
	8pm	(R) hand peripheral	0/5	–	Flush	–	[illegible]
22/12/23							
	8am	(R) hand	0/5	–	Flush	–	[illegible]
	2pm						
	8pm	Rt peripheral	0/5	patent	flushed	followed	[illegible]
23/12/23							

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NABH ACCREDITED

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/PHARM/2022/028

Medway Heart Institute
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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1   Height (cms): ±168   Weight (kg): ±60

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

Drug Details	Description of Allergy	Doctor's Sign:
—	NKDA	Name: Dr. Anish Nelson Reg. No. Reg. No: 88434

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
15/12/23	12:25	INJ LASIX	40mg	IV	[signature]	Dr. Anish Nelson Reg. No: 88434	[signature]	0208	12:25
,,	12:20	NEBS DUOLIN		P/N	[signature]	Dr. Anish Nelson Reg. No: 88434	[signature]	0208	12:20
,,	12:20	NEBS FORACORT	0.5mg	P/N	[signature]	Dr. Anish Nelson Reg. No: 88434	[signature]	0208	12:20
16/12/23	1540	Looz Enema	1	P/R	[signature]	88851.	[signature]	0162	1540
16/12/23	18:20	Inj. Paracetamol	1g	IV	[signature]	88851	[signature]	0162	18:20

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

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

Dates: 15/12/23, 16/12/23, 17/12/23, 18/12/23, 19/12/23, 20/12/23

DRUG NAME
INJ. LASIX

Dose	Route	Frequency
40mg.	iv	40-0-20-0

Dr. Sign & Reg. No. / Seal — [signature]
Start Date & Time: 15/12/22 @ 12.40
Stop Date & Time: 15/12/22 @ 16.00
Additional Info:

Time: 8.00, 16.00

DRUG NAME
T. PROSTAGARD

Dose	Route	Frequency
8 mg	P/o	0-0-1

Dr. Sign & Reg. No. / Seal — [signature]
Start Date & Time: 15/12/23 @ 12.40
Stop Date & Time:
Additional Info:

Time: 20.00 — 20.40, 20.00, 20.00, 20.30, 20.31

DRUG NAME
NEBS LEVOLIN

Dose	Route	Frequency
0.63mg	P/N	1-1-1

Dr. Sign & Reg. No. / Seal — [signature]
Start Date & Time: 15/12/23 @ 12.40
Stop Date & Time:
Additional Info:

Time: 8.00 — 8.00, 9.30; 14.00 — 14.00, 14.00; 20.00 — 20.40, 20.00, 20.00, 20.30, 20.30

DRUG NAME
NEBS FORACORT

Dose	Route	Frequency
0.5mg	P/N	1-0-1

Dr. Sign & Reg. No. / Seal — [signature]
Start Date & Time: 15/12/23 @ 12.40
Stop Date & Time:
Additional Info:

Time: 8.00 — 8.00, 9.30; 20.00 — 20.40, 20.00, 20.00, 20.30, 20.40

DRUG NAME
T. IVABRAD

Dose	Route	Frequency
5mg	P/o	1-0-1

Dr. Sign & Reg. No. / Seal — [signature]
Start Date & Time: 15/12/23 @ 12.40
Stop Date & Time: 18/12/23 @ 9.25
Additional Info:

Time: 8.00 — 8.00; 20.00 — 20.40, 20.00, 20.00

Area In-charge Nurse Signature: [signatures]

Clinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

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

DRUG DETAILS	Date → / Time ↓	15/12/23	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23		
DRUG NAME Inj. Rmmc	8.00	→							
Dose 50mg; Route iv; Frequency 1-0-1		STOP							
Dr. Sign & Reg. No. / Seal; Start Date & Time 15/12/22 @ 12.40; Stop Date & Time 15/12/23 @ 2000	19.00								
Additional Info:									
DRUG NAME Tab. NUSAM	8.00	→	8.00	8.30	[illegible]	9.00	9.10		
Dose 200mg; Route P/O; Frequency OD		15.00							
Dr. Sign & Reg. No. / Seal; Start Date & Time 15/12/23 @ 15.00; Stop Date & Time									
Additional Info:									
DRUG NAME Tab. UDILIV	8.00	→	8.00	8.05	[illegible]	9.00	9.10		
Dose 300mg; Route P/O; Frequency BD		15.00							
Dr. Sign & Reg. No. / Seal; Start Date & Time 15/12/23 @ 15.00; Stop Date & Time									
Additional Info:	20.00	20.40	20.10	20.00	20.30	20.35			
DRUG NAME Tab. -NAC	8.00	→	8.00	8.15	[illegible]	9.00	[illegible]		
Dose 600mg; Route P/O; Frequency BD		15.00							
Dr. Sign & Reg. No. / Seal; Start Date & Time 15/12/23 @ 15.00; Stop Date & Time									
Additional Info:	20.00	20.40	20.00	20.10	20.15	20.30			
DRUG NAME SYRUP DUPHALAC									
Dose 10ml; Route PO; Frequency 0-0-1									
Dr. Sign & Reg. No. / Seal; Start Date & Time 15/12/23 @ 18.00; Stop Date & Time 15/12/23 @ 14:00	21.00	21.10							
Additional Info:									
Area In-charge Nurse Signature:									

Clinical Pharmacist Medway Heart Institute

REGULAR PRESCRIPTIONS *To be filled in by Doctors only*	Date → / Time ↓	To be filled by Nursing Staff only. Sign and time given							
		16/12	17/12	18/12/23	19/12	20/12			
DRUG NAME T. Aldactone	9.00	11.40 [illegible]	9.20 [illegible]	[illegible]	9.00 [illegible]	9.05 [illegible]			
Dose: 25mg · Route: PO OD · Frequency:									
Dr. Sign & Reg. No. / Seal: [illegible] · Start Date & Time: 16/12/23 @11:40 · Stop Date & Time:									
Additional Info:									
DRUG NAME Inj PAN	7.00	→	7.00 [illegible]	7.00 [illegible]	7.30 [illegible]	8.30 [illegible]			
Dose: 40mg · Route: IV · Frequency: 1-0-1									
Dr. Sign & Reg. No. / Seal: [illegible] 8851 · Start Date & Time: 16/12/23 @14.00 · Stop Date & Time:	19.00	19.00 [illegible]	19.00 [illegible]	19.00 [illegible]	20.00 [illegible]				
Additional Info:									
DRUG NAME LOOZ ENEMA	8.00	→	N.H	[illegible]					
Dose: 1 · Route: P/R · Frequency: 1-0-1									
Dr. Sign & Reg. No. / Seal: [illegible] 8851 · Start Date & Time: 16/12/23 @15.00 · Stop Date & Time: 18/12/23 @ 19-00	20.00	WH	WH						
Additional Info:									
DRUG NAME Inj - Dytor	8.00	→	8.30 [illegible]	8.30 [illegible]					
Dose: 20mg · Route: IV · Frequency: 1-0-1-0									
Dr. Sign & Reg. No. / Seal: [illegible] 8851 · Start Date & Time: 16/12/23 @16.30 · Stop Date & Time: 18/12/23 @10.40	16.00	18.30 [illegible]	18.30 [illegible]						
Additional Info:									
DRUG NAME T-RUFAXY	8.00	→	8.00 [illegible]						
Dose: 550mg · Route: PO · Frequency: 1-0-1									
Dr. Sign & Reg. No. / Seal: [illegible] 8851 · Start Date & Time: 16/12/23 @16.30 · Stop Date & Time: [illegible] @9.30	20.00	20.00 [illegible]							
Additional Info:									
Area In-charge Nurse Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			

Clinical Pharmacist, Medway Heart Institute (stamp beside each drug entry)

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given
Time ↓	16/12/23, 17/12/23, 18/12/23, 19/12/23, 20/12/23

DRUG NAME Syp. LACTIHEP

Dose	Route	Frequency
20ml	P/O	1-0-1

Dr. Sign & Reg. No. / Seal

Start Date & Time: 16/12/23 @ 16.20

Stop Date & Time: 17/12/23 @ 11.42

Additional Info:

Time	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23
8.00		9.05			
20.00	20.00				

DRUG NAME Syp-LACTIHEP

Dose	Route	Frequency
20ml	P/O	1-1-1

Dr. Sign & Reg. No. / Seal 91410

Start Date & Time: 17/12/23 @ 11.42

Stop Date & Time:

Additional Info:

Time	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23
8.00			8.30	9.00	9.06
14.00		14.20	14.00	14.00	
20.00		20.00	20.30	20.40	

DRUG NAME T. INDERAL (PROPRANOLOL)

Dose	Route	Frequency
20mg	P/O	1-0-1

Dr. Sign & Reg. No. / Seal 97241

Start Date & Time: 18/12/23 @ 9.30

Stop Date & Time:

Additional Info:

Time	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23
8.00			9.40	9.00	9.05
20.00			20.30	20.41	

DRUG NAME INJ DYTOR

Dose	Route	Frequency
20 mg	IV	20-0-10-0

Dr. Sign & Reg. No. / Seal

Start Date & Time: 18/12/23 @ 10.40

Stop Date & Time: 19/12/23 @ 10.30

Additional Info:

Time	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23
8.00				9.00	
16.00			16.00	16.00	

DRUG NAME T. DYTOR

Dose	Route	Frequency
10mg	PO	1-0-0 (OD)

Dr. Sign & Reg. No. / Seal

Start Date & Time: 19/12/23

Stop Date & Time:

Additional Info:

Time	16/12/23	17/12/23	18/12/23	19/12/23	20/12/23
8.00					9.05
16.00					WH

Area In-charge Nurse Signature:

ANTIMICROBIALS

To be filled in by Doctors only

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

Time ↓ 15/12/23 | 16/12/23 | 17/12/23 | 18/12/23

Clinical Pharmacist Medway Heart Institute

DRUG NAME INJ MAGNEX FORTE (contd c PO)

Dose	Route	Frequency
1.5 gm	IV	1 – 0 – 1

Dr. Sign & Reg. No. / Seal

Start Date & Time 15/12/23 @ 12.40

Stop Date & Time 15/12/23 @ 2000

Additional Info:

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. AZEE × 3 DAYS

Dose	Route	Frequency
500 mg	PO	1 – 0 – 0

Dr. Sign & Reg. No. / Seal

Start Date & Time 15/12/23 @ 12.40

Stop Date & Time 18/12/23 @ 11.00

Additional Info:

Time: 8.00 — 15/12: 13.00; 16/12: 8.00; 17/12: 8.00; 18/12: 8.00

D1 D2 D3 D4

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. TAMIFLU × 3 DAYS

Dose	Route	Frequency
75 mg	PO	1 – 0 – 1

Dr. Sign & Reg. No. / Seal

Start Date & Time 15/12/23 @ 12.40

Stop Date & Time 18/12/23 @ 11.00

Additional Info:

Time: 8.00 — 15/12: 13.20; 16/12: 8.00; 17/12: 8.00; 18/12: 8.00

D1 D2 D3 D4

Time: 20.00 — 15/12: 20.40; 16/12: 20.00; 17/12: 20.00

DRUG NAME T. ~~Aldactone~~

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME ~~LOOZ ENEMA~~

Dose	Route	Frequency
?	P/R	1-0-1

Dr. Sign & Reg. No. / Seal 38881

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge Nurse Signature:

ANTIMICROBIALS

To be filled in by Doctors only

DRUG NAME Inj Monocef.

Dose	Route	Frequency
1g	IV	1-0-1

Dr. Sign & Reg. No. / Seal: [signature] 85856

Start Date & Time: 16/12/23 @ 16:30

Stop Date & Time:

Additional Info:

DRUG NAME T. RCIFAX.

Dose	Route	Frequency
550mg	P/O	1-0-1

Dr. Sign & Reg. No. / Seal: [signature] 91810

Start Date & Time: 18/12/2 [illegible]

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:

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

Date → / Time ↓	16/12	17/12/23	18/12/23	19/12/23	20/12/23
8.00 (Monocef)	→	8.00 [illegible]	8.00 [illegible]	9.00 [illegible]	9.30 [illegible]
	D1	D2	D3	D4	D5
20.00 (Monocef)	18.00 [illegible]	20.00 [illegible]	20.30 [illegible]	20.40 [illegible]	
8.00 (Rcifax)	→	→	8.20 [illegible]	9.00 [illegible]	9.05 [illegible]
		D1	D2	D3	D4
20.00 (Rcifax)	→	20.00 [illegible]	21.00 [illegible]	21.00 [illegible]	
Area In-charge Nurse Signature	[signature]	[signature]	[signature]	[signature]	[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.
15/12/23	15.00	NS	40/40	2ml/hr	Iv.	Inj. FRUSEMIDE			[illegible]	9546	15.00	19.00 16/12. ~~18.00~~	[illegible]
15/12/23	18.00	NS	80/40	4ml/hr.	Iv	Inj - PAN			[illegible]	9545	18.00	16/12/22. 13.50	[illegible]
16/12/23	19.00		100ml	15ml/hr	Iv	INJ. Albumin 20%			[illegible]	85851	19.00	17/12/23 2.00	[illegible]
17/12/23	18.00	-	100ml	20ml/hr	Iv	INJ. Albumin 20%			[illegible]	95468	17/12/23. 18.00	17/12/23 23:00	[illegible]

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

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
15/12/23	12.30	DM diet	[signature]	Dr. Anish Nelson Reg. No: 88434					
16/12/23	9.00	Dm diet	[signature]	85851					
17/12/23	8.30	Dm diet	[signature]	91810					
18/12/23	8.00	DM diet	[signature]	Dr. Anish Nelson Reg. No: 88434					
19/12/23	8.00	Diabetic diet	[signature]	134559					
20/12/23	8.00	Diabetic diet	[signature]	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				19/12/23	Morning	E. Cathrine	0207	E.C
15/12/23	Evening	S. Allwin gnanagrace	0162	[initials]	19/12/23	Evening	A. Albinus	0088	[initials]
15/12/23	Night	Karthumitha	0244	K.	19/12/23	Night	Pavithra	0072	[initials]
16/12/23	Morning	Mohanmay	2762	[initials]	20/12/23	Morning	B. Vanitri	0195	[initials]
16/12/23	Evening	S. Allwin gnangrace	0162	[initials]	20/12/23	Evening	Jeyalathya	0140	[initials]
16/12/23	Night	Premalatha	021	[initials]		Night			
17/12/23	Morning	Aarthi	0282	M.		Morning			
17/12/23	Evening	S. Allwin gnangrace	0162	[initials]		Evening			
17/12/23	Night	S. Premalatha	021	[initials]		Night			
18/12/23	Morning	Ramya. R	0159	[initials]		Morning			
18/12	Evening	R. Sushma	0081	R.		Evening			
18/12/23	Night	Pavithra	0072	[initials]		Night			

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient : Mr. Anantha Krishnan
Age / Sex :
Consultant Name :

IP No. :
DOA : 18/12/23
UHID No. :
Room No. : CCU

S.No.	Date	Medicine Name	Qty.
1	18/12/23	Under Pad	2
2	"	Nasal Prongs	1
3	"	Hand Care	2
4	"	Easy Bath	

Nurse Name 021

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient : Mr. Anantha Kaishvan. IP No. :
DOA : 17/12/23.
Age / Sex : 79 yes / Male. UHID No. :
Consultant Name : Room No. : CCU.

S.No.	Date	Medicine Name	Qty.
1.	17/12/23	Under Pad.	3.
2	"	Inj. Pan 40 mg	1
3	"	Inj. NONOCEF 1g.	2.
4	"	Diaper. Large Size	2.
5.	"	Foracort Neb.	5
6.	"	Levolin Neb.	3.

Nurse Name — [signature] 0211.

Pharm Bill & Name

123
16:37

Medway Hos[pitals]
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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

C.C.U.

1. DIAPER → (2)
2. EASY BATH → (1)
3. 20% ALBUMIN ... → (1)
4.

C. ...
0708

MHI/PHARM/2022/060

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REQUISITION

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Name of Patient		IP No.	:
Age / Sex		DOA	:
Consultant Name		UHID No.	:
		Room No.	:

S.No.	Date	Medicine Name	Qty.
1	17/12/23	syringe 5ml	4
2		syringe 10ml	5
3		Poshulich	5
4		Inj pan 40mg	2
5		Inj [illegible]	2

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR ME...

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Name of Patient	
Age / Sex	
Consultant Name	
IP No. :	
DOA :	C/U
UHID No. :	
Room No. :	

S.No.	Date	Medicine Name	Qty.
1.	[illegible]	[illegible]	2
2	"	[illegible]	[illegible]
3	"	[illegible] 62 mg	4
[illegible]	"	[illegible]	2

Nurse Name

Pharm Bill & Name

@ 16:29

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REQUISITION FOR MEDICINE

Name of Patient : Mr. Ananth krishnan

IP No. :

DOA :

Age / Sex :

UHID No. :

Consultant Name :

Room No. : CCU

S.No.	Date	Medicine Name	Qty.
1	13/10/22	[illegible]	1
2	"	[illegible] (G)	1
3	"	[illegible]	2
4	"	[illegible]	2
5	"	[illegible]	1
6	"	[illegible]	1
7	"	[illegible] (18)	1
8	"	[illegible]	1
9	"	[illegible] 100 ml	1
10	"	[illegible]	4
11	"	[illegible]	1
12	"	Glove	10 pair
13	"	Sterile glove (7½)	1
14	"	Hand care	4

13/10

Nurse Name

Pharm Bill & Name

17.12.

MHI/PHARM/2022/060

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NABH

REQUISITION FOR MEDICINE

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Name of Patient :
Age / Sex :
Consultant Name :

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

S.No.	Date	Medicine Name	Qty.
1	[illegible]	[illegible]	2
[illegible]	"	[illegible]	1
[illegible]	"	[illegible]	1
[illegible]	"	Inj. [illegible] mg	5
[illegible]	"	[illegible] mg	5
[illegible]	"	[illegible]	1
[illegible]	"	Inj. [illegible]	1
[illegible]	"	[illegible]	2
9	"	7 size Glove	1
		(INJ. D 1. 30ml 1	
10	"	INJ. [illegible]	1.
11	"	16 venflon	
12	"		

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

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

S.No.	Date	Medicine Name	Qty.
1	16/12/23 @ 13.09 pm	Tab. Aldactone 25mg	5

Nurse Name

Pharm Bill & Name

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REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex :

Consultant Name :

IP No. :

DOA :

UHID No. :

Room No. : CW.

S.No.	Date	Medicine Name	Qty.
1.	16/11/23	Tar 1000ml	1
	8.13 pm		

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : CCV.

S.No.	Date	Medicine Name	Qty.
1	16/12/23	Measurement glass	1
2	11	D/s gloves (10 pair)	1
3	11	Inj. Pan 40mg	2

02HH.
Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

18.58.

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REQUISITION FOR MEDICINE

Name of Patient: Mr.ANANTHA KRISHNAN.P.N
Age / Sex: 79/Male/MH1202381290
15/12/2023/IPH202302516
Consultant Name: Dr.K.JAISHANKAR

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

S.No.	Date	Medicine Name	Qty.
1.	15/12/23	INJ. PAN 40MG	2+2
2	"	INF. 100ML NS	1
3	"	16G NEEDLE	2
4	"	50ML SYRINGE	1
5	"	PMD LINE	1
6	"	20G venflon	1
7	"	Easy fix	1
8	"	10cm Extension	1
9	"	Poshi FLSH	1
10	"	INJ. HUMAN ACTRPID	1
11	"	INSULINE SYRINGE	1.
12	"	GLOVES 5 PAIR.	
13	"	SYP. DUPHALAC	1.

Nurse Name

Pharm Bill & Name

15:51

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REQUISITION FOR MEDICINE

Name of Patient	Mr.ANANTHA KRISHNAN.P.N	IP No. :	
Age / Sex	79/Male/MHI202381290	DOA :	
	15/12/2023/IPH202302516	UHID No. :	
Consultant Name	Dr.K.JAISHANKAR	Room No. :	CCU

S.No.	Date	Medicine Name	Qty.
1.	15/12/23	TAB. NICARDIA 20mg	10
2	"	TAB. [illegible] 50mg	10
3	"	TAB. [illegible] 5mg	10
4	"	100ml NS	1
5	"	[illegible]	1
6	"	[illegible]	1
7	"	[illegible]	1

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient: Mr.ANANTHA KRISHNAN.P.N
Age / Sex: 79/Male/MHI202381290
15/12/2023/IPH202302516
Consultant Name: Dr.K.JAISHANKAR

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

S.No.	Date	Medicine Name	Qty.
1.	15/12/23	INJ. LASIX 40mg	2
2	"	TAB. PROSTACARD 2mg	10
3	"	NEBS. FORACORT	5
4	"	INJ. RANTAC 50mg	4.
5	"	TAB. AZEE 500mg	5
6	"	TAB. TAMIFLU 75mg	10.
7	"	Urine Can	1
8	"	KIDNEY TRAY	1
9	"	ECG LEADS	10
10	"	FREE BATH	1
11	"	UNDER PAD	2
12	"	5ml, 10ml, 2ml syringe	2.
13	"	Hand Care	2.

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Name of Patient	
Age / Sex	
Consultant Name	
IP No.	:
DOA	:
UHID No.	:
Room No.	: CCU

S.No.	Date	Medicine Name	Qty.
		Tbj [illegible]	2
2	"	Neb [illegible]	5
3.	"	[illegible]	5
4	"	Neb [illegible]	1
5		[illegible]	1
6.	"	[illegible]	5
7.	"	veflon [illegible]	1
8	"	[illegible]	1
9	"	[illegible]	1
10	"	[illegible]	1

Nurse Name

Pharm Bill & Name

STENOSIS | ? UTI | CCF.

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/064

Medway Heart Institute
every heart beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : Mr. Anantha Krishnan . UHID NO : 202381290 AGE : 79yrs - SEX : Male .

BLOOD GROUP : 'O' Positive .

HEIGHT : ± 168cm WEIGHT : ± 60kg B.S.A : 1.7 m²

18/12/23 → (7)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
18/12/23 8.00	61	Sinus	98.4	136/78	86	warm	++	19	Br/d	99	2Ltr FiO2/O2 ON FLOW
9.00	68	Sinus	98.4	121/57	79	warm	++	20	Br/d	96	"
10.00	56	Sinus	98.4	122/55	78	warm	++	24	Br/d	96	"
			Pt SHIFTED to WARD @ 10.40								

PREVIOUS DAY - HOURS 24 hours -

DRAINAGE — TOTAL INTAKE 980 ml.

URINE 1250 ml . TOTAL OUTPUT 1250 ml

BALANCE 270 ml

B13 . | ? UTI | CCF

MHI/ICU/2022/064

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
heart beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : Mr Anantha Krishnan . UHID NO : 202381290 AGE : 79yrs . SEX : Male .

BLOOD GROUP : O' Positive .

HEIGHT : ± 168 cm WEIGHT : ± 60 kg . B.S.A : 1.7 m²

17/12/23 → (6)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
23:00	67	sinus	98°F	123/50	74	warm	++	24	Br/cl	98%	Pt on FiO2 @ litres
18/12/23 00:00	66	sinus	98°F	124/50	74	warm	++	26	Br/cl	99%	"
01:00	69	sinus	98°F	133/69	83	warm	++	28	Br/cl	99%	"
02:00	59	sinus	98°F	143/67	91	warm	++	28	Br/cl	98%	"
03:00	68	sinus	98°F	130/57	81	warm	++	26	Br/cl	100%	"
04:00	66	sinus	98°F	130/59	83	warm	++	28	Br/cl	100%	"
05:00	70	sinus	98°F	137/83	88	warm	++	30	Br/cl	99	"
06:00	72	sinus	98°F	123/50	74	warm	++	28	Br/cl	100%	"
07:00	69	sinus	98°F	130/57	81	warm	++	28	Br/cl	100%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

T' | .CCF

MHI/ICU/2022/064

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
heart beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : Mr. Anantha krishnan. UHID NO : 202381290 AGE : 79 yrs SEX : Male.

BLOOD GROUP : 'O' Positive

HEIGHT : ±168 cm WEIGHT : ±60 kg B.S.A : 1.7 m²

17/12/23 → (5)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
7.30	74	Sinus	98.4°	130/52	78	Warm	++	32	B/L cl	94%	RA on FM with 2 lit O2.
8.30	76	Sinus	98.6	128/50	74	Warm	++	34	B/L cl	95%	"
9.30	80	Sinus	98.4	123/51	79	Warm	++	32	B/L cl	94%	On RA
10.30	82	Sinus	98.	124/52	78	Warm	++	30	B/L cl	93%	"
11.30	70	Sinus	98.2	130/49	76	Warm	++	30	B/L cl	94%	"
12.30	72	Sinus	98.2	134/54	81	Warm	++	34	B/L cl	94%	"
13.00	73.	Sinus	97.4	148/54	84	Warm	++	34	Br/Cl	96%.	On Room air.
14.00	75	Sinus	97.4	158/64	96	Warm	++	30	Br/Cl	98%	On Fm O2 2 litr.
15.00	74	Sinus	97.4	126/57	80	Warm	++	22	Br/Cl	97%.	,,
16.00	70	Sinus	97.4	130/56	81	Warm	++	27	Br/Cl	97%.	"
17.00	69	Sinus	97.4	128/59	82	Warm	++	26	Br/Cl	96%	"
18.00	68	Sinus	97.4	124/57	79	Warm	++	26	Br/Cl	97%	"
19.00	70	Sinus	97.9	128/61	83	Warm	++	28	Br/Cl	97%.	"
20.00	68	Sinus	98F	137/68	90	warm	++	26	Br/cl	100%	"
21.00	69	Sinus	98F	125/52	77	warm	++	27	Br/cl	99%	"
22.00	70	Sinus	98F	124/65	85	warm	++	28	Br/cl	98%	"

PREVIOUS DAY - HOURS 24 hours.

DRAINAGE —

TOTAL INTAKE 1057 ml

URINE 1680 ml

TOTAL OUTPUT 1680 ml

BALANCE 623 ml

? UTI | CCF

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Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/064

Medway Heart Institute
heart beat counts

INTERMEDIATE CARE FLOWCHART

B

NAME : Mr. Anantha Krishnan. UHID NO : 202381290 AGE : 79 yrs. SEX : Male

BLOOD GROUP : 'O' Positive

HEIGHT : ±168 cm WEIGHT : ±60kg B.S.A : 1.7 m²

17/12/23 → (4).

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
00:00	68	Sinus	98°F	131/56	81	warm	++	20	Br/cl	99%	Pt O2 2 liters on flow
01:00	70	Sinus	98°F	123/87	69	warm	++	21	Br/cl	99%	"
02:00	71	Sinus	98°F	149/62	99	warm	++	28	Br/cl	98%	"
03:00	72	Sinus	98°F	123/60	84	warm	++	26	Br/cl	100%	"
04:00	70	Sinus	98°F	128/81	85	warm	++	25	Br/cl	100%	"
05:00	68	Sinus	98°F	120/66	77	warm	++	26	Br/cl	98%	"
06:00	74	Sinus	98°F	140/56	98	warm	++	25	Br/cl	100%	"
07:00	78	Sinus	98°F	139/58	86	warm	++	25	Br/cl	90%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

's / 2011 / CCR

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79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

ERMEDIATE CARE FLOWCHART

B

NAME | UHID NO : 202302516 | AGE : 79y | SEX : M

BLOOD GROUP : O positive

HEIGHT : 168 cm WEIGHT : 60 kg. B.S.A : 1.7m2

16/12/23 → ③

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	Temp (ST)	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8am	70	Sinus	98.1	123/61	82	warm	++	27	B/L	95	Room air.
9am	78	Sinus	98.2	132/63	90.	warm	++	26	B/L.	96%	"
10am	82	Sinus	99.8	146/56	86	warm	++	28	B/L	98%	"
11am	81	Sinus	98.	102/59	73	warm	++	28.	B/L	97%	"
12pm	90	Sinus	98.8	150/69	96	warm	++	30	B/L	98%	"
13	89	Sinus	98.1	144/53	83	warm	++	32.	B/L	96%	"
14.00	86	Sinus	97.1	165/66	99	warm	++	26	BL/L	97%	"
15.00	87	Sinus	97.1	163/74	104	warm	++	34	BL/L	96%	"
1600.	94	Sinus	97.1	147/67	94	warm	++	38	BL/L	97%	"
17.00	90	Sinus	97.1	162/77	105	warm	++	34	BL/L	96%	"
18.00	92	Sinus	101.7	183/78	113	warm	++	30	BL/L	98%	FACE MASK O2 4 litre.
19:00	82	Sinus	98.6	134/61	85	warm	++	32	BL/L	96%	"
20:00	81	Sinus	98.4	112/54	73	warm	++	19	BL/L	98%	"
21:00	85	Sinus	98.6	156/63	94	warm	++	29	B/L	96%	"
22:00	72	Sinus	98F	127/64	82	warm	++	27	B/L	97%	"
23:00	68	Sinus	98F	128/68	81	warm	++	28	B/L	97%.	"

PREVIOUS DAY - HOURS 20hrs.

DRAINAGE —

URINE ⇒ 2500ml.

TOTAL INTAKE ⇒ 684ml

TOTAL OUTPUT ⇒ 2500ml

BALANCE ⇒ -1816ml

stenosis / 2071 / CCF

MHI/ICU/2022/064

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79/Male/MH1202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

...RMEDIATE CARE FLOWCHART

B

NAME :

UHID NO : 202302516

AGE : 79y

SEX : M

BLOOD GROUP : O positive.

HEIGHT : ±168

WEIGHT : ±60

B.S.A : 1.7m²

16/12/23 (2)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
4.00	64	Sinus	97.2	115/61	79	warm	++	25	Brd	97%	On Room air
5.00	65	Sinus	96.2	139/69	92	warm	++	25	Brd	99%	"
6.00	66	Sinus	96.2	135/59	84	warm	++	25	Brd	96%	"
7.00	65	Sinus	97.2	128/64	85	warm	++	27	Brd	94%	"

PREVIOUS DAY - HOURS

DRAINAGE
URINE

TOTAL INTAKE
TOTAL OUTPUT
BALANCE

AORTIC STENOSIS / ? UTI / CCF

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INTERMEDIATE CARE FLOWCHART

B

NAME : MR. ANANTHA KRISHNAN. UHID NO : 20288129 AGE : 79 SEX : M.

BLOOD GROUP : 'O' POSITIVE

HEIGHT : ± 168 cm WEIGHT : ± 60 kg B.S.A : 1.7 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
12.15	106	Sinus Tachy	97.1	161/77	105	warm	++	28	BLAE	96%	4 L of O2
13.15	94	Sinus	98.1	143/84	92	Warm	++	26	B/d.	96%	"
14.00	88	Sinus	97.4	167/82	110	warm	++	27	BLAE	96%	ON Room Air.
15.00	87	Sinus	97.1	121/68	86	warm	++	25	BLAE	97%	"
16.00	84	Sinus	97.1	135/65	88	warm	++	26	BLAE	98%	"
17.00	82	Sinus	97.1	139/67	91	warm	++	27	BLAE	96%	"
18.00	85	Sinus	97.1	128/76	93	warm	++	28	BLAE	96%	"
19.00	82	Sinus	97.1	133/61	85	warm	++	25	BLAE	96%	"
20.00	83	Sinus	97.2	135/62	86	warm	++	23	B/d	96%	"
21.00	84	Sinus	97.2	152/65	94	warm	++	25	B/d	91%	"
22.00	83	Sinus	97.2	111/44	66	warm	++	26	B/d	90%	"
23.00	74	Sinus	97.2	129/59	82	warm	++	21	B/d	96%	"
00.00	77.	Sinus	97.2	139/59	80	warm	++	23	B/d	98%	"
1.00	74	Sinus	97.2	119/59	79	warm	++	25	B/d	99%	"
2.00	70	Sinus	97.2	124/59	81.	warm	++	24	B/d	99%	"
3.00	71	Sinus	96.8	135/63	87	warm	++	24	B/d	98%	

PREVIOUS DAY - HOURS

DRAINAGE
URINE

TOTAL INTAKE
TOTAL OUTPUT
BALANCE

Δ[sis]: T2 DM | HTN | SEVERE CALCIFIC AORTIC

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

MHI/ICU/2022/064

Medway Heart Institute
heart beat counts

INTERMEDIATE CARE FLOWCHART

A

NAME : Mr Anantha Krishnan. UHID NO : 202381290 AGE : 79 yrs SEX : Male.

SURGICAL PROCEDURE : –

POSTOP DAY : – FLUID REQUIREMENT : 1 to 1.5 Litres / day

18/12/23 → (7)

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS			H.T.	ORAL/ R.T. H.T.	G.T.	TOTAL INTEKE	TOTAL BALANCE
18/12/23 @ 8.00	110	110					110					30	30	30	-80
9.00	80	190					190	NS 50				150	180	230	+40
10.00	90	280					280						180	230	-50

SPECIFIC OBSERVATIONS/REMARKS

—

MEDICATION / DRUGS

→

A/s/s: T2DM | HTN | SEVERE CALCIFIC AORTIC STENOS

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79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

Medway Heart Institute
heart beat counts

INTERMEDIATE CARE FLOWCHART

A

NAME : Mr. Anantha Krishnan. UHID NO : 202381290 AGE : 79 yrs. SEX : Male.

SURGICAL PROCEDURE : —

POSTOP DAY : –

FLUID REQUIREMENT : 1 to 1.5 liters/day

17/12/23 → (6)

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS Inj. albumin			H.T.	ORAL/ R.T. H.T.	ORAL/ R.T. G.T.	TOTAL INTEKE	TOTAL BALANCE
23:00	50	870					870	20. DC				–	700	780	–90
18/12/23 00:00	50	920					920					100	800	880	–40
01:00	50	970					970					–	800	880	–90
02:00	50	1020					1020					–	800	880	–140
03:00	40	1060					1060					–	800	880	–180
04:00	50	1110					1110					–	800	880	–230
05:00	50	1160					1160					–	800	880	–280
06:00	50	1210					1210					100	900	980	–230
07:00	40	1250					1250					–	900	980	–270

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
——	——

Δsis : T2 DM | HTN | SEVERE CALCIFIC AORTIC STENOSIS / ? U

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15/12/2023/IPH202302516
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INTERMEDIATE CARE FLOWCHART

A

NAME : Mr. Anantha krishanan.P.N. **UHID NO :** 202381290 **AGE :** 79 yrs **SEX :** Male

SURGICAL PROCEDURE : _

POSTOP DAY : Do. **FLUID REQUIREMENT :** 1 to 1.5 liters/day

17/12/23 → (5)

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS			H.T.	ORAL/ R.T. H.T.	ORAL/ R.T. G.T.	TOTAL INTEKE	TOTAL BALANCE
7.30	50	50					50					-	-	-	-50
8.30	50	100					100					150	150	150	+50
9.30	70	175					175					-	150	150	-25
10-30	75	250					250					-	150	150	-100
11.30	50	300					300					-	150	150	-150.
12-30	50	350					350.					-	150	150.	-200
1300	50	400					400					100	250	250	-150.
14.00	50	450					450						250	250	-150.
15.00	15	465					465					200	450	450	-15
16.00	25	490					490						450	450	-40
17.00	50	540					540						450	450	-90
18.00	30	570					570.	Inj. Albumin 100ml					450	450	-120.
19.00	50	620					620.	20				100	550	570	-50.
20.00	100	720					720	20				100	650	690	-30.
21.00	50	770					770	20.				50	700	740.	-30
22.00	50	820					820	20.				-	700	760	-60

SPECIFIC OBSERVATIONS/REMARKS

—

MEDICATION / DRUGS

—

Δsis: T2DM | HTN | SEVERE CALCIFIC AORTIC STENOSIS |

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INTERMEDIATE CARE FLOWCHART

A

NAME : Mr. Anantha Krishnan. P. N. **UHID NO :** 202381290 **AGE :** 79 yrs **SEX :** Male

SURGICAL PROCEDURE : –

POSTOP DAY : D2 **FLUID REQUIREMENT :** 1 to 1.5 liters / day

17/12/23 → (4)

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.		Inj. Albumin			H.T.	H.T.	G.T.		
17/12/23 00:00	40	1350					1350.	15				–	550	777	–573
01:00	30	1380					1380.	15				–	550	792	–588
02:00	50	1430					1430	10 DC.				–	550	804	–623
03:00	50	1480					1480					100	650	957	–523
04:00	50	1530					1530					–	650	957	–573
05:00	50	1580					1580					–	650	957	–623
06:00	50	1630					1630					–	650	957	–673
07:00	50	1680					1680.					100	750	1057	–623

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
—	—

DIS: T2DM / HTN / Severe calcific Aortic stenosis

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Dr.K.JAISHANKAR

INTERMEDIATE CARE FLOWCHART

A

NAME : Mr.ANANTHA KRISHNAN.P.N   UHID NO : 202302516   AGE : 79y   SEX : M

SURGICAL PROCEDURE :

POSTOP DAY :   FLUID REQUIREMENT : 1-1.5 L/day

16/12/23 → ③

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS: Inopri 8/50	Sodium 20/40		H.T.	ORAL/ R.T. H.T.	ORAL/ R.T. G.T.	TOTAL INTEKE	TOTAL BALANCE
8 Am	-	-					-	4	2			50	50	50	+50.
9 Am	—	—					—	4	2			150	200	200	+200
10 am	—	—					-	4	2			-	200	200	+200.
11 am	—	—					—	4	2			-	200	200	+200.
12 pm	-	-					-	4	2			-	200	200	+200.
13 pm	800	800					800	4	2			-	200	200	-600
14.00		800					800	4	2			100	300	300	-500
15.00		800					800	D/C	2				300	300	-500
16.00	200	1000					1000		2			100	400	446	-554.
17.00		1000					1000		2				400	448	-552
18.00	50	1050					1050		2	Inj. Lasix 40 mg D/C			400	550	-500
19:00	75	1125					1125		2 D/C	IV ALBUMIN 100 ml		50	450	602	-523
20.00	40	1165					1165			15		50	500	667	-498
21:00	45	1210					1210			15		50	550	732	-478
22:00	50	1260					1260			15		-	550	747	-513
23:00	50	1310					1310.			15		-	550	762	-548

SPECIFIC OBSERVATIONS/REMARKS

—

MEDICATION / DRUGS

—

D/s : T2 DM / HTN / Severe calcific coronary...

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15/12/2023/IPH202302516
Dr.K.JAISHANKAR

RMEDIATE CARE FLOWCHART

A

NAME :

UHID NO : 202302516

AGE : 79y

SEX : M

SURGICAL PROCEDURE :

POSTOP DAY :

FLUID REQUIREMENT : 1–1.5 l/day

16/12/23 → (2)

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.		[illegible]	[illegible]		H.T.	H.T.	G.T.		
16/12/23 4:00		1100					2100	2	H				600	666	-1434
5:00		1100					2100	2	H.				600	672	-1428
6:00	200	1300					2300	2	H				600	678	-1622
7:00	200	1300					2500	2	H				600	684	-1816

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS

Δsis: T2DM / HTN / SEVERE CALCIFIC

MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

A

NAME : Mr.ANANTHA KRISHNAN.P.N
79/Male/MHI202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

SURGICAL PR

POSTOP DAY :

UHID NO : 202381290 AGE : 79 SEX : M

FLUID REQUIREMENT : 1-1.5 litres/day.

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS Inj. Lasix (2/240)	I.V. FLUIDS	I.V. FLUIDS	H.T.	ORAL/ R.T. H.T.	ORAL/ R.T. G.T.	TOTAL INTEKE	TOTAL BALANCE
12.15	200	200					200.	↓				100	100	100	-100.
13.15	-	200					200.	↓				-	100	100	-100
14.00	100	300					300	↓					100	100	-200.
15.00	200	500					500	↓				100	200	200	-300.
16.00	200	700					700	2.				100	300	302.	-398
17.00	200	900					900	2	Inj. Pan 80/40				300	304	-596.
18.00	200	1100					1100	2	↓				300	306	-794
19.00	300	1400					1400	2	4			100	400	412.	-988.
20.00	200	1600					1600	2	4				400	418	-1182
21.00	200	1800					1800	2	4			200	600	624	-1176
22.00		1800					1800	2	4				600	630	-1170
23.00		1800					1800	2	4				600	636	-1164
00.00		800					1800	2	4				600	642	-1158
1.00	100	900					1900	2	4				600	648	-1252
2.00		900					1900	2	4				600	654	-1246
3.00.	200	1100					2100	2	4				600	660	-1440

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS