

# 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)	1	
- Intake Output Chart	~	-
- Drug Chart (Duly filled)	/	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist	~	
- Anesthesia Assessment Sheet	1	
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon	1	
- Surgery Notes - Post Operative Plan	~	
- Pain Scoring System	~	
- Blood Transfusion if done	1	
- High Risk Procedures	V	
- A copy of the Discharge Summary	· ·	



Patient D Master, SIVAGURU.S

Name:

13/Male/MHI202381075

UHID:

02/12/2023/IPH202302423

D08: DOA:

Consultani

Dr.RAJESH.V

TO UNIVERSITATION DE L'ANDIONNE DE L

||HI/IPD/2022/002 Medway Heart Institute

The way to better (A Unit of United Alliance Health	neare Pvt Ltd)	ADMISSION	I SLIP	Every heart beat count
Admitting Doctor:	1. Rosesh.	Spec	iality:	
Advised Date & Time:	2/12/22/09	11.14am.		en e
Provisional Diagnosis:	Rheu mol	7	disan !	severe tosti
reguegi (	alway			
Reason for Admission:	Medical Managem	ent Surg	ical Management	
[	Others (please spe	ecify details)		
Admission Type:	Day Care	ER Ward	1	
		(Specify d	letails)	
Surgery / Procedure Name (	(if planned):	Muha	vial v al	
Blood Product Requirement  Expected Duration of Stay:	6 - 7 dc		mponenis required	
Expected Cost of Treatment		<del>/ </del>		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Payer: Self Insurance	Others:	seling Form):	CW St	all lines in the same
Instructions to Nurse (if any)	: -> Ad	mil-in	geneal	sald.
calegon	•			
Any other Instructions (if any	<i>y</i> ):			<del></del>
<i>i. i</i>	1			
	794			129
Doctor's signature	Reg No:	TESH Reg. No.	2794.	Date 2 Time

For admission desk staff o	only:		ر مرمد
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		
Admission intimation	Receipt Details	Admission Ti	me in HIS
Date	Time	Date	Time
2/12/23	11.1000	£2 /12 /23	11: 39An
To be filled only if Blood	OPD ER Direct requirement specified by the		□ No
Front office Staff Signature	Name Coundary	22.69	Date Time 02/12/23 /1:39/A
·		Dr. V Reg.	



# Medway Hospitals®

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



# Patient Name:

UHID:

D08:

DÔA:

Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V

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Medway

MHI/HOSP/2022/129

Consultant:

# **ADMISSION FORM**

Marital Statu	Full Address SIVEGURU-S-510 Sakethir manga No-3/82. Gandhi wagar - nother manga Keeron gudi. Villagen (Dibbe Valivalem 120t. Prin 600207	Telephone Number
Occupation	Keerongedi. Village (Disa	994392008
	<del></del>	
Referred from	Date of Time of Admission Date & Time of Discharge To	tal No. of Days
JE. F	Jehr 02/12/23@11:39 12/12/23@1600 11 D	ays
UNIT	otheraic MLC Yes No If Yes AR No.:	
<u> </u>	FINAL DIAGNOSIS	ICD Code
SEVER	E AORTIC REGURGITATION MILD MITTRAL	T35.)
RECT	RUITATION RHEUMATIC HEART DIREASK.	709.9
CLASS	II ANGINA ADEQUATE IN SYSTOLIC	<u>Iso.</u> 1
FUNC-	ION ~ EF-52/.	
	<del></del>	
DATE	OPERATION / PROCEDURES	ICPM Code
	GORTIC VALUE REPLACEMENT USING · 21 MM	
Í	ST. TUDE MASTER SERIES MECHANICAL	32.02
07.12.23	UALVE DONE DN 07.12.2027	99.00
	UA LUE DOISE	
DATE	TYPE OF ANESTHESIA	
07.12.27	GENERAL SPINAL LOCAL REGIONAL	☐ EPIDURAL
	DISCHARGE STATUS	
☐ Cured		Expired < 48 hours
☐ Improved	☐ Against Medical Advice ☐ Absconded ☐	Expired > 48 hours
☐ Unchang	<del>_</del>	Post-Operative Death
1/4	ayor jay	
	1764	149 dical Records Officer

# **AUTHORISATION FOR TREATMENT I PAYMENT**

hereby authorise the Administration, Medical and Nursing and Paramedical, Staf for 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 to perform such operation under anaesthesia or other wise as may be deemed necessary and to advisable in the diagnosis and treatment of my illness / patient. இடியில் and advinisters and advinisters are discovered and an appropriate of 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 fall 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 outhorities.  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 கிக்கை, பணம் செலுத்துல் முதல்தல்லை செய்ய அதிகாறம் வழங்கதல் இதன் முலமாக நான் நிங்காகம். மருத்துவல், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்க / நோயாளி.	
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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 .  ###################################	·
கிக்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்  இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி	and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the
க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுக்கு செய்முறைகள்/அறுவை சிகீச்சை செய்யவும் அதிகாரம் வழங்குகீறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கீறேன்.  மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேற்றாரு மருத்துவமனைக்கு, பிற சிசிச்சை / அறுவை சிகீச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கீறேன்.  மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி தெரிவிக்கீப்பட்டிருக்கீறேன்.  நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்ல நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்ன என உறுதி செய்கீறேன்.  மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கைபொட்பமிட்டேன்.	· · · · · · · · · · · · · · · · · · ·
மருத்துவமனைக்கு. பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் ்குகாரம் அளிக்கிறேன். மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன். நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடிக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெகுங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்ன என உறுதி செய்கிறேன். மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொட்பமிட்டேன்.	க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின்
நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடிக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்ன என உறுதி செய்கிறேன். மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.	மருத்துவமனைக்கு. பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம்
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, , , , , , , , , , , , , , , , , , ,	நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்ன
தெதி தெற்றின்ற கலியாப்பம் தேதி எனது உறவினர்/காப்பாளர் கையொப்பம் Signature of Admitting Nurse Date 02/12/23 Signature of the Patient / Relative / Gurdian	மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

உறவுமுறை அதிரை Nature of Relationship



relevant information on my part.

promise to abide by them.

handbook.

Patient Dr. Master.SIVAGURU.S

Name: 13/Mule/MHJ202381075

UHID: 02/12/2023/IPH202302423

DOB: Dr.RAJESH.V

DOA: Dr.RAJESH.V

MHI/IP/2022/008

Medway
Heart
Institute

Every heart beat counts

**GENERAL CONSENT FOR ADMISSION** 

1.	Masten: Saguru: S the Patient or Representative of patient have
(p	lease tick the correct option above and below)
Ë	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

 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 declare that I have been explained about my rights and responsibilities as a patient as outlined in the patient

I have been made aware of the rules and regulations of the hospital including those related to security and I

- 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	ŀ	Time
Patient	5. P. 20 6 6	8200	32/12/	23	11 786
Surrogate/Guardian (if applicable #)	V.568.	(Write name and relationship with patient)	02/12/	اوح	11:39
Reason for surrogate consent	Patient is unable to give consent I	because:		,	
Witness	s. Shilli	8104000 1: A176-S	02/12/	20 1	11:3%
Interpreter (if applicable)					

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



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

Pa Master.SIVAGURU.S

Na 13/Male/MHI202381075

UF 02/12/2023/IPH202302423

DC Dr.RAJESH.V

DC 118 W WALLEY BIT HAN COLUMN THE WALLEY WHILE IN



# **ADMISSION CRITERIA FOR INTENSIVE CARE UNIT**

S.	PARAMETERS		MARK ✓ AS		
No.	TATAMETERS	APPRO	PRIATE		
- 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				
ı	Diastolic arterial pressure more than 120 mm Hg				
ļ	Respiratory rate more than 35 breaths/minute				
	Cardio-vascular System				
	Acute myocardial infarction				
	Cardiogenic shock				
´	Complex arrhythmias requiring close monitoring and intervention		T		
- 1	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support				
2	Hypertensive emergencies		1		
- 1	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain	· · · · ·	1		
- 1	Post cardiac arrest				
Ì	Cardiac tamponade or constriction with hemodynamic instability	_			
1	Dissecting aortic aneurysms		1		
	Complete heart block		1		
	Miscellaneous Conditions		1		
	Septic shock with hemodynamic instability				
3	Hemodynamic monitoring		1		
ļ	Clinical conditions requiring ICU level nursing care				
	Post procedure elective admission				
4	Post Coronary Angioplasty		•		
	Post Cardio-vascular Surgery	1	<u> </u>		
	Following angiographic procedure	<del></del>	1		
5	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				
	Pulmonary System				
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		1		
	Pulmonary emboli with hemodynamic instability		1		
6	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	·			
	Renal failure				
_	Oliguria or anuria for more than 12 hours				
7	Metabolic acidosis (pH < 7.1)		1		
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		-		

	- -						
S. No.			K ✓ AS OPRIATE				
8	Diabetic insufficie Thyroid Hyperos Other en Severe hemody Hypo or mental s Hypo or Hypo or muscula	ency, or severe acidosis storm or myxedema coma with he smolar state with coma and/or hen idocrine problems such as adrena hypercalcemia (Serum Calcium namic monitoring hypernatremia (Serum Sodium le tatus hypermagnesemia with hemodyr	hemodynamic instability, altered mentioned mentions and constability or Serum Glucose mal crises with hemodynamic instability in more than 15 mg/dl) with altered mentions than 110 mEq/L or more than 155 mEq/mamic compromise or dysrhythmias less than 2.0 mEq/L or more than 6.0 mEq/L or more than 6.	ore than 800 mg/dl ental status, requir L) with seizures, alter	ing red		
	ctor	Signature	Name	Reg. No.	Date	Time	
	Ctol	V	pr. proven	112236	利的分	13.4:	
	DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT						
S. No.	PARAMETERS					K ✓ AS OPRIATE	
1	Stable h	emodynamic parameters				γ	
	Stable recrimatory status (Pt. extubated with stable arterial blood gases) & ainyay natent						

2	2 Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent					7	
3			nore than 3 L by nasal prongs)				
4			or support and vasodilators are n	o longer necessary			
5	Cardiac	dysrhythmias are controlle	ed				
6							
7	7 No signs of bleeding and hematoma at puncture site						
8	End of li	ife care pathway chosen					
	Signature Name Reg. No.						
Do	octor	V	Pr.B	nauer. 1127-36	9/11/12	11.20	







Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd)

: 02/12/2023

12/12/2023



## DISCHARGE SUMMARY

IP No.

: IPH202302423

UHID

: MHI202381075

Name

: MAST. SIVAGURU.S

Age / Gender

: 13 Years / MALE

Consultant

: Dr. V. Rajesh, MS, M.Ch (CTVS)

Senior Consultant Cardiothoracic and Vascular Surgery

D.O.S: 07.12.2023

Room No.: 202

D.O.A

D.O.D

### DIAGNOSIS:

SEVERE AORTIC REGURGITATION MILD MITRAL REGURGITATION RHEUMATIC HEART DISEASE CLASS II ANGINA

ADEQUATE LV SYSTOLIC FUNCTION - EF: 52%

## SURGERY:

AORTIC VALVE REPLACEMENT USING 21MM ST. JUDE MASTER SERIES MECHANICAL **VALVE DONE ON 07.12.2023** 

# BRIEF HISTORY:

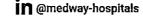
Mast. Sivaguru. S, 13 years old male, a known case of Rheumatic Heart disease, Severe Aortic Regurgitation, Mild Mitral Regurgitation, Adequate LV systolic function, has come for Aortic Valve Replacement. Patient was diagnosed to have Rheumatic heart disease at the age of 8 and was on regular medications. He was doing well with medications till 27.11.2023 when he developed palpitations, associated with giddiness and nausea for which he was taken to Government Thiruvarur Medical Collage where his Echo showed Moderate to Severe Aortic Regurgitation with holodiastolic flow reversal in descending aorta. He was managed conservatively. He then came to Medway Heart Institute on 29.11.2023 for further management. His Echo showed Rheumatic Heart disease, Severe Aortic Regurgitation, Mild Mitral Regurgitation with Adequate LV systolic function. He was advised early Aortic Valve Replacement. Patient and attenders were explained about the nature of disease, risks and the need for valve surgery. Currently, he is getting admitted for the same. No H/O Breathlessness, Chest pain, Syncope or Swelling of Legs. No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism.

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Kumbakonam Chengalpattu 044-2473 4455 044-27426829

Villupuram 04146-242000 Medway Centre of Excellence (Chennai) **Heart Institute** 

044 - 4310 8959

044-2473 4455 044-26530011 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665 Institute of Pulmonology 044-2473 4454

MHI/HOSP/2022/118





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UHID: MHI202381075 IPNO: IPH202302423

# NAME: MAST. SIVAGURU.S

**ON EXAMINATION:** 

Patient Conscious, Oriented and afebrile.

**TEMP** 98.6° F HR 68bpm

BP 100/60 mmHg SPO<sub>2</sub> 98% in room air CVS S1S2 (+), EDM (+)

RS **BAE** (+)

Abdomen Soft, non – tender

**CNS NFND** 

# **BLOOD INVESTIGATIONS:**

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	14.2	Male: 13.7 - 17.5	gms%
	· · · · · · · · · · · · · · · · · · ·	Female: 11.2 - 15.7	<u>                                     </u>
HAEMATOCRIT	41.3	39-52	%
TWBC	8300	4000 - 10000	Cells/Cumm
NEUTROPHILS	43.0	40-70	%
LYMPHOCYTES	45.0	20 - 40	%
EOSINOPHILS	7.9	0 - 6	%
MONOCYTES	3.6	0 - 6	%
BASOPHILS	0.5	0 - 2	%
PLATELET	366000	Male: 1.5 - 3.5	Cells/cumm
		Female: 1.5 - 3.7	
Urea	22	14 - 40	mgs/dl
Creatinine	0.56	Male: 0.7 - 1.2	mgs/dl
	·.	Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	140	135 - 145	mmol/l
Potassium (K+)	3.69	3.4 - 5.5	mmol/l
T. Bilirubin	0.37	0.2-1.0	mg/dl
D. Bilirubin	0.14	0.00 - 0.4	mg/dl
I. Bilirubin	0.23	0.4-0.6	mg/dl
S.G.O.T	20	<38	U/L
S.G.P.T	11	<41	U/L
ALP	292	Adult: 42 - 141	U/L
GGT	11	Male: 10 - 45	U/L
	,	Female : 5 - 32	
Total Protein	7.9	6.0 - 8.0	gm/dl
S. Albumin	4.7	3.5 - 5.0	gm/dl

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Villupuram 04146-242000

**Heart Institute** 044 - 4310 8959





(A Unit of United Alliance Healthcare Pvt Ltd)

IPNO: IPH202302423 NAME: MAST. SIVAGURU.S UHID: MHI202381075 PROTHROMBIN TIME Normal: 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction: 2.0 - 3.0 Deep Vein Thrombosis: 2.0 - 3.0 Pulmonary Embolism: 2.0 - 3.0 INR 1.0 Artificial Cardiac Value: 3.0 -4.5 Recur. Systmic Embolism: 3.0 - 4.5 INR T.S.H 3.76 Adult: 0.25 - 5.0 New bornulU/ml 4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0 T3 "Adult: 60 - 152 ug/dl 146 New born - 4 days : 96 - 730 1 - 11 Months: 102 - 243 1 - 9 yrs: 89 - 237 Т4 10.0 "Adult: 4.6 - 9.3 ug/dl New born - 4 days: 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs: 6.3 - 13.16

ECG: HR - 68bpm, sinus rhythm, LVH (+).

ECHO: EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 107ML, ESV: 52ML, EF: 52 %, AORTIC GRADIENT - MAX GRADIENT - 6 MM HG, MEAN GRADIENT - 3 MM HG, ALL CHAMBERS NORMAL SIZED, NO REGIONAL WALL MOTION ABNORMALITY. ADEQUATE LV SYSTOLIC FUNCTION - EF: 52%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 15CM/S, TAPSE : 19MM, THICKENED AORTIC VALVE, THICKENED MITRAL VALVE, PML MILDLY RESTRICTED, OTHER VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, E/A RATIO: 1.94, MEDIAL E/E: 6.65, LATERAL E/E: 6.20, TRA GRADIENT: 15MM HG, RVSP: 25MM HG, AR PHT: 541 MS, MR JET AREA: 3.1 SQ CM, RHEUMATIC HEART DISEASE, SEVERE AORTIC REGURGITATION, NO AS, MILD MITRAL REGURGITATION, NO MAS, TRIVIAL TRA, NO PAH, NO CLOT / VEGETATION / EFFUSUION.

# **AORTIC DIMENSIONS:**

**AORTIC ANNULUS: 21MM AORTIC SINUS: 32MM** ST JUNCTION: 26 MM

**ASCENDING AORTA: 24 MM** ARCH OF AORTA: 17 MM **DESCENDING AORTA: 14 MM** ABDOMINAL AORTA: 12 MM

CXR: PA film, BVM (+), lung fields clear.

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Chengalpattu





(A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH202302423

NAME: MAST. SIVAGURU.S

UHID: MHI202381075

PROTHROMBIN TIME	28.2	Normal: 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction: 2.0 - 3.0 Deep
		Vein Thrombosis: 2.0 - 3.0 Pulmonary
		Embolism: 2.0 - 3.0 Artificial Cardiac Value: 3.0 -4.5 Recur.Systmic Embolism:
INR	2.35	3.0 - 4.5 INR

ECG: HR - 72BPM, sinus rhythm, LVH (+), T wave inversion in lead II, III, V1 - V3 leads.

ECHO: S/P AVR WITH 21MM ST.JUDE MASTER SERIES VALVE, ALL CHAMBERS NORMAL SIZED, PARADOXICAL SEPTUM, ADEQUATE LV SYSTOLIC FUNCTION, EF: 52%, ADEQUATE RV SYSTOLIC FUNCTION. RV TDI:9CM/S, TAPSE: 16MM, THICKENED MITRAL LEAFLETS, OTHER VALVES STRUCTURALLY NORMAL, IAS/IVS INTACT, AORTIC GRADIENT - MAX GRADIENT - 12MMHG, MEAN GRADIENT - 7MMHG, NORMAL FUNCTION OF AORTIC PROSTHESIS, TRIVIAL VALVULAR LEAK, PARADOXICAL SEPTUM, INDETERMINATE DIASTOLIC DYSFUNCTION, MILD ECCENTRIC MR, MILD TR, NO PAH, IVC NORMAL IN SIZE AND NON COLLAPSING, MILD BILATERAL PLEURAL EFFUSION, NO CLOT/ VEGETATION/ PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, aortic prosthesis in position, lung fields clear, no effusion.

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IPNO: IPH202302423

NAME: MAST. SIVAGURU.S

UHID: MHI202381075

## **ADVICE MEDICATIONS:**

SI	NAME OF THE DRUGS			FRE	QUEN	CY	ROUT	RELATIONSHI	
NO.	WITH GENERIC NAME	STRENGTH	DOSAGE	М	A	N	E	P WITH MEAL	DURATION
1	TAB. ACITROM (NICOUMALONE)	1 TABLET	1MG/ 2MG	0	0	1	ORAL	AFTER FOOD	AT 7 PM (ALTERNATE DAYS)
2	TAB. ECOSPRIN (ASPIRIN)	1 TABLET	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0 .	ORAL	AFTER FOOD	X 2WEEKS
4	TAB.PARACIP (PARACETAMOL)	I TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
5	CAP. RAZO D (DOMPERIDONE + RABEPRAZOLE)	1 CAPSULE	20 MG / 30 MG	1	0	1	ORAL	AFTER FOOD	X 1 WEEK
6	SYP. CREMAFFIN (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	ISML \		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)
7	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		I	0	0	ORAL	AFTER FOOD	1 MONTH
8	SYP ALEX PLUS (DEXTROMETHORPHA N HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
9	TAB. PHENOXYMETHYLP ENICILLIN POTASSIUM	1 TABLET	250MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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NAME: MAST. SIVAGURU.S

UHID: MHI202381075

DISCHARGE ADVICE				
DIET	1. VITAMIN K RESTRICTED DIET			
	2. HIGH PROTEIN DIET			
PHYSICAL ACTIVITIES	RESTRICTED.			
FLUID RESTRICTION	NIL			
	REVIEW WITH			
REVIEW	DR. V. RAJESH AFTER 16/12/2023			
	WITH PT/INR, HB, UREA,			
	CREATININE, SODIUM, POTASSIUM,			
	ECG AND CHEST X RAY			

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

Typed by: Kalai

CONSULTANT SIGNATURE Dr. V. Rajesh, MS, M.Ch (CTVS)

Senior Consultant Cardiothoracic and Vascular Surgery

Dr. V. RAJESH Reg No: 62794

"I understood the Content of tha discharge summary,"

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Villupuram 04146-242000

Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454



Master.SIVAGURU.S

13/Male/MHI202381075

02/12/2023/IPH202302423

Dr.RAJESH.V





# INPATIENT INITIAL ASSESSMENT

Date: 2 2 2 Time of arrival in ward: 19:30 .
Allergies (if Yes, specify details):
Drugs Yes No
Blood Transfusion    Yes    Yes    Yes
Food
Others
Vital Signs: Temp: 49 (°F)   Pulse / HR: 68 (beats/min)   BP: 60 (60 (mmHg)  Respiration: 20 (breaths/min)   SpO <sub>2</sub> : 48 (%)   Height: 151 (cms)   Weight: 33 7 (kgs)   BMI: 14.9 4 (m²)
Pain: Yes No. If Yes, Score: C/C  Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)  Duration: Location: Location: Burning Referred / Radiant Pain
A 184 m came with the palpitation only the factory of present illness at 184 m came with the palpitation only the fact adapt paths for the palpitation on the factory paths from the deutle palpitation which gradual north, progressive in nature the adapting north and the factory with the constraint which for freether evaluation.  Past Medical History (with duration of illness):  Diabetes Mellitus: Yes No. If Yes, duration: Howard for the factory of the factory of the factory.  Others: KICLO Rheumatic neart - dual to have the factory.  Past Surgical History:
<

s.	0	1_	l	<b>-</b>	Date & Time	To be continued during
о.	Current Medication	Dose	Route	Frequency	of last dose	hospital stay
	J. DENTOCALLINI	250n	1 90	1-1	01.12.23	°⊟ Yes ⊟ No
,	T-FRUSEMIDE	HO M	PA	M-977	<u> </u>	.☐Yes ☐ No
	T. ENALAPRIL	DOMO	$\Gamma \rightarrow \mu V$	1/2 4/4	) 1.	∧□Yes □ No
Ì			, , ,	1200	l(	☐ Yeş ☐ No
Ī						☐ Yes ☐ No
1				-		☐ Yes ☐ No
1			\ <u>.</u>			☐ Yes ☐ No
1						☐ Yes ☐ No
1						☐ Yes ☐ No
+	<del></del>	<del></del>	<u> </u>			
<u> </u>	ily History: Father is UC					☐ Yes ☐ No
	tather is blo		- <u>-                                  </u>	, · · · · · · · · · · · · · · · · · · ·	•	☐ Yes ☐ No
·er	tather is blo	chever is a	- <u>-                                  </u>	, · · · · · · · · · · · · · · · · · · ·		☐ Yes ☐ No
er Life	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoh	chever is a	oplicable)		l Drug Use: ∐ Yes ∐ l	
er ≟ife	Sonal / Social History (Tick white	chever is au	oplicable)			
Per Life Sm	Sonal / Social History (Tick white estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol:	oplicable) ation: No -	Recreationa		
Per Life Sm Oth	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol:	oplicable) ation: No -	Recreationa		
Per Life Sm Oth	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol:	oplicable) ation: No -	Recreationa		
Per Life Sm Oth	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol:	oplicable) ation: No -	Recreationa		
Per Life Sm	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol:	oplicable) ation: No -	Recreationa		
er Eife Sm	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol:	oplicable) ation: No -	Recreationa		
Per ≟ife Sm Otti	Sonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholers:	chever is ap Occup ol: ☐ Yes ☐ be filled up	oplicable) ation: No -	Recreationa		

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5152 Musmus D
BAF®
stem: 607t, non-fender.
Stemi: NFNID - GICS - US US
ve / Locomotor System:
normal
hoomal
ious disease: Yes No, If yes, Contact Airborne Droplet
ation: us□ Depressed □ Others:
g (ESPEN Guidelines for Nutritional Screening - NRS 2002):
e last 3 months? Yes No Is the patient severely ill? (e.g. in Intensive Therapy) Yes No
ke in the last week? ☐ Yes ☐ No Is the BMI < 20.5? ☐ Yes ☐ No
answer is "YES" to any 2 questions, the patient is at nutritional risk unswer is "NO" to all questions, the patient is at Normal and not at risk
Heavet dislace normal 2v tunction
Admit V Do - ROUGH.
UR on monday.
of a most notife fitness
rue old medication

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Investigations Ac	dvised:						<b>,</b>
,						_	
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							-
						1	
Diet Advice:	<u> </u>	· · · · · · · ( · ·					
Nil per Oral	Clear liquid diet [	Normal liqui	d diet	☐ Diabetic	liquid diet		: :
Semisolid diet	Soft solid diet	☐ South Indian	normal diet	☐ North Inc	dian normal	diet	
☐ Neutropenic liquid	diet Others:	usalt, 1	ow fat	, diabefic	det		<u></u>
Early Discharge Plan	nning (fill in those which are a	ppropriate at thi	s stage):	PFE: Pa	atient Family	Education	5
Special support need	led at home	☐ Yes ☐ No	If Yes, PFI	E done	_		
Home equipment ant	icipated	☐ Yes ☐ No	If Yes, PFI	E done and eq	uipment adv	rised	
Physiotherapy at hon	ne anticipated	☐ Yes ☐ No	. If Yeş, edı	ucated on phys	sical limitatio	ns, if any	
Wound care needs a	nticipated at home	☐ Yes ☐ No	If Yes, edu	ucated on signs	s on infectio	n	!
Pain Management		☐ Yes ☐ No	If Yes, PFI	E done and me	dication adv	vised	
Special Dietary needs	S	☐ Yes ☐ No		ucated on dieta actions and all		ns, food	
Continuous / ongoino	g care anticipated	☐ Yes ☐ No	If Yes, edu	ucated on vario	ous aspects	of ongoing	
Other special educati	ion need, i.e.:	☐ Yes ☐ No	If Yes, PF	E done			2
Nature of post hospit infection control, fall i	al needs like patient safety, risk, etc, addressed	☐ Yes ☐ No	If Yes, spe	ecific education	ı given		
Others:						j S	
						·	
	Signature	Name		Reg. No.	Date	Time	
Resident Doctor	BUMM	· Do Anu	aina :	134759	02-12-	<del></del>	],
Consultant	V'Cufut"	Ja- V- R	-96010°	62795	Marz	3 12/60	m
Patient Attendant	1 V. 550	Relationship	TO HANGI	<b>}</b>	2 12 2	3 12-30	}





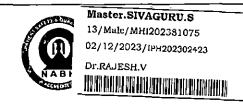
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UNIT: INSTITUTE OF CARDIO VASCULAR DISEASES

	Master.SIVAGURU.S 13/Malc/MHJ202381075	PERATION NOTES	
Name of Patient	02/12/2023/IPH202302423		Age :
UHID No. :	Dr.RAJESH.V		Sex:
Pre-Operative D	Diagnosis: RHD, SEY-A	R, Good Luf	•
Post-Operative	Diagnosis: -do-		
Operation Proce	edure AVR USING	SIMM ST. JUDE	MASTER SERIES VALVE
D.O. Operation	07122023		Please tick the type of procedure:
		<del></del>	Closed Open D
Operation Commenced:	(Ø ;⊃U	Operation /3:30 Completed:	Nature of 460 A Anaesthetic:
Surgeons Du	Rayech / PA: Lai		Perfusionist Mr. Reethi
Anaesthetist 4	. Praisen		Nurse My Laükumas
Incision Medi	as stanotomy	<b></b>	•
Cannulation	A	rterial 18	Venous 34
Oxygenator			caedotomy, Lyelenic
Total CPB	. Time hepaitneea	tion. CPB est	ablished by abuto-plsvc
Total ACC	Time Cannulatio	n - AXC LA ven	ted through RSPV. Anteq ADMoto
Findings and Re	done. A	ntegrade brypo	theimiz delrido ep gicol
	theough	colonaly bel	io. Natur destre valle
He vale - Trice ad up edoct	excled	ainm stitude	mechanical valle replaced in
and up edget.	- RCC CONLULU. Acosti.	Poetion = 2-0	ticion interested surely mines
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MHI/IP/2022/041

Heart
Institute

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	DOCTOR'S PROGRESS NOTES
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	RR-18/mun U
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2022/041

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Every heart beat counts

# **DOCTOR'S PROGRESS NOTES**

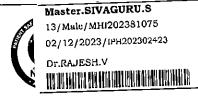
	DOCTOR 5 PROGRESS NOTES.
DATE	NOTES
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	· Mobilize to shair
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	Pr. Anbarasu / Dr. Rajech
	Par Manoy (MMIDO217)

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HI/IP/2022/041

Medway

Heart

Institute

Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
10/12/23	8/B. Dr. Sujith (DMO)
2 / //	
11: 25 Am	·
	S/p: AUR.
[POD-3]	
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	-Infam Sos.
Bp: 90/60	
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DATE	NOTES
10/12/23	6/B Dr. Apukuug
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11.00PM	SIPAUR
	patient reviewed.
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	S/B'. UR-51620
	RS - BAED
WHAT Stable	CNS-NTND
011	HE' Dressing intact
	nosockage .
	Advice
	- monitor vitals
	- Longenue douge els pos
_	Chart .
	- W/R Fellonspikes desaturation dehydration
million	Plan: suttice semonal tomosson.
BURM	- Inobilise the patient - Continue Chest Physip & spiroometry
13413	- my me chest trugs of sprouting
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Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V







Every heart beat counts

	DOCTOR'S PROGRESS NOTES			
DATE	NOTES			
11-12-23	5/B DO-AMMY			
11.40PM	SIP BUR			
	Patient reviewed.			
POD-34	do' mild pain in the suspical site			
	OB: Patiene conscious, oriented, prebale.			
	SE: OUS-5152P			
	RS - BAEP			
	cals—NFAD			
	P/A - SOFT, non-tender.			
	vitals stable			
	HE: Doesing removed buttined removed.			
	wound hoalthy of healing.			
	nduice.			
	- monitor vitals			
	- Continue too days as per chart			
	- W/P FOURSPINOS/ desatruation / dehydra			
K. POJORO				
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DATE	NOTES	111
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12/12/2028		•
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		Chart
	- Dischense to	dan-
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CHENNAI: # 2/26, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024.

Tel: 044 - 2473 4455 | Mobile No: 9962 985 985

**KUMBAKONAM**: No. 142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 61 2103. (Taniore Dist). Ph: 0435 - 2412345 | Mob : 7397720491

E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com

# Master.SIVAGURU.S 13/Malc/MHI202381075 UHID No:: 20238/07 Ğender: M 02/12/2023/JPH202302423 Age : /z Name: Dr.RAJESH.V Bed No.: 203 B.S. A.S. Ward: Clinical Diagnosis: RHD- SEVA Proposed Procedure: AK/R **CHECKLIST** Identification Band on Hand Checked? 1. 2. Surgical consent Signed? a. Special Consent signed if required. 3. Anesthetist Consultation (If required?) 4. History AND Physical Onchart? a. Height 151 cms b. Weight 33.71k 5. Allergic to drugs? NKDA Surgical Preparation done? 6. Nill by Mouth From 12MN 7. Blood Grouping & Rh Typing ... B. P.O. S. M. I VE 8. 9. Investigation X - Ray Blood Sugar LOS mald Time 6:30 10. 11. **TPR Chart** Pulse 110 Temp 98.6 BP 90 50 RR 20 Time Voided 12. a. Retention 13. Enema ☐ Yes

14.	a. Prosthesis Removed		
	d. Dentures Removed		( '
15.	Valuables and Jewellery Removed  ☐ Yes ☐ No Secured ☐ Yes ☐ No		
16.	Pre-Operative Medication Admistered		
	a. Time		(
17.	Blood Transfusion requisition Onchart 20 PCV		/
18.	X-Ray No		
	ECG/ECHO		
	Ultra Sound	; 	
	C.T. Scan		
	MRI Scan		
	TMT		
	Medication		
	TAB. RANTIDINE ISDM9		
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	TAB. ALPRAX O. 20mg Gliven Tolizas TAB. ALPRAX O. 20mg		
	J		
	Others		
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			Tay for
			3/11/3/20



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

Concerns from Surgical Team:

CRP - 0.5.



Every heart beat counts

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Master Civagiuns	Age 13/M UHID MHI02023 81075
ve AR / Mild MR / Adaquati	e/Plan replacement  Ly function ( predomical)
Serology Negative	(EF: 524)
EURO Score / STS Score	PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):
EURO Score / STS Score  RBS / 23 ·  Diabetes Mellitus (HB1AC) -	Associated Illness _
Carotid Doppler	72 · 146 Thyroid Enzymes 74 · 10 · 0 75# · 3 · 79
Sr. Creatinine 0.56	Any other illness of concern
Allen's Test	Myocardial viability if needed
Varicose Veins	
Pulmonologist Clearance	Nephro Clearance: ~
Neurology Clearance :	Dental Clearance: provisionally fit
Mitral Regurgitation Assessment Hold He	, No PAH
Nursing:	Billing Clearance:

SIGNATURE:

Parlong. (MH20217)

Marter Singgern (13/4) a K/c/o Rhumotic Heart dinane, Sever Hitral Aorlie reguegitation, Mild nitral reguegitation Adequali 14 cystolic function has come for AVR. Patient was treated for Rhumotic heart dissue rince he was 27 11. 2023 when he developed Palpitolioni for which he was taken to Rovenment Thinwarur Midical Collège where he Echo showed bloduede to Severe 12 with holodiactotic flow revend in decending assle. He was reanaged conservatively. He then come to HHI on 29/11/2022 for feutser Monagement. His Echo showed RH, Severe AR, Mild MR wild Adequate LV Systolic function. He was advised early AVR CXR: Pafian, any fielde clear, Bone (+)

AL MARK STREET

A who bloom







Pat	Master.SIVAGURU.S
	13/Maic/MHI202381075
Na	02/12/2023/IPH202302423
; UH	
DO	Dr.RAJESH.V
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	- 25 to 10 to 21 abra of fine a lie 1 fire & (1791 18: \$1 km 1 6 kb/1 1941 b))

## **CONSENT FOR SURGERY**

i. <b>I</b>	Mr./Mrsรางคนายการ
icł	k correct option and below):
	Read
	I/We have been explained the current clinical condition of me/my patient
	Been explained this consent form in English, which I fully understand and understood the information
	provided about the disease .Rหอบพลกร
	procedure
	given below in this consent form)
•	I am now aware of the intended benefits, possible risks and complications and available alternatives to the said operation / procedure. I am also aware that results of any operation / procedure can vary from patient to patient and I declare that no guarantees have been made to me regarding success of this operation / procedure. I am aware that while majority of patients have an uneventful operation and recovery few cases may be associated with complications. I am aware of the common risks and complications associated with this operation / procedures and understand that it is not possible to list all possible risks and complications of any operation / procedure.
•	ا have been told about additional procedure that may be come necessary during the surgery which includes
	I also understand that sometimes a planned operation / procedure may need to be postponed or cancelled if patient's clinical condition worsens or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequence by submitting the withdrawal in
	writing.

- I am aware that I may require administration of blood and / or blood products during or after the operation / procedure as found necessary by the doctor (for which a separate consent shall be obtained).
- I am now also aware that during the course of this operation /procedure the doctor will be assisted by medical
  and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the
  need arises.
- I am also aware of the expected course after the operation / procedure and the care to be provided and understand that sometimes admission to an Intensive Care Unit and or extension of duration of hospitalization may be required and or there may be requirement of extra medicines or treatments thereby leading to increase in the treatment expenses depending upon the body's response to the treatment / procedure.

Possible risks & complications 1. Bleeding 2. Infection 3 Shoke	, ,
	·
4. Anythmic 5. Prolonged 100 stay 6. Hild risk to life	1
7. Life long anticargulation	
- Benefits Symptom free survival	
- Alternatives NOT Available	
• The likelihood of success of the surgery (Percentage / Other commands) 95 1/-	,
Possible results of non-treatment 1. Heart Failure	

2. Anythmia.

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

DETAILS	PATIENT / RELATIVES	WITNESS ,
Name ( in BLOCK LETTER)		J.JEG.
Relationship		Father:
Signature		N. E. E. B.
Date & Time		6/12/23 at 18200

Name & Signature of Doctor with Registration No.:

112236

Cardiothoracic and Vascular Surgery

Reg No: 62794

**Doctor Seal** 







நோயாவி விவரங்க	ள்:(Affix Label here)
ណ្ឌាធាក់ :	į
: מואט	:
விளக்க கேகி :	மாகி <b>க</b> ாம் :

## அறுவை சிகிச்சை ஒப்புதல் படிவம்

. நான்நோயாளி அல்லது நோயாளியின் பிரதிநிதி தயவுசெய்து மேலேயும் கீழேயும் பொருத்தமானதை
தேர்வு செய்யவும்
படியுங்கள்
னனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.
இந்த ஒப்புதல் படிவம் ஆங்கிலத்தீல் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகிச்சையின் செயல்பாட்டின் முழுப்பெயர்
ு பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.

- நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கிடைக்கச் செய்கிறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும் நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கிறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும் மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் தொடர்புடைமுறையுடன் சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கிறேன்.
- நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில
  நேரங்களில் தீட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து
  கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை
  எழுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்
- மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நீர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).
- இந்த அறுவை சிகீச்சை / நடைமுறையின் போது மருத்துவர் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவார் என்பதையும், தேவை
  ஏற்பட்டால் தொடர்புடைய நிபுணர்களிடமிருந்து மருத்துவர் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது
  அறிவேன்.

•	சாத்தியமான அபாயங்கள் மற்றும் சி	க்கல்கள்	
		<del></del>	,
•	நன்மைகள்		<del> </del>
•	மாற்றுவழிகள்		
•	அறுவை சிகிச்சையின் வெற்றி வாய்	ய்பு (சதவீதம் / பிற கட்டளைகள்) 	·
•	சிகீச்சையின்றி சாத்தீயமான முடிவுக	கள் 	
•	நேரங்களில் தீவிரமான பராமரிப்பு	முங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர். அலகு மற்றும் / அல்லது மருத்துவமனையில் ள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம். இ	அனுமதிக்கப்படும் கால அளவு தேவைப்படலாம்
•		• - • • • • • • • • • • • • • • • • • •	முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய
			ிக்கீறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட ஆத்தில் கிருக்காக கூருக்கு கொண்கள்
			று அறிவிக்கீறேன். எனது வியாதி, செயல்பாடு ன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றுப்
			o பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நால்
	கையெழுத்திடும் நேரத்தில் என் முன் நிரப்பப்பட்டன என்று நான் மேலும் அ	- , <del>-</del> , ,	ண்டிய அனைத்து துறைகளும் இந்த வடிவத்தில்
$\lceil$	விபரங்கள்	நோயாளி / உறவினர்	சாட்சியம்
	பெயர்		
	<u>உ</u> றவுமுறை		
	கையொப்பம்		
	நாள் & நேரம்		
	மருத்துவரின் பெயர் மற்றும் பதிவ	ച്ച எண், കെயொப்பம்:	



Patir
Nam
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UHIE
DOB:
DOA:
Cons

Master.SIVAGURU.8
13/Male/MH1202381075
02/12/2023/IPH202302423
Dr.RAJESH.V



## **CONSENT FOR ANAESTHESIA SERVICES**

1. MOSTER · SIVAGUEU		the patient or the representative of patient have,
(please tick the correct option abo		
Read		
		al condition of me/my patient
Operation/Procedure		h, which I fully understand and understood the information provided about
Operation / Troccoure	CB KILL WATER	WE REPORTED
(full name of operation / procedur	e given below in this o	consentform)
expected outcome and what needed for this operation, so to the lith has been explained to me to with anaesthesia can occur sensation, loss of limb function. I understand that these risks a	could happen if my on that my doctor can perhat all forms of anaecand include the reron, paralysis, stroke, be apply to all forms of a	edure and has advised me of alternative treatments and told me about the condition remains untreated. I also understand that anaesthesia services are enform the operation or procedure.  In sthesia involve some risks. Although rare, unexpected severe complications note possibility of infection, bleeding, drug reactions, blood clots, loss of orain damage, heart attack or death.  In aesthesia and that additional or specific risks have been identified below, as understand that the type(s) of anaesthesia service checked below will be used
for my procedure and that th	e anaesthetic techn	ique to be used is determined by many factors including my / my relative's
		or's preferences, as well as my own desire.
		anaesthetic technique which involves the use of local anaesthesia, with or and therefore another technique may have to be used including general
	explained to me that t	the following may be needed as part of anaesthesia during or after surgery
		Lumbar Puncture Tracheostomy
		ransfusion TCU Admission / Recovery Others
General Anaesthesia	Expected Results	Total unconscious state that may involve placement of a tube into the windpipe to maintain airway
Alternatives	Technique	Drug injected into the blood stream, breathed into the lungs, or given by other routes
☐ Spinal ☐ Epidural ☐	Risks	Sore throat, injury to vocal cords, teeth, lips, eyes; awareness during the procedure, memory dysfunction / memory loss, aspiration pneumonia, permanent organ damage, brain damage
Others	Ph C:	- Early Recovery
	Benefits	- Relief of Anxiety
Spinal or Epidural Analgesia / Anaesthesia	Expected Results	Temporary decreased or loss of feeling and / or movement in the lower half of the body
☐ With Sedation /GA ☐ Without Sedation	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal
Alternatives ☐ GA ☐ Others	Risks	Nerve damage, persistent back pain, headache, infection, convulsions, bleeding / hematoma, toxicity due to local anaesthetic, chronic pain, medical necessity to convert to general anaesthesia, brain damage
	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions
Major / Minor Nerve Block	ock Expected Results Temporary loss of feeling and / or movement of a specific limb or area	Temporary loss of feeling and / or movement of a specific limb or area
With Sedation / GA     Without Sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
Alternatives ☐ GA	Risks	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to local anaesthetic, medical necessity to convert to general anaesthesia, brain damage
<ul><li>☐ IV Regional Anaesthesia</li><li>☐ Spinal/Epidural Anesathesia</li><li>☐ Others</li></ul>	Benefits	- Pain Free - Safer under certain conditions

Intravenous B	egional Anaesthesia	<del></del>				3 1
☐ With Sedat	ion / GA	Expected Results	Temporary loss of feeling and /	or movement of a limb		`
☐ Without Sedation  Alternatives		Technique	Drug injected into veins of arm or leg while using a tourniquet			
	or Nerve Block	Risks	Infection, convulsions, persiste	nt numbness residual	pain, injury to blood	i vessèls
□ GA		Benefits	- Pain Free			,
☐ Others			- Safer under certain conditions	·	<u> </u>	
Monitored Ana	=	Expected Results	Decreased anxiety and light se	dation similar to norma	al sleep	
(with sedation)  Alternatives		Technique	Drug injected into vein of arm			
☐ General ana		Risks	Prolonged sedation, need for a	irway control		
☐ Spinal / Epi☐ Others	dural 	Benefits	Anxiety free; Early discharge			
Monitored Anaesthesia Care		Expected Results	No changes in the system		•	•
(without sedati Alternatives	on)	Technique	None			
☐ General ana	<del></del>	Risks	Patient may have pain and anxi	ety		
☐ Mild Sedatio	on	Benefits	Early discharge		-	
carrying out t risks and com 1, the above n	ne said operation / pr aplications, intended amed Patient / name	ocedure on myso benefits and possib d patient's represen	tative, do further hereby decla	ent being fully awar are that I am about 1	e of the nature, po	tential
date of signin		sound and am giving 	g consent without any fear, thr	eat or false misconc	eption.  Date	Time
Patient						
Surrogate/Guar (if applicable #)	dian	282,	(Write name and relation	ship with patient)	8/12/23	12230
Reason for surrogate conse		able to give conse	nt because:			
Witness		282	A-monis	he.	8/12/23	12130
Interpreter (if applicable)						
	tales & Left Hand for Fe	•	atient is a minor or unable to give			
procedure co	ourse, and possible a	lternatives to the pl	e, potential risks and compli anned operation / procedure, fully as described in this docu	to the patient / pati		
	Signature	Name		Reg. No.	Date	Time
Consent obtained by	Eur	N	DEWANAWSAM	83722	B/12/13	12:30



் எம்பாயள் தூறிமாஜ	: (Affix Label here)
பெயர் :	
UKID:	
பிறந்த தேதி:	பாலினம்:
சேர்க்கை தேதி:	
மருத்துவர்:	



## மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1 நோயாளி மேலேயும் கீழேயும் சரியான விருப்பத் என்னை / என் நோயா விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்	தைத் தேர்ந்தெடுங்கள்) னியின்  தற்போதைய	படித்தல் மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம்
செயல்பாடு/செயல்முறை		
இந்த ஒப்புதல் படிவத்தீன் கீழே கொடு		டைமுறையின் முழு பெயர்)
எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி எ	ான்னிடம் கூறினார். என	ாங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகீச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எது நிலை சிகீச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து ன். இதனால் எனது மருத்துவர் அறுவை சிகீச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.
கடுமையான சிக்கல்கள் ஏற்படல	ாம். தொற்று நோய், <i>இ</i>	யங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத நூத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.
அடையாளம் காணப்பட்டுள்ளன விண்ணப்பிக்கலாம். கீழே சரிபார்க்	ா என்பதையும் நான் கப்பட்ட மயக்க மருந்து	மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே r புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது r மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை
		படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நூட்பத்தை, மயக்க மருந்து இல்லாமல் நந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.
🔲 பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாலையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை
மாற்று மருந்து	நுப்பம்	இரத்த ஓட்டத்தில் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகீன்றன
முதுகெலும்பு இவ்விடைவெளி 	அபாயங்கள்	தொண்டைப்புண், குரல் வடங்கள், பற்கள், உதடுகள், கண்கள், செயல்முறை, நினைவக செயலிழப்பு, நினைவக இழப்பு, அபிலாஷைகள், நிரந்தர உறுப்பு சேதம், மூளை சேதம் ஆகியவற்றின் போது விழிப்புணாவு
🗌 மற்றவை	நன்மைகள்	– ஆரம்ப மீப்பு – பதட்டத்தின் நிவாரணம்
முதுகெலும்பு அல்லது இவ்விடைவெளி / மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	உடலின் கீழ்பாதியில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு
🔲 மயக்க மருந்து / பொது மயக்க மருந்து	நுட்பம்	ஊசி / வடிகுழாய் வழியாக செலுத்தப்டும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாயுக்கு வெளியே வைக்கப்படுகிறது.
□ மயக்க மருந்து இல்லாமல் மாற்று மருந்து □ பொது மயக்க மகுந்து	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தம்போதல், ஹெமடோமா, உள்ளூர் மயக்க மருந்து, நாள்பட்ட வலி, மயக்க மருந்து, மூளை சேதத்திற்கு மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை
மற்றவை	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிட்யூவில் பாதுகாப்பாக விடக்கூடிய எபிட்ரி வடிகுழாய்களுடன் செயல்பட்டு வலி நிவாரணம்
பெரிய / சிறிய நரம்புத் தொகுதி மயக்க மருந்துடன் / பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முடிவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு அல்லது பகுதியின் தற்காலிக இழப்பு
	டுப்பம்	செயல்பாட்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகில் மருந்து செலுத்தப்படுகிறது
ெ பொது மயக்க மருந்து   IV பிராந்திய மயக்கமருந்து	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெம்டோமா, உள்ளூர் மயக்க மருந்து,மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூளை சேதத்திற்கு மாறுதல்
முதுகெலும்பு / இவ்விடைவெளி மயக்கமருந்து மற்றவை	நன்மைகள்	– வலி இலவசம் – சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை

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நரம்பு மண்டலம் மயக்க மருந்		எதிர்பார்க்கப்படு முடிவுகள்	தம் உண	ர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு	இயக்கத்தீன் தற்காலிக	இழப்பு ''	, ,
□ மயக்க மருந்து இல்லாமல் மாற்றுகள் □ பெரிய / சிறிய நரம்பு தொகுதி		நுட்பம்	9-(Б	 ர்னிக்கேயைப் பயன்படுத்தும் பே	 பாது கை அல்லது கை ந	ரம்புகளில் செலுத	<del>,</del> தப்படுகிறது
		<b>அ</b> பாயங்கள்	தொற்	று, வலிப்பு, தொபர்ச்சியான உண	ா்வின்மை, மீதமுள்ள வ	 லி, இரத்த காயங்	களுக்கு காயம்
☐ பொதுவான மயக்க மருந்து ☐ மற்றவை		நன்மைகள்		) இலவசம் நீபந்தனைகளின் கீழ் பாதுகாப்ட	பானவை		,
(மயக்கத்துடன்)	க்க மருந்து கவனிப்பு	எதிர்பார்க்கப்படு முழுவுகள்	ம் சாதா	ரண தூக்கத்தைப்போன்ற கவணை 	லயும் ஒளியும் குறைந்து ————————————————————————————————————	வருகிறது	
மாற்றுகள் பி பொதுவான ம	nás parés:	இப்பம்	கையி	ன் நரம்பில் மருந்து செலுத்தப்ப(	<sub>ලිසු</sub> කම්		
	பக்க மருந்து வ்விடைவெளி மயக்க மருந்து	அபாயங்கள்	நீண்ட	கால மயக்கம், காற்றுப்பாதை கட	ட்டுப்பாடு தேவை		
🔲 மற்றனவ		நன்மைகள்	கவை	ல இலவசம், ஆரம்ப கால வெளி	 யேற்றம்		
 கண்காணித்த மய (மயக்கம் இல்லாய	பக்க மருந்து கவனிப்பு மல்)	எதீர்பார்க்கப்படு முடிவுகள்	கணி	னியில் மாற்றங்கள் இல்லை		-	
மாற்றுகள்	all time can or in the	நுப்பம்	இல்ன	<del>o</del>	<u></u>		
<ul><li>பொதுவான ம</li><li>இலேசான ம</li></ul>		அபாயங்கள்	நோய	ாளிக்கு வலி மற்றும் கவலை இரு	தக்கலாம்		
மற்றவை		நன்மைகள்	ஆரம்	ப வெளியேற்றம்			
நோயாளியிடம் முமு நான் / மேற்கூறிய	ஓமையாக அறிந்திருக்கிற நோயாளி / பெயரிடப்பட்	ார். சாத்தியமான ட நோயாளியின்	, அபாயங் ர பிரதிநிதி,	றயை செய்வதற்கு) அறுவை சிகீல் கள் மற்றும் சிக்கல்கள் மற்றும் சா இந்த வடிவத்தில் கையெழுத்திடம் படுதல் அளிக்கீறேன் என்று மேலுர்	த்தியமான மாற்றுகள் ப்பட்ட தேதி, மன ரீதியாக	18 ஆண்டுகள் நி	_
				ப்புதல் அளிகையூல் எல்று மேலு. பெயர்	m See See See See See See See See See Se	தேதி	நேரம்
நோயாளி		<u> </u>					
நாயாளிகளின் பிரதிர் பாதுகாவலர் பொருந்தும் ஏன்றாக				நோயாளியுடன் பெயர் மற்றுட	ம் உறவை எழுதவும்)		
நோயாளிகளின் பிரதி சம்மதத்திற்கான சுர்ரணம்		தல் அளிக்க முடி	µயவில்லை 	o <b>ஏனெனி</b> ல்	<u> </u>		
<b>म्या</b> एक							
மொழிபெயர்ப்பாள (பொருந்தீனால்)	π						
நான் நியமிக்கப்பட்ட வரும் நடைமுறைகள	மருத்துவர், இயல்பு, சாத ள் மற்றும் தீட்பகிடப்பட்ட	த்தியமான அபாட செயல்பாடு/ நக	பங்கள் மர் நைம்	ப மாவிட்டால் மட்டுமே ஆண்களுக் ற்றும் சிக்கல்கள், நோக்கம் கொச கு சாத்தியமான மாற்றுகள், நோ ராகப் புரிந்து கொண்டார் என்று நா	ண்ட நன்மைகள், எதிர்பா ாயாளி / நோயாளி பிரதி	ர்க்கப்பட்ட பின் ந	டைமுறைக்கு
	கையொப்பம்	. 6	 JUUL		பதிவு எண்	தேதீ	நேரம்
பெறப்பட்ட ஒப்புதல்							
		<u> </u>				<del> </del>	

. (6)			MHI/OT/2022/094
	ANAECTHECL	A DECO	Heart
Medway Hospitals  , The way to better health  (A thirt of United Alliance Healthcare Pri Ltd)	ANAESTHESI	A RECU	, , , , , , , , , , , , , , , , , , , ,
Master SWACHEN	Type of Surgery :	Day Caral El	ective  Emergency
Nam 13/Malc/MHI202381075	1		
UHII 02/12/2023/(PH202302423			cms Weight: 33 Kgs <sup>T</sup>
DOB Dr.RAJESH.V	Pre-Operative Diagr	iosis: UAR	0111
Consumant.	Proposed Surgery:	Anae	esthetic Plan
ASA Grade: □   □    □    □    □    □	v □E	1P_	GA IRA
History of Present Illness:	COMORBIDITY M	•	Present Medication :
ANGINA DYSPNOEA	☐ HT ☐ SMO		7. Penul 1310
$\square$ SYNCOPE $/\omega$ $/\omega$	☐ DM ☐ ALCO		, 0,000
☐ MI / CCF	☐ HYPO THYROID ☐ CKD		
OTHERS		G ALLERGY	Anti Platelet Stopped on :
Previous Surgery :	☐ EPILEPSY ☐		
Physical Examination: ພ് <sup>™</sup> □ JAUNDICE □ PEDEL OEDEMA	SYSTEMC EXAMINATI		
CYANOSIS CAROTID BRUIT	CVS: Siletepm		s:NPW
☐ CLUBBING	RS: mBS7	Othe	rs:
HR: 63 NIBP:	10/22 SPC	12: 99+	TEMP: Kallne
INVESTIGATION	SEROLOGY	ANGIO	
HB: 1/41-2 TBILIRUBIN: 0.3)	T3: the ryale	21212	1
PLAT : U'LL	T4 : / O' Urine:	ECG HZ-	- 75/m. WIL
TC: 18:400 D. :023	TSH : 3-76 AO	- 10/	
CREAT: 056 T-PROTEINS : 7-9	1:375	CXR WAL	1
Na+ : 140 S.ALBUMIN : 4.7.	HBA1C:Others:		
K+ : 3 69 PTT/INR /24/	RBS : 139	ECHO CAB	V+ 521.
APTT :	CRP 0.5	$\Delta$ .	pun 1
AUDIANA		m-21m	. LUD 12-4/
AIRWAY CAR	ROTID DOPPLER	ser AT	Pun 1 LND D-4/ 2. PIH -54/
Mallampatti class			1 - 1
buth Opening		Other Opinion	
Veck Movement 10 Rythel		Other Opinior	18:
TM Distance 55/10			
Pre OP Instruction : N	PO From: 12 M N		
Pre Medication :	^	Blood Reservation	on -
Night Before Surgery: Randeds  Day of Surgery  Special Instruction:	150m (0 9)	1	∠ Platelet :
Day of Surgery	mad free Am Espet	FFP :	CRYO:
Special Instruction :	wal	Whole Blood:	
Remarks:			
	Dr. JEEVAN		<i>f</i>
Anaesthetist Name with Reg.No. :	Reg. No: 8:	3722 Signature	m
<u> </u>	>>/*.~	- <i>v</i>	

L.P.	ate: Anaesthetist	DR. Ad	EETHA	,	Surgeo	n DR.	. RAJE!	BH)			Anaesthe	esia Tech egional [	<b>nique</b> Others
PI	RE INDUCTION AN	AESTHE	SIA REC	ORD									
Pulse: 22 BP: loo loo BB: tofordwate NIBP Left Right INDUCTION:							-,						
	nsorium: <u>brilv</u>		_		ZIECG 🛛	Pulse Oxim	eter 🗹 End	Tidal CO₂	Pre O, [	☐ Rapid Se	edneuce	}1V 30	<u>ا</u>
Sig	n-in Completed: E	∃Yes □	No	Ι, Ι	Gas Ana	lyzer 🔲	Oxygen Se	nsor	Mode of	f Ventilation	: Sponta	Defler ineous C	ontrolled
Eq	uipment Chacked		No	б <sup>г</sup>	Disconne	ect 🖺	-Temperatur	e Probe					
Sig	uipmen Checked f gn: Ker No: 865 ne: 9,30	Mame:	bour		Eeleý Ca	theter 🔲	Nerve Stimi	ulator	Intubation( CL Grade: I	Oral) Nasa	EIT Size:	: <u>6.0</u> Type:	
Tin					TEE		Others:		Any difficult			:: <u>10</u> cm	
<u> </u>	PATIENT	SAFET	<u> </u>		е∨с тур	34486	wsite: R	IN	Throat Pack	c: Yes	☑No□R	emoved	- 1
	sition on Table:				<b>U</b> Standard	-			NG / OG Tu				
	essure points check		ded:□ Ye	es⊡No	Complica				OTHER A				
	e Care: ╚िYes □ No fety Belt: □ Yes ଢ੫							~	☐ Via Traci			ask 🔲 Nasa	d Prongs
	arming Blanket: 🖺 Ý			1	If Yes, de	ine - Type: <u>?</u>	ერSite:_[	e) ear	Others:		-	_	
	ıid Warmer: □Yes				Marterial L  ☐PVC Type	е: 🐲 🕅	Site:   b	Á 8	Antibiotic /	Dose / Ti	me		000
	D Stockings: ☐ Yes				—	e:	 Site:	Ba	LEWI.C	LIVRO	XIME	וייו פאות	6 10 G
	quential Compression	on / Deco	mpressio	on:	Others:				Reversal o	Anaesthe	sla	<del></del> -	
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	S	TART		STOP	FLUID TRA	NFL	JSED	BLOC	D PR	ODUCTS
ANAESTHESIA	9.	45		13.40	CRYSTALOII		COLLOID	10	PR <b>B</b> el	(Adda (4277)
PROCEDURE	10.	45		13,35	KABILYTE 501 KABILYTE 50		ML			
CPB 11.12 -	12-23	- 81	<b>ጠ</b> ነ ሕ				-			,
AXC  1.17 -	12/18 -	-61 min	٥							• •
CUF: 1200	•	MUF:								
<del></del>	HEPARIN				<del>-</del>	RES	SURE MO	NITOR		
DOSE	TIM 1 0.:	<del> </del>		ACT 446 jec	PRE OP	•	T <sub>DV</sub>		Pol	
		700	٠,	440 <u>Jec</u>	PA	/	RV		PĆ/	
					ABP	`				<u></u>
DOOF	PROTAM				POST OP	+	1		<del>-</del>	<del>-</del>
DOSE_	TIM ₹2.			ACT	PA ·		RV	•	PC	WP ,
					ABP	,	•		•	
DRUG D	OSE	START		END	<del>-</del>		DOSE	STAR		END
	ANGE)	TIME		TIME	, DRUG DILUTION	;	RANGE)	TIME		TIME
OP OPPE OPINE DIO	10000					, ·		·	<u>-</u>	1 (14)
ATCI DISME	g-Imis	12.20		13.00		ļ				·
acmg 2xcc 1316	I WR A	12.30	<u>.</u> .	12.40	1	_		•		
					<del> </del>					
					<u> </u>					
	_									
								_		
REGIONAL ANAI	ESTHESIA	YES/NO	 o		IABP: />c	CPI	B .	P	or c	PB.
DETAILS: ES	PB 0	20ml+2	_om	e Bli	Acres vila	ر- م	Mo 1-ser	Arch		eli vilne
IN Ro					ECMO: Ecce	ulv	AR 🕣	goers'	w	ell
In Den	•			nmia	Sur 311 TEE: triaus	MM		No po	hu v	Interbeet
1. Der	41 02000	,,,a <sub>ma</sub> ,a	30	, <u></u>	Nutrel velo	4	Turcher	/ l ' 0' '	المسيد. د د	104 11 va 5
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REMARKS / CRIT	TICAL EVE	NTS			or 0.1 mm	f	. Ruldinco	do	wid	rd: nul
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					Dilated a	vd	incle	[.,	<i>eu</i>	the state of
					Ademt L (1) RV (5)	nel	hã		vt	indier
								1		

ANAESTHESIOLOGIST NAME : REG.NO.

Reg. No. S. SIGNATURE



	POST OPER	ATIVE PLAN					
Transfer to: N=81CU [	Others, specify:		,				
	9b beats/min Rhythm		-	- ÷			
Conscious state:	tg CVP:tmm 			C.O: L/min			
VENTILATOR SETTINGS:	S/mn. + PS)	IONOTROP	ES:				
7v: 30	,	ทร์ (	<u>_</u>				
RP: 12 Flo2: 50							
PEEP: 5							
POST OP ORDERS:							
TO DO ACT, ABY  * TO DO Chest-Array  * Wear and Entubat patient getting awake							
MODIFIED ALDRETE'S SCO	RE (Score against each criteria)						
CRITERIA	PARAMETER		Scale				
Activity, able to move,	4 extremities		_2				
voluntarily or on	2 extremities		4				
command	No		0	Total Score : /O			
*	Able to breath deeply and co		27				
Breathing	Dyspnea, shallow or limited	breathing	1	Patient fit for discharge:			
<u> </u>	Apnea		0	'ES □NO			
7:	Fully awake		2	·			
Consciousnesss	Arousable on calling		1				
	unresponsive		a				
•	+20% of pre-anaesthesia leve	el	2				
Circulation (Blood Pressure)	+20% to 49% of pre-anaesthe		1 /	·			
	+50% of pre-anaesthesia leve	el	0				
	Maintains SPO <sub>2</sub> >92% in amb		12/				
SPO <sub>2</sub>	Maintains SPO <sub>2</sub> > 90P% with		1				
	Maintains SPO <sub>2</sub> <90% with O		0	'   			
	DOW AREDON						

Anaesthetist Name & Reg.No.:



Signature





### **OPERATION NOTES**

NAME:	MAST. SIVAGURU.S	AGE/GENDE	CR: 13 Years / MALE
UHID NO:	MH1202381075	IP NO:	IPH202302423
DOA:	02/12/2023	DOS:	07/02/2023
SURGEON:	DR. RAJESH	ANESTHETI	ST:
		DR. SYLVES	TER/DR. PRAVEEN
ASSISTED B	Y: DR. PRAVEEN JEYAKUMAR	PERFUTION	TST:
		MS. SAI PREI	ETHI/MS. DHIVYA
PHYSICIAN	ASSOCIATE: MS. SAIKUMARI	SCRUB NUR	SE: MR. SASIKUMAR

### **DIAGNOSIS:**

RHEUMATIC HEART DISEASE

SEVERE AORTIC REGURGITATION.

MILD MITRAL REGURGITATION.

ADEQUATE LEFT VENTRICULAR FUNCTION.

SINUS RHYTHM

**CLASS II ANGINA** 

#### **SURGERY DONE:**

AORTIC VALVE REPLACEMENT USING 21MM ST. JUDE MASTER SERIES VALVE.

### **FINDINGS:**

Aortic valve: Trileaflet, thickened, rolled up edges, especially RCC,LCC, Eccentric

regurgitation

Aortic annulus: Normal

No evidence of infection.

Supra annular placement – pledgets on LVOT side

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

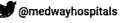
**★** @MedwayHospitals

Kodambakkam

(O) @medwayhospitals

**Medway Group of Hospitals** 

medway-hospitals



Heart Institute

044 - 4310 8959

Medway Centre of Excellence (Chennai)



Villupuram Mogappair Kumbakonam Chengalpattu 04146-242000 044-2473 4455 044-26530011 | 044-2473 4455 | 044-27426829 | E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665 Institute of Pulmonology 044-2473 4454

MHI/HOSP/2022/118





Every heart: beat counts
(A Unit of United Alliance Healthcare Pvt Ltd)

#### **PROCEDURE:**

Median sternotomy. Pericardium marsupialised. Systemic heparinisation. Cardiopulmonary bypass established by aortic and double staged single venous cannulation.

Aorta cross clamped. Left ventricle vented through right superior pulmonary vein. Transverse aortotomy done. Antegrade hypothermic delnidocardioplegia given through coronary ostia.

Native aortic valve inspected and excised. 21mm St.Jude Master series valve replaced in aortic position with 2-0 Ticron interrupted pledgetted mattress sutures. Aortotomy closed in two layers with 5-0 prolene sutures. Left atrial vent site closedHot shot given through aortic root. Heart deaired with aortic root vent.

Aortic cross clamp released. Heart picked up in sinus rhythm. Rewarmed fully. Weaned off bypass gradually. TEE showed no paravalvar leak with good prosthesis function. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one drain tube insitu.

CPB-81mins

ACC- 61mins

#### **Supports:**

He was shifted to ICU nil supports.

CONSULTANT SIGNATURE

Dr. V. Rajesh, MS, M.Ch (CTVS)

Senior Consultant Cardiothoracic and Vascular Surgery

Dr. V. RAJES1 Reg No : 6279 :

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

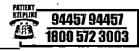
f @MedwayHospitals

Kodambakkam

@medwayhospitals

in @medway-hospitals

@medwayhospitals



Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Mogappair

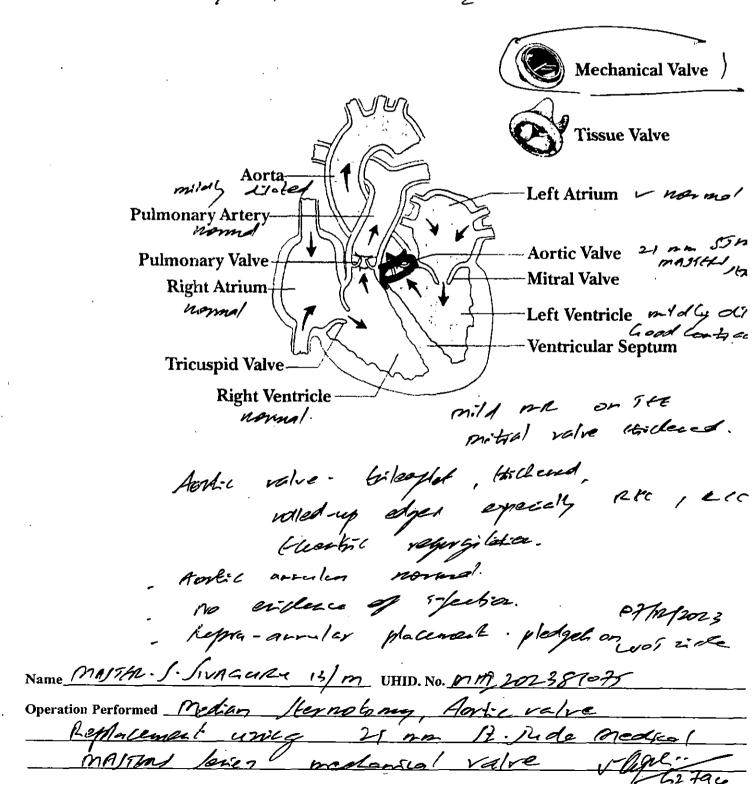
MHI/HOSP/2022/118





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

11: Phenolic Heart Brease / Severe Aortic Regargitation,
mild ritial Regargitation/
Adequate La rystolic puntion
from shylton/ MM clange







Master.SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V  Implantation Record

Date of Procedure / Surgery: 7/12/2022 Ark Copen hear?
Nature of Procedure / Surgery: Ark (open heart)
Name of the Implant: 95m masters series

Site of Implantation : Aorti C

Name of the Consultant / Surgeon :	AR. DATESH
, <u>, , , , , , , , , , , , , , , , , , </u>	

Size: 2/mm

Batch No. : 2/43884

, the investor

Manufacturer Date: えのよる /o午 //o

Expiry Date : 2020 | 04 | 09-

Implantation Stickers:

SJM™ Masters Series Mechanical Heart Valve 🖽 SJM™ 01175414734053884177280408(21)31438841

Signature of the Doctor with Registration No.

Name of the Patient / Relative:

Signature:

Date:

Time:



Medway Heart Institute

### **PATIENT'S INFORMATION SHEET**

Master.SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V	AGE/SEX 13) M SURGEON	UHID NO 202381075  ANAESTHETIST
Dr, RAJESH	Dr. RAJESH	Ar. TEEV A NANDOM
DIAGNOSIS (In Capital Letters)	1. RHD   SEVE	RE AR.
	2. NORMAL LY F	FUNCTION EF-527
,·	3. MILDMR TRIV	TAL TR
	4.	
	5.	
	6.	
	7.	
	8.	
PRESENT PROCEDURE/ SURGERY	AVR L GA	
PREVIOUS PROCEDURE/ SURGERY		
CONTACT NO. & RELATIONSHIP	1. SAKTHI (FATHER) 9943920034	2.

### **MEDICATION HISTORY**

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	20/11/23	T. PENCILLIN	25ong	Plo	1-01.	( <b>-</b>
2	2 1/2/23	7. LASILACTONE	20/50n	Plo	1/2-00	<b>`</b>
3				O		
4						-
5						
6 .	,					
7	· ', -	•	b , .			
8	_		; ; ;			
9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	20/11/23	1. PENKILUN	520mg	4	1017	
2	2/12/23	T. LASILACTONE	20 Sony	Pp	1/2-00	continue
3			J		)	
4						
5						
6						
7						
8						
9			<u> </u>			
10						_

### ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Patie	ent:			
Date and Time: 2/12/23 From: Admission To: 202	Stable / Unstable  3. Conscious / Semice  4. Febrile (A febrile)	2. Oriented / Disoriented 5. Intubated / Extubated			
Transfer Out	Condition of the Patio	 ent :			
Date and Time: 7/12/23	Stable / Unstable     Conscious / Semice		2. Oriented / Disoriented		
From: 203 To: CTO	4. Febrile / A febrile		5. Intubated / Extubated		
Transfer In	Condition of the Patie	ent:			
Date and Time :	Stable / Unstable     Conscious / Semice	2. Oriented / Disoriented			
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
1) Known Case of	Year	Months	Days		
Diabetic Mellitus					
2) Known Case of Hypertension	7				
3) Known Case of Bronchial Asthma/COPD	-				
4) Known Case Of Others					
Denture	☐ Yes ☐ Permanent Fixatio ☐ Temporary Fixatio	No n : Present / Absent			
Allergic Reaction : Drugs/Food	☐ Yes No				
Pressure Ulcer Present	☐ Yes  If you means mention a	No No about <b>Grade</b> : 1/2/3/	4 & Site:		

### ANY RELEVANT INFORMATION:

					Sign With Date
Peripheral Cannulation	1. Site:	1. Inserted Date and Time		1. Removed on:	
	2. Site:	2. Inserted Da	te and Time	2. Removed on:	
	3. Site:	3. Inserted Da	te and Time	3. Removed on :	
Neek Line: IJL/EJL	Site:	Inserted Date	and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date	and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date and Time		Removed on	
Pressure Bandage	Site:	Inserted Date and Time		Removed on	
Drain Site	1. Mediastinal: Inserted Date and Time			Removed on	
	2. Pleural Right / Le	ft : Inserted Da	ite and Time	Removed on	
Urinary Catheterization	Inserted Date and Tin	ne	Removed or	n	
Nasal / Oral Gastric Tube	Inserted Date and Tin	ne	Removed or	n	
Intubation Date and Time	Extubation Date And	Time	Reintubatio	n Date And Time	
Other Information	20 pur	reserved è	res Jeorg	odone benle	OIN'





13/Male/MHI202381075

02/12/2023/IPH202302423

T'Ş INFORMATION SHEET

Dr.RAJESH.V NAME

UHID NO AGE / SEX

CONSULTANT .	SURGEON	ANAESTHEŢIST
DR. RAJESH	DR-RAJESH	DR. AJEITHA
DIAGNOSIS (In Capital Letters)	1. RHD SEVERE	- AR
	2. NORMAL LV	FUNCTION
	3. MILD MR	TRIVIAL TR
	4. FF-FOY.	
	5. OF	,
	6.	
	7.	· · · · · · · · · · · · · · · · · · ·
	8.	
PRESENT PROCEDURE/ SURGERY	AVR Z 21mm	ST. JUDE
	MASTER SERIES	VAME
PREVIOUS PROCEDURE/ SURGERY	-	· ·
CONTACT NO. & RELATIONSHIP	1. mersuru caraami) 8526820775	2.

## **MEDICATION HISTORY**

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	311263	TAR FROGEMIDE	Lomu	plo	1/2-0-5	3/12/03
2	2112/03	THR - FIVEL PPRIL	2.5mb	Plo	1-0-1	2/12/23
3	2 विर्वार	TAB. LARILACTONE	Jolsomo	plo	1/2-0-0	
4	•	•				. • <b>•</b> •
5				•		
6						
7	-					
8	. "					
9	, -		+			
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	7.12.23	Syp. SUCHALFATE	isml	Plo	- - <u> </u>	
2	7-12.29	MPB. LEVOLIS	0.63 mg	INH	9614	
3	8.12-23	T. FRUSEMIDE	40mg	pla	1-1-0	
4	8.12.43	T' BEPLEX FORTE.	IJAB	Plo	1-0-0	
5	8.12.22	T- ASPIRIA.	75 mg	P/0	0-1-0	``
6	9.12.23	T PARACETAMOL.	500 mg	r[o	1-0-/	
7	8.12.43	T. METAPROLOL	12·5 my	Plo	1-0-1	
8				, , , , , , , , , , , , , , , , , , ,		
9		. :				
10				•		

ANY RELEVANT INFORMATION:

'Admission / OT Receival	Condition of the Patio	ent:	on vent
Date and Time: 07 16 3 @	Stable / Unstable     Conscious / Semice	onscious / Unconscious	2. Oriented / Disoriented
From: of To: SIW	4. Febrile / A febrile		5. Intubated / Extubated
Transfer Out	Condition of the Pation		
Date and Time: 9/12/23	1. Stable / Unstable		2. Oriented / Disoriented
1	3. Conscious / Semice	onscious / Unconscious	
From: SDIW To: 202	4. Febrile / A febrile		5. Intubated / Extubated
Transfer In	Condition of the Pation		
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented
	3. Conscious / Semice	onscious / Unconscious	
From: To:	4. Febrile / A febrile		5. Intubated / Extubated
1) Known Case of	Year	Months	Days
Diabetic Mellitus			
2) Known Case of	-		
Hypertension			
3) Known Case of Bronchial Asthma/COPD			
Dionemai Astuma/COI D	_		
4) Known Case Of Others	,		
	<b>←</b> .	,	
	☐ Yes	₽ No	
   Denture	Permanent Fixatio		
		n: Present / Absent	
,	☐ Yes	No.	
Allergic Reaction : Drugs/Food	If you means mention a	bout Drug / Food Name	<b>:</b> :
	☐ Yes	No	
Pressure Ulcer Present		about <b>Grade:</b> 1/2/3/	4 & Site:
	) ••		

### ANY RELEVANT INFORMATION:

	_						
				Sign With Date			
Peripheral Cannulation	1. SiteRTCUB (THE	1. Inserted Date and Tir		30,1			
,	2. Site:	2. Inserted Date and Tir		CARRO			
	3. Site:	3. Inserted Date and Tir	me 3. Removed on:				
Neek Line: IJL/EJL	Site: RT DJV	Inserted Date and Time	לולי שור אין	2400			
Arterial Line : Right/Left	Site: RT RADIAL	Inserted Date and Time		Ja.			
Sheath Arterial / Venous:	Site:	Inserted Date and Time	Removed on				
Pressure Bandage	Site:	Inserted Date and Time	Removed on				
Drain Site	1. Mediastinal: Inserted Date and Time  OF 1253 © 13.00  Removed on  OS 1253 © 9.20  2. Pleural Right / Left: Inserted Date and Time  Removed on						
Urinary Catheterization	Inserted Date and Tin	ne Remove 09 0	ed on 2 (2023 AM 04:45 1	0276.			
Nasal / Oral Gastric Tube	07/12/13 0	Remove	ed on 12/13 © 15-20	\$ 62 <del>\( \)</del> 0			
Intubation Date and Time		Time 1 Hk-36m Reintub	pation Date And Time				
Other Information	OF PALPITA  OF FURTHER  * ECUT DON	PATENT CAME WITH THE COMPLAINTS OF PALPITATION ON (A) OFF, CHEST FAIN (A) FURTHER MEDICATION  * ECUT DONE ON 02/12/23  * CXR DONE ON 02/11/23					
		VE ON 29/11/a					





# SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



MHI/OT/2022/086 Medway Heart Institute

### Every heart beat counts

#### Master.SIVAGURU.S

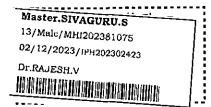
13/Malc/MHI202381075

Name of the Procedure :	AVR (open hear	Location: CT-OT - 11	Date & Time :_=	02/12/2023/IPH202302423	
Does the Procedure involve	e Procedural Sedation :	Yes □No	<u>:</u>	、 (340 dr.rajesh.v	
SIGN IN 9-30 Before Induction of Procedural S	Gedation	TIME OUT 10 415 — After procedural Sedation and before procedure	l	When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	an administering Procedural octor performing the procedure)		al Sedation + Nurse + Technician + Doctor dure		
Patient Confirmation		All team members introduce themselves by Name and R	ole	To be done for each procedure in case of multiple procedures	
Identity by two identifiers	☐Yes /	Identity by two identifiers	₽ Yes	Name of the Procedure done written down	
Procedure	√Yes	Procedures	<b>⊡</b> Yes	Name and site of all specimens / investigations Yes NA	
Side	□Rt □Lt □NA	Side	□Rt □Lt □NA	confirms labeling and sent to lab	
	Chest	Expected Blood loss	Chest		
Consent	U Yes .	Position Supine	Yes supine	Any recovery concerns : ☐ Yes ☐ None	
Known Allergy	☐ Yes ☑ Not Know If yes, plaese specify	Required equipment and implants available	☐¥es ☐ NA	If Yes, Pls. specify:	
Difficult airway / aspiration risk / dentures	□ Yes, equipment and assistance available	Essential Imaging displayed  Antibiotic prophylaxis within last 60 minutes	☐Yes ☐NA → ~	V	
Possibility of hypothermia	□ No □ Yes, warmer in place	Name of the Antibiotic given  Venous Thromboembolism Prophylaxis Pro(hed )	ZIXIMO I - S q V	Any Equipment / instrument problem that needs to be graddressed:   If Yes, Pls. specify:	
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	□Yes	Comple Suggest So Prostruments	
Spo2 □NHEP □Other	rs pls. specify	Anticipated blood loss briefed	D Yes □ NA	If Yes, Pls. specify: Chauge r Sponge & Postruments counts are cossect.	
Pre OP medication taken	'U⊒Yes □ No	Adequate fluids and blood available	□ Yes □ NA		
		Team briefed on any critical or unexpected steps	□ Yes	Corrective action :	
Required equipment for	d⊒Yes □NA	For procedural sedation cases	Yes None		
procedure available	,	Any patient specific concerns : Intra procedure glycernic control	Yes NA	_	
		Any concerns about sterility	Yes None		
Anaesthetist / Doctor giving Procedural Sedation	Doctor per mile t	PAJE\$14 Nurse: 90031	Technician :	Others Please Specify:	
P. A. I. Maria	Senior C	Copsultant RIN SASIKUMAR	OT SMIHY	17/2006 OF INC. CHRISTING	
132817 132817	Time: Hag N	Consultant RIN SASIKUMAR OF STORY Time: 13 140	Date: 7(12/23 Time: 13'40	Date: 7/12/23 · 2004	



signing this form.







## **CONSENT FORM - PHYSIOTHERAPY**

Been the inform	expla natior	ined th provid	is conse led abou	nt forn it Ope	nin <u>*</u> ration/pr	ocedu ≀wv∢	re		Name ST		-	e) whic ੧ਾ੮∪∈		lly und △AR			l understo
Puu	MOI	JAR	y		EHAB	11 (1)	ATIO	U									
(full name	e of op	peratio	n/proce	dure g	iven belo	w in thi	s conse	ent forr	n)					r			
Brief des	script	ion of	the Oper	ation	/Proced	ure:	DBE	ζ,		The	st j	percu	w	"on			
Brief des	90n	retory	<u>/</u>	,	AROI	n	An's	,	M	<u>10 b</u>	<u>iti`</u>	eatie	m				
l underst	and th	ne inter	nded ben	efits o	fundergo Jeom Lung	oing the	proced ₹	dure.1	The int	tende ا صد	d bene	efits from	n this	proce	dure	are:	ên,
10	0	<u>lear</u>	Du	<u> </u>	Lung	S	ecret	low	· ·	<u>,                                     </u>	70	En	mp?	ove.		ADL	
Lunderst	and th	nat all p	rocedure	es carr	y certain	risks. T	he pote	ential r	isks a	nd co	mplica 	tions fro	orth th	is prod	cedui	re:	
							aun'										
l have be	en ex	plained	I the impl	icatio	ns of not u	ınderg	oing thi	s proc	edure	and t	he alte	rnative	meth	ods o	ftreat	tment lik	(e:
			-			Ŋ	il										
l have be	en ex	plained	I the impl	icatio	ns of not u			s proc	edure	and I	he alte	rnative	meth	ods o	f treat	tment lik	(e:

Signature of Pa	Signature of Patient / Patient's Relative (only if Patient is unable to sign):								
Dr. <u>Pamar</u> procedure on [	nentioned operation(s) / procedure  The procedure of documents and possible alternatives	ctor perf	forming the operation / prod	f, I give my donsent v cedure) for carrying	oluntarily to	eration / cations,			
	ned Patient / named patient's repre his form, mentally sound and am g					s on the			
	Signature / Thumb Impres	sion*	Name		Date	Time			
Patient						,			
Surrogate/Guardi (if applicable #)	an + Alex		Prince And relation	· / /	7/12/23	1550			
Reason for surrogate consen	Patient is unable to give co	nsent I	pecause:						
Witness	D. Sheeba.		D. Shee	4/12/23	15:00				
Interpreter (if applicable)			* 13						
* Right Hand for Mal	es & Left Hand for Females   # Oni	y if Patie	nt is a minor or unable to give	consent					
procedure cour	ned doctor, have explained the n rse, and possible alternatives to the e/she has understood the informa	e plann	ed operation / procedure,	to the patient / patie					
<u> </u>	Signature	Nam		Reg. No.	Date	Time			
Consent	Signature	INan	ie ,	reg. No.	Date	Time			
obtained by		17	amanathan.p	0260	7/12/23	15:00			
Procedure performed by<	种。	Pay	amarathan p	0260	#12/3	15:00			
			•						



### Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





## **IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY**

Chief Complaints:							
the Palpitation on I alb x	4 day's						
Ho Palpitation on sobb x 4 day's Ho chytoan. On so all x 3 day's							
· ,							
Occupation: Heavy Activity Moderate Activity	/ Light Activity						
Past Medical / Surgical History:							
the Rever at the age	Ho Verez at the age at 8 yrs						
KICIO PHRIOMATIC Treat	disease x 5 the on medication						
	anseage & Syne on medication						
On Observation:  Built: ☐ Thin ☑ Fair ☐ Well Built ☐ Obese │ Postural Deviation: ☐ Yes ☐ No │ Muscles Wasting: ☐ Yes ☐ No							
Deformity: ☐ Yes ☐ No   Swelling: ☐ Yes ☐ No   Gait Deviate	· =						
On Palpation:							
Tenderness: ☐ Yes ☐ No   Warmth: ☐ Yes ☐ No   Muscle sp	_						
Oedema:□Yes ☐No   Crepitus:□Yes ☐No   Tone:□Norm							
FALL RISK SCREENING NA							
Fall Risk Screening for Adults: Age more than 65 years History of fall in last 3 months							
Tail thisk befeeling for Addits Age more than 05 years	∃History of fall in last 3 months						
	Any neurological problem						
☐ Walks with assistance ☐ In case of 2 or more criteria is met, initiate detailed fall assessm	Any neurological problem						
☐ Walks with assistance ☐ In case of 2 or more criteria is met, initiate detailed fall assessment. Fall Risk Screening for Pediatrics: ДА	Any neurological problem nent and fall prevention protocol.						
☐ Walks with assistance ☐ In case of 2 or more criteria is met, initiate detailed fall assessm	☐ Any neurological problem  nent and fall prevention protocol.  seizure, etc) ☐ Deranged mobility						
□ Walks with assistance □ In case of 2 or more criteria is met, initiate detailed fall assessm  Fall Risk Screening for Pediatrics: № □ H/O fall in last 3 months □ Neurological problem (vertigo,	Any neurological problem nent and fall prevention protocol.  seizure, etc) Deranged mobility nent and fall prevention protocol.						
□ Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessment   Fall Risk Screening for Pediatrics:  □ H/O fall in last 3 months □ Neurological problem (vertigo, In case of 2 or more criteria is met, initiate detailed fall assessment   Respiratory Status:	Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility nent and fall prevention protocol.  Brain Injury (if applicable): ДД.						
□ Walks with assistance □ In case of 2 or more criteria is met, initiate detailed fall assessment    Fall Risk Screening for Pediatrics: → A □ H/O fall in last 3 months □ Neurological problem (vertigo, In case of 2 or more criteria is met, initiate detailed fall assessment.)	Any neurological problem nent and fall prevention protocol.  seizure, etc) Deranged mobility nent and fall prevention protocol.						
□ Walks with assistance In case of 2 or more criteria is met, initiate detailed fall assessm  Fall Risk Screening for Pediatrics: ✓ ♣ □ H/O fall in last 3 months □ Neurological problem (vertigo, In case of 2 or more criteria is met, initiate detailed fall assessm  Respiratory Status: □ Room Air □ O₂ Support □ Ventilatory Support □ BIPAP	Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility nent and fall prevention protocol.  Brain Injury (if applicable):						
□ Walks with assistance  In case of 2 or more criteria is met, initiate detailed fall assessment in the composition of the com	Any neurological problem nent and fall prevention protocol.  seizure, etc) □ Deranged mobility nent and fall prevention protocol.  Brain Injury (if applicable): ДД. □ Traumatic □ Non Traumatic □ Mild □ Moderate □ Severe						

Spine Injury: Present Absent						
AIS:ISNCSCI SCALE:						
☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx						
Associated Injuries: Speech impaired: Yes No						
Voluntary Movements: ☐ Present ☐ Absent   Tone Modified: ☐ Hypotonic ☐ Normal ☐ Hypertonic						
ASHWORTH SCALE:						
☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit						
Balance: ☐ Good ☐ Fair ☐ Poor │ Co-ordination: ☐ Good ☐ Fair ☐ Poor						
Functional Activities						
Self Care: ☐ Independent ☐ Dependent   Bed Mobility: ☐ Independent ☐ Dependent						
Transfers: ☑ Independent ☐ Dependent │ Ambulation: ☑ Independent ☐ Dependent						
FIM Score:						
Breathlessness (If applicable):						
Dyspnoea Grading Scale:						
Abnormal Breathing Sounds: ☐Wheezing ☐Stridor ☐ Crackles ☐ Pleural Rub ☐ Pneumothorax Click ☐ Stertor						
Abnormal Breathing Pattern:						
Pain Assessment: Pain: ☑ Yes ☐ No						
Pain Score:						
Tick whichever is applied: ☐ Numerical Rating Pain Scale ☐ Visual Analog Scale ☐ Wong-Baker Faces						
Pain Scale Critical Care Pain Observation Tool FLACC						
Location: Character: July Frequency: On Solt Character: July 1						
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ Radiating ☐ Numbness						
☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing						
Aggravating Factors: Relieving Factors:						
7						
· on execution at 14st						

Examination	(Please tick and mention ab	normal findings only):			
☐ Range of M	lotion:				
│ │ │ Muscle Stre	Mormal ength:		-		1
	Mormal				
☐ Reflexes:	/\[01 wax				
	Mornal.		•		
Plantar Respo	nse: 🗆 Diminished 🗷 Brisl	∢ □ Clonus			
Biceps: □Dir	ninished ☑Brisk □Clonus	3	•		
Triceps: ☐ Dir	minished ☐Brisk ☐Clonu	s			
Supinators:	]Diminished ☑Brisk □Clo	onus			
Knee: □Dimi	nished ☑Brisk □Clonus				
Ankle: □ Dim	inished ☑Brisk □Clonus	•	~		
Sensation: ${\cal L}$	ood.		·		
Investigation	<del>-</del>		<u>-</u>	<del>-</del>	
	RAD, Sev	eses AR, Normal Lu F	inetton; will	WAR.	
ı T	Trivial TR	- 1 FF -52%.	,, , , , ,	617	
Physiotherap	y Management Plan:		· ·		
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	- Shironely ex				
	- Active can to	Ble of soll			
	- to thirove		•		
<b> </b>	Signature	Name	Emp. No.	Date	Time
Physiotherapist	· J. v.	Julgarachoan	2(02	07/12/23	اثور مص

	RE-ASSE	SSMENT FORM	
Date & Time  Queles  Q	- Aron to Bh or  - Mobili Zadian  - To Proposer  - To Proposer  - To Dean  -	eucowogld  Bips book in to Bh dust Well  Alc  Joan Rom  Lung expecting secretion  Set lung secretion	
Physiotherapist	Signature	Name AKASTA-AKS	Emp. No.
) amarakiat	UID GIRGO		```, `





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Master.SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



## PHYSIOTHERAPY TREATMENT CHART

	71845	DUVELOTHED ADV TO CATMENT	DEMARKS	
DATE	TIME	PHYSIOTHERAPY TREATMENT REMARKS		
7/12/23.	15:30	SB Abash		
8 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	<u>-</u>	It oral Nasal Suctioning	A1	
		done violded thick Secretions	MH10266	
1		- Pt Ostubated and Connected		
		to 02 mark - (52 - 02)		
	<del> </del>	- Pt voice Clear a Audible		
`		- DBE's encouraged		
		- Chert parcuesion to B/c Chert wall		
		-AROM fis to the ULZU		
		Episometry &'s encouraged The: 600a & p: 600a		
Aliala3	21:00	Sle J. VIDAYARACIA VAN		
		Den enlonnged		
		- Client remuton dove to	<b>\$</b>	
	<del>.</del>	She cheet wall	J. ving	
		- Solvonety En Enlouyel. As-Gooce Ro-Gooce	Mune-2602	
	:	-Active ear to Ble 11,86		
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Dr.RAJESH.V

## 

## PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
8/12/23	6200	S/3 J-VIIAYARAGAUAN - 33 and and maged	
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	-	Active Cxs to BL UCALL	
8/12/23	9:00	SB AKABH  - Drex encouraged  - Spisonetry en encouraged  - Ins: 600ce BRp: 600ce  - Chest peramena to Ble  - Chest peramena to Ble  - AROM to Ble verle	9, \$ 9kg/ M1-110256
8/12/23	14:00	S  & Ramañathan.1  - DBES encoungred  - Chust percussion to B c chust well  - Akom fo's bo B c vizu  - Spirrometry fo's encouraged  - Du: foor fop: 600 u  - Pt Chow mo filised	MA(10265





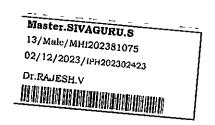
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PHYSIOTHERAPY TREATMENT CHART				
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS	
08/12/23	21:00	S/B J. VDAYARAGAVAN		
2 <b>2</b>		-DBR's Eulonmyed		
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		-Stirromely By Bookjed	mmc-2/02	
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		- Altre ex to Ble ulall		
09/12/23	-6200	S. B J. NI) AY AREAL AVAN		
		-DBRs Enlormyed		
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9/12/23	9:30	SB ALEASH	- NO 1	
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MHI/IP/2022/067



### CONSENT FOR BLOOD / BLOOD COMPONENTS

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

Red Cells for bleeding or low hemoglobin

Platelets for bleeding or low counts

Plasma for restoring blood volume or providing clotting factors

Cryoprecipitate for special clotting factors

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

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

Witness	Patients name
Doctor Dee Us W  Time 6/12(25	Patient signature  or Guardians name  Guardians signature  Relationship to patient  FATHER

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

Time: المحادة Date: و	112/23	Doctors Signature:
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சிவப்பு அ<u>ண</u>ுக்கள்

நோயாளியின் பெயர் :

கேக்:



## ஒப்புதல் : டூரத்தம் / டூரத்தத்தீன் பாகங்களை செலுத்துதல்

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

இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு

தட்டணுக்கள் இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு கருதீநீர் இரத்த கன அளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு கீரையோபிரைஸிபிடேட<u>்</u> சிறப்பு உறைவு அம்சங்களுக்காக எனக்கு /நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார் இரத்தம் செலுத்துவதில் கீடைக்கின்ற விருப்பத்தோவு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானமளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அமோஜெனிக்) அல்லது சுயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானமனிப்பதற்கு வாய்ப்புள்ளது. தேசிய விதீமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்படிருந்தாலும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்டன் ஹெபடைடிஸ் மற்றும் இதர வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடாகளையும் நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கீறேன். கணிக்க முடியாத எதீர்விளைவுகளும் தோன்றலாம். இவை காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகீயவற்றை உள்ளடக்கீ, அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொண்டேன். இரத்தம் செலுத்துவதன் மூலம் எதீர்பார்க்கப்படும் நன்மைகள், அதீர்ச்சி, மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல். з. குணமடைதலை துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம் என்றாலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன். இரத்தம் செலுத்துதல், மாற்று சிகீச்சை முறைகள், சிகீச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயாங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள **ூடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது, மேலும் தகவறைந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு** போதீய விவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன். 5. முறையான மருத்துவ பராமரிப்பின் பொருட்டு. இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதீர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முழுமையான காகைட்டத்தீற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக் கொள்கீறேன். நோயாளியின் பெயர்...... உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நீலை காரணமாகத் தகவறநிந்த ஒப்புதல் பெறப்படவில்லை. தகவறநிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அளவிற்கு நான் போதிய அளவு தகவலை நோயாளிக்கு வழங்கிவிட்டேன். மேலும் ஒர் உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நிலையை மாற்றுவதற்கு. மேம்படுத்துவதற்கு, நேர்மாறாக ஆக்குவதற்கான போதிய அளவில் இரத்தப் பொருட்களை வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான் மேற்கொண்டுள்ளேன். நேரம் :

மருத்துவரின் கையொப்பம்......

# MEDWAY HOSPITALS BLOOD CENTRE

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

Patroned by RYA COSMO UGTA FOUNDATION

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

LICENCE NO : 473 / 28C							
BLOOD DONOR	SCREENING 8	R CROSS MATCHING R	REPORT ====				
Recipient's Name : MASTER - SIVAC	ลบRU·S	Age / Sex :	13y1M				
I.P. Number : 2423		Hospital : /	YEDWAY HEART INSTITU				
Ref. by Dr. : DR. RAJESH.	V	Date : 07/	•				
DONOR			RECIPIENT				
POSITIVE	Blood Group	/ Sub Group	POSITIVE)				
NEGATIVE	Rh 1	Гуре 	NEGATIVE				
UNIT PARTICULARS		BLOOD IS CHECKED FO	<u>PR</u>				
Blood Bag No. : 4277		ABO Grouping / Sub Grou	uping 🔲				
D.O. Collection: 06/12/2023		Rh Typing					
D.O. Expiry : 17  01  2024		Haemoglobin Content					
CROSS MATCHING		PCV Determination					
Saline Cross Matching		BLOOD IS NEGATIVE FO	<u>DR</u>				
Bovine Albumin Cross Matching		HIV 1 & 2					
Coombs Cross Matching		Hepatitis_B Surface Antige	en (Hbs Ag)				
Gel Method		Heapatitis C Virus (HCV)					
COMPONENT		Malarial Parasite (MP) & I	· ——				
1. Whole Human Blood I.P.	-	Serological Test for Syphil	ils (VDRL)				
2. Fresh Frozen Plasma BP 93		OMBATIBILITY					
3. Packed Red Blood Cell I.P		Compatible	<u>  YES  </u>				
4. Platelet Concentrate I.P		Incompatible	<u> </u>				
Apheresis		UNIT PARTICULARS  Number of Units issued:					
5. Plateletpheresis	<u> </u>	Active substance ml :	1 <i>UNIT</i>				
6. Leucapheresis		Issued on :	293ml 07/12/2023				
7. Plasmapheresis	_	Issued time :	09-50/AM				
NONE OF THE ABOVE TEST HAVE	BEEN DONE FOR	THE RECIPIENT	N-lavarya				
			modical Officer / Technicism				
	/For use of Heavite		medical Officer / Technician				
PRE TRANSFUSION CHECK	(For use of Hospita	ır ətanı Only) (10 BE FILLED WI	TH PATIENT'S CASE RECORDS)				
Transfused on: 07/12/2023	Blood	Group / Rh Type : "B" りん	SITIVE				
To Patient : Mester, Studiusu	Blood	Bag Number : 42-7	1				
Transfused by: S ATHLA	Rema	TOUGH UM	AJEETHA P.K eg. No: 74617				
Time : Started at :	11-00 Comp	eleted at: 11·10	Signature of M.O.				

PLEASE AVOID RETURN OF THIS BLOOD UNIT

MEDWAY HOSPITALS BLOOD CENTRE  (A Unit of United Alliance Healthcare Pvt. Ltd.)  Patroned by RYA COSMO UGTA FOUNDATION  Ground Floor, New No. 8, Old No. 22, 4th Cross Street, Trustpuram, Kodambakkam, Chennai - 24.  CONCENTRATED HUMAN RED BLOOD CORPOSCLES IP								
Anticoagulant CP INSTRUCTIONS  1. Store the bag and +6°C). 2. DO NOT use Haemolysis, C 3. DO NOT add 4. DO NOT vent 5. Use a fresh, clo 6. Mix well before 7. Administer wit 8. DONOT dispe	50/350ml of whole blood colle DA, Solution U.S.P)(Additive 1: continuously at +4°C (Range if there is any visible evidence clotting or Discolouration, any medication.  ean, sterile transfusion set with factors a use. hout heating. ense without prescription.  LOOD GROUP ON THE LABEL AND	Solution Added) between+2°C c of deterioration like liter.  Rh Positive						
Bag No.	Date of Collection	Date of Expiry						
2277 06 12 2023 17 01 2024  No unexpected antibodies found when tested by multiple techniques for HIV  1 & II, and HCV, Non-reactive for HbsAg and Syphills by mandatory tests. No malarial parasites or Micro Filariae								



Master.SIVAGURU.S





BLOOD AND BLOOD PRODUCTS RECEIVED AND FEED BACK

13/Male/MHI2023816 02/12/2023/IPH20236 Dr.RAJESH.V PROCEDURE BLOOD GROUP & TY	12423 1 AVR	INI	DICATION.	Sure	IERYUNIT OT AI	CU PICU	ccu
DATE / TIME	NAME OF		TRANS	FUSION	NAME &	ANY REA	ACTION
OF RECEIVED	PRODUCTS	BAG NO	START	END	DR. SIGN	YES	NO
07/12/2023	IN PREC	4277	11.00	11-10			سيبا
<u> </u>			Added o	r Pum	(P)		
10.15					Dr. AJEET Reg. No: 7	НА.Р	K
					Reg. No: 7	4617	
		_					
				_			
							_
					- * <u></u>		
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			_	_	_		<del></del> .

Note:

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





### Every heart beat counts

Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V

### LIBINE BOLITINE ANALYSIS

## **MICROBIOLOGY SHEET**

URINE ROUTINE ANALY	(SIS MICINOPICEOUT STIE	<u> </u>
DATE	29/11/23	
COLOUR	pale yellow	
REACTION		
SPECIFIC GRAVITY	1.010	
APPEARANCE	cleur	
ALBUMIN		
SUGAR		
ACETONE		
BILE SALT		
BILE PIGMENT		
UROBILINOGEN	pornei	
PUS CELLS	2-3	
EPITHELIAL CELLS	(-2	
RBC	NTI	
CASTS	WT	
CRYSTALS	NI	
OTHERS	NT	
	` <u></u>	

### **MICROBIOLOGY-CULTURE REPORTS**

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





### Master, SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



# **DIABETIC CHART**

		33. 7. 4.J HbA,c			
PREVIOUS I	DIABETIC	MEDICATIONS			
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
2/12/2>	12/30	135 myldl		el och	doelvery
الم الم	130	99 ngedly	_	Con!	Olac US307 Car 165307
6112/23	6:30	105 malds	Юpo	Hayolos	Map 165307
H12/23	6:30	103 mg/dl	Npo	Hayows	K BURS
			,	·	
•		_			

### **INSTRUCTIONS FOR INSULIN INFUSIONS**

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	normal Saline (1u - 1 ml.)  Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 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.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
	asserting to the lone, may age turn.	251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.







### Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Na
UH
Dr.RAJESH.V

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# **DIABETIC CHART**

ACTUAL W	EIGHT	331 <u>-</u> 9 HbA <sub>1</sub> c			
PREVIOUS	DIABETIC ME	EDICATIONS			
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
=112/23	13-45	118-nigld	1	<del>-</del> -	DR i proveen
412/22	0000	118-nigled.	-		DR. PRAVETI
				_	
				-	
				·	
-		<del></del>			

### **INSTRUCTIONS FOR INSULIN INFUSIONS**

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	normal Saline (IU - 1 ml.)  Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 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.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
	actor and the teneral section of the	251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.







### Every heart beat counts

#### Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



### **BLOOD GROUP**

-B positive

## **INVESTIGATION SHEET**

Date	29/11/23		<del></del>		<u> </u>	
HAEMATOLOGY	0711123				1	
Hb	U12_		Į		r	
P.C.V	41.3	-	<del>-</del>			
Platelets	366∞0		_			
TLC	8300					
Polymorphs	43.0		·			
Lymphocytes	450					
Eosinophils	7.9					
Mono / Basophils	3.6/0.5					
E.S.R	<u>.</u> ව	_				
BIO-CHEMISTRY				}		j <b>j</b>
Urea	22					
Creatinine	0.26				<u> </u>	
Sodium	140					
Potassium	3.69					
Bicarbonate	26					
Chloride	98.2					
Magnesium				<u></u> _		
Calcium						
Phosphorus		_				
T LFT						
T.Bilirubin	0.37					
D.Bilirubin	0.14					
I.Bilirubin	0.73					
S.G.O.T	20			ļ		
S.G.P.T	U		·			
ALP	292					
GGT	(1					
Total Protien	7-9	_				ļ
S.Albumin	4.7			_		
CARDIAC ENZYMES						
Troponin 1	_				<del></del>	<u> </u>
CKNAC - CPK						
CK - M.B. MASS				ļ		ļ
LDH			<u> </u>		ļ	ļ
Ntpro bnp					1	

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Every heart beat counts

Master.SIVAGURU.S

Pai 13/Male/MHI202381075 Na 02/12/2023/IPH202302423

UH Dr.RAJESH.V

### **BLOOD GROUP**

B +VF

## **INVESTIGATION SHEET**

Date	29/11/23	8/12/23	9 12 03.		· ;	
HAEMATOLOGY	<del></del>					
Hb	14.2	11.6	10,7			j [
P.C.V	41.3					
Platelets	266000	_ ,				
TLC	8300					
Polymorphs	43.0	•		,		
Lymphocytes	_ મંદ્રજ					
Eosinophils	4.9					
Mono / Basophils	3.6 0.5					
E.S.R	20					
BIO-CHEMISTRY	·		i			
Urea	ని బ	ls'	31-0			
Creatinine	9.56	0.59	133 9.29			
Sodium	140 3.69 26,2		13%			
Potassium	3.69		3,71			
Bicarbonate						 
Chloride	98.2	_		_		
Magnesium	<u>.                                     </u>					
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.37					
D.Bilirubin	0.14					 
I.Bilirubin	0.23					
S.G.O.T	<b>40</b> 0					 
S.G.P.T	11					
ALP	292	_				
GGT	11	٦.				
Total Protien	7.9					 
S.Albumin_	4.7				_	 ļl
CARDIAC ENZYMES			•			]
Troponin I						<b></b>
CKNAC - CPK						
CK - M.B. MASS						
LDH		_				 <b></b>
Ntpro bnp						

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Date	29/11/23	8/12/23	10/12/23			,
COAGULATION	12.2 1.0	<b>I</b>	1 1 1			
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# **MEDWAY HOSPITALS BLOOD CENTRE**

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

Patroned by RYA COSMO UGTA FOUNDATION

Ground Floor, New No. 8, Old No. 22, 4th	Cross Street, Trus		n, Chennai - 24. F	n: 72990 57677
BLOOD DONOR S			NG REPORT	$\vdash$
Recipient's Name : MASTER · SIVAGI		Age /	Sex : 13y 1M	HEART INSTITUT
I.P. Number: 2423 Ref. by Dr.: DR. RAJESH: V		Date	07/12/2023	JIFINA   NSJIJU
DONOR POSITIVE NEGATIVE	Blood Group / S Rh Typ	C. C	B'	POSITIVE NEGATIVE
UNIT PARTICULARS  Blood Bag No. : 4277  D.O. Collection : 06   12   2023  D.O. Expiry : 17   01   2024  CROSS MATCHING  Saline Cross Matching  Bovine Albumin Cross Matching  Coombs Cross Matching  Gel Method  COMPONENT  1. Whole Human Blood I.P.  2. Fresh Frozen Plasma BP 93  3. Packed Red Blood Cell I.P  4. Platelet Concentrate I.P  Apheresis  5. Plateletpheresis  6. Leucapheresis  7. Plasmapheresis		BLOOD IS CHECKE  ABO Grouping / Sub Rh Typing Haemoglobin Contel PCV Determination  BLOOD IS NEGATIV HIV 1 & 2 Hepatitis B Surface A Heapatitis C Virus (H Malarial Parasite (M Serological Test for S  OMBATIBILITY Compatible Incompatible UNIT PARTICULAR Number of Units issued on: Issued time:	o Grouping  nt  VE FOR  Antigen (Hbs Ag) HCV) (P) & MF) Syphilis (VDRL)	10v/T 293ml 07/12/2023
NONE OF THE ABOVE TEST HAVE B	EEN DONE FOR TI			N-lavanya
	(For use of Hospital S		Bank medical Offi	$\overline{}$
Transfused on: 07/12/2023	Blood G	Sroup / Rh Type: B* Bag Number : 42	POSITIVE	CASE RECORDS)
To Patient : MASTER, SIVUTURN Transfused by: S ATHYA,	Remark		AJEE1	THA P.K

PLEASE AVOID RETURN OF THIS BLOOD UNIT

Completed at:

11.10

Signature of M.O.

Started at: 11.00

Time:



Every heart beat counts

redway Hospitals
The way to better health

A Unit of Master.SIVAGURU.S

13/Male/MHI202381075 Patient 0 02/12/2023/IPH202302423

Name: Dr.RAJESH.V UHID:

DOB:

# **VITAL INFORMATION SHEET**

AVE & 21 mm ST. JUDE MASTER

BLOOD GROUP A FUE ON ADMISSION Height in CM Weight in Kg. Islam 33 00%

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Master.SIVAGURU.S 13/Malc/MHI202381075

02/12/2023/IPH202302423

Dr.RAJESH.V



# **VITAL INFORMATION SHEET**

MHI/IP/2022/074

Every heart beat counts

BLOOD GROUP	B positive
ON AD	MISSION
Height in CM	Weight in Kg.
Inicm	22-2/4

NO. OF DAYS  DATE  PI   2   3   2   610   2	Diagnosis:	se	بر	A	Ŕ		ı O	2	<del>( }</del>	D	)													P	roc	cec	lur	e :																				\ 	<u>رم</u>	-	_		<u>~</u>	_			2	53	<u> </u>	7	<b>⊬</b>	7	-	_
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38.5° 38' 37.5° 38' 37.5° 38' 38' 38' 38' 38' 38' 38' 38' 38' 38'	39.5°	$\vdash \vdash$	+	╁	+	╀	+	+	╁	╁	╀	┝	╀	H		-	+	╀	╁_	┞	$\vdash$	+	+	+	+	+	$\perp$	╁	Н	$\dashv$	+	+	╀	+	╀	╀	Н	${oxed}$		4	4	4	+	4	+	+	+	+		+	4	_	$\dashv$	-	$\dashv$	+	$\dashv$	$\dashv$		Н	+	-	_	⊦
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38, 37.5° 37, 38, 37, 38, 37, 38, 38, 38, 38, 38, 38, 38, 38, 38, 38	38.5°	H	+	Н	#	t	‡	$\downarrow$	+	╁	╁		L		$\exists$	+	+		L			$^{\dagger}$	1	1	#	#	$^{\dagger}$	t	Н	╡	$\Rightarrow$	$\pm$	╁	╁	╆		Н		$\exists$	_	$\Rightarrow$	1	╛	1	$\downarrow$	#	#	1	$\pm$	#	$\exists$		$\exists$	Ⅎ	⇉	1					╡			F
37.5° 36.5° 36.5° 36.5° 36.6°  PULSE 08 42 58 56 78 82, 71 110 99 9/2/2  RESP 09 20 90 20 20 20 20 20 20 20 20 20 20 20 20 20		⊣-	╁	Н	+	╀	+	╀	+	╀	╀	├-	╀	Н	$\dashv$	+	+	╁	╀		$\vdash$	+	$\dashv$	+	╀	+	+	+	Н	Н	$\dashv$	+	╀	╀	╀	$\vdash$	┦	Н	-	$\dashv$	$\dashv$	$\dashv$	$\dashv$	+	$\dashv$	+	+	+	$\dashv$	+	$\dashv$	4	$\dashv$	-{	$\dashv$	+	$\dashv$	$\dashv$	_	Н	$\dashv$	$\dashv$		╀
36.50 36.50	38*	廿	_	$\Box$	$\perp$	t	士	1		t	$\perp$					1	$\dagger$	$\perp$			$\Box$	+	$\dagger$	$\dagger$	╁	t	$^{+}$	_			$\dashv$	$\dagger$	十	†			Н	⇈		_	7	+	+	1	$\dashv$	$\dagger$	$\dagger$	$\dagger$	$\dashv$	†	╛		_			$\exists$				Н	1			İ
36.5°  PULSE 08 42 58 66 78 82, 71 110 99 92%.  RESP 20 20 20 20 20 20 20 20 20 20 B.P. 109/101/43 20 60/100 60 80 90 (50/100 60 90/100	37.5°	$\vdash$	+	$\left  \cdot \right $	Ŧ	F	$\mp$	Ŧ	-	+	+	F	H	Н	-{	7	+	F	$\vdash$	H	$\square$	+	+	+	-	Ŧ	Ŧ	F	Н	$\exists$	4	7	F	7-	-	F	Н	H	-[	$\dashv$	4	-{	4	7	7	+	Ŧ	$\dashv$	4	4	4	=	$\dashv$	4	$\dashv$	$\dashv$	$\dashv$	Ц		Н	$\dashv$	4		F
PULSE 03 72 56 72 84 71 110 99 94%.  RESP 20 20 20 20 20 20 20 20 20 20 80 90 (50 100 [bt 95 150]  B.P. 10960 1017 12 45 60 60 80 90 100 100 100 90 90 (50 100 [bt 95 150]  SPO2 9649 974 98 9974 96-1. 96 977 974 983	37'	H	-		4	Ļ	‡	-	+		+	ļ.,	Ι,			<b>*</b>	$\downarrow$	\$	٠.	-		1	_			<u> </u>	⇟	ì		-	4	‡	<u> </u>	+-	1	Ļ	H	H		_	#	4	#	4	$\dashv$	#	#	$\downarrow$	#	#	_		4		_	4				H	7	_		Ļ
PULSE 03 72 56 72 84 71 110 99 94%.  RESP 20 20 20 20 20 20 20 20 20 20 80 90 (50 100 [bt 95 150]  B.P. 10960 1017 12 45 60 60 80 90 100 100 100 90 90 (50 100 [bt 95 150]  SPO2 9649 974 98 9974 96-1. 96 977 974 983	38:5°		1		$\pm$	土	#	‡	$^{\pm}$	†	#		t		$\exists$	#	士	t	t			#	#	#	#	#	#	t	Ц	$\exists$	#	$^{+}$	t	#	t	L			╛	$\rightrightarrows$	⇉	⇉	⇉	#	$\Rightarrow$	#	#	$\downarrow$	$\downarrow$	#	⇉			_		_				H	1	$\exists$		t
PULSE 08 12 58 66 78 84 71 110 99 94%.  RESP 20 20 20 20 20 20 20 20 20 20  B.P. 10960 1017 12 45 66 60 80 90 (50 100 60 95 10		┝╌┼╴	+	╁	+	╀	╀	+	╁	╀	╀	┝	╀	Н	$\dashv$	$\dashv$	+	╀	$\vdash$	⊢	Н	+	+	+	+	+	+	╀	Н	$\dashv$	+	+	╀	+	╀	╀	Н	H	-	$\dashv$	4	$\dashv$	+	+	+	+	+	+	+	+	$\dashv$		$\dashv$	_	$\dashv$	$\dashv$	$\dashv$	Н	_	Н	$\dashv$	$\dashv$		╀
RESP 20 20 20 20 20 20 20 20 20 20 20 20 20	36°	且	$\perp$		1	$\perp$	土	t	T	上	+					士	1-	t				$\pm$	$\pm$		t	1	t				1	$\pm$	$^{\dagger}$	t		L	Ш	Ħ		$\exists$	1	$\exists$	士	1	1	t	1	1		1	1		$\exists$	_		1	_			Ħ		╛		L
RESP 27 20 20 20 20 20 20 20 20 20 20 20 BP. COM 101/7324 60 60 80 90 60 100 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 60 60 95 60 95 6	PULSE	Ш		6	<u> 8</u>					<u>ጥ</u>	<u> 8</u>	S	<u>d-</u>					24		7	4		11.	0			_	0	A	۲.																	╧													L			_	
SPO2 961, 994, 98 997, 971 981, 96 977, 971 903		$\sqcup$		0	رصا	1	21	<u>)</u>	Ç	<u>-ر</u>	<u>}</u> _	Q	9	_	2	5	۾ ا	)n		2	Ф	4	δ	0	1	<u>21</u>	)	<u></u>	<u> </u>				퇶			L		_						_			┵			4														
		$\vdash \vdash$										IC.	9 / e	<u>st</u>	40	160		_,_				_											$\downarrow$					$\dashv$						_						4				_		4						ᅵ	_	
		$\vdash$		4	64	49	19	<u>y</u> ,		12		Ľ	Ц	7.	9	7.	4	98	<u>-/.</u>	-	<u>16</u>	$\downarrow$	q=	Ŧγ	1	9	#/	1	19				1					-						_					_	4			_			_						_		
▗▝▝▔▔▕▕ <del>▝▝▘▀▝▎▀▀▀▀▀▝▘▗▗▗▄</del> ▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀▀	DAILY WEIGHT	<del>   ,</del>				╁	<u> </u>			٦Ŋ		$\vdash$	1 .				+	•	<b>A</b>		A	<del>,  </del>		_			o	╀					+				_	$\dashv$				_		-+		_		_		$\dashv$		_	_	_	_	+	_					$\dashv$	-	_
24 HRS INTAKE 600 M 2100M 1200M 1200M 1300M						+						$\vdash$				_												+					+					$\dashv$			_		•	-						+			_		_	$\dashv$					_	ᅱ	_	<u> </u>
		<del>     </del>	450	אב	<u>u_</u>	<del> -</del>						$\vdash$	کا	07	<u> </u>	<u>'N</u> J	, -											╀					╀				_	┥	_					+						+	_				_	4				_		$\dashv$	$\vdash$	_
MOTION Y Y Y X X X		+	_			╁,		<u> </u>	ν	115	_	$\vdash$		ηυ	<u> </u>		_	<u> </u>		<u>&gt;</u> [ `	21 Y			_5	2								十		_		_	$\dashv$			_	_	_	+		_				$\dashv$				_	_	┪						$\dashv$	-	_



Dr.RAJESH.V





# EARLY WARNING SCORE MONITORING CHART

Name: _		100	1.01	ava	- 10	760	U.A.	1 10	2 1.19		atient	22 1	100	1	-
NEWS key 1 2 3	DATE	Alex	3/12	Silk	3/2	100	3 12	مراماء	3/12/	3(17/2	AIDO	nl	nly	14/12	DATE
	TIME	12:30	Ring	13-0-	2.00	Pass	Dien	Inpo	01	20.	6,	Colo	MES	18.00	TIME
FB	>25							2							>25
espirations eath/ min	21-24 18-20	-	0		-	3				_		-	2	-	18-20
eatily min	15-17		-	-	-		-	_	-			7			15-17
	12-14														12-14
	9-11							1							9-11
	<8		ESES!		SEE SE	PERS.	4495	3		100			No.		<8
+B	>96	-	4		*	4	-	7			-	-	_	-	>96
Po2 Scale 1	94-95							1							94-95 92-93
xygen Saturation (%)	92-93					-		2	-	700000		-	-		<91
oo2 scale 2 oxygen	<91 >96 on oxygen							3							>96 on oxygen
aturation ( %) use scale 2 target range is 88-92 % g: in hypercapnic espiratory failure only	250 CH OXYGEN														
se scale 2 under the	95-96 on o2							2							95-96 on o2
ction of qualified	93-94 on O2							1							93-94 on O2
cian	>93 on air														>93 on air
	88-92							1		7					88-92 86-87
	86-87 84-85				10000			2							84-85
	<83%	-	THE REAL PROPERTY.	10000	MARINE.	SECTION .	STEER ST	3	STATE OF THE PARTY OF	THE PERSON	100000	NAME OF TAXABLE PARTY.	THE REAL PROPERTY.		<83%
ir or Oxygen ?	A= Air	3	9	•	0	I	7		-			-	-	-	A= Air
	O2litre/ min				1000			2							O2litre/ min
	Device														Device
lood Pressure	>220							3							>220
	201-219							-							201-219
	181-200							2		Maria de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de					181-200
	161-180											-			161-180 141-160
	141-160 121-140			-											121-140
	111-120	5	9			-	,			_			-		111-120
	91-100											1		-	91-100
	81-90		1	15.55			1000	2							81-90
	71-80	THE REAL PROPERTY.	PERSONAL PROPERTY.	Service !	ES SE		BIANE	3		TO STATE		ESTATE OF	150000		71-80
	61-70							3							61-70
	51-60							3							51-60
	<50							3		STATE OF					<50
iastolic BP	mmHg							( <del>S</del> )	60	69	6 1	-60	60	60	mmHg
des	>131							2							>131 121-130
ulse eats / min	121-130 111-120							2							111-120
	101-110							1							101-110
	91-100							1		200					91-100
	81-90														81-90
	71-80														71-80
	61-70	4	0	- 60	9	0	-4								61-70
	51-60							~	-	- 1	-	-	2		51-60
	41-50							1							41-50
	31-40							3							31-40
	<30	-0					-	No. of Lot, Lot,		E SHOW	THE STATE OF		5		<30
onsciousness	Alert	10			Total Control			2 10000						-	Alert Confusion
core for New onset of	V							3							V
onfusion	P							3							P
no score if chronic )	U							3							U
	>39.1 degree	No. of Lot,			-			2	No. of Lot	THE REAL PROPERTY.			THE REAL PROPERTY.	NAME OF TAXABLE PARTY.	>39.1 degree Celsius
	Celsius		1						200				1		
emperature	38.1-39.0							1							38.1-39.0
egree Celsius	37.1-38.0	0	9									_			37.1-38.0
	36.1-37.0	-			•	-	T			- 0			-	-	36.1-37.0
	35.1-36.0					-		1			-				35.1-36.0
EWS Total	< 35.0	0	0	0	0	P	6	No. of Lot, House, etc., in case, the lot, the l	,	0	10	8	0	4	< 35.0
Nonitoring Frequency		Lota	Jety	WH	WID	CAM	4th	10	wh	ath	v	nota	Fall	4.15	
scalation of Care Y/N		NO.	NO	No	1/13	No	NO	8/2	100	NO	do	200,	100	MO	
nitials by RN		DO	OU!	2	0	X	12-5	wer	COY	Park	700	med	OM	5	
nitials by Sr. RN		30	20	ووا	Não	Nes	100	Note	200	100	to	10	1	109	
				F											

Score and monitoring	4	Every Hourly	
frequency	3	Every 2 <sup>nd</sup> Hourly	
	2	Every 4th Hourly	





Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





EARLY WARNING SCORE MONITORING CHART

Name: _	DATE			1/2	-/12	100	/Sex:_	11 12	1.16/2	31.	atient	1.4.2	-0110	-12/1	DATE
NEWS key 1 2 3	DATE	200	12	101,00	10/12	100	10/2	1011	11111	11/15	14/10	2200	12/10	140	DATE
	TIME	2950	6.0	10	Ma	18,0	20	6400	10.00	10.00	100	22000	600	00-	TIME >25
+B espirations	>25							2							21-24
reath/ min	18-20	_		-	10	10	1	-	_	-				-	18-20
	15-17								-			-			15-17
	12-14														12-14
	9-11							1							9-11
	<8		2.58	200				3							<8
A+B	>96			-	0	-		-	-	-	-	-	-		>96
Po2 Scale 1	94-95	-						1							94-95
Oxygen Saturation (%)	92-93							2							92-93
po2 scale 2 oxygen	<91 >96 on oxygen							3							>96 on oxygen
aturation (%) use scale 2 f target range is 88-92 % eg: in hypercapnic espiratory failure only															
ise scale 2 under the	95-96 on o2							2							95-96 on o2
lirection of qualified	93-94 on O2				1 100			1							93-94 on O2
ian	>93 on air														>93 on air 88-92
	88-92 86-87			A.S.				1							86-87
	84-85							2							84-85
	<83%							3							<83%
Air or Oxygen ?	A= Air	-		-	-0	-		-	9	-	-	-	4	-	A= Air
	O2litre/ min							2							O2litre/ min
	Device														Device
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			M.	-		_			-	-		-	-	111-120
	91-100							1							91-100
	81-90 71-80				and the latest designation of the latest des	-		2							81-90
	61-70							3							71-80 61-70
	51-60							3							51-60
	<50	100000						3							<50
Diastolic BP	mmHg	10	40	76	15	79	74	26	80	20	45	1	-18	20	mmHg
	>131		HEALTH.		9			3 (1							>131
ulse	121-130							2							121-130
s / min	111-120		_					2	2590						111-120
400000000000000000000000000000000000000	101-110					-	-	1							101-110
	91-100	-	-	-				1	-		-	-	-	,	91-100
	81-90										1000			4	81-90
	71-80 61-70														71-80
	51-60														61-70 51-60
	41-50							1			N. C. S. C.				41-50
	31-40	100000	10000		Carried S			3	100000			100000	-		31-40
	<30							3						SES 7/18	<30
	Alert	5	-	-	*	P	_		10	-		-	2	-	Alert
onsciousness	Confusion							3							Confusion
core for New onset of	٧							3							٧
onfusion no score if chronic )	Р							3							P
	U							3	Mary College					No. of Control	U
	>39.1 degree Celsius	1		1333				2			24913	BOOK STATE	Billion !		>39.1 degree Celsius
emperature	38.1-39.0							1							38.1-39.0
egree Celsius	37.1-38.0	-	~					-							38.1-39.0
	36.1-37.0			8-	Ço.			-	-	2	1	-		-	36.1-37.0
	35.1-36.0							1		100000					35.1-36.0
	< 35.0	10000	LICYAL PAR	STATE OF	SESE	SER SE		3		Application !			10000	-	< 35.0
EWS Total		4	A	1	0	1		b	1.0	2	2	10	Ø,	0	
Monitoring Frequency		un	UH	166	Still	40	MA	WL	489	wh	4) h	Le	U	ula	
scalation of Care Y/N		no	go	Nin	-01		Wo	no	N	M	N	no	M	200	
nitials by RN nitials by Sr. RN		100	50	800	.00	. 0	m	u	- 199	8/m	100	fu	64	73	
III III DV SE, KN		AUX.	N	N.K.	1000	V.	200	100	1	1 W	100	100	NUC	1000	

Score and monitoring	4	Every Hourly	
frequency	3	Every 2 <sup>nd</sup> Hourly	
	2	Every 4 <sup>th</sup> Hourly	





## Master, SIVAGURU.S

13/Malc/MHI202381075 · 02/12/2023/IPH202302423

Dr.RAJESH.V



Medway Heart Institute

eart beat counts

## **EARLY WARNING SCORE MONITORING CHART**

NEWS key  1 2 3  1 2 3  1 2 3  1 2 3  1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	TIME >25 21-24	1:00	Du 1	0/1	1611	010	0 14	01	1010	1100	101	d 11.	1111	DATE
espirations	>25	100	-012	1.12	1820	29 ac	1.4	1000	visio	0.00	9200	town	1 0	TIME
espirations			60%	(Mer	(0,	LUM	19400	3	10	18.	-	W NOO	7-7	>25
								2					-	21-24
	18-20			_	-	-	-	-			-			18-20
	15-17	4				-								15-17
	12-14													12-14
	9-11							1						9-11
	<8							3						<8
1+B	>96	0	-		_	-	_		•	1-	-	-	~	>96
Po2 Scale 1	94-95							1						94-95
Oxygen Saturation (%)	92-93							2		Name and Address of the Owner, where the Owner, which is the Own	-		Control of the last	92-93
po2 scale 2 oxygen	<91 >96 on oxygen							3			The latest to th			>96 on oxygen
aturation ( %) use scale 2 target range is 88-92 % g: in hypercapnic espiratory failure only	250 dii daygen													
se scale 2 under the	95-96 on o2							2						95-96 on o2
ection of qualified	93-94 on O2							1						93-94 on O2
nician	>93 on air													>93 on air
	88-92							1						88-92
	86-87							2						86-87 84-85
	84-85 <83%		THE REAL PROPERTY.	A STREET, SQUARE, SQUA	Contract of	-	100000	3		THE REAL PROPERTY.	The same	The same	Name and Address of the Owner, where the Owner, which the	<83%
	C0370													10370
Air or Oxygen ?	A= Air	0	-	-	-4	-27	4	-	ů.	-		-1	_	A= Air
	O2litre/ min Device					THE SALE		2						O2litre/ min Device
	>220				000000			3						>220
lood Pressure		1000												
	201-219													201-219
	181-200							2					10 miles	181-200
	161-180												200	161-180
	141-160													141-160
	121-140									-				121-140
	111-120		4		-		-	_*	-				-	111-120
	91-100	-6	-					1						91-100
	81-90							2						81-90
	71-80							3						71-80
	61-70							3						61-70
	51-60	-						3						51-60
i	<50	67	80	94-6)	2	30	70	-th	n	PL	20	20	an l	<50
Piastolic BP	mmHg >131	6-1	-	20	8-	70	Sp	70	9	69	40	30	No.	mmHg >131
ulse	121-130							2						121-130
eats / min	111-120				-			2						111-120
	101-110							1					District Control	101-110
	91-100							1						91-100
	81-90	0		_		-	4	P	۵	- Dec	_	1	_	81-90
	71-80		~							1				71-80
	61-70													61-70
	51-60													51-60
	41-50							1						41-50
	31-40							3						31-40
	<30	0						3		1000		-		<30
Consciousness	Alert	0	THE REAL PROPERTY.			-	000000	3		-			-	Alert Confusion
core for New onset of	V							3						V
onfusion	P							3						P
no score if chronic )	U							3						U
	>39.1 degree							2		No. of Lot		TO DO	THE REAL PROPERTY.	>39.1 degree Celsius
	Celsius										-			
emperature	38.1-39.0					-		1				10/10/19		38.1-39.0
Degree Celsius	37.1-38.0												1 1 1 1 1 1 1 1	37.1-38.0
	36.1-37.0	0		_	4	-	-		-	6	-	1		36.1-37.0
	35.1-36.0							1						35.1-36.0
SELACE Trace	< 35.0		40	b 1	9)	(Q	D	0	100	6	0	0	0	< 35.0
NEWS Total		118	49	sth	1.12	41/2	MA	485		1 141	0/17	100	116	
Monitoring Frequency Escalation of Care Y/N		NO	no,	200	NO,	wo	6	h)	46	MIN	412	200	n)	
nitials by RN		Hay	100	P	( PO)	100	(M	ar	120	V	1	lu	an	
nitials by Sr. RN		19	103	10	.6	19	100	-01	do	100	NOS	NOR	100	

Score and monitoring	4	Every Hourly	
frequency	3	Every 2 <sup>nd</sup> Hourly	
	2	Every 4th Hourly	

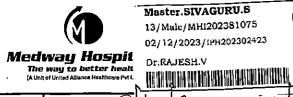


Master.SIVAGURU.S 13/Mule/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V





Every heart beat counts Bed No: >03 To: 3/12 (2 2 From: 2/12/23 Date **INTAKE & OUTPUT** Ended Time: みょう 24 Hrs: Started Time: 12230 **CHART** NPO Started at: NPO Over at: SHIFT Morning Night Restricted Fluid (RF) Afternoon INTAKE Im Gel 400 W 2 roml **OUTPUT** \$00 Ys **Total Output:** 450M Difference: Total Intake: 600m -150 W INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Time | Oral Total তিৰো Urine **Vomitus** Feeding Type of Fluid Time Others R/N Sign Aspirate Tube by Additions Amount By 1000 B230 160 150 OGN 601 Feed بانھر 47701100 250 350 400 19-30 150 22.45 150 550 2210 150 500 2-30 1150 750 6.00 200 4-30 100 600 0084 DULLAKE boom TOTAL From DUTPUT TOTAL Naca



Master.SIVAGURU.S 13/Malc/MHI202381075 02/12/2023/IPH202302423

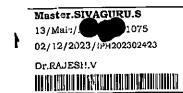






Date	Fro	m: 3 [/	e d3 to	०:५ । ध्र कु	} Be	ed No:	206	<del>যু ,</del>				INITAI	VE 0		DUT.
24 Hr	s : St	arted Time	··· Jam		Ended T	ime : 🕂						INIA			PUT
NPO	Starte	∌d at :			NP	O Over a	at:						CHA	KI	
SHIF	r		lorning		Aftern	100N			Nigh	t		Rest	ricted F	luid (R	F)
INTA		1100 m				OML		<u> </u>	300	my					
		950 ml				201mle		<u></u>	Att	ml					
Total	ntake:	: 2100M			Total Outpu	ıt: <u>18</u> 5	<u>om</u>					soul			
			INTAKE (	<u> </u>		1	Ļ	<del>,</del>		רַטס	<b>TPUT</b>	<u>(ml)</u>	1		
Time	Oral	Tube		nous Infusi		Total	Time	Urine	Vomitus	N/G	Drain	Others	Tec.	R/N Sign	Endorsed
	<u> </u>	recuiry	Type of Fluid	Additions	s Amount					Aspirate	lube				by
8.00	500			<u> </u>		500 m	7·40	100					100		
10.40	500			<u></u>		1000	8.50	200					30 D		
11.45	001		,			1100	10.15	200					500		
12.30						1200	10:40	150				<u> </u>	650		- ·
13.00							11.30						9 50		
15.15							12,30						1050		
15.30	Lot	)					14.15						1150	<u> </u>	
16.30	160	,				1700	(y.30)	300				<u> </u>	lyst	_	
17,00	IDC	)		<u> </u>		1800	22.00	ನಿರಾ				<u> </u>	1:500		
S1;00	150	1				1950	6:30	250					1850		
22:3º	150			<u> </u>		2100								2	7
									To	tal I	inta	Ke-	02100	, ,	Nag
									10	tal o	utipi	At 1	185	om	7
	i					,					,	nce -		1 1	









•		·				<del></del> ,							Eve	sy heart t	eat counts
Date	Fre	om: Le (12	123 To	5 12 2	ک Be	d No: 9	-23			_		INIT'A I	VE 0		DUT
24 Hr	s : S	tarted Time		_	Ended T	ime: 7	f Jool	-				INTAI			PUI
NPO	Start	ed at :	_		NP	O Over a	at:						CHA	IK I	
SHIF	Г	N	lorning		Afterr				Nigh	t	_	Rest	ricted F	uid (RI	F)
INTAI	-		300 ml	_		m or			40	<u> </u>					
OUTF			150 ml			150 V			600	oml					
Total I	ntake	<u>: Idmn</u>			otal Outpu	it: 1300	ml			Differen					
			INTAKE	<u> </u>				<del>,</del>		וטס	PUT (	(ml)			
Time	Oral	Tube Feeding	Intraver Type of Fluid	Additions		<b>Total</b>	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
بحرص	<b>2</b> 400	)				2,00	9130	150					100		
11200	100					300	1233	વ્યદ					3 %		
ويعازيوم	<sub>ა</sub> დ <sup>ე</sup>	<u> </u>				400	16:20	2 <i>0</i> 0					กรอ		
(ક્ટુડ) ટ	<i>9</i> 20					600	14748	150					700		ŕ
lbiha	ઉ૦)					700	<i>20:3</i> 0	200					900		_
<u>፟</u> ፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞	උලට	<u> </u>				Soom!	22,60	150					1050		
18:30	120					950	6:30	250					1300	·	
22.00	100					1050					_				_
91 <sup>30</sup>	120					1200			Tot	al In	tak	e ~ 1	2000	P	
									Total	al ou	tou	- 1	300m	P	
	_									B	lan i	<u> </u>	100m	f	Due
														Hay	
														០លើ	
														1	



Master.SIVAGURU.S
13/Male/MHI270771055
02/12/2023/tr





(A Unit of United Alliance Healthcare Pvt Ltd)		. 7	Every heart b	car conuc
Date From: 5 12/2>	To: 6/12/23	Bed No: 203	INTAKE 8 OUT	DUT
24 Hrs: Started Time: 子,00	En	ded Time : 💤 😊	INTAKE & OUT	PUI
NPO Started at :	- · · · · · · ·	NPO Over at :	CHART	

 SHIFT
 Morning
 Afternoon
 Night
 Restricted Fluid (RF)

 INTAKE
 \$00
 600M

 OUTPUT
 \$50
 500M

Total Intake: 1406m Total Output: 1350 Difference: 50m

		<u> </u>	INTAKE							OUT	PUT (	(ml)		-	
Time	Oral	Tube Feeding		nous Infusions		.togi	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Telell.	R/N Sign	Endorsed by
7.00	100					Dai	600	001					100		
R -30	100				<u> </u>	200	800	150					20		
1100	001					300	8,50	50					300		
12.30	120					450	11.100	COOJ				ļ	yob		
1400	150					600	130	250				ļ 	650		
15.8D	/00					700	12.00	100			<u>-</u>		750		
1700	00					00g	1800	[60]					826	<b>&gt;</b>	
19:00	150					950	21:30	150					1000		
21:00	100.			_		1050	23'00	150					1150	<u></u>	<u> </u>
	200.			<u>.</u>		1250	6:30	200					1350	<u> </u>	<u> </u>
23:10	150				_	1400			Tota	I Int	ake	- 14c	onl	<u> </u>	<u></u>
									_Tol	al put	put	- 135	onl		الادو معند
	_									Ва	laree	- 50	m	thy	
						,						<u> </u>		Over	



Master.SIVAGURU.S 13/Mulc/MHI202381075

02/12/2023/IPH202302423

Dr.RAJESH.V





(A On	I Of Onited Alia.	k k	110 100 1011 100 1010 1011 1011 1011 1	in <b>a</b> kaakkii <b>inii</b> lii [	l								Evi	ry heart	beat counts
Date	Fro	m: 👸 / c.		· 5/1/2/0	R3 Be	d No:	208					ATIAI	KE &	OUT	DIIT
24 Hı	s : St	arted Time	! JAm		Ended T	ime : 🦠	FAM					INIA			PUI
		ed at :			NP	O Over a	at':		_ <u>.</u>				CHA		
SHIF	<del></del>	N	lorning		Afterr				Nigh	t		Rest	ricted F	luid (R	F)
INTA			000 ~~			some			450	00					
OUTI		,	06 mr			<u>roml</u>	<del> </del>			<u> </u>		_			
Total	Intake:	1300	INITALE	/ T	otal Outpu	it: 1850	)			Differen				_	_
	I	T = 1	INTAKE				1			<del>-</del>	PUT	(mi)		-	
Time	Oral	Tube Feeding	Type of Fluid	ous Infusions		- ोळीबी:	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total·	R/N Sign	Endorsed by
9.30	UP	Ja	13.20 7	Nac		100001	- 7· o	G L	P 90	OUTP	5	,	Joom	-	
1230	2°°					300	12,30	goo					900		
13.30	20°Ò					800	14.30	3.00					1000		
14.00	100					600	१४५०	150	_				<b>B</b> 50		
15.30	100					700	18.30	00]					1850		_
1800	300					608	21100	250					1650		
19130	950					1050	22:∞	ρo				ļ	1750		
2015						1200	6:35	loo				ļ	1820		ļ
22100	100	<u> </u>				1300							ļ		
		<u></u>							Total	<b>6</b> 800)	Inta	ke-	1300		
		<u> </u>			_				Total	7	ukpi	<del>(t -</del>	1880		W 200
											alan	<u>ce</u>	- 550	M	124
		<u> </u>										<u> </u>		H24	
										]					









Date	Fro	m: 09	7/12/23 To	s: 10/12	l <sub>2.1</sub> Be	ed No:	200-1	A /		*3		INITA			DUT
24 Hr	s : St	arted Time			Ended T	ime :	<u>-00.</u>					INTAI			PUI
NPO	Starte	d at:	.,			O Over a				ç			CHA	(K)	
SHIFT	ī	N	Norning		Afterr	ıoon			Nigh	t		Rest	ricted F	luid (R	F)
INTA	KE	São N	nl.		300	>			AS	TOM		1	-5 G-	t Da	4_
OUTP	TU	A00	n		HOO				130	som			_		J
Total I	ntake:	1300M	N	<u>  T</u> ,	otal Outpu	ut: 210c	mc		_	Difference	:e: 8°С	ony_			
		<del></del>	` INTAKE (	<del></del>						דטס	rput (	(ml)			
Time	Oral	Tube		nous Infusio		ीळ्डा	Time	Urine	Vomitus	N/G	Drain	Others	52:0:-Л.	R/N Sign	Endorsed
		Feeding	Type of Fluid	Additions	Amount		IIIIE	Oline	Volintus	Aspirate	Tube	Others		Kit Sigi.	by
11.20	<b>1960</b>				<u> </u>	250	11-20	400					400		
12.00		!				.550	15-10	60					500		
13-50	<u>001</u>	<u> </u> !	<u> </u>			650	17.50	٥٥١					800,		
14.00	50.	<u> </u> !			<u> </u>	700	18:30	500					1800		
6.00	20	<u> </u>				750	ঐ ঃ ৮	600					1900		
17.40	00	<u>.</u>				850	6:30	200					2100		
192130	00					950									
21712		<del></del>		_	<u> </u>	1150				Total	Ind	ake	130	7	
J2200	180					1200				Total	out	Aut -	2101	<u> </u>	L
	<b></b>										Bal	ance.	800	nl	
	<u> </u>	<u> </u>												Hay	100
	<u></u>													ÓlÓ	- F
	<u> </u>														
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Master. GUI

13/Malc/

023...5 02/12/2023/IPH202302423

Dr.RAJESH.V





From: 1014/13 To: 11/124 Bed No: දැනු Date **INTAKE & OUTPUT** 24 Hrs: Started Time: ¥₩ Ended Time: **CHART** NPO Over at: NPO Started at : SHIFT Morning Night Restricted Fluid (RF) Afternoon **INTAKE** <u>600 N</u> Some 5 50 m 700 m **OUTPUT** 00. moor **Total Output:** Difference: - 200 M Total Intake: foom 2000 M **OUTPUT (ml)** INTAKE (ml) Intravenous Infusion Tube N/G **Drain Endorsed** ':Tofall Others 1061 Time | Oral **Time** Urine **Vomitus** R/N Sign Feeding Type of Fluid Aspirate Tube **Amount** bν Additions 00 lna 7.15 100 /ආ 7,00 300 12.45/h00 200 Tino 7.15 21.5 Doom  $\omega_0$ 400 2 44 200 1450 40 ဃ 2500 19.AL 1750 Jω 22.30 3000 9144 hon 2.00 2000 2500 12.00 1,50 02F <del>४७४</del> 14,00 200 9 C D 15-0 h 200 150 1.201102 TOTAL PUTAK 250 1800W 21-00 150 1400 BUTPUT 2000m TOTAL 1600 Reo 2.00 200 5-30 200m 1800



Master.SIVAGIIDII,S 13/Male/MH120; )75 02/12/2023/IPH202302423 Dr.RAJESH.V





(A Uni	t of United Allian	nce Healthcare Pv( Ltd)		**************************************	i with 110 111 111		11.00						Eva	ry heart l	beat counts
Date	Fro	m: W 12	123 To	0: 12/12/1	2_3 Be	d No: 2	02 (A)					INTAI	/E 9	OUT	TIIQ
24 Hr	s : St	arted Time	7-00		Ended T	ime : 🐬	600					INIA			PUI
NPO	Starte	ed at:			4	O Over a							CHA	KI	
SHIF	T	N	lorning		Afterr			T -	Nigh	t		Resti	ricted F	luid (R	F)
INTA	KE	-	160-		700	<b>^</b> ,			5000	u		1-1	- Wat	dy	
OUT	PUT		300		900	,			9000	M				<i>7</i>	
Total I	intake:		1950m	Т	otal Outpu	it: 2	loon	u		Differen	ce: ر	150 W	<u> </u>		
			INTAKE	(ml)							PUT				
Time	Oral	Tube Feeding	Intraver Type of Fluid	Additions		ीर्छा ।	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	[160]	R/N Sign	Endorsed by
ৰ্দ ১৮০	100					100	7.36	300		_			300		
क्षेत्रव	60				_	160	12.20	boo					900		
9.22	100					260	Bilo	300					1200		
OAP	200					460	19.30	250 M					1450a	4	
<u>0.30</u>	200	,				_66@_	22.30	970M					1700m	9000 g	_
11.00	100	ļ				<b>₫60</b>	2-00	150M					1850W	_	
12-36	201	<u> </u>				960	5:45	250 pm	-				aloon		
14.20	200					1160					_				
<u> </u>	w€	<u> </u>		ļ		1260			TOTA	INTAKE		1950 m		<u> </u>	
16,00	၂၈၀					1360		_	TOTAL	& OJPUJ	~	21000		<u> </u>	40
17.10	عوا			<u> </u>		1460	_							) -	eç a
J2.00	200 ।	<u> </u>				1650					,				
8.00	1500	ψ				1800									
600	Iton	4				1956									





### Maste: SIVAGURU S 13/Male/MHI202381075

02/12/20 20230 !423

Dr.RAJES...v





Every heart beat counts

Date	Fre	om: le/	12/23 To	): [3] 12/2	ு Be	d No: 🥇	202.					INITA		OUT	ידוום
24 Hr	's : S	tarted Time	2: J-row		Ended T					_		INTA			PUI
NPO	Start	ed at :				O Over							CHA	KK I	
SHIF	Т	N	lorning		Aftern	ioon			Nigh	t	-	Rest	ricted F	luid (R	F)
INTA	KE	700	oml									-			
OUT	PUT		oml.												
Total	Intake	:			otal Outpu	ıt:				Difference	ce:				
			INTAKE	(ml)						ดบา	PUT	(ml)			_
Time	Oral	Tube	Intraven	ous Infusio		Total	Time	Urine	Vomitus	N/G	Drain	Others	วัสราใชาที	R/N Sign	Endorsed
111110	O a	Feeding	Type of Fluid	Additions	Amount	IOLEI .	Tille	Offine	Volilitus	Aspirate	Tube	Others		KiN Sign	by
g.60	<i>3</i> 0ø	li .				Soo	8.30	300					300		
9.30	ഉള					\$00	9.00	300					6 <i>0</i> 0		
<u>ලංග</u> ට						ZÍO O									
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												20	<b>;</b>	94	
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## **Oral Anticoagulation Chart**

Every heart beat counts

Name

Master, SIVAGURU.S

13/Malc/MHI202381075

02/12/2023/IPH202302423

UHID / IP No.

Dr.RAJESH.V

Consultant

Age / Sex

Ward Unit

: S1CU-2

Diagnosis

: RHD , SEVERE AR.

				<del>*                                    </del>							
	Date	:		8/12/23				T	ime	:	
	Name	of Surgery:	-	AVR	C	2(mm	SI.JUDE.	D	ate of Surgery	7/12/23	
	Date & Time	Control	rom	b in Time Patients		INR	Drug order with d	ose	Ordered by	Time of Administration	Sign of Nurse
_		Value	$\dashv$	Value	<b>.</b>		J. ACITRON	4 9	- S		Jul 3
- <b>-</b> -	125	12-0	_	15.7	-	1.3.	71. 4(C) (FD)	1 ang	DR. Rajest		
9	23	-					2mg		8	4.02 -	Chab JC
	12/21	12.0	$\dashv$	17.4		1.4-	2mg		<del>                                     </del>	19.00	
	2 23						2mg		\$	19.00	7
12	12/23		_{		_				_		
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Date	Prothron	nb in Time			Ordered	Time of	Sign of
& Time	Control	Patients	INR	Drug order with dose	by	Administration	Sign of Hurse
	Value	Value			<u> </u>	, diffinistration	110,30
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### Every heart beat counts

Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V

## 

## NUTRITION ASSESSMENT AND CARE PLAN FORM

**Department of Dietetics** 

Dìagn	PAJ :cicon	) Au	1R. Mechanical	Value.	EF-52	<u> </u>		
Heigh	nt: (2)	ms	IR . Mechanical Weight:3	Food allergies	s: Yes/ No; if y	es, specify		
Religi	ous Beliefs:	C	] Vegetarian	Non Vege	tarian	,	Eggetarian	☐ Jain
Diet P	rescription:	tooc	Calows, t	* took ca	as Vol	teb	& pust	in dut-
SUB	JECTIVE	GLOBA	AL ASSESSMENT	(ADULTS) '		• / (	) ''	
Г		(A) -	Patient's related Medical History				<del></del>	
- 1		1)	Weight Change (overall change in					
		<u>-</u> ,		□ 2	<b>□</b> 3		<b>1</b> 14	T 🗆 s
		•	No weight change/	<5%	5-10%		10-15%	>15%
			gain			•		
	2}	Dietary Intake	Duration	· <u>·</u>	<del></del>		<del></del>	····
L			9	□ 2	<b>3</b>		<b>0</b> 4	
,		Oral -	No change	Sub - optimal solid diet	Full liquid diet moderate overall decrea		Hypo - caloric , liquid diet	Starvation
	_	Enteral / Parenteral Nutrition	Adequate / Excessive f	Sub - optimal	Inadequate		Typo - caloric feeds	Stanvation
-	3)	Gastrointestin	al Symptoms duration:					
			9	□ 2 ,	□ 3	<del>-</del> -	<b>-</b> 4	□ s ·
		(	No symptoms	Nausea	Vomiting / moderate GI		Diarrhoea	severe anorexia
-	.1	T			symptoms			
H	4)_	Functional Ca	spacity (Netrition related functional impair	□ 2			104	
			None /Improved	Difficulty with	Difficulty	with	Light activity	Bed / chair •
				ambulation .	normal a	ctivity		ridden with no or little activity
L	5)	Co - morbidity	(Disease and its relationship to nutrition n					<del></del>
			<u> </u>		3		<u> </u>	
			Healthy	Mild co - morbidity	mort	trate co - oldity/ age years	severe co - morbidity	Very severe multiple co - morbidity
Ī	8)	Physical exan	nination		•	•		
	1) .	Decreased fat	stores or loss of subcutaneous fat					
Γ			<u> </u>	□ 2	□ 3		<b>-</b> 4	5
	-	/	Normal	Mid	Moderate			Severe
	2)	Sign of muscle s	wasting					
·			<u> </u>	<b>D</b> 2	3	<u>.</u>	D4.	□ 5
			Normal	WEG	Moderate			, Severe
-	Total Score = Su	ım f above 7 comp	ponenta		-			<u>.</u>
ľ	Nutritional Stat	us ; Based on this	patient is					
j		Well Nourished			<b>□</b> (7 to 14)			
		Moderately Ma	Inourished		(15 to 18)		\	
	,	Severely Malno	urished		(19 to 35)		<u>/</u>	
	Nutrition Interv	rention:				•		
		D 0/31			☐ Enteral	D	arenteral	
]_	Diet counselling	g provided:			□ No		<del>. ,</del>	
I_	Frequency of re	-assessment:	Weekh			Fort - night	☐ Monthly	
	Enteral / Parent	teral 4		-		Calorie count: Yo	es No	· · · · .

Oletitian Signature / Name / Date / Time:



2/12/4, 13,40

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
2 Infu	A 13 year ord boy came E do shouting	•
- 13140	of beath wer arrived to be well	
	poursud or evident by 34A.	•
	12/eb- RHD.	,
	Educated les patriet and femine	_
	on 1600 caloring too fort , by salt, high	Collec
	pustin dit. Enfå en male frit	i.izria Catherine John Senior Distitian
	peal.	
#/12/u,	Patent shifted & OT for suggespark and legge on won. Patent wind to 800. Will instate on lighted shift	Maria Catherine John
	n pu doctor; adim. Nou ore. Potruit benated liquide us	Senior Dietitian
8/12/u,	Can initiate on high purstini, soft solid dut. Estimated to east were	Maria Catherina (im 701) Senior Dietitian
_	hitiated on avoid intomin' k dut.  (Aution due) Patient mid b stepdorum uv.	

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Master.SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V



# **Department of Dietetics**

# **CARE PLAN FORM - A**

CARL FLAN I ONWI - A									
DATE AND TIME	DIETITIAN NOTES	SIGNATURE							
allahen 13700	Reempfiel a the dit entroller . hotele boat was.	ind Ostherine John Senior Dietikian							
en/refu, es:00	Oral intale à god. Dit modification and claif cation des. Motosand b'est ness.	Maria Catherine John Senior Dietitian							
istubi, w.so	Oal intale is good. Educated the parties and Jamily as 1000 calains, by fed, to rate, high pusher; avoid								
	intamin k dit en direbage. Explid on made fort made - avoidance of exportance of intamin k dit. Dit	Maria Catherin (1622-79) Senior Dietitian							
,	hodif cation and claif cation dow.	·							





INTRAOPERATIVE NURSING RECORD

	Master.SIVAGURU.S 13/Male/MHJ202381075 02/12/2023/IPH202302423	
	op.rajesh.v	Consultant: Dr. Royesh
	Name of Surgery ! AVA	copen heart)  Date of Surgery: 7/12/
	Mode of Transfer to OR	Bed Stretcher Other
	Anaesthesia Type	: Epidural Dispiral LOC MAC
7	•	DEEN Regional
	Position	: Lithotomy Prone Supine Right Down Left down
		□ Lateral □ Other □
	Pressure Protection Pad	·
		Headrest Sand Bag Pillow Axillary roll
		Shoulder roll . Deve protection Chest roll Cysto/Gyn
		☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
		L aem rest padded / Sccured RArms tucked / padded
		□ Nil □ R □ L □ Other (Specify)
	Skin preparation in OT	Dehlorhexidine Prep Providone Iodine 75 Lodophor scrub
		☐ Alcohol Prep ☐ Others (specify)
	Electrocautery	: Monopolar Pad Loacation Bipolar
	Tourniquet	Location
		Applied Time
		Applied Time Released Time
		Applied Time Released Time
	Other equipment used	:
	Personal	: Surgeon Da: daylesh Asst.  Anaesthetist Da: Alcolha Asst.
		Anaesthetist Da Ailedha Asst.
	Type of Specimen	
	Lab	: Pathology Permanent Frozen Time sent
		Cytology Time of report
		☐ Microbiology
		☐ Bíochemistry

Туре	Type Size		Site		Туре		Amount		Sign	
Pomson's	15 24 FY		Right mediastinum		_				Sleep	
						·				
Sponge Court	0 C241	into air	γ <sub>Λ</sub> ‡, κζη	dono	h. 1	8. H	)	710	11 prive	yfr Folk
Sponge Court	Record	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~			pg r	1 110		· ·	30179	Catholic
Count	Raytex Sponges	Gauze Lined	Gauze Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	Needle	Circ. Nurse sign	Scrub Nurse Sign
Pre-op	Cograce	Coroca				-		Porte	200	319
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First closure count	Correct	(જેકાર્થ	<b></b>					cosset	Shirt	81
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	_		y: 🕒 □							
Transferred to:	816	$\mathcal{U}$	Ш	Patient	Room 🗆	CCU	□ Reco	overy Ro	om	
Scrub Nurse Sig		8k_		•						
Name: KIN	Sagik	umar								
Date & Time:	Sagik 7/12/2	3@1	3.40		•					
Circulating Nur	se Signature	der	١							
Name; RW Date & Time	christi	ina/	- 104 Hottka							
Date & Time	Christi Ho	128	Q 1	3-40						



Master.SIVAGURU.S
13/Malc/MHI202381075
02/12/2023/IPH202302423
Dr.RAJESH.V

PSYCHOLOGICAL WELLBEING REPORT

Date: 06 12 27

Time: 3. 30pm

Unit: 203-A

Clinical diagnosis: RHD, New AR

Surgery/ Procedure:

Impression: Junetianing well

- Neep & appetite D - calm affect - osiented, raponive.

Employee ID: HH1027 1/Psy

Signature of the Psychologist:





### Master.SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423





# **NURSING ADMISSION ASSESSMENT (ADULT)**

Date of Admission: 2 12 2 Time of Arrival: 11 .50 Mode of Admission: Walking Wheelchair Stretcher								
Accompanied by Relative: Yes No If Yes, Name of the Relative:								
Relationship with Patient: Contact Person's Name: CAKTHI Relationship: FATHER								
Contact No.: 9913920034 Primary language spoken: Tamil English Indian International								
Interpreter needed: Yes No								
Patient status: Conscious Unconscious Disoriented   Patient Vulnerable: Yes No								
Menstrual History: LMP: Menopause:								
Medical History: DM / HTN / Co - Morbility:Yes If yes specify								
Drugs History : Antiplatelet (Specify)								
Psychological Status; Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty								
Do you have any special religious, spiritual or cultural needs to be considered? Yes No If Yes, specify details:								
Socio Economic Status: Employed Retired Own Business Home-Maker Others: Studying								
Vital Signs: Temp: 9 (°F)   Pulse / HR: 100 (beats/min)   BP: 100/70 (mmHg)  Bespiration: Des (breaths/min)   Sp0 (01) (%)   CBG(22) (mg/dl)   Height: 1 (cms)   Weight: 1 (kgs)								
Respiration: 20 (breaths/min)   SpO <sub>2</sub> O <sub>1</sub> (%)   CBG: 135 (mg/dl)   Height: 10 (cms)   Weight: 33-7 (kgs)								
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known								
If Yes, specify:								
Pain: Yes No. If Yes, Score: OID Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years								
Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)								
Duration: Location:								
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain								
Nutritional Screening:								
Last 3 months Appetite: Increased Decreased No Change								
Last 3 months Weight: Increased Decreased No Change								
Type of Patient: Diabetic Non Diabetic Type of Diet: Normal Oliot								
Dietician Informed: Yes No. If Yes, mention the Name: <u>NRS. CNHOPUR</u> Time: 12-30								
Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented								
Room Dside Rails Dioilet Bell Patient Information Board Bathroom Bed Controis								
Use of Footstool Grab Bars Nurses Call Bell Television Utight Controls Telephone								
Functional Assessment:								
Particular Assessment Remarks Outcome								
Visual Impairment Yes No								
Hearing Impairment Yes No								
Chewing Difficulty Yes No								
Walking Difficulty Yes No								

								ì	s 1	
Daily Activity Of L	.iving:								- 1	
Activity	Independent			Assisted				pende	ent .	
Bathing				<u> </u>		П				
Dressing										
Eating	1	<del>-                                    </del>			-片			<del></del>		
Walking	<u> </u>					<u></u>	<del></del> -	<u></u>		
	1			<del>                                     </del>						
	Toilet Use						- '			
		<del></del>	r		Coore	Doore				
Sensory Percep No Impairment	HOH	Score	Moisture Paraly Maist		Score 4		e of Activit	<u>y</u>	Score	
Slightly Limited		3		Rarely Moist Occasionally Moist		Walks Frequently Walks Occasionally		llv.	3	
Very Limited	_	2	Very Moist	·		Chair Fast		ıı y	2	
Completely Limit	'ed	1	Constantly Moist		1	Bed Fast		1		
Mobility		Score			<u> </u>	<u> </u>				
No Limitation	<del></del> -	Score	Nutrition Excellent		Score 4	Friction & Shear  No apparent problem			Score	
Slightly Limited		3	Adequate		3		tial Problem		2	
Very Limited		2	Probably In-	.∆deguate	2		m Present	<u> </u>	1	
Completely imm	obile	1	Very Poor	Adoquato	1 1		ann resent		'	
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: 9 Action needed: Yes No Pressure injury present at the time of admission: Yes No  If yes, Location: Grade: Size: Relationship: Relationship:									<u>.</u>	
MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)  Fall Risk Assessment (Modified Morse Scale):										
Variables								Numeric Val		
History of falling	(immediate	e or within 6	months)				No	<b>├</b>	<u> ۱۹۷</u>	
	•		<u> </u>				Yes	}	25	
Secondary diagr	nosis (≥ 2	medical diag	jnosis)				No Yes	+-	15	
Ambulatory Aid			<u> </u>	<del>,</del>	· ·	<del>-</del>	+ 103	┼-		
None / Bed Rest		ssist							•	
Crutches / Cane		-							15	
Furniture									30 `	
, The			de a a frants.				No		\9	
Intravenous Therapy / Heparin Lock / Tubes Insitu							Yes	$\mathbb{L}_{-}$	20	
Gait Normal / Bed Rest / Wheel Chair Weak								<u> </u>	0/	
Impaired									20	
Mental Status Oriented to own stability										
Overestimated or forgets limitations								1.	15	
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics,							No		0	
laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics							Yes	T	15	
Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk  Total Score							ore		15	

### As per the score, tick the following appropriate boxes: Low Risk Interventions (0 - 24) Eamiliarize 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 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: Remarks (please specify) Yes No 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** Score Yes / No Active cancer (on-going treatment or diagnosed within 6 months or palliative care) Yes No 1 2 Bedridden recently >3 days or major surgery within four weeks Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle 3 (Assess for both legs) 4 Collateral (nonvaricose) superficial veins present (Assess for both legs) 0 0 Entire leg swollen (Assess for both legs) 5 $\langle O \rangle$ 6 Localized tenderness along the deep venous system (Assess for both legs) Pitting edema, greater in the symptomatic leg (Assess for both legs) 7 Ø 8 Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs) **(**) 9 Previously documented DVT (Assess for both legs) Yes Ø 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) 10 $\otimes$ 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. Risk Score Interpretation (Probability of DVT): **Final Score** Tick the score obtained (✓) **Action Taken** Date Time Dow. Low Risk -2 to 0 Moderate Risk 1 to 2 High Risk 3 to 8 Personal Belongings / Valuables: Name & Signature of the With With Patient's **Valuables** Description Remarks Patient / Patient's Attendant Patient Attendant □Upper □ Lower Dentures □ Both □ Nii □Right □Left **Hearing Aid** Eye glasses / ☐ Yes ☐ No Contact lens ☐ Yes ✓☐ No Jewellery Other valuables (specify) Report (List of X-ray, ECG, lab reports retained with the nurse): Name Emp. No. Time Date Sign. Patient / Relationship Patient's Attendant Nurse Unit In-Charge 00Au





13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date: 2	Date: 2(12(2) Shift: Morning Evening Night							
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: Seel FIZ PEWS Score: — day: — al line day: Right: Lef be:		GCS: \ POD:  Central line of the contral line	days:			
В	On room		m w 🗸	Date of surg	_			
A	BP: LCC Others: Pain Scc Fall Risk Braden S Pressure	SMENT  ns: Temp@R-(J°F)   Pulse  pre: Jo (mmHg)   SpO2 Q (mmHg)   Spo2 Q (mmHg)   Spo2 Q (mmHg)   Scale used  Score: Pain Scale used  Score: Minimal Risk: 23-19 [  Ulcer Scale for Healing (PUlser)   Check the control of the control	Height: 15) (c  Height: 15) (c  PIPPS / CRIES / FLAC  Otocol:	cms)   Weight: CC / Wong-Bal um	<u> </u>	1A 19kg   r ting Scale /(NR k: 12-10□Sever	) СРОТ	
R	Referral of Pending Pending Pending Critical volumes Pending Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: instructions if any:	()	care plan date	<b>3</b> :			
		Signature	Name		Emp. No.	Date	Time	
Handover of		00	A-mone	Shai.	0/21	2/12/23	19/21 7.0	
Handover t		974	A-ALBIA	108	0086	2/12/23	19.36	
Document of	endorsed	1) 00	S-Nali	72	0024	2/12/23	20:00	

	NURSES PROGRESS NOTES	,
Date & Time	Observations / Action	Signature with Emp. No.
9	Admiss Pon poofe	
2/12/7		
21	pr got Admitted on	_ ^
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19,50	Recovered	
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	Signature Name Emp. N	o. Date Time
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# Master.SIVAGURU.S. 13/Malc/MH1202381075 02/12/2023/1PH202302423 Dr.RAJESH.V



Date: 2	1223	Shift: Morn	ing Evening W	ight - · ·	S 10 3 Se	
S	Ventilator Periphera Ryle's Tuk	S: SCI PR PEWS Score: O  day: I line day: Right: — Left  De:		GCS: /5/L5 POD: — Central line days: — VIP Score: 0/L pecify organism:		
В	Type of su Allergies i On room	ROUND urgery: ー if any: 人足じら air / oxygen: むい Roo ts / New Symptoms in last si		Date of surgery:	· · · · · · · · · · · · · · · · · ·	
A	Others: Pain Sco Fall Risk Braden S	re: D/CO Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS)	### Height: 5   (cr ### PIPPS / CRIES / FLACO ### Dtocol: □ Low □ Medium ### Arrisk-Mild Risk: 18-15 □ ### SH): □ Yes □ Ne □ NA	ns)   Weight: <u><b>33 : 7</b>(kgs)   E</u> C / Wong-Baker FACES Pain m ∐High	BMI: <u>14 - 9 l 9</u> /n Rating Scale / NR: Risk: 12-10 □ Severe	
R	Pending Pending Pending Critical va Changes	imendation doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: estructions if any:	· ~	are plan date:		
Handover g	iven by	Signature	Name A - ALBIA	Emp. No.	Date 3/12/23	Time 700
Handover ta	ken by	I: Cato	E Cathrine	0207	3 12/23	7-30
Document e	ndorsed		& Nath	000/4	2/12/93	8:00

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No
2/12/23	MIGHT DUM NOTES	
19.00	Patient handover taken from the evening duty stable. Patient is & lable	A0186
2000	Due medications are govern to the patient	A1/80
જુર. <b>૦</b> ૦	vital signs is checked & seconded	Aug .
6.00	Monitoged Witals signs	NAD
7.00	Parish t and patient suppost	0129
	unaing away staff	NODE OID
	Signature Name Emp. No	. Date Time
Document endorsed by	Signature Name Emp. No.	·





### Master.SIVAGURU.S 13/Male/MHI202381075 Ne 13/Male/MHI202381075 UI 02/12/2023/IPH202302423 D( Dr.RAJESH.V



MHI/NUR/2022/048 Ínstitüte′

Every heart beat counts

	عادم	No Carrio			MOHOLO	
Date:	3116	21&3′ Shift: ☑Morr	ing LEvening LNi	ght . 		
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: SEN ATO PEWS Score: day: line day: Right: De; Statheter: Yes TNo Day	t:	GCS: ILIS POD: — Central line days: VIP Score: OLS ecify organism:		
В	On room			Date of surgery:		
A	BP: 100 Others: Pain Sco Fall Risk Braden \$	ins: Temp: 18.9°F)   Pulse    H	8_(%)   Height: 15   (cm  : PIPPS / CRIES / FLACC   Diagram	rs)  Weight: <u>33 7</u> (kgs)   Wong-Baker FACES     □ High   Moderate Risk: 14-13 □	BMI: 14.8 19	re Risk: 9-6
R	Referral of Pending Pending Pending Critical vo Changes	medications: — medication indent: — lab reports / Investigations: alue alert and its corrections: in nursing care plan:  follow-up orders: — nstructions if any: —	No. If Yes, modified ca			
	-	Signature	Name	Emp. No	Date	Time
Handover o		E-Cati	F. Cathres	r 030	न 3/12/23	12.30
Handover t		MOX	h Lowith	1 022	5 3/p/23	12.30
Document	endorsed	Nee	C. Nalen		14 3/12/83	13:00

	NURSES PROGRESS NOTES				
Date & Time	Observations / Action		Signat	ure with En	np. No.
3/12/230	Morning duty Notes			J	
<u> 7·30</u>	=) patient faker over from	~~	3	) 59)	
	-> parier us chock	e P			l
	=> perfiert had of				
10,00	-) patient muts er.	5.	Í	2537	
	=25/18 marteri	-	•		
(2-3-3-	2) Pt Handlo one to Every Dry	J Sh	, . J		
		-	_		
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;	Signature Name E	mp. No.		Date	Time
Document endorsed by	Noo l- Walini			3[12[23	13: 6





13/Malc/MHJ202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date:	11212	۲,	Shift: Morr	ning Devening D	Night			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: SOU P PEWS Score day: — Il line day: I be: $\Box$	e: ¯ Right: Le Yes □No Da Yes □No Da		GCS:\Sir POD: — Central line VIP Score: o specify organi	days: —	•	
В	On room	urgery: — if any: عر air / oxyger	n: On Recomptoms in last s	om wy	Date of surg			
Α	Others: Pain Sco Fall Risk Braden S Pressure	re:	mHg)   SpO₂:94 Pain Scale used Fall Risk Pr nimal Risk: 23-19 [	/ HR:	cms)   Weight: CC / Wong-Ba um	: ﮐﮑﯿﮐާﮐާﮔެ (kgs)   BMI: ker FACES Pain Rat isk: 14-13 □ High Risk	14, 9 kg/, ing Scale (NR x: 12-10 Sever	CPOT
R	Pending Pending Pending Critical va Changes Pending	medication medication lab reports alue alert ar	s: indent: / Investigations: nd its corrections care plan: \( \text{Yes} \)	No. If Yes, modified	care plan date	Đ:	·	
		Signatur		Name		Emp. No.	Date	Time
Handover g	-	Œ	<b>7</b> 2'	A-mon	PSterr	0[4]	3/12/21	19230
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NURSES PROGRESS NOTES						
Date & Time	Observations / Action		Signat	ure with E	mp. No.	
	ovening duty vote	9			_	
3/12/23	<u> </u>			- <u>-</u>		
	pt got papithed .	•	~~			
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12120	from morning chify stuff			<u>~</u>		
	pt a stable &					
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	& Record	_				
(H)D)	pt head tood		$\Box$	PV .		
	APE GOOD MOBILIZEDE EN	Ø .		<b>一</b> ————		
	ha complaints					
12-00	STOMOSSOW AVR Plan.					
	->NPO from DHV. Dropano	etion				
	done			· 		
16.00	sconsont takon, spiro					
	explain.				_	
17.00			RAF.	)		
18.30	= was chooked & rocard	109	- Oh	1		
	- x 10 Chart Monitoroop		(¢0	& ———		
19.30	aget hand over given t	_ھ_		_		
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endorsed by	C. Nalini	000/0	7		<i>~</i>	





### Master.SIVAGURU.S 13/Male/MH1202381075 02/12/2023/IPH202302423 Dr.RAJESH.V



PATIENT CLINICAL HANDOVER RECORD FOR NURSES										
Date: B (2) 23 Shift: Morning Evening Night										
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: RHD, AR PEWS Score: O day: al line day: Right: — Lef be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	t: —' VIP Score	e days:	· · · · · · · · · · · · · · · · · · ·					
В	Allergies On room	ROUND urgery: — if any: つとりみ air / oxygen: かん どわか nts / New Symptoms in last s								
A	BP: \(\)(\)(\) Others: Pain Sco Fall Risk Braden S	ns: Temp: 97-80°F)   Pulse    1-   1-   1-   1-   1-   1-   1-   1	•	ht: <u>옷옵러</u> (kgs)   BMI:_ Baker FACES Pain Ratir	12-10 Sever	S / CPOT				
R	Referral of Pending Pending Pending Critical via Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: ☐ Yes follow-up orders:	No. If Yes, modified care plan de Pour Reservation		n prive	2.				
		Signature	Name	Emp. No.	Date	Time				
Handover	given by	Hay	Hannah Grave	0105	4/12/23	J.'30				
Handover t	aken by		p-nonshe.	oth	1/0/03	7-130				
Document	endorsed	1000	Q. Nalini	008 4	4 12123	250				

	NU	IRSES PROGRESS NOTES			•/,
Date & Time	(	Observations / Action		Signature with Er	np. No.
3/12/23	Night	oluty notes			
	· · · · · · · · · · · · · · · · · · ·	V			
19:30	Patient chance	ling over taken to	som		
	Evening du	y staff in a		Hey.	
	hempdynami	ling over taken for by staff in a cally stable Conc	lition	0195	
20:00		checked & Record		Hayous	
24.00	Que dougs	ase allen as D	0 94	llay	
	deug chart	are given as p		Hay.	
	patient 31	eeping well, ha	d	- Play	
	no Complain	eeping Well, Ina		Play	
1:00	patient 10	as Sleeping		flav_	
<del></del>	V	. 0		flay olos	
6500	Patient Vita	D Signs Checked 2	2		_
	Remoded			Hay	
	Ilo chart	Maintained		060	
<b>#</b> :30	SlB Dr. Anba	Lary Tatormed			<u> </u>
	Sugery pos	tponed		Elos	— <del>-</del>
R:30	patient ha	ending over give	<u></u>	-	
	to Mooning	duty Stay	€	Hafour	
	:				
D	Signature	Name	Emp. No.		Time
Document endorsed by	Nes	e-Nalèni	00 & L	4 4(121833	9:00





13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





	PAHE	NI CLINICAL F	IANDOVEN NECO	ND FOR NOR	1929				
ر :Date	1/10/12	Shift: Morr	ning Devening Night	133333333333 <u>-</u>					
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	SELVENT Score:  day:  day:  line day: Right:  Lef  be:  Yes  No  Day  atheter:  Yes  No  Day	t: — v: VIP Sco.	ne days:					
В	On room		かいない IV fluids (	surgery:  on flow:					
A	ASSESSMENT  Vital Signs: Temp: 49 6°F)   Pulse / HR: 88 (beats/min)   Respiration: (breaths/min)  BP: 00 80 (mmHg)   SpO <sub>2</sub> : 90 (%)   Height: 151 (cms)   Weight: 33-7 (kgs)   BMI: 14-7 (kg) m <sup>2</sup> Others: Pain Score: 2Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale NRS CPOT Fall Risk Score: Risk Protocol: 0w 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 No NA Wound Dressing done: Yes No NA Current diet: No Year Area Core								
R	Referral of Pending Pending Pending Critical va Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan	date:					
		Signature	Name	Emp. No.	Date	Time			
Handover		W/Y	A-montshe.	0(41	1/12/22	(9/3)			
Handover	aken by	Hery	Hannah Cisace	plos	4/12/23	19130			
Document	endorsed	Nice	Q. Nalini	200 H	4/12/23	20-60			

NURSES PROGRESS NOTES							
Date & Time	C	Observations / Action	Signa	ature with Emp. No.			
A11.2123	due	of duty note					
#25P	from Nigh	t duty vote		/dhl			
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	10 Pful	conscious.		SW SW			
B > 70		ed tood					
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	Signature	Name	Emp. No.	Date Time			
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13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date: 4 12	4.23	Shift: Morn	ing Evening A	light 				
S	NEWS / P Ventilator Periphera Ryle's Tul Urinary C	s: PHD, SEVAR PEWS Score: © day: Il line day: Right: Left be: Yes No Day atheter: Yes No Day		GCS: \S\[1] POD: \Central line of \VIP Score: \textit{\alpha} pecify organis	lays: —		,	
В	Allergies On room	urgery: — if any: NKDA air / oxygen: on ४००៣ (		Date of surge				
A	ASSESSMENT   Vital Signs: Temp: 978 (%)   Pulse / HR: 90							
		Signature	Name		Emp. No.	Date	Time	
Handover g	iven by	Hay	Hannah G	race	olor	5/12/23	7:30	
Handover ta	aken by	(A)	A- mond	hai	olr	Sloos	420	
Document endorsed			e. Nalini		0084	5/2123	8,00	

	NU	JRSES PROGRESS NOTES		-	<u> </u>
Date & Time	,	Observations / Action	Sig	nature with E	np. No.
14/12/23	Nig	ht duty notes			
19:30	patient hand Joon Evening	ling over taken cluty State Condition	n a	they otes	
00:0¢	Vital Signs C	hecked & Reloade		Hay	
2(:00	Due deuge chal	tel geven as per	Λ.	Hay	
	patient was	Steeping well	:		
2:00	Patiend Sleep Complaints	ping well, had	no	Houter	
6700	Patient Vital Recorded Ilo Chaet	Signs Checked Mointained	k	Hayolos	
7,00	patient han	ding over given .	10	Hoy	
Document endorsed by	Signature	8-Nalini	Emp. No. ඉල දි <sup>\</sup>	1 5/12/28	Time



11 . .



# Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date: 5	112-12	-> Shift: □Morr	ning Evening []	Night					
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: 8tes ( A1) PEWS Score: r day: al line day: Right: Lef be: Yes No Day Catheter: Yes No Day	<i>t</i> :	GCS: [p]() POD: Central line VIP Score: specify organi	days:	·			
В	On room		n eiv	Date of surg					
A	ASSESSMENT  Vital Signs: Temp: 90 'G°F'   Pulse / HR: (beats/min)   Respiration: (breaths/min)  BP: 100 (0-0) (mmHg)   SpO <sub>2</sub> : 96 (%)   Height: 61 (cms)   Weight: 33 'F(kgs)   BMI: (F-F)   Fall Risk Score: 9-0 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale (NRS / CPOT Fall Risk Score: A Fall Risk Protocol: 1.0w 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: No S A Lect Drains: No NA Drains: NA								
R	Pending Pending Pending Critical va Changes Pending	MENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections; in nursing care plan:  follow-up orders: nstructions if any:	·	care plan date	e:	_	,		
Handover g	iven by	Signature	Name		Emp. No.	Date	Time		
Handover g Handover ta		10 -	H. mon	) fes	eth!	5/10/23	رحد ک		
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	NU	JRSES PROGRESS NOTES	•	```
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(B)	pt had	food medical	<del>*'0</del> 1)	
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(B)	offic	ry chadrod		
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ا مهام	dight el	up Staff		· 
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<u>.</u>		T.:	<u> </u>	
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13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date:	12/12	Shift: Morr	ning Evening N	light			
S	Ventilator Periphera Ryle's Tul Urinary C	S: LAB	t: /:	GCS: LS L POD: Central line of VIP Score: pecify organis	days:		
В	_Oproom		hift:	Date of surg		·	
A	Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: \\ \frac{\frac{1}{2}}{2}  \( \cap \) \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	P_(%)   Height: L\$\frac{1}{2} (c)  I: PIPPS / CRIES / FLAC  otocol: \bigcup Low \bigcup Medit.  At Risk-Mild Risk: 18-15	ms)   Weight: C / Wong-Bak Im ∐High ⊒ Moderate Ris	(kgs)   BN ker FACES Pain F sk: 14-13 ☐ High F Dressing done: ☐	Al: LGG LG Rating Scale / NRS	
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:	1	care plan date	»:		
		Signature	Name	-	Emp. No.	Date	Time
Handover g		le .	Moula	<del></del>	Ditte-	6/12/23	7200
Handover to	aken by		Paulher		0072	6/12-123	7.30
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NURSES PROGRESS NOTES						
Date & Time		Observations / Action		Signa	ture with Er	np. No.
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	parmy	confortable	1 20	0		
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6,00	Patient vi	tal Signs check	2000	<del>  -</del> -	11	_
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### Master, SIVAGURU.S 13/Malc/MHI202381075 02/12/2023/iPH202302423





Date: 6	12/23	Shift: Morr	ning Evening Night						
S	Ventilator Periphera Ryle's Tul Urinary C	S: RHD   Severe   A a   PEWS Score: 0 day: al line day: Right: Lef be: Yes   No Day tatheter: Yes   No Day	POI Cen t:- v: VIP	tral line days: Score:					
В	On room		cs i IV flu	e of surgery: uids on flow:					
A	ASSESSMENT  Vital Signs: Temp: 10   Pulse / HR:								
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 o	iven by	Pofr	Paintlea	00 to	6/12/23	13-0-			
Handover t	aken by	idi	A). Anotha	0121	6/12/23	18100			
Document	endorsed	Need	s-Nalini	0024	412/23	1320			

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
6/12/23	Morning Duty Notes	
7-30		
	- Patreit takes over from night  - July Stoffer  - While take over patient is  Langely namically stable  - Today plan AUR	Ref n
	- NPO from 12 MB - 20 PW respection done - Posts preparation done	
8.30	- Protient S/R Dre Ahbreraen 918  ceso for AUR today cancelled  - Case reservabled to tomorrou	psln
9.00	- orals started	Park 2
10.00	- vital signs clerked & secondard	pod n
مدرا	- fatial harded over to evering duty Stoff	pyln
	,	
	Signature Name Emp.'No	Date Time
Document endorsed by		224 6/12/23 1329





#### Master.SIVAGURU.S 13/Male/MHi202381075 02/12/2023/IPH202302423





Date: [	0/12/2	Shift: Morr	ing Evening Night			٠		
S	NEWS / F Ventilator Periphera Ryle's Tul	il line day: Right: Left be: ☐ Yes ☐ No Day átheter: ☐ Yes ☐ No Day	POD:, Central  Central  VIP Sco	line days:	- ·			
В	On room		기 . IV fluids	surgery: —	, ,			
Α	ASSESSMENT  Vital Signs: Temp: 98-6°F)   Pulse / HR: 64 m(beats/min)   Respiration: 20 (breaths/min)  BP: 10 10 (mmHg)   SpO <sub>2</sub> : 9 (%)   Height: 157 (cms)   Weight: 23:3 (kgs)   BMI: 14-9 kg/m²  Others:  Pain Score: Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  Fall Risk Score: Fall Risk Protocol: Ow 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: Orains:							
R	Referral of Pending Pending Pending Critical va Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	NI)	date:				
Liandara:	duon his	Signature	Name	Emp. No.	Date	Time		
Handover t		Ør`	A. Smitha	0222	6/12/23	10-00		
Handover t	<del></del>	ne 100	Nalini	2268	6/2/23	G-30		
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	NURSES PROGRESS NOTES	· · ·
Date & Time	Observations / Action	Signature with Emp. No.
	Evening duty notes	
6 (2/23	spot hand over taken down	A)
14.00	7 pt Conscious and priented	Ai,
	drug chart	OIL OIL
16.00	> pt seft voided  > pt groomed well  > To chart monitoring	
18.00	=> pt vital signs charled	
1000	Pt hand over given to night duty staffs	OT L
_		
Document endorsed by	Signature Name Emp. No.	

	SET	Master.SIV	AGURU.S	MHI/NUR/2022/048
un. Vulti Emp. 40.		N 13/Male/MH		Medway:
augus (	(a)	02/12/2023/		Heart
Medway Hosi		Dr.RAJESH.V		Institute
(A Unit of United Alliance Healthcan		C THE THE STATE OF	<u> </u>	Every heart beat counts
PATIEN	IT CLINICAL	HANDOVER REC	ORD FOR I	NURSES
Date: 4 12/23	Shift:Mor	ningEveningNight	-	1
			<del>-</del>	
		GCS:	15/15	
NEWS-/-PE	WS Score: O		·	
Ventilator da	- (	ft:	al line days:	
Ryle's Tube	: │ Yes ☑ No Da	y: VIP S	core: -	
	heter: ☐ Yes ☑ No ─ Da ing ☐ Yes ☑No MI	y:OR:	organism:	
BACKGRO Type of surg		Dete :	of surgery =	
	any: NKDA		of surgery:	
On room air	r/oxygen: on yeom	وريم IV fluid	ds on flow: _	
Complaints	/ New Symptoms in last	shift:		1
ASSESSM	IENT			
Vital Signs	: Temp: <u>94/8(</u> °F)   Pulse	e / HR: 88 (beats/min)	Respiration: 20	_(breaths/min)
BP: 10/-	<u> -o</u> (mmHg)   SpO <sub>2</sub> :_€	18 (%)   Height:   5   (cms)   V	Veight: <u>多才</u> (kgs)	BMI: 12 9/9/m2
				J.
Pain Score	: 🍎 🔯 Pain Scale use	d: PIPPS / CRIES / FLACC / Wo	ng-Baker FACES Pai	in Rating Scale / NRS / CPOT
Fail Risk S	core: <i>15</i> Fall Risk P	r <b>otocol: ☑Lo</b> w☐Medium ☐H	ligh	
Braden Sco	ore Minimal Risk: 23-79	At Risk-Mild Risk: 18-15 Mod	erate Risk: 14-13 Hig	jh Risk: 12-10 Severe Risk: 9-6
Pressure U	lcer Scale for-Healing-(PL	JSH)÷⊟Yes⊟No⊡∕NAW	ound Dressing done	: Yes No No NA
Current die	t:		Drains: -	
RECOMM	IENDATION			
Referral-do	ctors:	·		
Pending me	edications:		•	
Pending me	edication indent:	Nº1		
Pending lat	o reports / Investigations:			
Critical valu	e alert and its correction	s: /	<del></del>	
	nursing care plan: Yes	No. If Yes, modified care pl	an date:	
Pending for	low-up orders:		- 0	
Special inst	tructions if any: $P(a)$	in AVR tomos	ow, Npo	Jsom 12 mu
	Signature	Name	Emp. No.	Date Time
Handover-given-by-		Harriah Ciraci	2 0165	+112 7:30
Handover taken by	Posh	Pavisha	00%	= 7/12/2010 Files
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	NU	JRSES PROGRESS NOTES			
Date & Time		Observations / Action	Sig	nature with En	np. No.
6/12/23	Night	duty Notes			
	0-	<del></del>			
19:30	patient hand	ing over taken In	m		
	Evening duty	Stay in a		Hay_	
	hemodynamical	ing over taken Iso Staff in a ly Stable Condition	Hion	dus	
\$0:00	Vital Signs C	hecked & Recorded	<i>y</i>	Hayous	
21:00	Due deugs deug chaet	ael given as p	Pear	Hay	
22:00		de & Conscious		Hay 0105	
2200	Patient wa Complaints	s Sleeping had	ИØ		
6:00	Patient Vita Recorded Ilo Chart	l Signs Checked! Maintained	2	flay	
7:00	patient hand	ing over given to	0	Hay	,.l
	·				
	Signature	Name	Emp. No.	Date	Time
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				THE	RESS W	Master.SIVAG		- 	t tures no conserva-		/2022/048
r Emp. 40.	s( <b>V</b> ).s	होंट	company at the property of the con-		Acric .	13/Malc/MHI20			hyanaman		eart
Medw				N Z	A B H	Dr.RAJESH.V	1202302-	723		• •	stitute'
	<b>ry to better</b> nited Alliance Healt				CAEDITED.				Ever	y heart b	eat counts
	PATIE	NT	CLINI	CAL H	IANDO	 VER REC	ORI	D FOR	NUR	SES	
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_Date:	12/23		Snift:		iing_[jEve	ning. Night_				<del>-  </del>	
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	Barrier nu	ırsing	☐ Yes ☐	MO MD	R: Yes I	lo. If Yes, specify	organis	sm: 			·
·—·-	BACKG								,	<u> </u>	
	Type of so Allergies					Date o	of surg	ery:		-,	
D	On room	air / o	xygen: 27)			IV fluid	ds on fl	ow:		south contribut	
	Complair	its / N	ew Sympton	ns in last sl	hift: NI					. see the second	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ASSESS	MEN	IT			,			<del></del>		
	Vital Sign	ns: Te	mp:(°	F)   Pulse	/ HR:	(beats/min)   i	Respira	ation:	(breath	ns/min)	
	-BP:		(mmHg)"	SpO <sub>2</sub> :	(%)   Heig	nt: <u>[5] (cms)</u> [V	Veight:	33- <i>3</i> -(kgs)	вмі: <u>_/</u> ,	4.9	9/m2
	Others-∺		4					<del></del>			
			1			IES / FLACC / Wo ow ☐ Medium ☐ H		ker FACES Pa	ain Rating	g Scale / N	IRS / CPOT
A			i 7			Risk: 18-15 Mode		sk: 14-13 H	igh Risk: 1	2-10∐Se	vere Risk: 9-6
						 ]ng⊒naw					
<del></del>	Current c	liet:	NPO	·-····································			Drain	s:			
	PECON	BEEN!	DATION	<del></del>		· <del>* ****</del>					
	Referral-c				<u> </u>						
	Pending				<u>l:</u>						
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D	Pending	lab re	ports / Inves	tigations:							
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	_	i		an:⊟Yes	☑No-If-Yes	-modified-care-pla	an-date	):			<u> </u>
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7/12/23	Moe	ning Duty Notes							
7.30	<u> </u>								
	- Patient take  - Auty staff  - while take  - tonodynamics  - takey plan for  NPO Jeon  - consent signed	over patient is Ly Stable De AVR	ight	Port 12					
8-30	Adviced to Sh	Dr. Rajesh six & to	am	Pell 2					
9.40	- Patient Shifted - All eccords &	seports handed oc	ee to	pyln					
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	N	JRSES PROGRESS NOTES		_		······································
Date & Time	(	Observations / Action		Signa	iture with E	mp No.
	CTOT R	ECEIVAL REPORT				
		To CTOT With Blue Op File A	And Case			~~ <u>~</u>
	Sheet ECG: \ ECHO:	X-RAY: ANGIO CD	): with			
	CT FILE:	Atte	nder			
7/12/23		ire: AVR (open heart)			<del></del>	<del></del>
@ 9-30				·	3 luf	
	Under Anesthesia: Job	A	:		280	
	Allergy Status: Not 1	cnown				<del></del> _
<del></del>	Known Case Of: —					
	Past Surgical History:	-				
	VITAL SIGN: TEMP: つき	F HR: 726/m SPO2: 997. BP 110	Hommhey			
	CTOT S			-		
	Patient Shifted From CT Case Sheet Along With					
	*Surgery Safety Check Lis *Intra Operative Record					
	*Nurses' Record * Implantation R	X-RAY:   ANGIO CD				
	ECG: \ ECHO:	- - -				
	CT FILE: -		<u></u>			
7/12/23	Patient Posted And Underv Under Anesthesia: Jr U Procedure: AVR (OPEN	went For Procedure: AVR COPE	en heaut)	·. (	2 PX ge	) <u>·</u>
@ 13.40		,				
	Drain tube size and placem	ient: 24 FY - Right modias	tinum			
	Pacing wire placement: Pro	esent/Absent Site:				
	Implants: 2 John Spec	b C				
		towel clip mark: Present/Absent				
	Site: VITAL SIGN:	and and and				
	TEMP: 975 HR: 10051m S	SP02: 991. BP: 90/sommhy				
	Notes:	e master sierce impla	1			
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13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





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	PATIE	MT CLINICAL F	IANDOVER RECO	RD FOR NU	KSES '
Date: 0구	12/23	Shift: Morr	ning Evening Night		
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		ROUND	Date of au		•
R	• •	urgery: AVP if any: N DA	Date of Su	irgery: 07 12 03	•
ב	On room	air / oxygèn: (2) V FIVI nts / New Symptoms in last s	IV fluids or	n flow: CABILYTE	
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	BP: 106	<del>ੀo (හි)</del> (mmHg)   SpO₂: <b>t</b> 0	<b>6/</b> (%)   Height: <u>  5                                   </u>	ht: <u> 33 (</u> kgs)   BMI <u>:</u>	14.5gm2
		Cup - 7 mm+19,			. 9
<b>A</b>			I: PIPPS / CRIES / FLACC / Wong-E		ing Scale / NRS / CPO
Δ			otocol: Low Medium High		,
		Score: Minimal Risk: 23-19 L Ulcer Scale for Healing (PU	At Risk-Mild Risk: 18-15 Moderate	Risk: 14-13 ∐High Risk d Dressing done: ∐Ye	
	Current		. 4.	ains:	· · ·
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ı	RECOM	IMENDATION			
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	_	medication indent:	JDR-RAJRSh	WC+1	
R	_	lab reports / Investigations: alue alert and its corrections		1 1	*
			☐No. If Yes, modified care plan d	ate:	
	_	follow-up orders:			
	_	nstructions if any:			
	••	•			
		Signature	Name	Emp. No.	Date Time
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES										
Date:	2/23.	Shift: Morr	ning Evening	Night						
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: PHD, SEV AR.  PEWS Score: day: day: Il line day: Right: WBJALef be: Tyes Who Day atheter: Wes No Day		GCS: 15 15 POD: DoS Central line of VIP Score: of specify organis	olays:D <sub>1</sub>	t				
В	Allergies i On room	ROUND urgery: AUR if any: NKDA- air / oxygen: On Naid Co ats / New Symptoms in last s			Pry: 귀비23 DW: KABIUTE					
A	ASSESSMENT   Vital Signs: Temp: 97 (°F)   Pulse / HR:   Alpha (beats/min)   Respiration:   Asha (breaths/min)   BP:   Alpha (mmHg)   SpO <sub>2</sub> :   Ob (%)   Height:   51 (cms)   Weight:   33 (kgs)   BMI:									
R	Pending Pendin	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:	,	care plan date	:_ Ni)					
		Signature	Name		Emp. No.	Date	Time			
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19.30		
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<u> 7.30</u>	Patrick details handed out to the	-
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Patip Master.SIVAGURU.S Nam 13/Male/MHI202381075

13/Male/MHI202381075 02/12/2023/IPH202302423

DOB. Dr.RAJESH.V DOA





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	PATIE	NT CLINICAL H	IANDOVER RE	CORD FOR NUF	RSES					
Date: 8	12/23	Shift: Morn	ing Evening Night	t						
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary Ca	:: (C. ND) . SEVENE HK. EWS Score: © day: — I line day: Right: CUR (TPL De: ☐ Yes ☐ No Day athete(: ☐ Yes ☐ No Day	: D2	S:  S    S    S    S    S    S    S						
В	Allergies i On room	ROUND  urgery: AVR  fany: NKDA  air / oxygen: ON ROOM  ts / New Symptoms in last sh	તીંપું . IV fl	e of surgery: 7 12 23	· · · · · · · · · · · · · · · · · · ·					
A	ASSESSMENT   Vital Signs: Temp:   O (°F)   Pulse / HR: 130 (beats/min)   Respiration: 28 m (breaths/min)									
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					
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8.00	> patient had	l liquid diet							
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Dr.RAJESH.V





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Date: 🛭	· 1४· १ ङ	Shift: Morn	ing Evening 1	Night						
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: RHD - SEV AR PEWS Score: day: CUDITA- L Il line day: Right: Left be: Yes No Day atheter: Yes No Day	:	GCS: ( \$\frac{1}{2}\) POD: \( \sum_{contral line of the contral line line of the contral line line of the contral line line line line line line line lin	alays: 2					
В	Allergies On room	ROUND urgery: AVA if any: 从oT はんいいよ air / oxygen: its / New Symptoms in last si	hift:	Date of surge	ery: 07°/2°2 ow: -	<u>.</u> <u>B</u>				
A	ASSESSMENT  Vital Signs: Temp: 97 (°F)   Pulse / HR: 102 (beats/min)   Respiration: 14 (breaths/min)  BP: 90 99 (mmHg)   SpO <sub>2</sub> : 91 %)   Height: 107 (cms)   Weight: 33 (kgs)   BMI: 14.5 - 109 / m <sup>2</sup> Others:  Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  Fall Risk Score: 35 Fall Risk Protocol:   Low   Medium   High  Braden Score:   Minimal Risk: 23-19   At Risk-Mild Risk: 18-15   Moderate Risk: 14-13   High Risk: 12-10   Severe Risk: 9-6  Pressure Ulcer Scale for Healing (PUSH):   Yes   No   NA   Wound Dressing done:   Yes   No   NA   Current diet:   Liquid Well   Well   Orains:									
R	Referral of Pending Pending Pending Critical vo Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yese follow-up orders: nstructions if any:		care plan date	÷					
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Dr.RAJESH.V





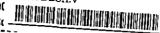
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Date: 8	112/20	23 Shift: Morn	A ening Evening	₩ght				
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В	Allergies i	ROUND urgery: AVR fany: AI KDA ・ air / oxygen:のか 足u ts / New Symptoms in last sl	hift:	Date of surg	-			
A	ASSESSMENT  Vital Signs: Temp: 974F)   Pulse / HR:   24							
R	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: Reforts to called.							
		Signature	Name		Emp. No.	Date	Time	
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Date: 00	llizlas	Shift: Morn	ing Evening Night			
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В	Allergies On room	urgery: 40/2	ルカイン	ery: 07/12/03 ow: _		
A	Others: Pain Sco Fall Risk Braden S	re: BS A Moreover Fall Risk Processore: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	HR: No Mit(beats/min)   Respira  (HR: No Mit(beats/min)   Respira  (A) Height: (P) (cms)   Weight:  (PIPPS / CRIES / FLACC / Wong-Bak  (Nocol: Dow Medium High  (A) Arrisk-Mild Risk: 18-15   Moderate Ris  (SH): Yes No No No Drain	_33_(kgs)   BMI:_) ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	y - C Pg [m g Scale AR	
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date			
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Dr.RAJESH.V





Date: _	7/12/	Shift: ☐ Morr	ning □ Evening □ N	ight			
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: KI-JO & EV PEWS Score: day: day: Fight U Diff Let be: Yes No Day satheter: Yes No Day	t: 1200,	GCS: S k POD: DO S Central line of VIP Score: C Decify organis	15		
В	Allergies On room	ROUND urgery: F) V R. if any: NKIOF) air / oxygen: O N POOT nts / New Symptoms in last s	n. Air	Date of surg	ery: 1 /12/23 ow: _		
A	BP: Q Others: Pain Sco Fall Risk Braden S Pressure Current o	ns: Temp?   \( \frac{1}{2} \cdot \text{(PF)} \)   Pulse  \( \frac{1}{2} \cdot \text{(mmHg)} \)   SpO_2: \( \frac{1}{2} \)  \( \frac{1}{2} \cdot \text{Pain Scale used} \)  \( \frac{1}{2} \cdot \text{Score: } \frac{1}{2} \cdot \text{Fall Risk Proscore: } \text{DMinimal Risk: 23-19} \)  Ulcer Scale for Healing (PU	Height: /S / (cr : PIPPS / CRIES / FLACO otocol: Low Mediu At Risk-Mild, Risk: 18-15	ms)   Weight: C / Wong-Bak m	<u>32</u> (kgs)   BMI:_ ser FACES Pain Ratin	ILI.SIC.9 ng Scale / NAR 12-10⊡Sever	e Risk: 9-6
R	Pending Pending Critical va Changes Pending	doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:	.		- Tomorro	w.	
Unuder	-1 t	Signature	Name		Emp. No.	Date	Time
Handover o	-	<u> </u>	A. Nandhi'	<del>}                                    </del>	0170	9/12/23	19:30
Handover t		Hong	, ne	vale	0105	9/12/23	Q:191
Document	endorsed	Nee	Natiri		mod4)	9/12/23	(0.00

	NURSES PROGRESS NOTES			
Date & Time	Observations / Action		Signature with I	Emp.`No.
13.00	Evening duty Motes  - patient taken over from  Morning duty 8 talif			
	Nurse => patient conscious Exorter -> patient vital Digns Chelod & Priorded	_		
16.00	per drug Chart per drug Chart Le plebilitation Juin Le patient Mobilited world			
18.30	s The Charf Monifored special vital Digns Checked & Recorded special handing over Night duty Steep		A.	
	Murse.			
Document	Signature Name	Emp. No.	.1.1	Time
endorsed by	Nalini Nalini	002A	9/12/23	10,00







13/Male/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V





Date: 역 (12)	38:-	Shift: Morn	ing Evening Night:		,	
S	Ventilator Periphera Ryle's Tul Urinary C	S: RHD; SEV HX PEWS Score: 0 day: Il line day: Right: D3 Left be:	POD: Centr :: : VIP S	al line days: —	. ,	
B	Type of s Allergies On room	ROUND urgery: AVR if any: NKA air / oxygen: のれ かしのか ats / New Symptoms in last s	) air IV fluid	of surgery: Hizlzs	*	-
,	ASSESS	SMENT	,	,		
	Vital Sig	ns: Temp:	/ HR:(beats/min)	Respiration: 20 (breat	hs/min)	
E	BP: <u></u>  @0 Others :_ Pain Sco	To (mmHg)   SpO <sub>2</sub> : 9?	<u>∤ (</u> %)   Height: <u>  √  </u> (cms)   V  : PIPPS / CRIES / FLACC / Wo	Veight: <u>33</u> (kgs)   BMI: /	4.5Kg/1	<u> </u>
			otocol: □Low☑Medium □H	,		
	Pressure	Score: Minimal Risk: 23-19 [ Ulcer Scale for Healing (PUS liet: Autrom-diet	•	erate Risk: 14-13  High Risk: lound Dressing done: Yes Drains: —	*	e Risk: 9-6
	RECOM	IMENDATION	<u>-</u> .		-	
	Referral d Pendina	doctors: medications:	$\mathcal{I}_{\mathcal{A}}$	' ,		
	_	medication indent:	/ ลไ	. :		
	•	lab reports / Investigations:	[NP]			
H	Critical va	alue alert and its corrections:		·		
	Changes	in nursing care plan: ☐ Yes•	No. If Yes, modified care place	an date:		
1	Pending	follow-up orders:				
	Special in	nstructions if any: To	do PTINR to	mossow		
		Signature	Name	Emp. No.	Date	Time
Handover giv	en by	Hay	Hannah Grave	0105	10/12/22	4:30
Handover tak	en by	5. <b>D</b> i	S. Doun-thanh.	n 02/2	10/12/22	7,30
Document en	dórsed	106	k m O in	0024	10/10/92	/n .nn

	NU	IRSES PROGRESS NOTES		
Date & Time		Observations / Action	s	ignature with Emp. No.
9/12/23	· · · · · · · · · · · · · · · · · · ·	t duty start notes		
19:30	patient han from Eveni in a hem condition	iding over takes ing duty stay; odynamically st	able	Hay .
20,00	Vital Signs	Checked & Rec	rided	Hay
21:00	Due deugs de Chaet	e given as per a	desig	Hay-
22:00	Nebulization	was given		Hujoros
2:00	Patient is had no	Steeping well Complaints		Hoyor
5.30	Debulization	on was given		Hout
6:00	Recorded	al Signs checke Maintained	de	Hayolor
#wo	patient he to Mosning	ending over gr duty Staff	ren	Hey.
	. : .,			
	Signature	Name	Emp. No.	Date Time
Document endorsed by	No	Nalin	0000	6 23 10.00







13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date: (o	12/2	3 Shift: ☐ Morn	ing Evening Nigh	t		
S	Ventilator Periphera Ryle's Tut Urinary C	S: P40. Sev 170 PEWS Score! O day: I line day: Right: Left De: Yes No Day atheter: Yes No Day	PC Ce: : ~ VIF	S: 15/15 D: 3 / L Pop Intral line days:  Score: 0  fy organism:		
В	Allergies i On room	ROUND urgery: AUL if any: 人にりみ air / oxygen: <i>PA</i> ts / New Symptoms in last sl	IV fi	re of surgery: ゴバュルュュ uids on flow:		
A	BP: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	re: (°F)   Pulse	(%)   Height: / (cms)  : PIPPS / CRIES / FLACC / Notocol:   Low   Medium  At Risk-Mild Risk: 18-15   M  SH):   Yes   No   NA	Respiration: 20 (bread)   Weight: 33 (kgs)   BMI:   Wong-Baker FACES Pain Rate   High   Description of the content of the c	ing Scale / NR:: 12-10 Sever	S / CPOT
R	Pending of Pending of Pending of Pending of Critical values of Pending of Pen	IMENDATION floctors: medications: medication indent: flab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:		plan date:		
	iven hv	Signature	Name	Emp. No.	Date	Time
Handover g		Los	far from	00न2	10/12/22	1300
Handover ta		<u> </u>	M. Levile		70/12/2	13~>
Document e	endorsed	<u> All</u>	<u>Malene</u>	0084	[d[b]38	14.00

NURSES PROGRESS NOTES					
Date & Time		Observations / Action		Signature with Emp. No.	
10/12/23	Moon	ing Duty Notes			
7.30				•	
	- Patient tay	kan over from	night	John	
	- while take	e ouer patient	e is		
	Lemochynani	Stable		<del></del>	
<del></del> <del></del>	- On C. MUTLON	2 mg			
8-30	م کے م	lications given as		Polin_	
9.00	- pt S/e	Dr peaceer Ste			
lo · so	- Nebel-zahi	on given		Offs	
ود، اا	- pt mobiliz	red well			
13.00	- patient has	led over to	rulaing	Patler	
	and only	-			
_					
	Signature	Name	Emp. No.	Date Time	
Document endorsed by	Nec.	Naline	0024	10/12/28 10.00	







## Master, SIVAGURU, S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date:(0)(2)	n>	Shift: ☐ Morr	ning Evening N	Night -			
S	Ventilator Periphera Ryle's Tul Urinary C	s: PHO > SOUTH AND DAY  BEWS Score: O  day: —  If line day: Right: ✓ Lef  be: ☐ Yes ☐ No Day  atheter: ☐ Yes ☐ No Day	<b>/</b> :	GCS: IS (4) POD: \(\bar{1}\) Central line d VIP Score: \(\begin{array}{c} Specify organisis	2		
В	Allergies i	ROUND urgery: AVԲ- if any: ハやか <sup>か</sup> air / oxygen: のりで <sup>DOM</sup> ats / New Symptoms in last s	hift: んうし	Date of surge	ery: 4/12/20 DW:		
A	BP: 92 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u> </u>	.(%)   Height: 15 (c 	cms)   Weight:_ CC / Wong-Bake um	<u> 33</u> (kgs)   BMI:_ er FACES Pain Rati k: 14-13 □ High Risk	<i>  H · 5                                 </i>	<del>S</del> -/ CPOT
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: instructions if any:	$\mathcal{U}_{-}$	care plan date:		_	
	bran br	Signature	Name		Emp. No.	Date	Time
Handover gi Handover ta		<del>du</del>	Il Dais Jan	<del></del>	0182	10/12/12	19.0
Document e	- 432	100	A ALBIN	10 K	<u>00 fr</u>	10/2/23	19100
Pocalitient 6	11401264	N.QQ_	i . Paula	t l	00 <i>2</i> 4	10/12/83	16.00

NURSES PROGRESS NOTES								
Date & Time	Observations / Action	Signature with Emp. No.						
10/10/2>	Evening elicly Notes							
@	J - J							
18.00	-> patient hand over taken from							
	Morning cluty Stuff	25.0						
12-30	-> pertions Normal Dick & pt stoble	<del> </del>						
	Exiful signly Chedrol.	- Sov						
14-0	-> prefignt Medicitées gruen as pros	<del> </del>						
	divide cheekeel rounds	_						
lb.60	> patient rubitisection given.							
	-> patient ventell vomite 2 sporling	0 /						
	given to T. Emector done.	25/						
	James Grand							
18-40	-> patient 10 vitel siges challes							
1830	>parient to and rewel.							
	->prefiont heund our gruen	8						
_	->prefiont heined our gruen as right cluty stuff	di						
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		-						
		_						
er -	Signature Name Emp. N	lo. Date Time						
Document endorsed by	polisi oò	24 10/12/20 16.00						







13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date: [0]	12/2>	Shift: ☐ Morr	ning Evening Nigh	t	; ~			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: KHD S EUEVE * PEWS Score: O day: Il line day: Right: — Lef be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	PO Cer	S: 15/15 D: — Intral line days: Score: 2/5 fy organism:				
В	Allergies On room	ROUND  urgery: AUR  if any: MRDA  air / oxygen: ONRAP  its / New Symptoms in last s	MAIR IVII	e of surgery: フルスス	<b>}</b> .			
ASSESSMENT  Vital Signs: Temp: 98 (°F)   Pulse / HR: 60 (beats/min)   Respiration: 22 (breaths/min)  BP: 10 70 (mmHg)   SpO <sub>2</sub> : 97 (%)   Height: 5 (cms)   Weight: 85 (kgs)   BMI: 3 kg/m R  Others:								
R	Referral of Pending Pending Pending Critical value Changes	medications: — medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: nstructions if any:	୍ୟାରି If Yes, modified care		-			
Vandevar e	ivon by	Signature	Name	Emp. No.	Date	Time		
Handover g	<del>, ,</del>	97-	A. ALB WO	2 00 BK	14/12/23	700		
Handover to		RO	faulton.	<u>2072</u>	1/1/2/23	4-30		
	ciluui sed	NU	NUCLUM_	0021	11/11/2 <i>1</i> 93	10.00		

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
10/12/23	MIGHT DUTY NOTES	
[9.00	Patriet handover beken from the evening duty stage:	\$ 0080 10080
20.00	Du redications are guen to the patient	Sed 80
22.00	vilalsague are checked &	A 6607
6.00	No chart is rountained	84 00 8
700	patient handovis gwan to the morning duty: Stable	di
	-	
	.\ .\ .\ .\ .\ .\ .\ .\ .\ .\ .\ .\ .\ .	
Document endorsed by	Signature Name Emp. No	Date Time







Master.SIVAGUKU.S 13/Male/MHi202381073 02/12/2023/IPH202302-23

Dr.RAJESH.V





		NT CLINICAL H	IANDOVER F	RECORL	) FOR NUI	1SES		
Date:	1/12/2	Shift: Morn	ing Evening N	light				
S	Ventilator Periphera Ryle's Tul Urinary C	s: fdtf r Sower A3 PEWS Score: ∂ day: al line day: Right: Left be: ☐ Yes ☐ No Day datheter: ☐ Yes ☑ No Day	:	GCS: 15 POD: 内外 Central line o VIP Score: pecify organis	o			
B	On room	. la . a	nift: Ni)	Date of surge	ery: 7/12/23 ow: _			
A	ASSESSMENT  Vital Signs: Temp: 772°F)   Pulse / HR:							
R	Referral of Pending Pending Pending Critical va Changes Pending	imendations: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:	_ 🌽	care plan date	:	-		
		Signature	Name		Emp. No.	Date	Time	
Handover g		Post	Partha		Ook	11/12/2	#3~00	
Handover t	aken by	(1991	B. Vanis		0195	11/12/23	13:00	
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	NU	IRSES PROGRESS NOTES		
Date & Time	(	Observations / Action	Signa	ture with Emp. No.
11/12/23	Hon	ring Duty Notes		_
7.30				
	- Patiet du	ten one from nig	Lt Di	N72
	duty Stell			* * * *
	- while take	- 0 cer patiet i	۵	
	landy namicaly			
	- on P. Actua	on any		
8.00	- 1 Salue	general done		
	- word site	Loalthy	R	s/a
8,30	- parial of	Loalthy By An bacesu Sill		
9-00		cations given as	per	
	Last		Po	f/n
lo so	- Nebulyaction	done	Lon	sfon_
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13-00	- Partiet has	led one to en	entry of	offen
	chty Seff			
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		· 		D-4
Document	Signature	Name	Emp. No.	Date Time
endorsed by	Nee	palini.	0081	11/12/23 10.00







# Patient Dataile (Afficial Lands) Master.SIVAGURU.S

13/Malc/MH1202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





P	ATIE	NT CLINICAL F	IANDOVER REC	COR	FOR NUF	RSES			
Date:	<u>llas</u>	Shift: Morr	ning Devening Night			_			
S	/entilator Periphera Ryle's Tut Jrinary C	s: PHD : SEVER PEWS Score: day: Il line day: Right: Lef be: Yes No Day atheter: Yes No Day	t: — VIP S	Score:					
RA	Type of su Allergies i	ROUND  urgery: AYR  if any: AKDA  air okygen: ON POOM  its / New Symptoms in last s	•	of surge	ery:-flpb3 ow: -	·			
A F	ASSESSMENT  Vital Signs: Temp: 96 r°F)   Pulse / HR: Soble (beats/min)   Respiration: 20 hours/breaths/min)  BP: 86 65 (mmHg)   SpO <sub>2</sub> : 9 (%)   Height: 15 (cms)   Weight: 5 (kgs)   BMI: 24 19 (mmHg)   SpO <sub>2</sub> : 9 (%)   Height: 15 (cms)   Weight: 6 (kgs)   BMI: 24 19 (mmHg)   SpO <sub>2</sub> : 9 (kgs)   BMI: 24 19 (kgs)   BMI: 2								
RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes INO. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:  To do BC Oroa, Oreals No Fine									
Handover cive	on by	Signature	Name		Emp. No.	Date	Time		
Handover give		Au.	H. Manchini		0 H=	11/2/22	14:2		
Document end		NOR	ALBINUS AMALA	<del>}</del> ^/	00 SK	17/12/22 11/10/28	19:30		

NURSES PROGRESS NOTES								
Date & Time	Observations / Action	Signature with Emp. No.						
11 12 23	Evening duby lotes							
	= () = () =	<u> </u>						
123.	-> patient taken over from							
	Morning duty Staff							
	Nurso	-17						
	- putient conscious goriented							
	-s patient vital Signs							
	hellad & Revorded							
14100	- Meditation given as per							
	drug chart	,						
	= Tomorrow Plan Sutur							
	Comora!							
<u></u>	= 1/0 Chart Monifored							
	Spatient vital Bigns chelon	E						
}	Porordod	<del> </del>						
19:30	s patient handing over to							
 	Night duty 8taly							
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## Master.SIVAGURU.S 13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Date: 11	112/23	3 Shift: ☐ Morr	ning Evening L	Night .		` 	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: RHD SEVERC A PEWS Score: O day: — Il line day: Right: — Lef be:	t: —	GCS:13-14 POD: — Central line of VIP Score: (specify organis	lays: —	-	
В	Allergies On room	urgery: AVR if anv: AIK D ね	ッタ <i>月1年</i> hift: ー	Date of surge IV fluids on flo	ery: キリスクス - ow:		,
A	BP: <u>L20</u> Others : Pain Sco Fall Risk Braden S	ns: Temp: 47 (°F)   Pulse  //O (mmHg)   SpO <sub>2</sub> : 97  //O Pain Scale used  Score: 50 Fall Risk Pro  Score: Minimal Risk: 23-19 5  Ulcer Scale for Healing (PUS	: PIPPS / CRIES / FLAC otocol: Low Mediu At Risk-Mild Risk: 18-15 SH): Yes No	cms)   Weight: <u>.</u> CC / Wong-Bak um	용경 (kgs)   BMI: er FACES Pain Rat sk: 14-13 □ High Rist ressing done: □ Y	<b>2.4: 3 kg / r</b> ting Scale / NR k: 12-10∐Sever	S / CPOT
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: mstructions if any:		care plan date	:	_	
Handover g	iven by	Signature A.J.	Name A. ALBINI	ي د	Emp. No.	Date  २/ २/२९	Time チぬ
Handover to		Hay Nec	Hannah C	isase	0034	11/	F:3D 10·00

		NURSES PROGRESS NO	TES	-
Date & Time		Observations / Action		Signature with Emp. No.
12/12/23	Nic	HT DUTY NOT	<u> </u>	·
19:00	-	houndoves / he evening Paljent is	alocu cluby Plabla	\$5580
20.00		edications to the patre	Oll ent	20081
35 ob	15 tal. 819 & 2009		recked	A Ja
6.00	Ho cl	ravit is Man	lawed	Ports.
700	Pahent to the	handover Morning du	gwein ly slabb	A Ja
Document	Signature	Name	Emp. No	. Date Time
endorsed by	nol.	palini	0024	1/12/23 10.00







## Master.SIVAGURU.S 13/Mate/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V

HARDESH.V



Date:	2/12).	3 Shift: ☐Morn	ing Evening !	Night 1	· -				
S	Ventilator Periphera Ryle's Tut Urinary C	l line day: Right:		GCS: 15   U5 POD: Central line days: VIP Score: 0   5 specify organism:	· -				
В	Allergies i On room	ROUND urgery:		Date of surgery:	7/12/2 <u>5</u>	3	-		
Α	ASSESSMENT  Vital Signs: Temp: 98 (°F)   Pulse / HR: 80 (beats/min)   Respiration: 90 (breaths/min)  BP: 10/80 (mmHg)   SpO <sub>2</sub> : 97 (%)   Height: 17 (cms)   Weight: 38 (kgs)   BMI: 04, 85 m <sup>2</sup> Others:  Pain Score: 100 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  Fall Risk Score: 100 Fall Risk Protocol: 10w Medium 11igh  Braden Score: 11minal Risk: 23-19 11 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6  Pressure Ulcer Scale for Healing (PUSH): 12 INO NA Wound Dressing done: 12 INO NA  Current diet: 12 INO NA Drains: 12 INO NA								
	Referral o Pending i Pending i	medications: -				-d			
K	Critical va Changes Pending f	alue alert and its corrections: in nursing care plan: Yes follow-up orders:	· ·	care plan date:		· · · · · · · · · · · · · · · · · · ·			
	_	Signature	Name	Emp.	No.	Date	Time		
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Handover ta	aken by		Dis Charge	d 2		, _			
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NURSES PROGRESS NOTES								
Date & Time		Observations / Action		Signat	ture with E	mp. No.		
12/18/23	MOPNING	DUTY NOTES:	-		<del>.</del>			
8.00	Joan form	rding over bake Night duby stoff. onscious and		£ s.	Ф			
10-00	thable	ls sings are	drug	र्चिया	ivi .			
11.00	- Today Plas - T/O chau  - Pt Vital Si  secorded.	n hor discharge t Monitered. ngs are checked	and	Jan	2 -			
10.30	-> Patient hand evening duty	ling over fiven to	the	Lan	<del>р й ,</del>			
12 . 30	Dischary  Statt.		Luty	Que de la constante de la cons	mo'	 		
U. 00	- (   1'   '   1	locks order	rooj					
16.50 18.00	to the pt atte		ged,	Out of a	6			
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# ADULT NURSING CARE PLAN

Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





×

Initial Date: > 10-1	25 Time: 12:30	Modified Date: Time:				
Reason for Modification:	<u> </u>	Diagnosis: Reu AR				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
NUTRITION ☐ Keep NPO ☐ Regular Diet	-Patient will have adequate nutrition with no nausea and vomiting	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M			
` ☐ Others:	requirements in accordance to his activity level and metabolic needs		E pt head corned	Fan		
			N PE MAA NORMOL	Podes		
OXYGENATION  Room Air  Nasal Cannula / High Flow O <sub>2</sub> Mask  BiPAR / CPAP	Accom Air    Patient ABG levels will return to and   Coughing exercise / Spirometry exercises     Nasal Cannula / High Flow O₂   remain within normal limits   Provide well-ventilated environment / respiratory     Mask   No other respiratory abnormalities   Description   Patient respiratory rate will remains   Utilise pulse oximetry to check O₂ saturation and pulse rate		М			
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits  Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	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	E 8poz-987-	OST / Sh)		
			N 3POZ - 97%	20084		
FEUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	M			
Parenteral Nutrition Others:		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	NHO chart promored	John		
		Indiana. 2. 101 Orangotano Grangota	NHO chart	Suf		

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





**Patient Specific** Sian & **Nursing Interventions** Measurable Goals **Evaluation** Problems / Needs Initials Encourage patient to do daily bathing and oral hygiene **HYGIENE** Patient will stay clean and well-groomed Change patient's gown daily ☐ Bed-Bath Assist-Bath ☐ Patient will demonstrate lifestyle Encourage hand hygiene Self-Care CBD Care changes to meet self-care needs Consider the patient's need for assistive devices Patient will recognize individual Apply moisturizing solution (if present) ☐ Others: weakness or needs • SAFETY ☐ Patient will have no life-threatening ☐ Check the identity with ID band before any Check ID Hand situations interaction with the patient ☐ IV care □ EJV ☐ Raise side rails CENTRAL LINE Provide proper invasive line care ☐ Side rails ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient Others: Follow restrain policy (if needed) ☐ Patient will have comfortable sleep☐ Patient will verbalize / or through **COMFORT AND SLEEP** ☐ Provide clean calm and restful environment ☐ Pain Control Provide privacy at all time ☐ Sleep Patterns behavior about pain relief and Monitor pain scale / sleep pattern Ε ☐ Others: ☐ Provide pharmacological and adequate sleep non-pharmacological therapy / 1 N Patient will have normal range Monitor vital signs regularly OBSERVATION Vital Signs M of vital parameters ☐ GCS Assess physically for any abnormality ☐ Blood Sugar Inform doctor if there is any abnormality ☐ Others: Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order PSYCHOLOGICAL / ☐ Patient will achieve spiritual needs Pray or encourage the patient to pray M Patient will be able to control his SPIRITUAL SUPPORT ☐ Use inspirational words ☐ Spiritual Needs feeling toward his illness Respond to spiritual needs as they arise ☐ Beliefs / Values / Customs Patient will maintain normal ☐ Evaluate spiritual needs Anxiety and Copying Pattern ☐ Encourage verbalization of feelings / therapeutic touch psychological pattern E ☐ Identify Stressors ☐ Provide empathy and reassurance ☐ Others: N

Patient Specific Sign & Nursing Interventions Evaluation Measurable Goals 'Problems / Needs Initials Introduce the care giver
Encourage the use of call bell
Obtain interpreter if needed
No negative speaking about the patient's condition Patient will communicate effectively COMMUNICATION Verbal with positive feedback ☐ Non-verbal NOT COMMUNICATIONS ☐ Sightlanguage or prognosis in the patient's presence Others: Double check for high alert medication SPECIAL INTERVENTIONS ☐ To manage on time Medication Observe and report any medication reaction M Provide proper measures of wound care

Follow hospital polices and protocols of isolation ☐ Wound care ☐ Isolation ☐ Ostomy Care and explain to the patient / family ☐ Blood / Blood products ☐ Check for cross matching and typing, to ensure Ε transfusion compatibility ☐ Fluid tapping Practice strict asepsis while transfusing blood or DVT Management blood products and fluids Others: ☐ Monitor DVT score and continue treatment as per doctors order Ν Signature Name Emp. ID Date Time 8- Nalin's 0004 4 2182 18:00 Endorsed by

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# ADULT NURSING CARE PLAN

Pa Master.SIVAGURU.S
Ni 13/Mule/MHI202381075
UI 02/12/2023/IPH202302423

Dr.RAJESH.V



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Every heart beat counts

Initial Date: 공기기	23' Time:	Modified Date: Time:		
Reason for Modification:		Diagnosis: Sevore AR		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION  ☐ Keep NPO ☐ Hegular Diet	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	mpt had diet	85,
Others:	requirements in accordance to his activity level and metabolic needs		E pt heed worm	W/OIN!
			N Pt chad normaldieb	Hort
OXYGENATION  Room Air  Nasal Cannula / High Flow O,	☐ Patient will have normal O₂ saturation☐ Patient ABG levels will return to and cemain within normal limits	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises  Provide well-ventilated environment / respiratory	Pt on Room	P
☐ Mask ☐ BiPAP / CPAP	No other respiratory abnormalities     Patient respiratory rate will remains within established limits     Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	Provide well-vertilated environment / respiratory medications / Oxygen as per doctors order     Utilise pulse oximetry to check O₂ saturation and pulse rate     If any O₂ 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		277
☐ Ventilator ☐ Tracheostomy ☐ Others:			E 2000 - 487	
		central venous peripheral cyanosis  Note for changes in level of consciousness	3/1-2- (-1	(an)
		Send sputum for culture and sensitivity based on physician order     Maintain clear airway by suctioning or encouraging	n Pt was stable on room air	Hay
		patient with successful coughing	on soom our	D(D)
FIVID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	M I (o Monite	( 3)
☐ Parenteral Nutrition ☐ Others:		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	E Elo Charlipre	Shil
		- House I is surestand on angua	NIto chaet Maintained	tfay.

Patient Specific Sign & **Nursing Interventions Evaluation** Measurable Goals Problems / Needs Initials Patient will mobilize freely MOBILITY ☐ Encourage regular ambulation ROM exercise ☐ Mobile / Immobile ☐ Patient will perform physical ☐ Apply Anti-Embolic stocking / SCD ☐ Walk with assistance activity independently or within Evaluate the need for assistive devices ☐ Physiotherapy limits of disease Assess the safety of the environment ☐ Others: Putient will use safety measures Consider the need for home assistance (e.g., physical therapy, visiting nurse) to minimize potential for injury pt mobilized well ☐ Note for progressing thrombophlebitis ☐ Patient will demonstrate the use of adaptive devices to increase mobility (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) Pt mobilized well Hoy Dios Patient will have normal elimination **ELIMINATION** ☐ Encourage fluid intake ☐ Catheter, bedpan, urinal ☐ Encourage fibre diet intake Encourage early ambulation ☐ Nasogastric tube Patient will control of urinary ☐ Bowel movement in-continence or urinary retention. Report any abnormalities to physician Urination control of bowel incontinence. ☐ Observe voiding accessories as foley's / ☐ Others: and regular elimination patterns silicone catheter ☐ Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Pt Isad normal elimination patter ☐ Check for malena / constipation / urinary retention SKIN INTEGRITY Patient will maintain normal Minimize / Eliminate friction and shear Maintain normal skin integrity healing status Minimize pressure (off-loading) with special beds ☐ Pressure points site Patient will discharge with intact М assessment and devices skin integrity [ ] Early skin inspection and treatment ☐ HAPI ☐ OPI Keep position changing 2 hourly and manage pain **GRADES OF PRESSURE** Manage moisture, clean and dry skin INJURY · Maintain adequate nutrition and hydration ☐ GRADE 1 ☐ GRADE 2 Proper application of medications and dressing ☐ GRADE 3 ☐ GRADE 4 ☐ Follow doctors and TVN order properly ☐ Unstageable Monitor the healing status Ε ☐ Deep Tissue Injury Educate patient and family members about further pt had normal N Skin Integrity ☐ Healing Status skin care ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given Others: 0005





Patient Specific Sign & Nursing Interventions Measurable Goals Evaluation Problems / Needs Initials Patient will stav clean and Encourage patient to do daily bathing and oral hygiene HYGIENE ☐ Bed-Bath well-groomed Change patient's gown daily Assist-Bath ☐ Patient will demonstrate lifestyle Encourage hand hygiene Self-Care CBD Care changes to meet self-care needs Consider the patient's need for assistive devices Patient will recognize individual Apply moisturizing solution (if present) ☐ Others: weakness or needs. SAFETY ☐ Patient will have no life-threatening. ☐ Check the identity with ID band before any Check ID Hand situations interaction with the patient Raise side rails
Provide proper invasive line care □ FJV ☐ IV care CENTRAL LINE ☐ Side rails Keep bed locked and low at all time Others: Educate care providers to be the patient Follow restrain policy (if needed) ☐ Patient will have comfortable sleep☐ Patient will verbalize / or through COMFORT AND SLEEP Provide clean calm and restful environment M ☐ Pain Control Provide privacy at all time ☐ Sleep Patterns behavior about pain relief and Monitor pain scale / sleep pattern E Others: adequate sleep ☐ Provide pharmacological and non-pharmacological therapy Ν OBSERVATION Thatient will have normal range Monitor vital signs regularly ☐-Vital Signs М of vital parameters ☐ Monitor vital signs on ordered time ☐ GCS Assess physically for any abnormality ☐ Blood Sugar Inform doctor if there is any abnormality Others: Monitor GCS of patient Determine and treat the underlying cause of altered LC
 Regular blood sugar monitoring as per doctors order 4EP Determine and treat the underlying cause of altered LOC -01 h nlos ☐ Patient will achieve spiritual needs☐ Patient will be able to control his ☐ Pray or encourage the patient to pray☐ Use inspirational words PSYCHOLOGICAL / М SPIRITUAL SUPPORT ☐ Spiritual Needs feeling toward his illness Respond to spiritual needs as they arise ☐ Beliefs / Values / Customs Patient will maintain normal Evaluate spiritual needs ☐ Anxiety and Copying Pattern Encourage verbalization of feelings / therapeutic touch psychological pattern Ε ☐ Identify Stressors ☐ Provide empathy and reassurance Others: Ν

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( t ) **Patient Specific** Sign & **Nursing Interventions Measurable Goals** Evaluation Problems / Needs Initials \* COMMUNICATION ☐ Patient will communicate effectively ☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed ☐ Verbal with positive feedback ☐ Non-verbal ☐ Sigh language No negative speaking about the patient's condition ☐ Others: or prognosis in the patient's presence Pt Communicated Hay-SPECIAL INTERVENTIONS ☐ To manage on time Double check for high alert medication Medication Observe and report any medication reaction ☐ Wound care ☐ Provide proper measures of wound care ☐ Isolation ☐ Ostomy Care Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Blood / Blood products ☐ Check for cross matching and typing, to ensure Ε transfusion compatibility ☐ Fluid tapping ☐ Practice strict asepsis while transfusing blood or DVT Management
Others: blood products and fluids ☐ Monitor DVT score and continue treatment Due deugs are as per doctors order Emp. iD Signature Name Date Time 8- Malini 18:00 3/12/23 0024 Endorsed by





# ADULT NURSING CARE PLAN

Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V





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Initial Date: HILLEY (P3, Time: 8,200		Modified Date: Time:			
Reason for Modification:		Diagnosis: Sed An			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
NUTRITION  ☐ Keep NPO、 ☐ Regular Diet	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	MA had Ochet	PO CAL	
Others:	requirements in accordance to his activity level and metabolic needs		E pt feed wormed	Popu	
			NPt chad normal oliet	Hout 5105	
OXYGENATION Acom Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP Ventilator Tracheostomy Others:	☐ Patient will have normal O₂ 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	<ul> <li>□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises</li> <li>□ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order</li> <li>□ Utilise pulse oximetry to check O₂ saturation and pulse rate</li> <li>□ If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>□ Place patient with proper body alignment for maximum breathing pattern</li> <li>□ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> <li>□ Note for changes in level of consciousness</li> <li>□ Send sputum for culture and sensitivity based on physician order</li> <li>□ Maintain clear airway by suctioning or encouraging patient with successful coughing</li> </ul>	M 8/200 - 9800	TO/m/	
			E Spor - 987.	19h1	
			Pt was 3-table n on soom air	Hay	
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	Malo chest red	TIBLE ON	
			E 20 chort me)	1 Dan	
		Information or for orthostatic changes	N I/o Chaet Maintained	Hay	

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Patlent Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy	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)	Mips mofiles	OPH OPH
☐ Others:			E pot mahiltond	Van
			N Pt Mobilised Well	Hay
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bewel movement	<ul> <li>□ Patient will have normal elimination pattern</li> <li>□ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns</li> </ul>	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 elpowntoon	2an
☐ Urination ☐ Others:			M elpownition  putten indomal  elpownent por al  muttern organical	EM COW
			pt had normal elimination pattern	Hay OLD
SKIN INTEGRITY  Maintain normal skin integrity Pressure points site assessment HAPI OPI	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	
GRADES OF PRESSURE INJURY  ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable	; ī			
☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted			E	
☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	





Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care	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	Boin!
SAPETY  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 = D found D,  E = D beind D  N ID band present	John Hay
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 /	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range ef 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 refer vers  E refer vers  Stable  N Pt vital signs  are stable	Hay our
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	

Patient Specifi Proble <del>ms</del> / Ne		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		<del></del>	murfacte well well	ON ON
						N Pt Comm	unilated well	Hay or
SPECIAL INTERVENTIONS  Medication  Wound care Isolation  Ostomy Care Blood / Blood products transfusion Fluid tapping		☐ Jo manage on time	Double check for high alert medication  ☐ Observe and report any medication react ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of i			m modra	goven	Pory
		,		and explain to the patient / family  ☐ Check for cross matching and typing, to compatibility ☐ Practice strict asepsis while transfusing		E mode.		Voin
DVT Managem Others:	GIIL			blood products and fluids Monitor DVT score and continue treatmer as per doctors order	nt	l .	engsæle Liven	Hay.
	Signature		Name		Emp. !D		Date	Time
Endorsed by		Jug-	Q	L. Nalini	චර	<b>૭</b> ૫	4/2/23	18:00
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# ADULT NURSING CARE PLAN

Master.SIVAGURU.S

13/Mulc/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V





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Initial Date: らい2つ23	Time: 8-100	Modified Date: Time:				
Reason for Modification:		Diagnosis: RHD, SEV AR				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
NUTRITION  ☑/Keep NPO	Patient will have adequate nutrition with no nausea and vomiting	Provide Prescribed diet on time     Encourage patient to consume the served meal	M Pt had Normal diet	fur our		
☐ Regular Diet ☐ Others:	Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Record amount of food consumed	E pt had Normal	Sens		
			N por had @ adol	Mass		
OXYGENATION  Room Air  Nasal Cannula / High Flow O₂  Mask  BiPAP / CPAP  Ventilator  Tracheostomy  Others:	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	<ul> <li>□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises</li> <li>□ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order</li> <li>□ Utilise pulse oximetry to check O₂ saturation and pulse rate</li> </ul>	M Room air	fer.		
	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	<ul> <li>If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>Place patient with proper body alignment for maximum breathing pattern</li> <li>Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> <li>Note for changes in level of consciousness</li> </ul>	E Room air	Jan Onen		
		<ul> <li>Send sputum for culture and sensitivity based on physician order</li> <li>Maintain clear airway by suctioning or encouraging patient with successful coughing</li> </ul>	N Dr in Moon air	IL Wes		
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 Dlo chart was	fen		
			E Dlo chart was	Luig ozan.		
	,		N & lo Chant	not		

Patient Specific Sian & Nursing Interventions Evaluation Measurable Goals Initials Problems / Needs □ Patient will mobilize freely ☐ Encourage regular ambulation ROM exercise MOBILITY pt mobilized Apply Anti-Embolic stocking / SCD ☐ Mobile / Immobile ☐ Patient will perform physical ☐ Walk with assistance activity independently or within T Evaluate the need for assistive devices Assess the safety of the environment ☐ Physiotherapy limits of disease ☐ Others: Patient will use safety measures Consider the need for home assistance Pt mobilized to minimize potential for injury (e.g., physical therapy, visiting nurse) Patient will demonstrate the use of Note for progressing thrombophlebitis Ferry Dest adaptive devices to increase mobility (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) of mostiled are ☐ Encourage fluid intake M elimination

Pattern vas normal

E elimination

Pattern was normal

N M an Scheddel Patient will have normal elimination ELIMINATION for going ☐ Encourage fibre diet intake Catheter, bedpan, urinal pattern ☐ Encourage early ambulation ☐ Nasogastric tube Patient will control of urinary Report any abnormalities to physician ☐ Bowel movement in-continence or urinary retention, ☐ Urination control of bowel incontinence. ☐ Observe voiding accessories as foley's / ☐ Others: and regular elimination patterns 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 Met SKIN INTEGRITY Patient will maintain normal Minimize / Eliminate friction and shear Maintain normal skin integrity healing status ☐ Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces Pressure points site ☐ Patient will discharge with intact assessment skin integrity and devices ☐ HAPI ☐ OPI ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin **GRADES OF PRESSURE** ☐ Maintain adequate nutrition and hydration☐ Proper application of medications and dressing INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 Follow doctors and TVN order properly ☐ Unstageable Monitor the healing status Ε ☐ Deep Tissue Injury ☐ Educate patient and family members about further ☐ Healing Status skin care PUSH Decreased ☐ PUSH increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given Ν Others:

		-	,	· · · ). · · ·
Patlent Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	/ Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene	M pt groomed	J.m
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution  E	E pt groomed	Been Ongs
			N Mappined well	21
SAFETY  Check ID Hand  IV care	Patient will have no life-threatening situations	□ Check the identity with ID band before any interaction with the patient     □ Raise side rails	M DD Band Present	Fire
CENTRAL LINE Side rails Others:	Others:	E DD Band Present	Soul Pasu	
		Follow restrain policy (if needed)	N 2s Sand @	ma
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	М	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern     Provide pharmacological and     non-pharmacological therapy	E -	
		· · ·	N ~	
OBSERVATION  Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters		M Vitale is striple.	Fen
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E vitale was	Jeni Oxox
			NPH US Checked	M
PSYCHOLOGICAL / SPIRITUAL SUPPORT  Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise	м _	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	E ~	
			N	

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interve	entions	Ţ	Evaluation		Sign & Initial
COMMUNICAT  Verbal  Non-verbal  Sigh language  Others:	TION	Patient will communiwith positive feedbac	cate effectively k		e use of call bell	s condition		menication well-	Jen Sen
SPECIAL INTE  Medication  Wound care  Isolation  Ostomy Care  Blood / Blood p transfusion  Fluid tapping  DVT Manageme	products	To manage on time		Observe and r Provide prope Follow hospita and explain to Check for cros compatibility Practice strict blood product	score and continue treatmen	isolation ensure blood or		drugs are treegs are fixen	Jen Ten
	Signature		Name			Emp. 1D	· · ·	Date	Time
Endorsed by		12000	ي (	2. Nalin	÷ /	0024	<u>.</u>	5/12/23	1820

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Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Every heart beat counts

Initial Date: 6 00/12	— Time: 8 нль	Modified Date: Time:		
Reason for Modification:		Diagnosis: RAD- Sev AR		-
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION  Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M Takes normal dist  E pt had @ diet  N M-had @ Mid-	Almain Silver
OXYGENATION  Room Air  Nasal Cannula / High Flow O,  Mask  BiPAP / CPAP  Ventilator	Patient will have normal O₂ saturation  □ Patient ABG levels will return to and remain within normal limits  □ No other respiratory abnormalities  □ Patient respiratory rate will remains within established limits	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 <sub>2</sub> saturation and pulse rate	M Patient is on	lodn
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	□ If any O₂ 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	E pt is on Room	A' 0212
			NM 12 an booms	ll
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	M takes adequate	Pathr
☐ Parenteral Nutrition ☐ Others:		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	E I/o chout Monitored	85° 022 L
		E Monte of the ordinate of things	N 860 Charl- maratarned	· M 2108

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	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	M Patiet habit-zed well	Poln
☐ Others:	Patient will use safety measures to minimize potential for injury     Patient will demonstrate the use of adaptive devices to increase mobility	<ul> <li>☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse)</li> <li>☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)</li> </ul>	E Pt mobilized well	011L
			N Pt-mobilized was	ll Not
ELIMINATION  Catheter, bedpan, urinal Nasogastric tube Bowel movement	Patient will have normal elimination pattern  Patient will control of urinary in-continence or urinary retention.	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	M Self voiding	Postn
☐ Urination ☐ Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter     Check placement before feeding     Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E Pt sey voided	A' OUL
·		and follow proper protocol  Check for malena / constipation / urinary retention	N Sect Workled.	No.
SKIN INTEGRITY  Maintain normal skin integrity  Pressure points site assessment	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	Mate Preparation	
☐ HAPI ☐ OPI  GRADES OF PRESSURE	JAII TROGITY	☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin	done	Rola
INJURY  GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		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	Maintain Novemed E skin întegrites	A1 011L
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N hornal Spire  Dateguity	Il.

	<b>•</b>			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	Patient will stay clean and well-groomed  Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene     Change patient's gown daily     Encourage hand hygiene	MPH well gesomed	poli
Self-Care CBD Care (if present)  Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	Consider the patient's need for assistive devices Apply moisturizing solution	Ept well goomed	Air OIL
			N pr how promed	1e 2d
SAFETY  Check ID Hand  IV care  EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M 10 bond O	foln-
CENTRAL LINE Side rails Others:		☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient	EIP band (1)	81 011 L
		Follow restrain policy (if needed)	N 20 Sand A	2208
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	м	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern     Provide pharmacological and     non-pharmacological therapy	E	
,	11		N -/	
OBSERVATION  Vital Signs  GCS  Blood Sugar	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	M Vital Signs chekad &	Path
Others:		Monitor GCS of patient   Monitor GCS of patient   Determine and treat the underlying cause of altered LOC   Regular blood sugar monitoring as per doctors order	EV/s checked & el	8 01 L
			1118 Melled A	se not
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	M Period Psychological Suggest	Postn
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs     Encourage verbalization of feelings / therapeutic touch     Provide empathy and reassurance	E priorided comfortable  Position	922 L
			N Breowage To May	Il gros

Patient Specific Problems / Nee		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATI Verbal Non-verbal	ION _	Patient will communic with positive feedback		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		M Effective	- Verbal	Postn
☐ Sigh language ☐ Others:				No negative speaking about the patient's or prognosis in the patient's presence	s condition	EPT 9004	nunicated	Ai oil
	_				<u> </u>	N A Com	un' lated	sle not
SPECIAL INTER Medication Wound care Isolation Ostomy Care	RVENTIONS	☐ 76 manage on time	/	□ Double check for high alert medication     □ Observe and report any medication react     □ Provide proper measures of wound care     □ Follow hospital polices and protocols of i and explain to the patient / family		M redation	rs given	folm
☐ Blood / Blood pr transfusion ☐ Fluid tapping ☐ DVT Manageme				Check for cross matching and typing, to compatibility     Practice strict asepsis while transfusing be blood products and fluids	olood or	E Medica	ution given buy chart	011 V
☐ Others:				Monitor DVT score and continue treatment as per doctors order	nt	N Dae An	ge d'ory	Step.
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Need		l- Nalini	002	4	6/12/23	10:00

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13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



Initial Date: 귀加恕	Time: 87.00	Modified Date: Time:				
Reason for Modification:		Diagnosis: Ser As				
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	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M NPO	Soft		
	activity level and metabolic needs		N			
OXYGENATION    Floom Air   Nasal Cannula / High Flow O,   Mask   BiPAP / CPAP   Ventilator	Patient will have normal O₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits	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 <sub>2</sub> saturation and pulse rate  If any O <sub>2</sub> abnormalities detected inform immediately to	M Patrent is on	pstn		
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	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	E			
	, ,		N			
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	electrolytes balance  electrolytes balance  Travenous  nteral Nutrition  arenteral Nutrition  arenteral Nutrition  withers:  electrolytes balance  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	M NPO	lough to			
Parenteral Nutrition Others:		Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses	Е			
			N			

			Of some P
Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the need for home assistance	M Pt mobilized well	Paden
to minimize potential for injury  Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse)	E	
		<b>N</b>	
Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention,	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as follows.	M Self Voiding	Joban
☐ Urination control of bowel incontinence, ☐ Others: and regular elimination patterns	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	E	
		N	
Patient will maintain normal healing status Patient will discharge with intact skin integrity	<ul> <li>☐ Minimize pressure (off-loading) with special beds</li> <li>☐ Make sure wrinkles free bed / comfort surfaces and devices</li> <li>☐ Early skin inspection and treatment</li> <li>☐ Keep position changing 2 hourly and manage pain</li> <li>☐ Manage moisture, clean and dry skin</li> </ul>	M Skin integrity	Postn
	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	E	
	,	N	
	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility  Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns  Patient will maintain normal healing status Patient will discharge with intact	Patient will mobilize freely   Patient will perform physical activity independently or within limits of disease   P.ttient will use safety measures to minimize potential for injury   Patient will demonstrate the use of adaptive devices to increase mobility   Patient will have normal elimination pattern   Patient will control of urinary incontinence or urinary retention, control of bowel incontinence, and regular elimination patterns   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will discharge with intact skin integrity   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintain normal healing status   Patient will maintai	Patient will mobilize freely   Patient will perform physical activity independently or within limits of diseases   P. Etient will use setley measures to minimize potalistic for injury   Patient will use setley measures to minimize potalistic for injury   Patient will demonstrate the use of adaptive devices to increase mobility   Q., physical threapy, visiting nurse)   Note for progressing thrombophilebits   Q., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)   Patient will control of urinary increase increase incontinence, and regular elimination patterns   Patient will control of bowel incontinence, and regular elimination patterns   Patient will control of urinary incontinence or urinary retention, control of bowel incontinence, and regular elimination patterns   Patient will maintain normal healing status   Patient will discharge with intact   Patient w

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  Bed-Bath  Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene	MPt well geomed	Adln
Self-Care CBD Care (if present)  Others:	changes to meet self-care needs  Patient will recognize individual weakness or needs	Consider the patient's need for assistive devices Apply moisturizing solution	E '	_
	, , , , , , , , , , , , , , , , , , ,		N	
SAFETY Check ID Hand IV care EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M 10 band P	pollo
CENTRAL LINE Side rails Others:	÷ ,	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)	<b>E</b>	
	,		N .	•
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment  Provide privacy at all time	м —	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep		E	
	,		N	,
OBSERVATION  Vital Signs  GCS  Blood Sugar	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	M Vital signs classed	Polm
☐ Others:		☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E	
			N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs	M Provided Psychological Support	Post n_
Anxiety and Copying Pattern Identify Stressors Others:	psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	

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Patient Specific Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
✓ Verbal ☐ Non-verbal	Verbal with positive feedback  Non-verbal		Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		M Effective	verbal icclion	Jufan	
☐ Sigh language☐ Others:				No negative speaking about the patient's or prognosis in the patient's presence	s condition	E		
		<u>/</u>			·	N		_
☐ Medication ☐ Wound care ☐ Isolation	☐ Wound care 1 ☐ Provide proper measures of wound		Double check for high alert medication  Observe and report any medication react  Provide proper measures of wound care  Follow hospital polices and protocols of i		м —		Post n	
☐ Ostomy Care ☐ Blood / Blood p transfusion ☐ Fluid tapping	<b>^</b>			and explain to the patient / family  Check for cross matching and typing, to compatibility  Practice strict asepsis while transfusing be		E		
DVT Managem	ent		blood products an  Monitor DVT score as per doctors ord		d continue treatment			
	Signature		Name		Emp. ID	1	Date	Time
Endorsed by	•	la la	,	Nalin	0081		7/12/23	10.00
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UHI 02/12/2023/IPH202302423

DOE Dr.RAJESH.V

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#### ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 04 10 3	Time: 14-00	Modified Date: Time:		
Reason for Modification:		Diagnosis: PHD, Que AR.		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN  ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs Maintain proper positioning of patient Assist or turn patient every two hours Assess incision area for redness, heat, induration, swelling, separation and drainage Non-Pharmacological therapy	M  E Administer modicates  CUSPOT Charry  N Patrus had disnound  Text of Pain - You	Jan Jan
OXYGENATION  Oxygen Hood  Nesal Cannula  Nebulizer  Ventilator  Others:	Patient will have no shortness or difficulty of breathing	<ul> <li>□ Provide well ventilated environment</li> <li>□ Check oxygen saturation</li> <li>□ Perform suctioning if needed</li> <li>□ Ventilator settings as per physician orders</li> <li>□ Monitor rate, depth of respiration</li> <li>□ Administer oxygen and nebulizer therapy if needed</li> <li>□ Encourage spriometry, deep breathing and coughing exercises</li> <li>□ Monitor amount, viscosity, colour and odour of sputum if present</li> </ul>	M  E ON VENTILATION.  Support  N Policia is on from  ai - Spez-984.	Janj 0270
ANXIETY ☐ Increased Pulse Rate ☐ Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	<ul> <li>□ Explain all procedures to patient or family member in simple language they understand</li> <li>□ Encourage and support patient while increasing anxiety level</li> <li>□ Help patient to cope with outcomes of surgery</li> <li>□ Keep patient in comfortable position in bed to enhance sleep</li> </ul>	M E - N NA	Jamy -
MOBILITY  ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ Apply Anti-Embolic stocking / SCD     □ Evaluate the need for assistive devices     □ Assess the safety of the environment     □ Consider the need for home assistance     (e.g., physical therapy, visiting nurse)     □ Note for progressing thrombophlebitis     (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M  E Primobile.  N Paturi & on Bed Haut	0240 2017

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE  Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M  E Monttored 26  Chart  N. Ho Chart  Manufacial	de de de de de de de de de de de de de d
RISK OF INFECTION  Prevent Infection  Others:	The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care  Restrict visitors and use appropriate PPE  Meticulous hand washing before and after patient's care  Inspect wound for signs of infection, purulent drainage or discoloration  Administer antibiotics as ordered  CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M  E Mod asoptic  E Promuteons Followed  N Ayuri Jurameta and  Fallowed	6170 6170
RISK OF FALL Giddiness Independent State Dependent State	☐ The patient will have safe, free from fall hospitalization	<ul> <li>Keep bed on low position</li> <li>Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed</li> <li>Remove clutter, keep items patient needs within reach</li> <li>Avoid movement out of bed after surgery for 46 hours</li> <li>Review patients' medication like narcotics and hypotensive agents</li> <li>Offer urinal or bedpan to the patient if needed</li> </ul>	M  E Dept bed in Low portion  N Safety procedure one followed	oh 6270 Junt
SKIN &WOUND CARE  Observe REEDA Oozing Foul Smell	The patient will have intact skin while staying in the hospital and on discharge	□ Check all drains from the operation site more frequently     □ Provide wound care as ordered     □ Minimize pressure     □ Provide adequate nutritional support     □ Report signs of poor healing or trauma to doctor	M  E NO 002/19 in the  Europical site  N 3kin - Intat	OTO.
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	<ul> <li>□ Encourage patient to consume prescribed diet</li> <li>□ Record amount of food consumed</li> <li>□ Provide high calories, high protein diet as prescribed</li> <li>□ Monitor patient's weight</li> <li>□ Administer supplemental vitamins and minerals as prescribed</li> <li>□ Administer parentral or TPN per protocol if dietary needs are not met through oral intake</li> <li>□ Report abdominal distention, large gastric residual volume or diarrhea to doctor</li> </ul>	M  E NPO  N Palaul is on  Named ass	Jour dr.

Patient Specific Problems / Needs	Measurable Goals		Nursing Interventions		Evaluation	Sign & T Initials
CARE OF CATHETERS, DRAINS, ETC.	Patient will have patent, maintained catheters, dr	properly ains etc	□ Check the catheters, drains etc freque     □ Observe I/O Chart     □ Watch for any symptoms related to kin blocked tubes     □ Maintain adequate cleaning and dress	ked or	M E magnitude and a  N observe 1/0 chart	2 200
DISTURBED BODY IMAGE	☐ The patient will demonst initial acceptance and to		☐ Note non verbal body language, nega and self talk		M	
	body image		☐ Note emotional reaction (grieving, dep ☐ Acknowledge and accept expression of grief and hostility		E	
					N	
OBSERVATION  ☐ Vital Signs	Patient will have normal range of vital parameters		Monitor vital signs regularly Assess physically for any abnormality			
☐ GCS ☐ Blood Sugar ☐ Others:		☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient  ■ Monitor GCS of patient  ■ Monitor GCS of patient		E Monttoned what	1 0210	
					N vital signewie suche	dr
HEALTH EDUCATION  ☐ Patient ☐ Family / Guardian ☐ Diet	Patient / Family / Guardia Domestic Partner / Care- others will gain adequate knowledge regarding tre	-giver / e	Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medication Provide clear, thorough, and understandable explanations		M	
☐ Disease process ☐ Infection control / PPE ☐ Médication ☐ Educate about TAC level and immunosuppressant	modalities and life style modifications		regarding safety precautions.  Explain to perform activities / skin care that recommended by concerned doctor  Use the teach-back technique to determine the patient's understanding regarding importance of treatment		Explained about E to Pt condition  D 2 co stay	) gh 0270
Personal Safety Treatment Regimen Others:					Nexplained about of	e disce
ANY OTHER NEEDS					M	<u> </u>
					E - '	
	1			<del></del>	N	<u> </u>
Signature	1	Name		Emp. ID	Date	Time
Endorsed by	pee.	N	alini	0024	7/12/03	10.00









### **ADULT POST-OPERATIVE NURSING CARE PLAN**

Initial Date: 8   12   23	Time: & , ∅ ♡	Modified Date: Time:	<b>/</b> -	
Reason for Modification:		Diagnosis: RHD SEV AR		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN  ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs Maintain proper positioning of patient Assist or turn patient every two hours Assess incision area for redness, heat, induration, swelling, separation and drainage Non-Pharmacological therapy	M paminister medication of per drug chart  E Administered dough N per arder  N per medicates	1001 Name 1027 6.
OXYGENATION    Room Air   Oxygen Hood   Nasal Cannula   Nebulizer   Ventilator   Others:	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment  Check oxygen saturation Perform suctioning if needed Ventilator settings as per physician orders Monitor rate, depth of respiration Administer oxygen and nebulizer therapy if needed Encourage spriometry, deep breathing and coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	m pt is on Room, Add  E patient on AA  Patient 12 of  N Room,	2.170 0111 0111 0276
ANXIETY  Increased Pulse Rate Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	□ Explain all procedures to patient or family member in simple language they understand     □ Encourage and support patient while increasing anxiety level     □ Help patient to cope with outcomes of surgery     □ Keep patient in comfortable position in bed to enhance sleep	M NA  E relocation of the patient  N Psychological  N Psychological	S. Warn
MOBILITY    Mobile / Immobile   Walk with assistance   Physiotherapy   Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Apply Anti-Embolic stocking / SCD  Evaluate the need for assistive devices  Assess the safety of the environment  Consider the need for home assistance (e.g., physical therapy, visiting nurse)  Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt is on Bed Mobilized E NOWWELL Full EUVISIONALLI- N Safety Environment N Previous	2112 - Naer

Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
☐ 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	m monitored To chart	Ar on
	as diaphoresis, wound drainage, and gastric losses  Monitor for possible sources of fluid loss	hected IV sites	
	Monitor BP for orthostatic changes		Simony.
☐ The patient will be discharged with no hospital acquired infection	☐ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand washing before and	followed	12/2 ODL
	Inspect wound for signs of infection, purulent drainage or discoloration	= fechnique duoung could	afois
	CVC dressing changing every 24 hours and	N Apoplic technique mointained.	8.1MDQ.4
☐ The patient will have safe, free from fall hospitalization		M	
·	Avoid movement out of bed after surgery for 46 hours  Review patients' medication like narcotics and hypotensive agents	E	
	Offer urinal or bedpan to the patient if needed	,	& rigidan
in the patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered	swelled site	
•			by
Patient will have adequate nutrition with no nausea and vomiting	Encourage patient to consume prescribed diet  Record amount of food consumed	mpt vis on liqued	Ai on
	☐ Monitor patient's weight     ☐ Administer supplemental vitamins and minerals	F ration on liquid	l du
	as prescribed Administer parentral or TPN per protocol if dietary needs are not met through oral intake Report abdominal distention, large gastric residual volume or diarrhea to doctor	N On Soft Diet	(m294 0)26,
	Atient will have balanced fluid and electrolytes balance  The patient will be discharged with no hospital acquired infection  The patient will have safe, free from fall hospitalization  The patient will have intact skin while staying in the hospital and on discharge	Patient will have balanced fluid and electrolytes balance	Patient will have balanced fluid and electrolytes balance   Check N sites and assess if there is any complication   Provide tube feedings   Monitor intake and output   Measure or estimate fluid closes from all sources such as disphoresis, wound drainage, and gastric losses   Monitor to possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources of fluid loss   Monitor of possible sources   Monitor of pos

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
CARE OF CAT DRAINS, ETC.		Patient will have paten maintained catheters,	nt, properly drains etc	Watch for any symptoms related to kinked or blocked tubes   Maintain adequate cleaning and dressing		M monitours  E Muintains  N Stocha	d I/o cham	Horn
DISTURBED B	ODY IMAGE	☐ The patient will demote initial acceptance and body image		<ul> <li>Note non verbal body language, negative attitude and self talk</li> <li>Note emotional reaction (grieving, depression, anger)</li> <li>Acknowledge and accept expression of feeling of grief and hostility</li> </ul> E <ul> <li>N</li> </ul>				
OBSERVATION	N	☐ Patient will have norm of vital parameters	al range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		N Whale m	eight Hegulous ut vitall light crytered!	Air Duty
HEALTH EDUC    Patient     Family / Guardi     Diet     Disease proces     Infection control     Medication     Educate about     and immunosu     Personal Safety     Treatment Regi     Others:	ian ss ol / PPE TAC level ppressant	☐ Patient / Family / Guar Domestic Partner / Ca others will gain adequ knowledge regarding modalities and life styl modifications	re-giver / ate treatment	Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medication Provide clear, thorough, and understandable explanations regarding safety precautions. Explain to perform activities / skin care that recommended by concerned doctor Use the teach-back technique to determine the patient's understanding regarding importance of treatment		M Explaine the pt conc explaining conclibion palient 9 of teath N g	d the	8' NOW ONE
ANY OTHER N	EEDS	,		,		M E		
	Signature		Name		Emp. ID	N	Date	Time
Endorsed by	4			Analu.	000),		7/12/25	9.00





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### **ADULT POST-OPERATIVE NURSING CARE PLAN**

Initial Date: 09/12/29	Time: 8-00	Modified Date: Time:		
Reason for Modification:		Diagnosis: RHD, REV AR		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN    Comfortable Position   Pain Scale   Pain Score   Others:	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs Maintain proper positioning of patient Assist or turn patient every two hours Assess incision area for redness, heat, induration, swelling, separation and drainage Non-Pharmacological therapy	M Provided Comforta  E PI provided  E PI provided  N Pt had Dull pain	Control of the state of the sta
OXYGENATION  Room Air Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	□ Provide well ventilated environment     □ Check oxygen saturation     □ Perform suctioning if needed     □ Ventilator settings as per physician orders     □ Monitor rate, depth of respiration     □ Administer oxygen and nebulizer therapy if needed     □ Encourage spriometry, deep breathing and coughing exercises     □ Monitor amount, viscosity, colour and odour of sputum if present	on ROOM APA  Eft on Room APA  N Pt was stable  on room air	The Start of the s
ANXIETY  Increased Pulse Rate Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	<ul> <li>Explain all procedures to patient or family member in simple language they understand</li> <li>Encourage and support patient while increasing anxiety level</li> <li>Help patient to cope with outcomes of surgery</li> <li>Keep patient in comfortable position in bed to enhance sleep</li> </ul>	M	
MOBILITY    Mobile / Immobile   Walk with assistance   Physiotherapy   Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Apply Anti-Embolic stocking / SCD  Evaluate the need for assistive devices  Assess the safety of the environment  Consider the need for home assistance (e.g., physical therapy, visiting nurse)  Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	m mobilized to chown  E mobilized to chow  N Pt mobilized well	Old Stay

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	□ Enhance fluid intake unless restricted     □ Check IV sites and assess if there is any complication     □ Provide tube feedings     □ Monitor intake and output     □ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses     □ Monitor for possible sources of fluid loss     □ Monitor BP for orthostatic changes	monstored 260  Chart  Ept Dlochout  mountoned  N. Patient en waged  staid adequate in	OD ODE
RISK OF INFECTION Prevent Infection Others:	The patient will be discharged with no hospital acquired infection	□ Use aseptic technique in all aspect of patient care     □ Restrict visitors and use appropriate PPE     □ Meticulous hand washing before and after patient's care     □ Inspect wound for signs of infection, purulent drainage or discoloration     □ Administer antibiotics as ordered     □ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M ched aseptic  precautions to lload  E used aseptic  precaution followed  N	الوا
RISK OF FALL Giddiness Independent State Dependent State	☐ The patient will have safe, free from fall hospitalization	<ul> <li>Keep bed on low position</li> <li>Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed</li> <li>Remove clutter, keep items patient needs within reach</li> <li>Avoid movement out of bed after surgery for 46 hours</li> <li>Review patients' medication like narcotics and hypotensive agents</li> <li>Offer urinal or bedpan to the patient if needed</li> </ul>	M tept bed 9 n Low post-tion  E latept in Siderights  N	OJ OJ OJ
SKIN &WOUND CARE  Observe REEDA  Oozing Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M Rungfal grto  E  N	2)110
DIET & NUTRITION  NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	<ul> <li>□ Encourage patient to consume prescribed diet:</li> <li>□ Record amount of food consumed</li> <li>□ Provide high calories, high protein diet as prescribed</li> <li>□ Monitor patient's weight</li> <li>□ Administer supplemental vitamins and minerals as prescribed</li> <li>□ Administer parentral or TPN per protocol if dietary needs are not met through oral intake</li> <li>□ Report abdominal distention, large gastric residual volume or diarrhea to doctor</li> </ul>	M 80ft allat  Ept had a Both Diet  N Pt had Acitsom diet	Hay olds

Patient Specific Problems / Need	ls	Measurable Goals		Nursing Interventions		Evaluation	Sign & Initials
CARE OF CATHE DRAINS, ETC.	ETERS;	Patient will have patent, p maintained catheters, dra	properly ains etc	Check the catheters, drains etc frequentl Observe I/O Chart Watch for any symptoms related to kinke blocked tubes Maintain adequate cleaning and dressing	ed or	M Mountained 2 to Chart mahatained  N Dio Chart mahatained	To Carlo
DISTURBED BOD	DY IMAGE.	☐ The patient will demonst initial acceptance and to body image	rate newly	<ul> <li>Note non verbal body language, negative and self talk</li> <li>Note emotional reaction (grieving, deprediction)</li> <li>Acknowledge and accept expression of the of grief and hostility</li> </ul>	ssion, anger)	M ,— E — N —	
OBSERVATION  Vital Signs GCS Blood Sugar Others:	·	Patient will have normal r of vital parameters	ange	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M 29914 nogularly Evitab declard	Que de la companya della companya de
Patient / Family / Guardian / Domestic Partner / Care-giver / Others will gain adequate knowledge regarding treatment modalities and life style modifications   Diet   Medication   Educate about TAC.level and immunosuppressant   Personal Safety   Treatment Regimen		Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medication Provide clear, thorough; and understandable explanations regarding safety precautions. Explain to perform activities / skin care that recommended by concerned doctor Use the teach-back technique to determine the patient's understanding regarding importance of treatment		Explained about  M fle pt Condition  Des strey  E -  Health education	gh oxfa		
Others:	EDS					N was given	olos
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s	Signature	N	lame		Emp. ID	Date	Time
Endorsed by	W.		. 9	mair	<i>Do</i>	9/12/23	9.00





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Initial Date: しし (12) 23	Time: 🖟 🞾 🌣	Modified Date: Time:				
Reason for Modification:		Diagnosis: CEVAS				
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 piet.  E pt heu D piet  N pi had Diet	Larott.		
OXYGENATION  Hoom Air  Nasal Cannula / High Flow O  Mask  BiPAP / CPAP	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	☐ 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 O₂ saturation and pulse rate	Mpt on som	f.on 623 H		
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	<ul> <li>If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>Place patient with proper body alignment for maximum breathing pattern</li> <li>Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> <li>Note for changes in level of consciousness</li> </ul>	e pt on room	Dia Pour		
, 		Send sputum for culture and sensitivity based on physician order  Maintain clear airway by suctioning or encouraging patient with successful coughing	N 376 - 95%	dy ook		
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	M Pt 210 Chaut	Jen 02304.		
☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:		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	E p4 To Chavel	Son		
,		- Monitor or for outhostatic changes	N Pt Sto Chart	State		

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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 Putient will use safety measures	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	M Pt Mobilized well.	Sen 0280
Cuters.	to minimize potential for injury  Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse)  Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E pt loobilised well	802
			N PT Mobilized well	Sof
ELIMINATION  Catheter, bedpan, urinal  Nasogastric tube Bowel movement	□ Patient will have normal elimination pattern     □ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence.	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's /	M pt Normal elimination pattern	Jen 5224
Others:	and regular elimination patterns	silicone catheter  Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E pt D elimination well	8019
	,	☐ Check for malena / constipation / urinary retention	N Pt @ Elemination	00/85
SKIN INTEGRITY  Maintain normal skin integrity Pressure points site assessment HAPI OPI  GRADES OF PRESSURE	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	M Pt Noomal Skin Integrity.	Sey 02841
INJURY  GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	•	<ul> <li>☐ Manage moisture, clean and dry skin</li> <li>☐ Maintain adequate nutrition and hydration</li> <li>☐ Proper application of medications and dressing</li> <li>☐ Follow doctors and TVN order properly</li> <li>☐ Monitor the healing status</li> <li>☐ Educate patient and family members about further skin care</li> </ul>	E P+ hormal Skin Interjet	8)61
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			3 prin is	XII

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  Bed-Bath Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene	M pt groomed well.	fer.
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	Consider the patient's need for assistive devices Apply moisturizing solution	E pr groomal welly	& Gul
	,		N pr Orloomed well	2006
SAFETY  Check ID Hand  IV care EJV	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails	M Pt DD Band present.	Ben
CENTRAL LINE  Side rails Others:		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)	E pt Ilo Brand prosecut	Dur
		Pollow restrain policy (if needed)	NPt 20 Bond	94
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns	☐ Patient will have comfortable sleep☐ Patient will verbalize / or through behavior about pain relief and	☐ Provide clean calm and restful environment☐ Provide privacy at all time☐ Monitor pain scale / sleep pattern	м —	, , <u>, , , , , , , , , , , , , , , , , </u>
Others:	adequate sleep	Provide pharmacological and non-pharmacological therapy	E	
	·		N	
OBSERVATION  ☑ Vital Signs □ GCS □ Blood Sugar	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	M Pt Vitals are	800
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E pt vitule circ Stephe	800
			N Pt Floris	dif
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise	M	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs     Encourage verbalization of feelings / therapeutic touch     Provide empathy and reassurance	E	
			N	

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT  Verbal  Non-verbal  Sigh language  Others:	TION	Patient will communic with positive feedbac			ent's condition e	E pt loi	nmunication nmunication nmunication noul	8001 8001
SPECIAL INTE Medication	products	☐-To manage on time		Double check for high alert medication of Observe and report any medication of Provide proper measures of wound of Follow hospital polices and protocols and explain to the patient / family Check for cross matching and typing compatibility Practice strict asepsis while transfusition blood products and fluids Monitor DVT score and continue treat as per doctors order	eaction care s of isolation I, to ensure ng blood or	are	given.  given.  gjun  drugs  gjun  drugs	Sen Star
	Signature		Name		Emp. ID		Date	Time
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Initial Date: 11/12)	23 Time: 7.00	Modified Date: Time:				
Reason for Modification:		Diagnosis: AUR				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
NUTRITION  ☐ Keep NPO ☐ Regular Diet	Patient will have adequate nutrition with no nausea and vomiting  Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	MPt had Normal	Jen		
Others:	requirements in accordance to his activity level and metabolic needs	Hecold amount of food consumed	EPI had @ Diet_	6		
			NPT had @ Diel	de fo		
OXYGENATION	Dom Air  asal Cannula / High Flow O₂  ask  PAP / CPAP  Patient ABG levels will return to and remain within normal limits  No other respiratory abnormalities  Patient ABG levels will return to and remain within normal limits  Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order  Utilise pulse oximetry to check O₂ saturation and puls		Mpt Municipal on Poom air.	Jen .		
☐ Tracheostomy ☐ Others:	within established limits  Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	<ul> <li>If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>Place patient with proper body alignment for maximum breathing pattern</li> <li>Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> </ul>	E.P.A on Room Atr	Sigs -		
		□ 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	N SPO2-95%	Del colso		
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	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	M pt Dlo Chout	Jen onot.		
☐ Parenteral Nutrition ☐ Others:			E do chartained	000		
			N T/o chart	000		

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

**Patient Specific** Sign & Nursing Interventions Evaluation Measurable Goals Problems / Needs Initials Patient will stay clean and Encourage patient to do daily bathing and oral hygiene HYGIENE М ☐ Bed-Bath Change patient's gown daily well-groomed Assist-Bath ☐ Patient will demonstrate lifestyle Encourage hand hygiene Self-Care CBD Care changes to meet self-care needs Consider the patient's need for assistive devices Apply moisturizing solution (if present) ☐ Patient will recognize individual ☐ Others: weakness or needs Check the identity with ID band before any SAFETY Patient will have no life-threatening М Check ID Hand situations interaction with the patient □ IV care ☐ Raise side rails CENTRAL LINE ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Side rails Others: Educate care providers to be the patient ☐ Follow restrain policy (if needed) COMFORT AND SLEEP Patient will have comfortable sleep T Provide clean calm and restful environment Pain Control Patient will verbalize / or through Provide privacy at all time Monitor pain scale / sleep pattern E provided compostable ☐ Sleep Patterns behavior about pain relief and Others: adequate sleep ☐ Provide pharmacological and non-pharmacological therapy Patient will have normal range Monitor vital signs regularly OBSERVATION Vital Signs Monitor vital signs on ordered time Μ of vital parameters `□ ccs ☐ Assess physically for any abnormality Inform doctor if there is any abnormality ☐ Blood Sugar ☐ Others: ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order Patient will achieve spiritual needs
Patient will be able to control his PSYCHOLOGICAL / Pray or encourage the patient to pray M SPIRITUAL SUPPORT ☐ Use inspirational words ☐ Spiritual Needs feeling toward his illness Respond to spiritual needs as they arise Beliefs / Values / Customs Patient will maintain normal ☐ Evaluate spiritual needs ☐ Anxiety and Copying Pattern ☐ Encourage verbalization of feelings / therapeutic touch psychològical pattern Ε ☐ Identify Stressors ☐ Provide empathy and reassurance ☐ Others: Ν

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION  Verbal  Non-verbal Sigh language Others:		Patient will communic with positive feedback		☐ Introduce the care giver ☐ Encourage the use of call to ☐ Obtain interpreter if needed ☐ No negative speaking about or prognosis in the patient's	I It the patient's condition	NPE COO	mumaded_	Coly State
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood ptransfusion Fluid tapping DVT Manageme Others:	products	☐ To manage on time		Double check for high alert Dobserve and report any me Provide proper measures of Follow hospital polices and and explain to the patient / Check for cross matching a compatibility Practice strict asepsis while blood products and fluids Monitor DVT score and cor as per doctors order	edication reaction f wound care protocols of isolation family and typing, to ensure transfusing blood or	Mpt du	edwysare ven. edwarfor siven drugs given	Jan onson, Organia
,	Signature		Name		Emp. ID		Date	Time
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MHI/NUR/2022/044

Medway

Heart
Institute

Every heart beat counts

Initial Date: 12/12/2	3 Time: 7.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: 8/p AVR		
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  E pt had (n) boot  N	Tenory.
OXYGENATION   Room Air   Nasal Cannula / High Flow O₂   Mask   BiPAP / CPAP   Ventilator   Tracheostomy   Others:	Patient will have normal O₂ 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 O₂ saturation and pulse rate □ If any O₂ 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	M pt on Room dir	Janus.
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	patient with successful coughing  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 2/0 chart Monteul. E 26 chart rained	Jan.

Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Puttent will use safety measures	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	M Pt Mobilized.	Sen
to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse)  Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E At well mobilised	Bar
		N	
Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence.	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's /	M pt Normal elimination pattern.	San y
and regular elimination patterns	silicone catheter  Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E py @ Slim in a floor Pattern	0000
	Check for malena / constipation / urinary retention	N	
Patient will maintain normal healing status  Pátient will discharge with intact skin integrity		M pt Maintoin Normal Skin Integrity.	Jan 629 1
		E Pt maintain,  B Skin Integrity	0100 000
		N	
	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility  Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns  Patient will maintain normal healing status Patient will discharge with intact	Patient will mobilize freely	Patient will mobilize freely   Patient will perform physical activity independently or within limits of disease et   Patient will use safety measures   Patient will use safety measures   Patient will use safety measures   Patient will use safety measures   Patient will use safety measures   Patient will demonstrate the use of adaptive devices to increase mobility   Patient will demonstrate the use of adaptive devices to increase mobility   Patient will demonstrate the use of adaptive devices to increase mobility   Patient will demonstrate the use of adaptive devices to increase mobility   Patient will demonstrate the use of adaptive devices to increase mobility   Patient will control of urinary inconfinence or urinary retention, control of bowel inconfinence, and regular elimination patterns   Patient will control of urinary inconfinence or urinary retention, control of bowel inconfinence, and regular elimination patterns   Patient will discharge with intact   Patient will maintain normal healing status   Patient will discharge with intact   Patient will discharge w

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Patient Specific Sign & Measurable Goals **Nursing Interventions Evaluation** Problems / Needs Initials Pen . HYGIENE Encourage patient to do daily bathing and oral hygiene It oroned well. ☐ Bed-Bath well-groomed Change patient's gown daily Assist-Bath ☐ Patient will demonstrate lifestyle Encourage hand hygiene ☐ Self-Care ☐ CBD Care changes to meet self-care needs Consider the patient's need for assistive devices (if present) ☐ Patient will recognize individual ☐ Apply moisturizing solution ☐ Others: weakness or needs Ν Patient will have no life-threatening Check the identity with ID band before any Jen 5204 SAFETY ☐ Check ID Hand☐ IV care☐ □ situations interaction with the patient ☐ Raise side rails CENTRAL LINE ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Side rails Others: ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed) N COMFORT AND SLEEP Provide clean calm and restful environment ☐ Patient will have comfortable sleep Provide privacy at all time
Monitor pain scale / sleep pattern ☐ Pain Control ☐ Patient will verbalize / or through ☐ Sleep Patterns behavior about pain relief and E Others: ☐ Provide pharmacological and adequate sleep non-pharmacological therapy 1.4 N Patient will have normal range OBSERVATION Monitor vital signs regularly Jen 0204 ☐ Vital Signs of vital parameters Monitor vital signs on ordered time ☐ GCS ☐ Blood Sugar Assess physically for any abnormality Inform doctor if there is any abnormality ☐ Others: Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order Ν PSYCHOLOGICAL / ☐ Patient will achieve spiritual needs ☐ Pray or encourage the patient to pray М SPIRITUAL SUPPORT ☐ Patient will be able to control his ☐ Use inspirational words ☐ Spiritual Needs ☐ Respond to spiritual needs as they arise feeling toward his illness ☐ Beliefs / Values / Customs ☐ Evaluate spiritual needs ☐ Patient will maintain normal ☐ Anxiety and Copying Pattern ☐ Encourage verbalization of feelings / therapeutic touch psychological pattern Ε ☐ Identify Stressors Provide empathy and reassurance ☐ Others: N

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**Patient Specific** Sign & Measurable Goals Nursing Interventions Evaluation Problems / Needs Initials COMMUNICATION Patient will communicate effectively Introduce the care giver M pt communication Encourage the use of call bell
 Obtain interpreter if needed Verbal with positive feedback ☐ Non-verbal ☐ Sigh language ☐ No negative speaking about the patient's condition Others: or prognosis in the patient's presence Ν To manage on time **SPECIAL INTERVENTIONS** Double check for high alert medication M Pt Due deugs are given E pt Due madration often as per chocker Observe and report any medication reaction
Provide proper measures of wound care Medication ☐ Wound care ☐ Isolation Follow hospital polices and protocols of isolation Ostomy Care and explain to the patient / family ☐ Blood / Blood products Color ☐ Check for cross matching and typing, to ensure transfusion compatibility ☐ Fluid tapping ☐ Practice strict asepsis while transfusing blood or DVT Management blood products and fluids Others: ■ Monitor DVT score and continue treatment as per doctors order Ν Signature Name Emp. ID Date Time 00-0 Endorsed by 002/





#### Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





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Every heart beat counts

(A Unit of United All	lance Healthcare Pvt Ltd)			i		BIL DI		Turits
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK	Date:	2	2	23 14
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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 ver commands. Has no sendeficit which would lability to feel or voice paidiscomfort	sory limit		4	A
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	A. Rarely Moist Skin is usually dry, linen requires changing at rot intervals			4	人
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		room		7	4
MOBILITY ability to change and control body position	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 freq changes in position wit 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	Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary	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	Usually eats a total of	eal. 4 or and enally Does		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. During a move skin probably slides to some extent against sheets, chair, restraints or other devices.	3 No Apparent Problem  Moves in bed and in chair independent strength to lift up completely during move. Nor chair		bed		3	3
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. of Staff Nu	rse:		N.	9
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	High Risk: 12 - 10; Severe Rísk: 9 - 6	Initial & Emp. of Sr. Staff Nu			N3rx	\





#### Master.SIVAGURU.S

13/Malc/MHi202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Every heart beat counts

3 12 25

Date:

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time:							12 E	<u>೩</u> ೬ ४√
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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 Hesponds to vecommands. Has no s deficit which would ability to feel or voice discomfort	ensory d limit	7	F	4
MOISTURE degree to which skin is exposed to moisture	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, lin requires changing at intervals		7	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 twice a day and insid at least once every twi during waking hours	le room	7	7	4
MOBILITY ability to change and control body position	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	A:No Limitation Makes major and frechanges in position assistance		4	ðí	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		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 Never refuses a Usually eats a total more servings of me diary products. Occas eats between meals not require suppleme	meal. of 4 or eat and sionally c. Does	7	Н	4
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independently and has sufficient strength to lift up completely during move. Maintains good position or chair			3	3	ع
& SHEAR	slides down in bed or chair, requiring chair, restraints or other devices. frequent re-positioning with maximum assistance. Spasticity, contractures or or bed most of the time but occasionally		TOTAL S		27 (D)	23	23	
,	agitation leads to almost constant friction	slides down		of Staff I	Nurse:	2)X		they
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6  of Sr. Staff Nurse:						124	192	Big





#### Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V





Every heart beat counts

(A Unit of United A	Illance Healthcare Pvt Ltd)		TANK THE STATE OF THE MANAGEMENT OF THE STATE OF THE STAT	Everg	<u></u>	DEALL	
	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Tim	i H	13	(J.)
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 verba commands. Has no sensor deficit which would limi ability to feel or voice pain o discomfort	ر ا	i h	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	A. Rarely Moist Skin is usually dry, linen onle requires changing at routing intervals		17	净
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 hour during waking hours	n	Ff	4
MOBILITY ability to change and control body position	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 Makee-major and frequer changes in position withou assistance		H	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		1. or d y s	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	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	3. No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. No or chair	Maintains good position in bed	3	3 8 2	3 30
Score	agitation leads to almost constant friction  Interpretation: Minimal Risk: 23 - 19; At Risk /	slides down	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No of Staff Nurse Initial & Emp. No of Sr. Staff Nurse	: <i>(2)</i> : \	<b>/</b>   a	al sur





Master, SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V

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MHI/NUR/2022/045

Every heart beat counts

Date: 5 /2

RDADENI SCALE FOR	PREDICTING PRESSURE INJURY RISK
DUADEM SCAFE LOW	FREDICTING FRESSORE INJUNT RISK

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Til	ne: M	6	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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 verb commands. Has no sense deficit which would lir ability to feel or voice pain discomfort	ory   nit   人	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 o requires changing at rout intervals		H	7
ACTIVITY degree of physical activity	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 le twice a day and inside ro at least once every two ho during waking hours	om	4	4
MOBILITY ability to change and control body position	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 freque changes in position with 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 ments of every refuses a ments of every ments at total of every more servings of meats diary products. Occasion eats between meals. Description of the every meal of e	al. or and ally oes	力	7
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. N			3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction		TOTAL SCO	RE 92	23	28	
		-		Initial & Emp. 1 of Staff Nurs		2 55	
Score	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:						250





13/Malc/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V

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	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK	Date: Time:	6 14	13	- 23 -/J
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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 ve commands. Has no se deficit which would ability to feel or voice a discomfort	ensory I limit	4	۴	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 any extra linen change approximately once a day	Arely Molst Skin is usually dry, linen only requires changing at routine intervals		4	ch	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 a twice a day and inside at least once every two during waking hours	e room	4	P	4
MOBILITY ability to change and control body position	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 frohanges in position assistance	without	4	4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of, 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every Never refuses a Usually eats a total more servings of me diary products. Occase eats between meals not require suppleme	meal. of 4 or eat and sionally . Does	4	4	4
FRICTION	Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3 No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. No or chair			3	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTALS	CORE	23	23	23
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Em of Staff I	• 1	Soft	R	
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:								SQ Sq









Every heart beat counts

#### BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

	DRADEN 3	CALE FOR PREDICTI	NG PRESSURE INJUR	Time:	ሾኒ	€	ル _
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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 Besponds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Parely Moist &kin is usually dry, linen only requires changing at routine intervals	4		
ACTIVITY degree of physical activity	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	Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	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	14		
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	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4		
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independently strength to lift up completely during move. Nor chair		3		
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	chair, restraints or other devices.  Maintains relatively good position in chair or bed most of the time but occasionally		TOTAL SCORE	23		ļ <u>'</u>
	agitation leads to almost constant friction	slides down		Initial & Emp. No. of Staff Nurse:	8ª		
Score	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:						





Patient /

Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

UHID: DOB: DOA:

Name:

Dr.RAJESH.V

DOA:



	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	40	გით	8.00
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited     Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment	de 2		2
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	82	1	ţ
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	١
MOBILITY ability to change and control body position	Completely Immobile     Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		1	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		1	2
FRICTION	1. Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independent strength to lift up completely during move. No or chair		1	)	١
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE	to	Ь	9
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	5	1 Jan 1717,	Air Or
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	1	14	1 X





13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Every heart beat counts

Date:	910.2	3812	210
Time:	14-00	1900	ار موري

#### SENSORY 1. Completely Limited 2. Very Limited 3/Slightly Limited 4. No Impairment PERCEPTION Unresponsive (does not moan, flinch,or Responds only to painful stimuli. Cannot Responds to verbal commands, but Responds to verbal ability to respond grasp) to painful stimuli, due to diminished communicate discomfort except by cannot always communicate discomfort commands. Has no sensory meaning-fully to level of consciousness or sedation OR moaning or restlessness OR has a or the need to be turned OR had some deficit which would limit pressure-related limited ability to feel pain over most of body sensory impairment which limits the ability sensory impairment which limits ability to ability to feel or voice pain or 3 discomfort to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort 3 Occasionally Moist 1. Constantly Moist 2. Very Molst 4. Rarely Moist MOISTURE Skin is kept moist almost constantly by Skin is often, but not always moist, Linen Skin is occasionally moist, requiring an Skin is usually dry, linen only degree to which extra linen change approximately once a perspiration, urine etc. Dampness is must be changed at least once a shift requires changing at routine skin is exposed 3 detected every time patient is moved or intervals to moisture turned 1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently **ACTIVITY** Confined to bed Ability to walk severely limited or non-Walks occasionally during day, but for very Walks outside room at least degree of existent. Cannot bear own weight and / or short distances, with or without twice a day and inside room physical activity must be assisted into chair or wheelchair assistance. Spends majority of each shift at least once every two hours Q in bed or chair during waking hours 2. Very Limited 1. Completely Immobile 3. Slight Limited 4. No Limitation MOBILITY Does not make even slight changes in body Makes occasional slight changes in body Makes frequent through slight changes in Makes major and frequent ability to change 2 or extremity position without assistance or extremity position but unable to make body or extremity position independently changes in position without and control body frequent or significant changes assistance position $\mathbf{Q}$ independently 2. Probably Inadequate 1. Very Poor 3. Adequate 4. Excellent Never eats a complete meal. Rarely eats Rarely eats a complete meal and generally Eats over half of most meals. Eats a total of Eats most of every meal. more than any food offered. Eats 2 servings eats only about 2 of any food offered. 4 servings of protein (meat, diary Never refuses a meal. NUTRITION or less of protein(meat or dairy products) per Protein intake includes only 3 servings of products) per day. Occasionally will refuse Usually eats a total of 4 or usual food day. Takes fluids poorly. Does not take a meat or diary products per day. a meal, but will usually take a supplement more servings of meat and intake pattern liquid dietary supplement OR Is NPO and / or when offered OR Is on a tube feeding or Occasionally will take a dietary diary products. Occasionally 2 maintained on clear liquids or IV's for more supplement TPN regimen which probably meets most eats between meals. Does than 5 days of nutritional needs not require supplementation 2. Potential Problem 1. Problem 3. No Apparent Problem Requires moderate to maximum assistance Moves feebly or requires minimum Moves in bed and in chair independently and has sufficient muscle in moving. Complete lifting without sliding assistance. During a move skin probably strength to lift up completely during move. Maintains good position in bed FRICTION against sheets is impossible. Frequently slides to some extent against sheets, or chair & SHEAR slides down in bed or chair, requiring chair, restraints or other devices. 14 TOTAL SCORE ው frequent re-positioning with maximum Maintains relatively good position in chair assistance. Spasticity, contractures or or bed most of the time but occasionally Initial & Emp. No. agitation leads to almost constant friction slides down of Staff Nurse: 020 Initial & Emp. No. Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 of Sr. Staff Nurse:

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK





13/Male/MHi202381075 02/12/2023/iPH202302423

Dr.RAJESH.V





	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time:		12	23_
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	A. No Impairment  Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	3	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, butfor 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	9	3	
MOBILITY ability to change and control body position	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. Stight 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	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 putritional 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 independentl strength to lift up completely during move. Nor chair		3	20	H
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /		High Risk: 12 - 10; Severe Risk: 9 - 6	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	n ol	0100	`





13/Male/MH1202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Every heart beat counts Date: 10

12 23

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RIS	Time:	M	<u>E</u>	$\bar{N}$
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	Respo commar deficit	nds. Has no sensory which would limit feel or voice pain or	4	H	4
MOISTURE degree to which skin is exposed to moisture	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	Skin is occasionally moist, requiring an extra linen change approximately once a day	Skin is u requires	Rarely Molst     Skin is usually dry, linen only requires changing at routine intervals		3	Ā
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	Walks of twice a at least of	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		3	4
MOBILITY ability to change and control body position	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	Makes change:	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 putritional needs	Never Usually more so diary pro eats be	lent ost of every meal. refuses a meal. eats a total of 4 or ervings of meat and oducts. Occasionally tween meals. Does ire supplementation		3	4
FRICTION	Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independent strength to lift up completely during move. No or chair			3	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair	or or all		TOTAL SCORE	ەر	20	23
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			Initial & Emp. No. of Staff Nurse:	روزي	8	A 08
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	High Risk: 12 - 10; Severe Risk: 9 - 6		Initial & Emp. No. of Sr. Staff Nurse:	rel 24	Nec 21	24





Patient Netalls (Affix Label here) Master.SIVAGURU.S 13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/NUR/2022/045 **Nedway Heart** Institute

Every heart beat counts Date: 1) D

	BRADEN S	CALE FOR PREDICTII	VG PRESSUNL III	Y RIS	SK Tir	ne:		12 F	<u> </u>
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	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	Resp comma deficit	inds. Has no senso which would lin o feel or voice pain	ry nit		4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst 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 aday	Skin is require:	K. Rarely Moist Skin is usually dry, linen only equires 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	Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	Walks of twice a at least	is Frequently outside room at leading and inside roo once every two how waking hours	m	,	2	4
MOBILITY ability to change and control body position	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	Makes change	4. No Limitation Makes major and frequent changes in position without assistance			3	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	Never Usually more s diary pi eats be	ellent nost of every me refuses a me reats a total of 4 ervings of meat a roducts. Occasiona etween meals. Do uire supplementati	al. or nd ally es	.	3	4
FRICTION	Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair					3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair			TOTAL SCOP	E _		v	a3
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			Initial & Emp. N			O S	Ø
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6		Initial & Emp. N of Sr. Staff Nurs				





13/Malc/MHi202381075 02/12/2023/IPH202302423

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(A Unit of United All	llance Healthcare Pvt Ltd)		- 110 100 that the discussion in the control of the	Date:		ac codia	
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time:	15	12 2 X	7
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	A 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 Molst Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst 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	Afarely Moist Skin is usually dry, linen only requires changing at routine intervals		4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	A. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		4	
MOBILITY ability to change and control body position	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		l.	
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	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	25	
FRICTION & SHEAR	Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring.	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.	Moves in bed and in chair independent strength to lift up completely during move. No or chair	Maintains good position in bed		+ +	
	frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	Maintains relatively good position in chair or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	23 Sey	22	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	198	JOR DA	





13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/NUR/2022/052



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.
2/2/3°	ا ا	NO pern	(			Join,	Due
18/27	6/6	No piùn		_		San	Naa 024
20.00		No Pain	_			States	Ncea 024
0:00	0/10	No Pain	~			set octo	Naa 024
4.00	0 /10	No Paris	_		-	dy cost	Nea
1 8:00	0/10	No pain				(P)	Nas- 02/2
12/20	g,s	No prin				Polhl	Nao.
1000	Oylo	NO pain	-			140/	Nag-
201.50	0/60	No pain	_	<u> </u>	<b>-</b>	Hay poo	Nua

Date &	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions					Staff Ini & Emp.		lni	or Staff tial & p. No.
•-					Pt wa	us Sleeping									
A112123 6:00	, 0[w	Λ.	o pain		_			•			_	Hey Olo	5	17	224
(OfD)	of go	/	uo pin	<u></u>	).	(					Ç	W 1014	1	۲۵	24
العلما	ν	(	os puin									(91)		0 h	g m
		, ,			P#	IN SCALES			_	1				. ,	
(28 week	PIPPS s to < 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to severe	le comfort me		on			-						· ·
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal sc pesic administration is indic				score is	s > '4,	•	′		
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	iscomfort, 4-6: Mode	rate discomfort, 7-10: Seve	re discomfort / pai	in / both		•		i.			. 1
		· ;		(20)	(60)	(pa) (pa)	Numerio	al Ratin	g Sc	ale (ag	e mo	re than	12 y	/ears	3)
Pain	-Baker FA Rating Se ars - 12 ye	cale	O 2 No Hurts Little Bit	4 Hurts Little Mare	6 Hurts	8 10 Hurts Whole Lot Worst	0 None	2 3	4 1	5 Modera	6	7	8	9	· 10 
Observat	cal care F tion Tool tor / com	(CPOT)	FACIAL EXPRESSION: 0 BODY MOVEMENTS: 0 - COMPLIANCE WITH VEN	- Relaxed, Ne Absence of m ITILATION (in Ibated patier elaxed, 1 - Te	eutral, 1 - Tense, 2 - G novements or normal   ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	rimacing position, 1 - Protection, 2 - Re - Tolerating Ventilator or Mov rmal tone or no sound, 1 - Sig nse, Rigid	estlessness / Agitativement , 1 - Coughi	on ng but tole		, 2 - Figh		ntilator (c	Seve	. v	
	narmacolo ervention		Cutaneous Stimulation a Thermal Therapies (no lo	nd massage: nger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and me ubbing / Massage the skin old application; H - Hot applic erferntial therapy   <b>Psycho</b> -	ation; I - Shortwave			dividual (	ounsel'	ing; L - Fa	amily	couns	seling
Pharmaco	ological I	ntervention	s as per doctor's prescrip	lion					_	1					





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Dr.RAJESH.V



MHI/NUR/2022/052



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.
(B)=0	els.	no prin	<u></u>			Olhl	Dec-
92:00				1		Hay	Nac
5/12/23 6:00	Olco	No pain		_		Hay 0105	Nach
8.60	$\theta \log \theta$	No poù h	_	_	-	fu over	Nac
(D. 00	a (la	Nopain		_		h	Noo
H-Pro	ollo	No pair	•			Jun 00-24	Nary
[3.00	olio	No pair	-	<u> </u>	,	Jen.	Nus
2200	260	No fail	1			est.	Nag
Grace	200	do gain				Mrs.	Nag-

Date &	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
500	oho		la fum			-	Pal	191
74.00	Ofes		No pom	_			Con Cod.	101 24
18.00	્ૃિ		No Jam				Pin	24
22-60	0/10		No pasa	_			2100	29
				_	PA	IN SCALES	,	•
(28 week	PIPPS ks to <u>&lt;</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to seven	de comfort me		n		
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is > esic administration is indicated for a score of 6 or higher.	4,	1.
	ACC Sca		0: Relaxed & comfortab	le, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		` .′
Wong Pain	-Baker FA Rating S ars - 12 ye	ACES cale	O 2  No Hurts Little Bit	4 Hurts Little More	6 Hurts	Numerical Rating Scale (age    State   State   State	<del>                                     </del>	years) 9 10
Observa	Critical care Pain Observation Tool (CPOT) (ventilator / comatose)  BODY M COMPL VOCALI MUSCL			Absence of m NTILATION (Intubated patier Relaxed, 1 - Te	ntubated patients): 0	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fightin mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	⊖   /   g ventilator (or) <sup>()</sup>	<i>n</i> ,

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 Theraples (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





# Master.SIVAGURU.S 13/Malc/MHJ202381075 02/12/2023/IPH202302423 Dr.RAJESH.V

MHI/NUR/2022/052



Every heart beat counts

## PAIN RE-ASSESSMENT & MONITORING CHART

		F-WOOFOOINFIA	. C. IVIC	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OHAH	P =	<u></u>	
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shootin burning, referred / radiant pain)	g, <b>Duration</b>	Location / Site		Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
				Patient	was	Sleeping		
71,213 6:00	olio	No pain		_		_	Hay Forth	124
	ماره	No pain	_	-			Podh	124
						, ,		
								-
					_			

Date & Time	Pain Score	(dull, achy	Pain Character , sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	Interve	entions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
,									
									:
	•				P/	IN SCALES	<u> </u>	_	·
(28 week	PIPPS s to <u>&lt;</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		n			
(38 we	CRIES eks - 2 ma	onths)				of gestation. A maximal score of 10 esic administration is indicated for a		,	
	ACC Sca nths - 7 y		0: Relaxed & comfortabl	e, 1-3: Mild di	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discom	fort / pain / both		
Paln	-Baker FA Rating So ars - 12 ye	cale	O 2  No Hurts Hurt Little Bit	60 Hurts Little More	6 Hurts Even Moro	8 10 Hurts Worat  None	umerical Rating Scale (age m	7 8	9 10
Observa	cal care F tion Tool tor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (li ubated patier Relaxed, 1 - Te	novements or normal ntubated patients): ( nts): 0 - Talking on no nse, Rigid, 2 - Very Te	rimacing  cosition, 1 - Protection, 2 - Restlessness  - Tolerating Ventilator or Movement, 1  rmal tone or no sound, 1 - Sighing, Mod  nse, Rigid	s / Agitation - Coughing but tolerating, 2 - Fighting	<u> </u>	
	narmacolo tervention		Cutaneous Stimulation a Thermal Theraples (no lo	ind massage: onger than 15	: E - Positioning; F - R to 20 minutes): G - C	- Music; D - Physical and mental exercubbing / Massage the skin old application; I - Serferntial therapy   Psycho-social the	shortwave diathermy	seling; L - Famil	/ counseling
Pharmace	ological li	ntervention	ns as per doctor's prescrip	tion					





Ni 13/Male/MH1202381075

UF 02/12/2023/IPH202302423

D( Dr.RAJESH.V

MHI/NUR/2022/052



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.
04 12 13 12 - CD	0/8			i.	· · C-poT	al. 027b	Lionos
16-00	1/10	Dull Paun	110 20C	eunglical et to	proceeded. Comfortable	0140	Cous
18.00	1/10	Dill poin	210-13 800	Stemum	non-planmaco cog Pcal Portercention done	50 min	Low
20.00	Yin	ALLY PARM	SEA SEA	SURGILLAT SME	Phasimanological Intervention are	Dawl	W 200
22.00	2/10	DUIL PAIN	SB3 <a></a>	STERNUM.	Non- Pharmanogral Intervention	Jamil 1977	of aus
3/14/23 34 24:00	•	~,	-	}	Postant Was Steeping Computaty	Dant.	Lows
diap	<b>-</b>	_	-	1	Potent was Straping compartably	Dowl HIO	N 2003
H190				1	Patient was Steeping combining	Jamy 0171	You
\$100	1/10	AUTY PAIN	10 SE	SURLIUM 3175	Phennacologial Introduction are	Jamt 18.	Host

Date & Time	Pain Score	(dull, achy	Pain Character , sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
8-00°	1/10	b	ull pain	10 - 5 sec	sternum	non Phanmacological intervention	Ai oll	A god
10.00	1/10	DI	ell pair	5sec	Sternum	To give compositable position to the Pt	Ai OLLL	160°2
12.00	Vω	<u> </u>	ul pain.	Llosee	- Bl-èsnim	Mon phownwoodsgical interention given	and a	Loo
14. ve	· 410	۹	all jain	_∠(05€c	: stooming	1 0 0 1 .	and sin	
	•	•-		1	P/	IN SCALES	<u>.                                    </u>	<del></del>
(28 week	PIPPS s to < 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to severe	le comfort me	easures	The state of the s	, /,	
(38 we	CRIES eks - 2 mo	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, pesic administration is indicated for a score of 6 or higher.	,	
FL	ACC Scal	le				erate discomfort, 7-10: Severe discomfort / pain / both		1
Pain	-Baker F <i>A</i> Rating So ars - 12 ye	cale	O 2  No Hurts Little Bit	4 Hurts Little More	6 Hurts Evan More	Numerical Rating Scale (age model)  8 10 Hurts Whole Lot Worst  Numerical Rating Scale (age model)  1 2 3 4 5 6  None Mild Moderate	7 8	9 10
Observa	cal care P tion Tool tor / com	(CPOT)	COMPLIANCE WITH VEN	Absence of m ITILATION (in Inbated patler Ielaxed, 1 - Te	novements or normal ( ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting vermal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing ense, Rigid	ventilator (or)	
	narmacolo ervention		Cutaneous Stimulation a Thermal Therapies (no lo	nd massage: nger than 15	: E - Positioning; F - R to 20 minutes): G - C	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy   <b>Psycho-social therapy/counselling:</b> K - Individual Couns	eling; L - Family	y counseling
Pharmac	ological li	ntervention	ns as per doctor's prescrip	tion				





13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/NUR/2022/052

Medway

Heart

Every heart beat counts

Institute

## 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.
16-00	410	dull pain	2-10860	<i>Elennim</i>	Mon phonma cological intervention done	July otan	(veo)
18-00	1/10	dull pain	5-10360	8/01Ni	Mon pharma cological intervention don	of n.	Moos
30,00	No.	achy pain	5-10 Sec	g felneum	confertable politing	0276	Love
22,00°	1/10.	Achy pair.	10 see	Stelrum	Confertable polities	286	Kars
00:00	1/10	Archy Pain	S	Stenan	Confertable proffs given.	may osts	las
07.00	-	Sleeping	-	· _		19.KCO .	Nody
du po		Sleapiny	<b></b>	-		629.P	Lous
OP.'00		Sleapiny.				mean oza c	Voor
8-00	1/10	Dull pain	210-15 20c	Ebonum	non-planmacological Entervention done	2/02/10	Jaws

Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
 [0-80	1/10		Dull Poun	Lib SOC	2 hrofican Site	uon-plarmacocoglica/ Pertoruentos dona	8270	Noos
14.00	Уw		Dull pain	2 lo see	Singlices)	provided contortable position	519	
18-00	Уw		Dull palus	y losee	Singical.	provided comportable position	5100	
200°	1/10	j	Oull pain	ons obt	Suegical Site	Phaemacological. Intervention Given	Hay ODS	
				·	P/	IN SCALES		<u>-</u>
(28 week	PIPPS (s to <u>&lt;</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		n	-	
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is > 4 esic administration is indicated for a score of 6 or higher.	ļ,	
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	iscomfort, 4-6: Mode	ate discomfort, 7-10: Severe discomfort / pain / both		
Pain	-Baker F <i>F</i> Rating So ars - 12 ye	cale	O 2  No Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age no notation and	7 8	years) 9 10
Observa	cal care F tion Tool ttor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (III ubated patier Relaxed, 1 - Te	novements or normal   ntubated patlents): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing ise, Rigid	ventilator (or)	
	harmacol tervention		Cutaneous Stimulation a Thermal Therapies (no lo	and massage: onger than 15	E - Positioning; F - R to 20 minutes): G - Co	Music; D - Physical and mental exercisers bbing / Massage the skin application; H - Hot application; I - Shortwave diathermy rerntial therapy   Psycho-social therapy/counselling: K - Individual Coun	seling; L - Famil	∕ ċounseling.
Pharmaco	ological l	ntervention	ns as per doctor's prescrip	tion				<del></del>





13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/NUR/2022/052



PAII	N RI	E-ASSESSMENT	& MC	NITORING	CHART MANUAL LINE	Every heart	beat counts
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.
·	,			Patient	is sleeping.		,
6:00	110	Dull pain	ons oft	Svegical Site	-Phaemalological intervention Given	Hay.	Ol an
8,00	1/10	Dull pain	ON Off.	sugical site.	non pharmalogical Intervention vive	Jen -	24
1 <b>9</b> .93	1/100	Dull Pain	on 21	surgical site.	provided comfortable position.	Seu oron.	1902
d S	Ίω	pull pain	on & OPF	Swigral	providue confrorble position or the patient	808	rol
9840	Yw	Dull Pain	on 9	surgicul	provided Comportie  Position Of the patient	Sour	l ga
22.00	0/60	No Pain	J	_	_	A 000 81	Pel 24
2,00	0/10	No Pain	_	<del></del>		det	24
6.00	0/10	No Pain	J	-		dita	124

Date & Time	Pain Score	(dull, achy,	ain Cha , sharp, st , referred	aracter abbing, shooting, / radiant pain)	Duration	Location / Site	Inte	erventions				Staff Initial & Emp. No.	Senior S Initial Emp. N
g-30	olo		No	Pain		-	_					Jan 6204	127
00.00	olio	N	р {	Pain_	_	-	_					J. 24.	100
14.00	0[w		Mο	puin	_	-						019	124
18°100	9,0	· •	Jo :	Pain	-					•		dy	100
<u> </u>						 P <i>F</i>	IN SCALES						
(28 week	PIPPS s to < 38	weeks)	7 - 12 =	ss = Minimal to no = Mild pain - Provid Moderate to sever	de comfort me	asures nocological intervention	on.					·	
(38 we	CRIES eks - 2 mo	onths)					of gestation. A maximal score of esic administration is Indicated f				e is > 4,		
	ACC Scal nths - 7 ye		0: Rela	xed & comfortabl	e, 1-3: Mild di	scomfort, 4-6: Mode	rate discomfort, 7-10: Severe dis	comfort / pain / b	oth				
	-Baker FA Rating Sc		((8))		( jo			Numerical F	Rating	+-	<del></del>	+++	+
	irs - 12 ye		0 No	2 Hurts	4 Hurts Little	6 Hurts	8 10 Hurts	0 1 2	3 <b>↑</b>	4 5 <b>↑</b>	> 6 <del>↑</del>	7 8 <b>↑</b>	9 10
			Hurt	Little Bit	More	Eyen Mora V	/holo Lot Worst	None Mild		Mod	erate	Se	/ere
Observat	cal care P tion Tool ( tor / coma	(CPOT)	BODY I COMPI VOCAL MUSCI	MOVEMENTS: 0 - LIANCE WITH VEI IZATION (non-int LE TENSION: 0 - F	Absence of m NTILATION (in ubated patien Relaxed, 1 - Te	ntubated patients): 0	position, 1 - Protection, 2 - Restless - Tolerating Ventilator or Movemen rmal tone or no sound, 1 - Sighing, nse, Rigid	t, 1 - Coughing b			ighting ve	entilator (or)	
Non-ph	narmacolo	ogical	Distrac Cutane	tion: A - Relaxation	n-conducive e and massage:	nvironment; B - TV; C	- Music; D - Physical and mental e						





13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/NUR/2022/052



Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senlor Staff Initial & Emp. No.
22:00	o/w	No Pain	Ĵ		•	2008	Nel 24
2200	$O(\omega)$	No Pain	_	J	_	Aufor	12A
6.00	olio	No Pain	_		<del>_</del>	Solar	De 24
8-00	olw	No Pain	<b>~</b>	4	j	Jen osen.	NO.
12.00	olto	No pain	_	-		Je 0204	100
16.00	oho	νο ραύρ				011	124
					,		

Senior Staff Initial & Emp. No.
<u></u>
years) 9 10 yere
y counseling
9



13/Malc/MH1202381075 02/12/2023/iPH202302423

Dr.RAJESH.V





## **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

	egn a score of 1 if (125) in parameter nos. 1 to 5,							1
		2/12/5			5/12/23			ļ
	Time	هرو	8-00	6,00	6:00	GABO	6000	
S. No.	PARAMETERS	<u> `</u>					/	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	Ø	0	0	0	۵ر	0	
2	Bedridden recently >3 days or major surgery within four weeks	0	0_	0	0	Þ	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	D	В	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	Ø	p	
5	Entire leg swollen (Assess for both legs)	0	0_	0_	0	p	Ø	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	p	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	D	0_	0	0	Ø	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	$^{\sim}$	Φ_	0	0	Ø	0	
9	Previously documented DVT (Assess for both legs)	ଚ	0	0	0	0	Ø	
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.	7	6	0	0	0	0	
	FINAL SCORE	0	0	_0	0	0	Ø	
Low R	isk: -2 to 0   Moderate Risk: 1 to 2   High Risk: 3 to 8	فتحر	Low	Low	Low	Lau		
	DVT prophylaxis started	□ Yes \□ No	□ Yes □ No	□ Yes √⊒ No	□ Yes Ū/No	□ Yes ☑ No	□ Yes I□ No	☐ Yes ☐ No
_	Signature & Emp. No. of RN	7011	924	Houts	test	Mon	Wer.	
	Signature & Emp. No. of Sr. RN	No	معو	المولم	سحو	100	20	



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Patin Master.SIVAGURU.S 13/Malc/MHI202381075 Nam 02/12/2023/IPH202302423 UHII DOB Dr.RAJESH.V DOA Cons



## **DVT RISK ASSESSMENT**

ASS —	ign a score of 1 if (YES) in parameter nos. 1 to 9,	and ass	_	_	-	-		
		व्य गिर		Q(12/12)	10/12/2		ام ا	
	Time	14.00	6100	Moo	6:00	6.0€	6.00	
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	b	0	0	Ø	O	
2	Bedridden recently >3 days or major surgery within four weeks	+1	+1	14	+1	+(	+1	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	ව	0	0	O	80	0	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	Ø	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	٥	0	0	0	O	
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)	<u></u> ೨	0	0	0	0	0	
9	Previously documented DVT (Assess for both legs)	0	O	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	O	0	O	0	0	
	FINAL SCORE	+1	귀	H	1-1	41	71	
Low R	isk: -2 to 0   Moderate Risk: 1 to 2   High Risk: 3 to 8	mol)	Fru	MOD	mod	MOD	GOM	
	DVT prophylaxis started	□Yes □No	□ Yes y No	□ Yes □ No	□ Yes ↓□ No	□ Yes □ No	☐ Yes ☐ No	☐ Yes
	Signature & Emp. No. of RN	6	Hamp	Mary	Hay	COR	took	
	Signature & Emp. No. of Sr. RN		/ //	1	100	'sol	ADR.	

## Medway Hospitals

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



#### Master.SIVAGURU.S 13/Male/MHI202381075

02/12/2023/IPH202302423

dr.rajesh.v



MHI/NUR/2022/046

## MODIFIED MORSE FALL RISK ASSESSMENT CHART

	_						_	·		
Variables	Date	1/3/2	2/2/23	3/12/23				HOB	Alisty	<u>द्री।र्थ23</u>
, variables	Time	12520	8.00	8 60	(A)20	9D,00	8)00	(N/20)	20:00	8.00
History of falling	No	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	9	- ,0	16	\Q	0	- 0	9	-0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	18	0	ø	-0	10	0_	0 _	0	_0_
(≥ 2 medical diagnosis)	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy /	No	O.	_ق	0/		u	9	0 _	-0	بھ
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		10	0	6	و	\0	9	0_	.0/	٥
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT	<b>,</b>							İ		
Normal / Bed Rest / Wheel Chair		10	•	0	۵	60	8	0	9/	_0_
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS							<del></del>			
Oriented to own stability		٥	e	· ø_	6	0	0	0 /	0/	اس
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants,	No	<i>8</i>	<b>a</b>	<b>a</b>	.01	0	0	0	0	0
anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	15	15	15_	18	457
Total Score	<u>_</u>	0	Ø	0	16	18	(6	(જ	15	Lo
Low Risk (0 - 24)			~							~
Medium Risk (25 - 44)				-						-
High Risk (45 or above)										
Signature & Emp. No. of RN	2	Sant	The state of the s	51	Sch	they	M	Elan	Hord	Fire
Signature & Emp. No. of Sr. RN		1994	1991	1201	1924	200	عددا	Var Der	1264	WO P
		0 -	24: Lów	Risk; 2	5 - 44: N	/ledium	Risk; 45	or abo	ve: High	Risk

-	T	· ·	n.			M )		Г-	<del>' ' '</del>	
INTERVENTIONS	Date	76/2	9/15	2/12	162/2	2/12/23	1126	MIN	1 101	*
Tick as per the Risk Score	T:	4/	<u> </u>	١,١	20\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	20.00	4//	, (	7 (2)	<del>\$. '`</del>
Hek as per the hisk score	Time	19/30	<sup>20.</sup> ∞	g= 50	(A1/20)	20.0	25	(D-1/20)	20:00	<b>6</b> :6
Low Risk Interventions (0 - 24)			_						_	
Familiarize the patient with the immediate surround										<del></del>
Remind the patient to use call bell before getting ou										\
Keep the two side rails in the raised position at all t	imes for			/		_				
all patients regardless of age			/	/						
Keep the call bell, bedside table, water, glasses w	ithin the							_		
patient's easy reach	- •								4	
Remove excess equipment or furniture to make	a clear			/			/	_		
path  Keep the patient's bed in the low position at all time.	c overant		ļ. —			<u>-</u>				
during procedure	sexcept	<b> </b>	レレ	/				_	/	
Teach fall-prevention techniques, such as sitting	un for a		-			<u> </u>				
moment before rising from the bed	ap 10. a	<b> </b>	<u> </u>	/						
Bed wheels should be locked			~	1	/			-		
Encourage family participation in the patient's care			~					~		
Ensure that floor of the bathroom is dry and not slip		/	ン				-	-		
Review medications for potential side effects t	<u> </u>			/		/				
promote falls		L	\ <u>``</u>	//				1		
Use safety belts during movement in wheelchair			<b>~</b>					1		_
The patients are not ambulated by themselves. The	ey are to			/	1			_		
be ambulated only with assistance		/	~	1	_		1			
Medium risk interventions (25 - 44)										-
Apply all the low risk interventions		ļ		-						
Tie yellow fall risk tag in the bed and Wheel chair / S			<del> </del>							
Make sure that proper transfer precautions are in										
for heavy or debilitated patients in a bed or wheel on a toilet seat	chair or									
Use restraints and bed monitors as ordered by the	doctor	<del> </del>								-
Allow the patient to ambulate only with assistance	400101	<b>-</b>				<b></b>				
Consider peak effects of the medications that effe	cts level									
of consciousness, gait and elimination when p					-					
patient's care	· · · · · · · · · · · · · · · · · · ·		ļ							
Do not leave patients unattended in diagno	ostic or									
treatment areas			1		ļ			ļ		
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 underst	and the					1			•	
restrictions mentioned above						1				
High-risk interventions (45 or abovc)										
Apply all the low and medium risk interventions		<b> </b>	<u> </u>	ļ	ļ					
Tie red fall risk tag in the bed, wheel chair and streto		1								
Locate the high-risk patients in a room close to the station	nurses		1							
Answer these patients call bells as quickly as possi	hle	<del>                                     </del>				<u> </u>				
Provide a commode at bedside (if appropriate)	<del></del>	<del>                                     </del>				<u> </u>				
Urinal/bedpan should be within easy reach (if appro	opriate)	t	<b> </b>			<b>+</b>				
Encourage family members or other visitors to s										
If appropriate, consider using protection devices belts	s: safety		:							-
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Signature & Emp. No. of	Sr. RN	کوئی ا	200	209	. 09	. 19-	100	سف ۱۱	حويدا	
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## Medway Hospitals

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



#### Master.SIVAGURU.S 13/Malc/MHJ202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





## MODIFIED MORSE FALL RISK ASSESSMENT CHART

			<del>- :</del>						,	
Variables	Date	1/2/2)	12 [12	<u> [</u> [12]23	6/13	8/12	<u> 4\12\123</u>			
Valiables	Time	Into?	20.00	8.00	10,00	20.00	صو. م			
History of falling	No	10	re/	01	يو ا	9/	ø	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	10	20	مر	0	9/	9	0	0	0
(≥ 2 medical diagnosis)	Yes	15	15	<b>1</b> 5	15	15	15	15	15	15
Intravenous Therapy /	No	20	0	0	JØ	0/	رو	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID		<u> </u>		n 1						
None / Bed Rest / Nurse Assist		10	₹ <b>0</b>	9	(A)	9/	.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	<u></u>	0	<b>√</b> 8∕	9/	4	9	20	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	ļ	0	10	0		9/	<i>8</i>	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,	No Yes	0	0	0 15	0	0	0	0 15	0	0
anti-hypertensives, hypoglycemics and psychotropics				<i></i>						
Total Score		16	(&	17	15	15	18			
Low Risk (0 - 24)						4	/			
Medium Risk (25 - 44)										
High Risk (45 or above)				-						
Signature & Emp. No. of RN		Donl	121	& Sm	CON .	Wha	Rolln	/		
Signature & Emp. No. of Sr. RN		Now	الحول المواد	سيوا	1300	1984	100			
		0-	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk

INTERVENTIONS Tick as per the Risk Score Time  Work 15th Interventions (0-29) Familiarize the patient with the immediate surroundings Remind the patient to use call beli blodroe getting out of bed Keep the two side ralis in the raised position at all times for all patients regardless of ago Keep the two side blodside fable, water, glasses within the patients easy reach Formove excess equipment or furniture to make a clear path Keep the patient's bed in the low position at all times developed during procedure Teach fall-provention techniques, such as sitting up for a moment before rising from the bed Blod wheels should be locked Ensure that floor of the barknoom is dry and not slippery Ensure that floor of the barknoom is dry and not slippery Ensure that floor of the barknoom is dry and not slippery Hole of the barknoom		Bata	2089	202	5 1.59	211.	1/12	1.12	1	<u>·</u>	<u> </u>
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## Medway Hospitals The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



#### Master.SIVAGURU.S

13/Malc/MHI202381075

P; 02/12/2023/IPH202302423

N: Dr.RAJESH.V





MHI/NUR/2022/046

## MODIFIED MORSE FALL RISK ASSESSMENT CHART

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Variables	Date	<u>क्</u> री।ग्रेष्ड	7 1/123	8/12/23	8-12-4	g/12/25	9/12/23	alis	17/12/23	
variables	Time	14-00	20100	8 00	14.00		8-06	94.00	70,00	8.00
History of falling	No	0	0	ر کھی	9	(9)	<u> </u>	<u>@</u>	0/	مه،
(immediate or within 6 months)	Yes	25	25	25	25	25	25	`25	25	25
Secondary diagnosis	No	<u> </u>	9	۰	_x	(6)	(b)	Ø	0	_0_
(≥ 2 medical diagnosis)	Yes	15	15	15	15	15	15	<u>`</u> 15	15	15
Intravenous Therapy /	No	0	0	0	0/	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	(20)	20	20	20	20	80	<b>2</b> 0	20/	.20
AMBULATORY AID		_	/		/		,	4		
None / Bed Rest / Nurse Assist		<b>(b)</b>	.0	9	9⁄	(o)	<u> </u>	<u>(0)</u>	10	_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		<u>(0)</u>	9/	0	√o	(o)	<b>(</b>	0	V	رگ_
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS		<u> </u>			/					
Oriented to own stability		0	ر ا	ے	6	6	<b>(9)</b>	<b>(</b> 0)	10	رق
Overestimated or forgets limitations		(15)	15	15	15	15	15	15	15	15
MEDICATIONS Includes P.CA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	6	0	0	0	0	0 (	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	<b>†5</b>	<b>≯</b> 15	<b>1</b> 5	15)	(15)	<b>/15</b>	15	15-
Total Score		35	35	35	Z)	35	35	35	35	35
Low Risk (0 - 24)										
Medium Risk (25 - 44)		~	V.	<b>✓</b>		<b>/</b>		V		
High Risk (45 or above)					J		•			
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——————————————————————————————————————		V.2.	רול	L	7,4971	/ <i>I⊼</i> ∿-I	$M_{\sim}1/1$	<u>\</u> `to, \	ו אוביו ו	<u>"</u> A

MITERIENT	Date	4/4/3	进	8/12/23	0120	10XXX	Mala	9/2	, ,	ı ı
INTERVENTIONS Tick as per the Risk Score	-	04/1.4	23	-	·	6/0	9/12/23	112	9112/2	
nck as per the hisk score	Time	1345	∂b∙a	8.00	14.07	NO0.	X .000	14-00	Spoon	•
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroun				ļ <u> </u>			<u> </u>	<u> </u>		
Remind the patient to use call bell before getting o								$\sim$	<u> </u>	_
Keep the two side rails in the raised position at all all patients regardless of age	umestor					/	j	~	. /	
Keep the call bell, bedside table, water, glasses v	within the									
patient's easy reach				1		^		/	<b> </b>	
Remove excess equipment or furniture to make	e a clear								/	
path			-			_		~		
Keep the patient's bed in the low position at all time	es except		-						./	
during procedure			•					/		1
Teach fall-prevention techniques, such as sitting	up for a	,						١	/	1
moment before rising from the bed									V	
Bed wheels should be locked								~		
Encourage family participation in the patient's care		_		ļ	_			~	<u> </u>	مست
Ensure that floor of the bathroom is dry and not slip		•		ļ 			<u> </u>		$\checkmark$	
Review medications for potential side effects	tnat can							/		سد
promote falls Use safety belts during movement in wheelchair										
The patients are not ambulated by themselves. The	nev are to								$\sim$	
be ambulated only with assistance	iey are to			,		_			./	
Medium risk interventions (25 - 44)										
Apply all the low risk interventions						/	_			7
Tie yellow fall risk tag in the bed and Wheel chair / \$	Stretcher							7	./	1
Make sure that proper transfer precautions are		-			<u> </u>			~		
for heavy or debilitated patients in a bed or whee							·/		<b>/</b>	1
on a toilet seat							`			
Use restraints and bed monitors as ordered by the	doctor						V			
Allow the patient to ambulate only with assistance						-	/			7
Consider peak effects of the medications that eff						_		_		•
of consciousness, gait and elimination when	planning									1
patient's care										
Do not leave patients unattended in diagr	ostic or									7
treatment areas				ļ	ļ <u></u>					
Accompany the patient while going to bathroom	L _4L4L			<del> </del>						
Advice the patient to use grab bars near the toilet, and shower	paintub,			ŀ	\_/	_				~
Make sure the family and other visitors unders	tand the			<del> </del>					7	
restrictions mentioned above	italia tile					_			\ \ \	1
High-risk interventions (45 or abovc)					ļ					
Apply all the low and medium risk interventions		~			Ì					7
Tie red fall risk tag in the bed, wheel chair and stret	cher		2/	~						7
Locate the high-risk patients in a room close to th	e nurses'								. /	
station		>		- ~					V	-
Answer these patients call bells as quickly as poss	ible	M	NA	44				5		7
Provide a commode at bedside (if appropriate)		m	NA	44	<u> </u>			<u>/</u>	<u> </u>	
Urinal/bedpan should be within easy reach (if app		Me	NA	Aq.			ļ		<u> </u>	
Encourage family members or other visitors to	stay with	M	NA	Reg				/		-
them	· ·	(AN)	-	<u>  ` </u>	<u> </u>			<u> </u>		
If appropriate, consider using protection device	s: satety	MA	No	40		,				~
belts		ı	Dans	<u> </u>	12	1967	41-	MA 11	رسلىسى:	رورک
Signature & Emp. No	o. of RN		019	O'S'A'	472	123VP	1653	<b>1</b> 2/4/5	45.65	A SA
Signature & Emp. No. of	Sr. RN	L ,	/		1/	-1A	LA	róe	All I	No
			205	275	NOS	35	مندو	VON	04	M
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## R Medway Hospitals The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





## MODIFIED MORSE FALL RISK ASSESSMENT CHART

MODIFIED MOR			- 1110		JOE (		PIAI	O1 17		
Variables	Date		10 उद्		11/15	11/2	12/12/2	12/12		_
	Time	1X+00	22:08	8,00	1400	220	8-00	14.00		
History of falling	No	ص	0	<b>.</b>	0	p	.0	_هر_	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	~6	•	9	0	0	<b>19</b>	0	0	0
(≥ 2 medical diagnosis)	Yes	15	15	15	. 15	15	15	15	15	15
AMBULATORY AID	- 	10-	9	.0	_ه_	2	رو	0	0	0_
None / Bed Rest./ Nurse Assist Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
Intravenous Therapy /	No	0	Ο,	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	_20	20	20	ر20	<b>\20</b>	20	20
GAIT	-	ص	0_	9/	Jø-	0	ے ا	9	0	0
Normal / Bed Rest / Wheel Chair 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		00	8	_ه_	<u>o</u>	0	٠.٥٠	18	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0	0	0	0	0,	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	45	18	15	45	ধর্হ	15	15
Total Score		35	35	35	35	35	35	35		
Low Risk (0 - 24)										
Medium Risk (25 - 44)		\				<u></u>				
High Risk (above 45)			A-A-		~ 4	4				
Signature & Emp. No. of RN		8	9600	Despir.	Galor.	800	Sen	9		
Signature & Emp. No. of Sr. RN		120	00	120	1800	OSA AEO	120			
,		1.	0 - 24: L	ow Risk	; <mark>25 - 4</mark> 4	1: Mediu	ım Risk;	Above	45: High	ı Risk

	<u> </u>		1,2	1.10	1	\ <sub>2</sub>	),,	\ \		
INTERVENTIONS	Date	10/12/2	10/13	11/12/2	11/18	11/	12/2	12/12		
Tick as per the Risk Score	Time	127.W	22-0°	\$00	14.00	20:00	₽.00	14:00		
Low Risk Interventions (0 - 24)	e e		_	<u>س</u>						
Familiarize the patient with the immediate surround	lings									
Remind the patient to use call bell before getting ou	t of bed		-	w		<u> </u>				
Keep the two side rails in the raised position at all t	imes for									
all patients regardless of age				مب	<u> </u>		-/			
Keep the call bell, bedside table, water, glasses w	ithin the		_			V				
patient's easy reach	••	, ,	· V		1	V	<u></u>			
Remove excess equipment or furniture to make	a clear			مس		<b>~</b>				
path						_	~			
Keep the patient's bed in the low position at all times	s except	]					ا را			
during procedure										
Teach fall-prevention techniques, such as sitting	up for a		~	_			ا			
moment before rising from the bed	<del> </del>									
Bed wheels should be locked						~	- <b></b>	<del></del>		
Encourage family participation in the patient's care				1	//					
Ensure that floor of the bathroom is dry and not slip					<u> </u>	V		<del>                                     </del>		
Review medications for potential side effects to	nat can			1			سد ا			
promote falls Use safety belts during movement in wheelchair		-						1/	<u> </u>	
The patients are not ambulated by themselves. The	ov oro to	<del> </del>			-					
be ambulated only with assistance	ey are to					V	ا			
Medium risk interventions (25 - 44)				7						
Apply all the low risk interventions		\	1	1		\	<u></u>			-
Tie yellow fall risk tag in the bed and Wheel chair / St	tretcher									
Make sure that proper transfer precautions are in							<u> </u>			
for heavy or debilitated patients in a bed or wheel					/	<u> </u>		<b>-</b>		
on a toilet seat	<b></b>								<b>-</b> -	
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	cts level	-								
of consciousness, gait and elimination when p						_				
patient's care	_				ľ		بسب			
Do not leave patients unattended in diagno	stic or	/	~					\		
treatment areas									-	
Accompany the patient while going to bathroom		)	\			$\langle$				
Advice the patient to use grab bars near the toilet, t	oathtub,				_		_			
and shower				<i>\</i>			_			
Make sure the family and other visitors underst	and the	1			/	$\checkmark$				
restrictions mentioned above	}						4	/		
High-risk interventions (above 45)				<u> </u>						
Apply all the low and medium risk interventions										
Tie red fall risk tag in the bed, wheel chair and stretc		ļ <del></del>		<u> </u>						
Locate the high-risk patients in a room close to the station	nurses									
Answer these patients call bells as quickly as possil	nle					-	_	-		
Provide a commode at bedside (if appropriate)	OIG	-		<u> </u>	<u></u>					
Urinal/bedpan should be within easy reach (if appropriate)	opriate)									
Encourage family members or other visitors to s								-		<del></del>
them	, ••••••									
If appropriate, consider using protection devices	s: safety								, –	
belts		. ا	N	_						
Signature & Emp. No.	of RN	g	<b>*</b>	. A3 37	Missel	9	Jezu.	Code /		
<u> </u>		3,00	<u> </u>	NE NE	. XV	000	W 00	100		
Signature & Emp. No. of	Sr. RN	<u> </u>	15X							
		19/	<del>- 31</del> /-	100	<del>\ \ \ \ \ \ \</del>	<del>22</del> 4	<del>3/(</del>	(4)		



Master.SIVAGURU.8 13/Malc/MHI202381075 02/12/2023/IPH202302423 Dr.RAJESH.V



## PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f	filled	by cond	cern	ed d	iscip	olines. U	lse k	ey b	elov	٧				
Barriers to Learning Plan to Address Factors  None Vision / Hearing limitations Use of Interpreter														
None		Vision	/ He	arin	g lin	nitations	;			Use	of Ir	iterp	rete	F
Limited Reading Abilities		Physic	al b	arrie	rs	_			Ш	Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	iers					Sim	ole L	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	ı / dı	esire to	learı	1		Writ	ten l	nstu	ctio	ns
understand and follow directions												1		
Completed By : Date 1575Tim	ne	(2)	<u> გბ</u>	ı	lurs	e Signa	ture	:			Æ)	<b>\</b>	(h	
							·							
Learning Record														
Need		Date	۱ ا	Visit •	1	Date	\ \	/isit	2	Date	\	/isit	3	Signature
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Disease		′								<u> </u>				Doctor
Information on								}						
Disease / Diagnostics			طا	er.	Ŋ		P	90	V		a	15D	y	
Treatment				<b>3</b>	μ		10	o O	<b>V</b>		_	8	3	,
Medications			ľ	\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							_			Doctor / Nurse
☐ Information on Safe and														14
Effective use of medicines														-01
Information on drug / drug and														6/2
drug / food interactions														
☐ Discharge Medications	ı													
Surgical Instructions														Nurse
Pre - Operative Instructions		•	P	Ø)	٨		12	(ای	<u></u>		12	92	7	They !
Post - Operative Instructions							l					ŀ		
(Wound / Dressing Care)									L					
Pain Management													L	Nurse
Reporting of pain			P	00	V		P	8	$\geq$					Noo
Pain Management			P	00	$\vee$		P_	9)						Oly
Safe and effective use of medica	ı		•											Doctor / Nurse
Equipment (if required)								<u> </u>	_			<u> </u>		
Name of Equipment										İ				
Rehabilitation Techniques				l									l	

	Date	] \	/isit	1	Date	١	∕isit	2	Date	1	/isit	3	Signature,
		L	Р	0		L	Р	0		L	Р	0	,
Nutritional Guidance													Dietician
Diet Instruction for patients at				_				1					
Nutritional risk		$\overline{l_b}$	ÞΝ	<u>ر</u>		η	هد	$\sim$					idania Catherin Co
Diet advice for home			_	\				1				$\prod_{i}$	r Nürse <sup>jetitlan</sup>
Discharge Planning		L_	<u> </u>	Ш				Ш			L		
Self care											L		
Follow up		<u> </u>	-					Ц			┡		_
Reporting Concerns Immunizations													
Parenting education													
☐ Others													
Risk Factor Reduction													
Smoking Cessation													Doctor
☐ Weight Control													<u></u>
☐ Exercise	_												
The standard of the standard o													
Hypertension			1								L.,		
Other Risks  LEARNER (L) - R-Patient, M - Mother, I  PROCESS (P)- OD - Oral Discussion, I  OUTCOME (O) - RD - Return Demonstr	D- Dem ration,	ons	trati	on,	W- Wri	itter					(	Stat	te Relationshi
Other Risks  LEARNER (L) - R-Patient, M - Mother, I  PROCESS (P)- OD - Oral Discussion, I  OUTCOME (O) - RD - Return Demonst	D- Dem ration,	ons	trati	on,	W- Wri	itter					(	Stat	te Relationshi
Other Risks  LEARNER (L) - R-Patient, M - Mother, I  PROCESS (P)- OD - Oral Discussion, I  OUTCOME (O) - RD - Return Demonst	D- Dem ration,	ons	trati	on,	W- Wri	itter					(	Stat	te Relationshi
Other Risks  LEARNER (L) - R-Patient, M - Mother, I  PROCESS (P)- OD - Oral Discussion, I  OUTCOME (O) - RD - Return Demonstr  Written Material given and explained (	D- Dem ration, if any)	ons	trati	on,	W- Wri	itter				1		Star	
Other Risks  LEARNER (L) - R-Patient, M - Mother, I  PROCESS (P)- OD - Oral Discussion, I  OUTCOME (O) - RD - Return Demonstr  Written Material given and explained (	D- Dem ration, if any)	ons V - \	trati	on,	W- Wri	itter				1			
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Other Risks  LEARNER (L) - R-Patient, M - Mother, I PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given :  Given Pending	D- Dem ration, if any)	ons V - \	trati	on, paliz	W- Wri	itter	etano			1 			
Other Risks  LEARNER (L) - R-Patient, M - Mother, I PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given :  Given Pending Discharge Summary ECG Report	D- Dem ration, if any)	ons V - \	trati	Oiet	W- Write Advice	epor	etano			1			
Other Risks  LEARNER (L) - R-Patient, M - Mother, I PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given :  Given Pending Discharge Summary ECG Report Doppler Report	D- Dem ration, if any)	ons V - \	trati	Oiet CT S	Advice Scan Re	eport	t			1			

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Uf 02/12/2023/IPH202302423
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## PATIENT AND FAMILY EDUCATION RECORD

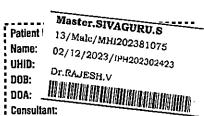
Assessment To be	tilled	by con	cern	ed di	SCI	olines. U	ise K	ey b	erov	<u>~</u>				
Barriers to	Barriers to Learning										o A	ddı	ess	s Factors
None		Vision	/ He	aring	g lin	nitations	<u> </u>			Use	of Ir	iter	rete	er
Limited Reading Abilities		Physic	al b	arrie	rs					Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers	•				] Sim	ple L	ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ d	esire to	learı	1		Writ	ten l	nstu	ıctio	ons
understand and follow directions										J				
Completed By : Date	ne	8 ½	୭୦	N	lurs	e Signa	ture	: _	<	FXX	H			
Learning Record						-			_	•				
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Disease		, , , , ,												Doctor
Information on														n 1)
Disease / Diagnostics			₽	o D	y		Læ	ΩĐ	ر		0	ଫ	,	155132
Treatment			- Ç	ற	ท		ľ	οØ			Ę,	ത	<b>V</b>	
Medications			U				٧				5			Doctor / Nurse
Information on Safe and														S AN
Effective use of medicines			10	උතු.	✓		10_	04)	<b>&gt;</b>		ø	) QO	<b>/</b>	@\/6 pl
☐ Information on drug / drug and	_						1							
drug / food interactions														
☐ Discharge Medications														
Surgical Instructions														Nurse
Pre - Operative Instructions			P	Ø)	7		10	me			)O	02	V	Chin
Post - Operative Instructions			4				•				A			
(Wound / Dressing Care)														
Pain Management														Nurse
Reporting of pain							12	<i>7</i> 60	$\overline{V}$		Þ	50		John
Pain Management							_	20			P	89	V	Postn
Safe and effective use of medica	ıl						V							Doctor / Nurse
Equipment (if required)														
Name of Equipment														<u></u>
Rehabilitation Techniques														

	Date	١ ١	∕isit	1	Date	١	/isit	2	Date	١	∕isit	3	Signatur
Chicket and the control of the contr	•	(L)	P	Ö	a astem a	2: <b>L</b> ~	Р	데		Г	Р	0	17.7
Nutritional Guidance	,	一	<del>                                     </del>		-	: erbber	-					V	Dietician
Diet Instruction for patients at	_	┢		┢	-	2.,,		1 1	<u>'</u>			1 - 12 -	
Nutritional risk		_	<u> </u>	,	Haair	2007 7.75	-	Ы		$\mathcal{B}$	8i~	Ŋ.	Senior Dietitian
☐ Diet advice for home		$\vdash$			1,111	CHILLY	_	H					Nurse
Discharge Planning	. 19.50	30,	. ì	-	7, 12,				المرسمة ا	βe. 0			<del> </del>
Self care	- 11	n		-			1.41	∺	<del>'</del>	-	$\vdash$	-	The first of the second
Follow up	*********		$I^-$	<u> </u>	_			1					
Reporting Concerns Immunizations	41	1.7	. 14.		e de de de de de de de de de de de de de					٠.,	1.0		Sept to the figure
Parenting education			-				Ī	$\Box$	,		}r.~;	77. 7	141,310,
Others		T	Ť	-	<u> </u>			$\vdash \uparrow$	i			<del> </del>	7 - 7 - 1.
Risk Factor Reduction		$\vdash$	Ι					┌┤				T	
Smoking Cessation			T -	·		、	74.		· · · · · ·	·		- 50.	-Doctor
Weight Control								$\Box$					
☐ Exercise								П					
☐ Hypertension													
Other Risks	i												
LEARNER (L) - P-Patient, M - Mother, PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	D- Dem ration,	ons V - V	trati	ion,	W- Wr	itter	ı Ma		,			,	te Relations
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	D- Dem ration,	ons V - V	trati	ion,	W- Wr	itter	ı Ma		,	9 11		Ser.	, , , 1 <sub>14</sub>
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	D- Dem ration, if any)	ons V - V	trati	ion,	W- Wr	itter	ı Ma		,	S and the second		Ser.	An Charles
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	D- Dem ration, if any)	ons V - V	trati	ion,	W- Wr	itter	ı Ma		,	2		Ser.	An Charles
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	D- Dem ration, if any)	ons V - V	trati	ion,	W-Wr	itter	ı Ma		,	Figure 1900		Ser.	An Charles
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PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (	D- Dem ration, if any)	ons V - V	trati	ion,	W-Wr	itter	ı Ma		,	F		Ser.	An Charles
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PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (  Reports Given :  Given Pending Discharge Summary	D- Dem ration, if any)	ons V - V	trati Verb	on,	W- Wr	itter	n Ma			- 10	a. v	18 (17) (4) (4)	THE STEP IN
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given:	D- Dem ration, if any)	ons V - V	trati Verb	Diet	W- Wr	itter	n Ma			- 10	a. v	18 (17) (4) (4)	THE STEP IN
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonst Written Material given and explained (  Reports Given :  Given Pending Discharge Summary	D- Dem ration, if any)	ons V - V	trati Verb	Diet	Advice Scan Re	itter ders	n Ma			- 10	Pe	ndi	ng - NA
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given :  Given Pending Discharge Summary ECG Report	D- Dem ration, if any)	ons V - V	trati Verb	Diet	W- Wr	itter ders	n Ma			- 10	Pe	ndi	THE STEP IN
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PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given:  Given Pending Discharge Summary  ECG Report Doppler Report X-Ray Report	D- Dem ration, if any)	ons V - V	trati Verb	Diet	Advice Scan Re Scan Fil	eport m Rep	i Ma			- 10	Pe	ndi	ng - NA
PROCESS (P)- OD - Oral Discussion, I OUTCOME (O) - RD - Return Demonstr Written Material given and explained (  Reports Given :  Given Pending Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film	D- Dem ration, if any)	ons V - V	trati Verb	Diet	Advice Scan Re Scan Fil IO Repo	eport m Rep	i Ma			- 10	Pe	ndi	ng - NA











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### PATIENT AND FAMILY EDUCATION RECORD

Assessment To be	filled	by con	cern	ed d	isci	plines. U	se k	ey b	elov	N			1	
Barriers to	Le	arning								Plan t	o A	ıbb	es	s Factors
None		Vision	/ He	arin	g lin	nitations				Use	of Ir	nterp	rete	
Limited Reading Abilities		Physic	al b	arrie	rs					] Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barr	iers			•		] Sim	ple L	ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	1 / d	esire to l	earr	1		] Writ	ten l	nstu	ctic	ons
understand and follow directions									<u> </u>					
Completed By : Date 08 (2) Tin	ne	8.0	0		turs	e Signa	ture	·:_	2	il				
Learning Record												_		
Need Need		Date	Γ,	/isit	: 1	Date	١	/isit	2	Dațe	<u> </u>	/isit	3	Signature
		07/12/13		Р	To	08/12/23	L	Р	Го	9/12/3	┢	Р	О	oignaturo
Disease			-		Ė			Н	Ť			$\vdash$	$\vdash$	Doctor
Information on				$\vdash$	t		_		┢					
Disease / Diagnostics			8	Ð	V		\$	OD	ļν		F	Ø	$\nu$	
Treatment			δ	(7)	V		_	010	_		1=	Ø		
Medications			_	20			•	DD.			E		V	Doctor / Nurse
☐ Information on Safe and							7							Щ
Effective use of medicines		l	-	┢╴	t			.						
☐ Information on drug / drug and					Г								Γ	
drug / food interactions			-		+									
☐ Discharge Medications			ړ	m	V		۶	οjo	5)		F	OD	ν	
Surgical Instructions			Q	00	ν		P	20			τή.	CD	V	Nurse
☐ Pre - Operative Instructions			J		ŀ		_							24 T
Post - Operative Instructions			•											
(Wound / Dressing Care)			£	Ø)	$\bigvee$		F	00	V		7	Ø	u	
Pain Management			2	<b>3</b>	V		F	מס			#	OD	$\nu$	Nurse
Reporting of pain			ļ											10-1-
Pain Management				_	-		ĺ		7					par.
Safe and effective use of medica	aľ													Doctor / Nurse
Equipment (if required)							_			~~				Ay.
Name of Equipment														
Rehabilitation Techniques				<del> </del>	<del> -</del>			<u> </u>	_			-	┝╽	
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Nutritional Guidance    Diet Instruction for patients at Nutritional risk   Diet advice for home   Discharge Planning   Diet advice for home   Discharge Planning   Diet advice for home   Discharge Planning   Diet advice for home   Discharge Planning   Diet Advice   Diet advice for home   Discharge Summary   Diet Advice   Diet Advice   Diet Report   Doppler Report   Doppler Report   Doppler Report   Diet Report   Diet Advice   Diet Advice   Diet Report   Diet R	Need			Dațe	Γ,	/isit	1	Date	\ \	/isit	2	Date	<u> </u>	/isit	3	Signature
Nutritional Guidance    Diet distruction for patients at Nutritional risk   2				07/15/ <sub>18</sub> 2	L	Р	0	alre	L	Р	0	almbr	L	Р	0	,
Diet advice for home	Nutritional Guidance							<i>A</i> ()				3111187				Dietician
Discharge Planning    Self care   Follow up   Follow u	Diet Instruction for Nutritional risk	patients at			S	~	2		2	97	S		h	a.	þ ′	Senior Death Sw
Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other ROCESS (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 X-Ray Report ECHO Report ECHO Report	☐ Diet advice for hon				-	-	F		-	-	-		_	-	F	Nurse
Follow up   Reporting Concerns   Remunizations   Parenting education   Others   Risk Factor Reduction   Doctor   Smoking Cessation   Doctor   Weight Control   Exercise   Hypertension   Other Risks   LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other   State Relations   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)   N C   Reports Given :   Given Pending NA   Given Pending NA   Discharge Summary   Diet Advice   ECG Report   CT Scan Report   CT Scan Film   X-Ray Report   ECHO Report   ECHO Report   CHO Repor	Discharge Planning	_			1									Г		_
Reporting Concerns   Reporting Education   Doctor	Self care				-		1									
mmunizations   Parenting education   Others   Risk Factor Reduction   Doctor   Smoking Cessation   Doctor   Doctor   Weight Control   Exercise   Hypertension   Other Risks   LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other   (State Relations 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   CT Scan Report   CT Scan Report   CT Scan Film   X-Ray Report   ECHO Report   ECH	Follow up				<u> </u>		L				L					
Others   Risk Factor Reduction   Doctor     Smoking Cessation   Doctor     Weight Control     Exercise   Hypertension   Other Risks     CEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other   (State Relations     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)     N       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     CEG Report   CT Scan Film     X-Ray Report   ECHO Report     CEG Report   CT Scan Film     X-Ray Report   ECHO Report     CEG Report   CT Scan Film     X-Ray Report   CT Scan Film     X-Ray Report   ECHO Report     CEG Report   CT Scan Film     X-Ray Report   CT Scan		s														
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Smoking Cossation   Doctor	Others		1										,		Г	_
Weight Control   Exercise   Hypertension   Other Risks   LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	Risk Factor Reduction				~				-		F				Г	
□ Exercise □ Hypertension □ Other Risks  LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	Smoking Cessation	1			~											Doctor
Hypertension   Other Risks   Care Relations   Other Risks   Care Relations   Other Risks   Care Relations	☐ Weight Control								)							
Other Risks   LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	☐ Exercise		_				_									
LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	Hypertension															
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	Other Risks	· .				-		٠.		-				L		
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Given Pending NA  Discharge Summary Diet Advice  ECG Report CT Scan Report  Doppler Report CT Scan Film  X-Ray Report ECHO Report											•					
Discharge Summary Diet Advice  ECG Report CT Scan Report  Doppler Report ECHO Report	Reports Given :					-		·								
ECG Report CT Scan Report CT Scan Film CT-Ray Report ECHO Report		Given	Pending	, 1	AA			:		-		Give	1	Pe	ndiı	ng NA
ECG Report CT Scan Report  Doppler Report CT Scan Film  X-Ray Report ECHO Report	Discharge Summary						Diet	Advice								
Doppler Report CT Scan Film  X-Ray Report ECHO Report			-				CT S	Scan Re	por	t			_			
X-Ray Report ECHO Report	<u>-</u>								-							
440																
								=		ort						
Compact Disk Any Other Report	_								-							
Compact Disk Any Other Report							niy.	Julei I	-OP							
	Name of Discharge	Nurse								Sig	nat	ure :				



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02/12/2023/IPH202302423
Dr.RAJESH.V



## PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f	illed	by con	cern	ed di	isci	olines. U	lse k	ey b	elov	<u>v</u>				
Barriers to	Lea	arning								Plan t	o A	ddr	ess	s Factors
None		Vision	/ He	aring	g lin	nitations				Use	of Ir	nterp	rete	 Pr
Limited Reading Abilities		Physic	al b	arrie	rs				Ш	Edu	cate	fami	ily	
Religious / Cultural Factors		Langu	age	barri	ers					Sim	ple L	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ de	esire to	lear	1		Writ	ten l	nstu	ctío	ns
understand and follow directions														-
Completed By : Date 10/12/2 Tim	1e	8-4	೨	/	lurs	e Signa	ture	:		85	روا	-		
Learning Record												_		
Need	ļ	Date	١	/isit	1	Date	١	/isit		Date	١	/isit	3	Signature
		idin	L	Р	0	1/12	L	Р	0	12/12	L	Р	0	
Disease		WARE												Doctor
☐ Information on														
Disease / Diagnostics							  D	pD			l p	OD_	<b>1</b>	
Treatment			'P ~	017	υ		۲	\			<del>-</del>	<del></del>		
Medications				OD			<u></u>	910			Ю	ov		Doctor / Nurse
☐ Information on Safe and			,				14	<u> </u>			1			<i>S</i> -
Effective use of medicines				•			b	OD	$\mathcal{S}$				į	96m
Information on drug / drug and		_					<u> </u>		,					
drug / food interactions							P	aD	J		Q_	OD		/
☐ Discharge Medications											Γ-			
Surgical Instructions														Nurse
Pré - Operative Instructions			P	00	J						99	<b>Q</b> _		all
Post - Operative Instructions											1			60
(Wound / Dressing Care)							$L_{\rm L}$	on		_	Þ	an		
Pain Management											_	•		Nurse
Reporting of pain														
☐ Pain Management														_
Safe and effective use of medical	[ ]													Doctor / Nurse
Equipment (if required)										_				
Name of Equipment														
Rehabilitation Techniques														

Need	Date	١	/isit	1	Date		/isit	2	Date	\	/isit	3	Signature
	ļ	L.	Р	0		L	Р	0		L	Р	0	
Nutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk						E'	<b>3</b>	0		6	مر		ria Calification
☐ Diet advice for home			Ш			1	1	1		7	ŝ	ز	Nurse
Discharge Planning													
☐ Self care													
Follow up													
Reporting Concerns Immunizations				<u> </u>									
Parenting education				П									
Others													
Risk Factor Reduction				$\Box$				П				П	
Smoking Cessation				П									Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
Other Risks													
LEARNER (L) - P-Patient, M - Mother, I	F-Fathe	r, S	-Spo	ous	e Other	r					(;	Staf	te Relationship
PROCESS (P)- OD - Oral Discussion, I	٦. Dem	ons.	trati	on	W- Wri	itter	ı Ma	teri	al				
, ,													
OUTCOME (O) - RD - Return Demonst	ration,	V - 1	/erb	aliz	ea und	aers	tane	aing	<b>I</b>				
Written Material given and explained (	if any)												
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			•										
D. d. Ohan				_	_								
Reports Given :					_							_	
Given Pending	g <b>N</b>	NΑ							Giver	1	Per	ndir	ng NA
Discharge Summary			[	Diet	Advice			_		_	_		
ECG Report			_ (	CT S	Scan Re	port	t	-					
Doppler Report					Scan Fil	-							
X-Ray Report			_		O Repo			•		_			
X-Ray Film					asound		ort			_			
· · · · · · · · · · · · · · · · · · ·						-		•		_		_	i
Compact Disk			<b>– '</b>	чпу	Other F	<b>teh</b> c	Ŋι			—			
Name of Attendant / Patient :	SA	K٦	-H(	J)			Sig	nati	ure :	- \)	,	មា	SA)
	<u> </u>	/	<del> , «</del> -	0	_		_			<u>ب</u>	$\sim$		
Name of Discharge Nurse	wa	م	~	9.			Sig	natı	ıre :	$C_{\ell}$	رج	/	
<i></i>	•									/	<i>6</i> 0°	>	



Master.SIVAGURU.S

13/Malc/MHi202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



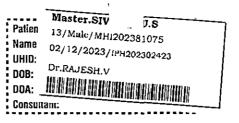


## Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 2 12/22	خ. :Time	<b>P</b> :-	3ª		<del></del>	<del></del>	
Checklist	Yes	No	NA		Action / Remarks	<del>-</del>	
MEDICAL .		•		3,			
Daily Consultant Visit					·		
e ı of care discussed	1						
⊔ischarge Planning	×	•			<u>-</u>		
Others if any	8	_			<del></del>	<del>-</del>	
NÜRŞING *				e de la companya de l	•		
Safety Precautions Ensured	~						
Care of Lines and Tubes							
Infection Control Measures	1			,			
Skin Care	1						
Response to assistance	1						
Others if any	イ						
DIETICIAN	P 41			P P P P P P P P P P P P P P P P P P P	# <b>2</b>		
Diet Adequate	$\perp$						
Special Request				,			
PHYSIOTHERAPIST	u 7			A Lat a Bag		, <del>'</del>	
Available for Assistance for Activities of Daily Living				-	•	-	
Others if any	/					•	
PATIENT CARE SERVICES	1	•					,
loom Cleaning satisfactory						_	
Room Amenities Adequate							
Billing Update available	Ti i						
Non-Availability of any service					<u></u>		_
Spiritual Needs (if yes specify)				,	•		
Others if any							
:		<u>'          </u>	ter Dis	ciplinary Team Member	rs		
	Signatur	B 1		Name .	Reg. / Emp. No.	Date	Time
Doctor		سلبر		3. Sewanya	155752	A)12/23 1	<b>3.6</b> 0
Nursing Staff	0	<del></del>		Amorghe.	olhl	2 [2623/2	2:27
Dietician		<del>6610</del>	سليلا	isiana Catheline John Senior Dietitian	201	2/12/12/1	3.4
Physiotherapist	SHAR	1		Ranftak	0260	7/12/23 1	٥٥٠نو
Patient Care Service Staff	-						









## **FAMILY COUNSELLING FORM**

CONSU	LTANT- DR_	RAJECH	DIAGNOSIS- RHD, SEV PR			
DATE	HOSPITAL MEMBERS	FĂMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
othels	D-SHEEBD	-	# Explained about pathents condition, Dev Etery Q Hospital policy		1868	(12236
06.12.7	doay n	Pziyanta.3 (SISTER)	explains the family one gooding patient condition & about word which		Six.	F 11236

MHI/HOSP/2022/110



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13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V





Every heart beat counts

#### **WOUND ASSESSMENT CHART**

<del></del>				,	<u> </u>	r	,	
DATE	11/12/2	>(2) 12/2	?					
SITE OF WOUND	,		_					
CHEST	<b>✓</b>							
LEG L/R								
ABDOMEN								
SACRAL REGION								
'IEEL					· .			
OTHERS	ļ		_					
SIZE OF THE WOUND								
SUPERFICIAL / DEEP IN NATURE					-			
PRESSURE Specify system used :			_					
RISK FACTORS Specify system used :	DM	НТМ	Age	Obesity				
WOUND TISSUE TYPE(S) PRESENT								
necrotic							Π	
slough	🗆							
	1							
undermining								
undermining granulation	<b>5</b>							
•		_	_	_				_
granulation	e							
granulation overgranulation								
granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S)								
granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated								
granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated erythema								
granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous								
granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis								
granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis blistered								
granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis blistered bruising								
granulation overgranulation epithelialisation other  SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis blistered								

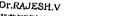
## **WOUND ASSESSMENT CHART**

EXUDATE AMOUNT								
none	   <u> </u>							
evidence of some moisture		·						
evidence of significant flow								
EXUDATE								
serous				]				
sero - sanguinous			\ \ !					
_			1					
ODOUR	<u> </u>	<del></del>	<del>- 1</del>					
, ·			/					
none		<b>P</b> .		] []				
some evidence of odour								
significantly malodorous								
PAIN AT WOUND SITE (nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)	1/10	:/(0						
INFECTION SUSPECTED*								
SWAB SENT							□.	
ANTIBIOTIC THERAPHY								
BLOOD GLUCOSE / URINE ANALYSIS								
PATIENT / CARER TO DO DRESSING		Þ						
SIGNATURE	Jan.	test /						
*SIGNS & SYMPTOMS OF WOUND INFECT  • Pytexia • excess exce		*SUSP	ECT WOUL	ID ÎNFECTI	ON IF:			i s
licalised pain     erythema     localoedema	odour	• gra	nulation tiss	ue bleeds ea	asily •	healing is sl wound brea		nticipated



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02/12/2023/IPH202302423







## **IN-HOUSE TRANSFER FORM**

	· · · · · · · · · · · · · · · · · · ·						
Part	A (to be filled by Nu	rses)					
Date	e of Transfer: og p	_}	<i>∂</i> <sub>0</sub> Tr	ansferred	from:	<u> SDLW·</u> To:	( 200)
Diag	gnosis: RHD 18	ev. Alecs	;	مرمرلغالي	J. P. R. (		
Vital	Signs: Temp: 08 - 10°F	F)   Pulse / HR:				60 (mmHg)   Respi	iration: 24 (breaths/min)
Part	B (to be filled by Ph	ysicians)	Any Critic	al Investig	ations:		
	Check for			Trai	sferring Doct	or	Receiving Doctor
	iratory (Breath sounds)	Clear	Crepitat	tion	thonchi 0	thers:	Yes No
Abdo		Soft	Tender		oistended O	thers:	Yes No
Hear	t Sound	Normal [		Loud			Yes No
CNS		Consciou	us U Or	iented	GCS Sco	ore: [[]]	Yes No
	burgical Patients plicable)	Surgical Site:	Heal	Ithy S	oakage 🔲 O	thers:	Yes No
		Prese	nt Medic	ation (for	Medication R	econciliation)	
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	Syp. Sucra	CPATE	( Chi)	Plo	1-1-1	09/2/23 07-30	Д∕Yes □ No
7	NED. LEVOL		0.63m	1171)	964	09/12/23 010-00	✓ Yes ☐ No
<u>J</u>	T. YRUSF MI	DF	40mg	P/0	1-1-0	09/12/23 68.00	
4	T. BEPLEX	fortc_	17AB	P/o	1-0-0	09/10/03 60 8.00	∐ Yes □ No
٠٠ ر	J. ASpIRINT	-	+5mg	\(\nu / v	0-1-0	08/12/23 01400	☑ Yes □ No
<u>b.</u>	T. PARACA		Domg	p/0	1-0-1	09/12/2 08.30	☐ Yes ☐ No
7.	_ T. MMORR	0100	12.5 ing	7/0	1-0-1	09/12/20 8-30	Yes 🗆 No
8,	T. RA20-		1713	p10	1-0-1	09/12/2 67.00	☐ Yes ☐ No
9,	T'. COPDAR	eme	comp	Plo	1-0-1	09/12/13 08.20	☐ Yes ☐ No
_		·					☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
_							☐ Yes ☐ No
t			-,			}	☐ Yes ☐ No 🤇

Additional Det	tails <i>(i</i>	if any):					
•							
			_				
Patient Condit	tion:	Stable 🗌	Sick-need urgent care   Othe	ers:			
	Sign	•	Name	Reg. No.	Date		Time
Transferring Doctor		6	DR. Viewer	132236	190	(12/23)	11:12
Receiving Doctor		<u></u>	DR. Azun	153268	0 01/	12/23	11:45
Part C (to be f	illed t	oy Nurses)					
Check for		_	Transferring Nurse			Receivir	<del>-</del>
Drains		Chest A	Abdominal Others:			√Yes	☐ No
Respiratory		Air Way Type Oxygen Therap	= -	s:li/m	— in	☐ Yes	☐ No
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction		Yes	☐ No
Foley's Catheter		Yes No		<u>,                                     </u>	-	Yes	☐ No
Intravenous Acc	ess	Peripheral Li	ne Central Venous Line Others	:		Yes	☐ No
Pressure Injury		Yes No	If Yes, give details:			Yes	☐ No
Score		Fall Risk: 35	WELLS: NEWS / PEWS:			Yes	No
Patient Belongin	igs	Yes No	If Yes, give details:			∐√Yes	☐ No
Handover Detail	s		ninistration Record explained: Yes CReports handed over: Yes No	No		✓ Yes	☐ No
Patient Attendar	it	Yes No	If No, give details:			√Yes	
Additional Det	tails <i>(i</i>	if any): 🕡				-	
		1					
		•	MiL				
		*					,
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	Sign	<u> </u>	Name	Emp. No.	Date	!	Time
Transferring Nurse	· ,1	<del>λ</del>	7) - diaba		0	9/12/22	12
Receiving Nurse		BOUN	2 - dueba pavitha	0078 0078	9	2/23	11.30

ç



Doctor Clinical

Pharmacist



Every heart beat counts

Master.SIVAGURU.S 13/Malc/MHI202381075 02/12/2023/IPH202302423

165302

0151

HOME MEDIC FO		USAGE		RAJESH.V			_
Allergies: NKDA.					_		
Diagnosis: RHI	/ (3)	LV functi	on.				
Prescribed drug name		name brought t/ Attender	Dose	Freq.	Qty.	Batch No. & Expiry date	
T. Fausemide	T. Fau	Semide	Aong	9	8	A34A6	
T. Fursemide T. Methyl penicillis	T. Melli	ylpeniallin	250 mg	B	lo	2248200	9
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	<del></del>						1
		<del></del>					4
Sig	nature	Name	[	Emp.	No.	Date & Time	-

This is to certify that, I take full responsibility of the quality and potency of the medications that I have brought to the hospital. Medications that I have got are stored with proper medication storage recommendation given by the manufacturer (Room temperature (below 25°C) or Fridge temperature (2°-8°C)). Any Adverse effects that is caused or effects that affects my recovery due to improper storage condition of medications that I have got from home, will be under my responsibility. I am aware that several medications that are available in Indian and International market are spurious and bogus which can cause harm to my health. I assure that Medway Hospitals or its employees will not be held responsible for any outcome/ results in the future.

	Signature/ Thumb impression	Name	Date	Time
Patient			_	
Guardian	. NESS.	Shakthi (Father) (Name and Relationship with the Patient)	a   12   23	3:50 pm

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff	OLY.	A- monutes	2/12/25	3259



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

о.т. № .....

Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/OT/2022/099



Every heart beat counts

#### **PERFUSION DATA SHEET**

HLM Maquet Date Dall 10/23 Category CMS Risk Factors. Surgeon: Dr. Rajesh
Anaesthotist: Dr. Ajestha Dr. Psaveon
Pertusionist: MS WSP | MS. Hari'
Oxygeneator: AFFLNITY .NT
Arterial Filter: E VRO SET
Haemofilter SORIN Age/Sex 15 ()F 3-54 Heparinisation time Height 151 2.4 Pump on: cms 33 12:23 Pump off: Weight Kgs. 2.0 Total Pump Time: 多りかiの Surface area: 1-18 m² 1.8 Haemoglobin /4-2 Aortic occiusion time: 61min lit/min 1.6 <u>1.88</u> Haemofilter SORIN
CP Device SPICTRA 0.5 TCA time Haematocrift 11.3 0.59

Prediagnosis: Mi MMR, Turval TR Procedure AVR (1 mm STH mechanical Vulve)

Cannulation (Can type and size): RF - 34fRsvc DSSVC: Acrtic 18 Fy - Fem Art Fem Vein LSVC:

TIME	BYPASS	PRESS	URES		FLOW	S LPM_	%			PERATU	RES		BLOOD	GAS A	NALYSIS	AND CH	EMISTR	Y	
IIIME	BIFASS	AMP	CVP LA/PA	Line	Blood	Gas	FiO,		NAS_ REC	ART	VEN	PH	PCO,	РО,	BE	O <sub>2</sub> SAT	К+	Na	Hc
	Pre									_									
12	ON	47		110	1.33	4.5	601.		33-b										L
32		69	_	150	23	2	50%		33			7.3	357	224	32	99.5	4.40	135	30
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CAR	DIO PLEGIA				TIME DOSE			25	3 and				R	BS 12	2 mgl	AL.			

FLUID LOSS OR GAIN Prime Pump add Blood Fluid Bicarb Mannitol: Heparin: Potassium Others Others Others Others Total Gain Post perf pump vol O.R. Loss Bleeeding Urine 00 m CUF / MUF: **Blood Samples** Others (600 w Total loss Fluid loss/gain

•	EXYGENERATOR PRIME ()	
Blood	297-ml 00	
Others	1200ml =	
Bicarb	n MEQ/cc	
Нераліп	11.5ml	
Mambl:	сс.	
Ahmin:		
Others:		ı
	Total (cc) 1498.5 W	μ

	BLOOD ADDED	_
Type 2	tve.	
Unit No	Product Type	Time
4277	PRBC	11:00
· ·	,	
	_	
HEP	TIME	ACT
	[1:32	446

LIDINE	PRE	DURING	POST
- URINE -	200mg	.100 m	
OTHER			
	5.		

VALVESSJM MASTERS SERIES NECHANICAL
SIZE 21 S.NO.31458841 HEARTVALUE

(L'(7 - 12:18 6/min

PERFUSION SIGNATURE CELLO III







Every heart beat counts

#### VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

Master.SIVAGURU.S

13/Malc/MH1202381075

02/12/2023/IPH202302423

AGE / SEX:

Dr.RAJESH.V

HR TO HALLEN FOR THE HEALTH DEPORTED HEALTH DE

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.
,		<b>N</b> T.					
व्मीश्रीय	14-00	CUBLLAC	0/5	PHIENT	#LUCHED	OBSERVATION	8270
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ادماما	8,00	CUBITAL	0 (3	PATENT	PIUSHED	OBSERVATION	-012L
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1 ),	8.00	RI WBITH	015	PATENT	CHI 2U13	OBSERVATION	0270
9/12/23	14.00	(Whital	0/5	Datont.	Flushed	Observation	Ol or
	g0:00	er cutital	olr	Patent	Hushed	<b>-</b>	Hayow
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	2200	entral	0/5	Pateent	Flustea	-	24
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ار کنکا			_ =	V Line	Peno	Vd.	
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	8/12/23 9/12/23	11 12 23 14.00 22:00 11 12 23 14.00 22:00 11 12 23 14.00 22:00	07/10/20 14-00 CURTAL 8000 27 8000 CURTAL 8000 CURTAL 14-	07/10/20 14-00 CURITAL 0/5 8000 RT WETTAL 0/5 8000 CURITAL 0/5 14-00 CUBITAL 0/5 14-00 CUBITAL 0/5 14-00 CUBITAL 0/5 2000 CUBITAL 0/5	14-00 CURTAL OLS PATENT  8:00 CURTAL OLS PATENT  8:00 CURTAL OLS PATENT  14:00 CURTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  14:00 CUBTAL OLS PATENT  10/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/22 H. 00 CUBTAL OLS PATENT  11/12/23 H. 00	14.00 CURTHAL OLS PATENT FLUCHED  80.000 CURTHAL OLS PATENT FLUCHED  8/000 CURTHAL OLS PATENT FLUCHED  14.00 RIGHT OLS PATENT FLUCHED  14.00 RIGHT OLS PATENT FLUCHED  14.00 RIGHT OLS PATENT FLUCHED  14.00 RIGHT OLS PATENT FLUCHED  14.00 RIGHT OLS PATENT FLUCHED  14.00 RIGHT OLS PATENT FLUCHED  10/12/13  14.00 RIGHT OLS PATENT FLUCHED  10/12/13  14.00 RIGHT OLS PATENT FLUCHED  10/12/13  14.00 RIGHT OLS PATENT FLUCHED  10/12/13  14.00 RIGHT OLS PATENT FLUCHED  10/12/13  11/	OFFICE OF PATENT FLOCKED OBSERVATION  RELIGION PRIMET OF THE NT FLOCKED OBSERVATION  RED 13 600 (LIRITAL OLS PATENT FLOCKED OBSERVATION  RED 14.00 RIGHT OF PATENT FLOCKED OBSERVATION  PICO CLICTEL OF PATENT FLOCKED OBSERVATION  PICO CLICTEL OF PATENT FLOCKED OBSERVATION  PICO CLICTEL OF PATENT FLOCKED OBSERVATION  PICOLOGICAL OF PATENT FLOCKED OBSERVATION  PICOLOGICAL OF PATENT FLOCKED OBSERVATION  PICOLOGICAL OF PATENT FLOCKED OBSERVATION  PICOLOGICAL OF PATENT FLOCKED OBSERVATION  PATENT FLOCKED OBSERVATION  PATENT FLOCKED OBSERVATION  PATENT FLOCKED OF PATENT FLOCKED  PATENT FLOCKED OBSERVATION  PATENT FLOCKED OBSERVATION  PATENT FLOCKED OF PATENT FLOCKED  PATENT FLOCKED OBSERVATION  PATENT





#### Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/PHARM/2022/028



Every heart beat counts

# MEDICATION ADMINISTRATION RECORD

1			_	•	•		• •		•	
Drug	Chart:	:(of			Heigl	nt (cms):	191 cm	Weight	it (kg): <u> </u>	FIRE
_		KNOWN MEDICINE AL	LERGIE	S (if NC	ONE is co	onfirmed,	, write NKDA iı	n box 1)		
Drug De	tails			ption of A	Allergy			Docto	or's Rign:	700
		'		• • •			•	`	K ON TO	3 DUI
						<u> </u>		. Name	TJK	FILL
								Reg.	No. 12	1.56
		- ····C	<del> </del>	• ,	- ATL		TAPE INICION	<u>.l</u>	,, ,0	ψυυ.
		R INSTRUCTIONS	1. Check	k entries ir		IRSING ST	TAFF INSTRUC d omissions	CTIUNS	1	•
		me when prescribing drug  K LETTERS, clearly and legibly	2. Nurse	in-charge	e should ver	erify drug cha	art on daily basis as of doctor's presc	crintian on	∩av 1 only, ar	nd then
3. Sign ar	ınd enter N	MCI registration no. or apply seal	follow	standard t	timings	_	33 of doctor 3 presc 212hrly: 10:00hrs, 22	•		
1	•	n should be altered / overwritten rmat when writing time	Q8hrly:	y: 06:00hrs,	, 14:00hrs, 2	22:00hrs or 09	212011y: 10:0001s, 22 09:00hrs, 14:00hrs, 2 :00hrs, 06:00hrs, 10:	21:00hrs, Q6	16hrly: 05:00hrs,	3,
		Stat / C		<del></del>		lication l			ome, release	
		<b>D</b>		7			Doctor		Administere	b
Date	Time	Drug	- <del></del>	Dose	Route	Sign.	Reg. No.	Sign.	Emp. No.	Time
3)12		J. RANTAC		Isom	10	go.	165307	404	0605	مزالاً ا
3/12	كالي	T- ALPRAX		2.5m	Pb	20	1.65307	that	005	21,00
4/12	6.00	_		٥٠٥٣	P/2	Ro	162308	Hay	Olor	6:00
SIR	21:3	O T. RANTAC		120~	P6	Q	165302	Hay	0105	21:35
5/12	<del> \(\rangle\)</del>	<del></del>	- <del></del>	0.23	1 0/0	@	162300	Horst	0005	11:35
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Clinical Pharmacist Medway Hearl Institute

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٦		filled in by Doctor	s only <b>♦</b>	Time <b>↓</b>	2/1/2	3/12	411	5) P2 /2	BIN	NIB	,	<b>\</b>
[]	DRUG NAME			San	ļ		[[ [					
	• •	CEMIDE		- Juli	/_/							
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al Phai y Head	HO MU	170	Start Date * Time	_	<b> </b>						-	
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1	Additional Info:	י רימין.	<u> </u>			8.1	Dy. 6	بويس	/ <b>-</b> /			
, <b>,</b> ,	DRUG NAME			1	1	\ \ \		-				
- \		VALAPRIC		sam		<b></b>						 
3	Dose .	Route	Frequency	<u> </u>		,						
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Clinical Pharmacist Medway Head Institute	Dr. Sign & Reg. N	lp. / Seal	Start Date & Time	•		700	<b>1</b> 7.					
Clinica	_ \\(\frac{1}{2}\)	प्रियानिष	Stop Date & Time	8PM		<u>,</u>		<u> </u>				
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	Nurse Signature	B:			120	え~	37	. 20,	_ã√			

Minical Pharmacis

Clinical Pharmacist

**Nurse Signature:** 

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
2/12	14.00	Normal diet	180	65507					
3/12	8,00	Normal diet.	Ole	165307					
4/12	12Am	NPO from 12 Am	0000	ussoz					
5)12	Son	Normal diet	Ø2	165302					_
6/n	128m	NPo from 120m	aa	140202	,				

#### 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
2/12/23	Morning				6/12/13	Morning	Parishea	1012	-Page
2/2/02	Evening	A. mond fer.	0111	II)	8 1223	Evening	A. Anither	6172	٤
2/2/23	Night	A. A.B. Mus	0088	d	6412	Night	Surula	2tu 8	
2/12/2	Morning	Daugno of in	237.	∾.	7/12/2	Morning	Pariller	0072	-Pays
3/12/03	Evening	A. monister.	0/41	B		Evening			
3/12/23	Night	Harnah Grace	0105	Hay		Night			
4/12/00	Morning	Douadhachini	02/2	7		Morning			
4/12/2	Evening	Denadhachini	0212	5	!	Evening			
4/12/23	Night	Hannah Grace	olos	they		Night			
,	Morning	A- mon's re.	0141	R)		Morning			
Spiss	Evening	A. monisher.	0141	<del>A</del>		Evening			7
5 12/21	Night	Suleila	2202	M		Night			, , ,





Paties Name UHID:

DOB:

Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/IPH202302423

Dr.RAJESH.V



MHI/PHARM/2022/028



Every heart beat counts

## MEDICATION ADMINISTRATION RECORD MANUBAYEL NEBVARS AG

ficg. ilo:112235

Drug Chart: Q of 1 Height (cms): 15 cm Weight (kg): 33

KNOWN MEDIÇINE	ALLERGIES (if NONE is confirmed, write NKE	PA in box 1)			
Drug Details	Description of Allergy	Doctor's Sign:			
·	NKDA.	Name: DR- PRIVEEN			
		Reg. No. 1122-36			
DOCTOR INSTRUCTIONS	NURSING STAFF INST	RUCTIONS			
1: USE generic name when prescribing drug	Check entries in every section to avoid omissions     Nurse in-charge should verify drug chart on daily ba	sis			

- 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
- 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	Door	Boute	ı	Doctor		Administered	ď	l
Date	Time	, Drug	Dose	Route	Sign.	Reg. No.	Sign.	Emp. No.	Time	
07/12/13	12-90	DNJ. AVIL	100	٧۵	8/	112256	PO-F	0270	15-20	
8/1/23	8;02	,	Smig	OPPER CHEST	8	112236.	نط	0265	8:00	١
12/23	9:15	INJ. PARACETAMOL.	500mg	Iv	8	112236	Ort.	0219	9:15	
8-12-13	17:30	ANT KETORLAC.	lomq	IV	8	112236		02:30		
9/12/22	01:00	In cardanone	2000 1200 1200	ΙV	8	112236'	سفهنا	0236×10	91700	K
9/12/23	01/00	FJ. PARACETAMOL	2005 My	Ţν	· F	112236	Moood		७। १००	
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To be filled by Nursing Staff only. Sign and time given Date → **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time 4 **DRUG NAME** 4,00 07.00 INT. PARACETAMO Dose Route Frequency Clinical Pharmacist Medway Heart Institute 500 mg Q841 Dr. Sign & Reg. No. / Seal Start Date & Time 07 1262 @15.00 15.00 Dr. PRAVEEN JEYAKUMAR SOOTH Stop Date & Time Reg. No:112236 Additional Info: J3-00 **DRUG NAME** 7.30 BYP SUCRALFATE SUSPENSION Route Frequency Clarical Pharmacist Medway Head Institute Pla 1-1-6 15 ml Start Date & Time Dr. Sign & Reg. No. / Seal 07/12/13 @19·30 13.30 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112236 0 19-30 Additional Info: **DRUG NAME** 4.00 NEB. LEVOSALBUTOMOL Clinical Pharmacist Medway Heart Institute Route Frequency Dose 10.00 Qc-H 0.63mg INH Start Date & Time Dr. Sign & Reg. No. / Seal 7/12/23 AT 16:00 Dr. PRAVEEN JEYAKUMAR 16,00 Stop Date & Time Reg. No:112236 Ø, 28,00 Additional Info: **DRUG NAME** 8.00 TAR, FRUSEMIDE Dose Route Frequency Clinical Pharmacist Medyay Heart Institute 40mg Plo 1-1-0 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 8/12/22 at 8.00 16.00 Reg. No:112236 Stop Date & Time 10 123 at Additional Info: DRUG NAME TAB BEPLEX FORTE Rewrite Route Frequency Dose 8.00. Plo 1-0-0 1+ab 0 Start Date & Time Dr. Sign & Reg. No. / Seal 81423 0 8.00 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112236 Additional Info: P Area In-charge **Nurse Signature:** 

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Date → To be filled by Nursing Staff only. Sign and time given **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time 1 **DRUG NAME** T- DICLOFENAC 9.00 Dose Route Frequency 25mg 1-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal 9/12/23 9.00 8(22)6 Stop Date & Time 2070 21-00 Additional Info: 8.40 01:00 **DRUG NAME** T. FRUSEMIDE Clinical Pharmacist Medway Heart Institute Dose Route Frequency 40mg Pa 1-0-0 Start Date & Time Dr. Sign & Reg. No. / Seal 10/12/22 9.00 Stop Date & Time gnerse Ø Additional Info: **DRUG NAME** 10.00 000 T. SPIRONO LACTONE Clinical Pharmacist Medway Head Institute Route Frequency Dose 25mg 80 1-0-0 Start Date & Time Dr. Sign & Reg. No. / Seal . 14,212, 9,00 & mish Stop Date & Time Additional Info: **DRUG NAME** 430 T. EMESET Dose Route Frequency 4mg Po 1-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal 10/2/23 9.00. 812236 Stop Date & Time 19.30 Additional Info: **DRUG NAME** T. BEPLEX FORTE Dose Route Frequency 8.00 P fas itab Start Date & Time 10 112 123 @ 1オーの Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info Area In-charge **Nurse Signature:** 

Clinical Pharmacist
Medway Heart Institute

To be filled by Nursing Staff only. Sign and time given Date -> **ANTIMICROBIALS** To be filled in by Doctors only Time **↓** 6.15 **DRUG NAME** 6.15 INJ. CFFORDXIMF SODUM Dose Route Frequency  $\sim$ W 1-59 Q12H ව්ූ Start Date & Time Dr. Sign & Reg. No. / Seal 07/12/03 @10.15 Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Stop Date & Time 18-12 8/12/4 at 19.13 18.15 Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Route Frequency Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: DRUG NAME Route Frequency Dose Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: Area In-charge **Nurse Signature:** 

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Date	Time	Intravenous Fluid	Volume	Rate / Duration	Route	Additive Drug  Name	Dose	Range		ctor	Start Time	ninistration End Time	_
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Date	Time	Intravenous		Rate /	-	Additive Drug				ctor	<del></del> -	Administration	
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8/12/23	1900	Soft Diet.							
tliebs	9-00	29ft dfet							

#### **NURSE IDENTIFICATION RECORD**

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

							<u>-</u>		
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning		, ·		11/12/2	Morning	Pavilho	1072 <u></u>	808
07/12/13	Evening	D. SHEEBA	0270	- 3210	11/2/2	Evening	A. Nordaini	0122	A
7112123	Night	D. RANEERA	이래	Jamlan.	dan	3 Night	lucida	2208	m
8/12/23	Morning	MAHA SATHUA	02/9.		Jahrh	la	Hannah Grace	0105	Hay
8.12.13		PURYALAMA J.P	0232	def		Evening		( ,	
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9/12/13	Morning	Sheeba	wto	250	· ·	Morning	,	,	
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2/2/2	Night	M. Doute	OU	35	<u> </u>	Night			
10/12/23	Morning	Teni Rija.	18c0	Fan 0204.		Morning			
polisto	Evening	& Kaoka	0195	Qu_		Evening	1	,	
10 12/23	Night	M. Sulenta	224	M		Night		<u>, , , , , , , , , , , , , , , , , , , </u>	<b>19</b> -0-

AVR & 21 mm ST-JUDE MASTER SERI- VALVE







Master.SIVAGURU.S 13/Malc/MHI202381075			_ M	HI/ICU/2022/076
02/12/2023/IPH202302423	ļ !			Sheet No.
DI.RAJESH.V	<u></u>	Age	Sex	
Blood Group	Height	Weight	BSA	Α
Bhe	ட்டு	1 33149	1.102	

SURGICAL PROCEDURE:

DATE OF SURGERY: D7 12/2023

POST-OP DAY: Dos

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						VENTIL	ATORS P	ARAMET	ERS						BLOOD	GAS		
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO <sub>2</sub>		pН	PCO <sub>2</sub>	PO <sub>2</sub>	HCO₂	SAT%	BE
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#### **NEURO**

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

#### **VERBAL**

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

#### MOTOR

Br-Brisk

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

**CAPILLARY REFILL** 

#### **MOTOR ARMS/LEGS**

S-Strong Wk-Weak O-Absent A-Anasthesia **CP-Chemical paralysis** 

#### **PUPILS SCALE (mm)**

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1	2	3 4	•
	5	6	
	7	8	

#### **PUPILS REACTION**

Br-Brisk
SI-Sluggish
O-Absent

#### **CARDIOVASCULAR**

**EDEMA** 

SI-Sluggish O-Absent
HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

## **NECK VEINS**

**D-Dependent** 

G-Generalised O-Absent

JVP N-Normal In-Increased

#### **VALVE CLICK/** SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

#### **PULMONARY**

WORK OF BREATHING	SUCTION
Ab-Abdominal	ET-Endotracheal
TA-Thoraco-abdomial	N-Nasal
L-Laboured	Or-Oral

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

#### **GASTROINTESTINAL**

**NGT POSITION** 

**BOWEL SOUNDS** 

**LIVERSIZE** 

N-Normal

E-Enlarged

+Present O-Absent	Air injected +Heard in Abd O-Absent GA-Gastric contents aspirated Dr-Dependent Drainage
ABDOMINAL TONE So-Soft F-Firm Tn-Tender Ob-Obese D-Distented	GASTRIC RESIDUAL G-Green B-Bleeding Y-Yellow C-Coffee ground

AVR & 21 mm ST-JUDE MASTER SEKIES VALVE







	Master.SIVAGURU.S	MHI/ICU/2022/076						
Name	13/Male/MH1202381075 02/12/2023/IPH202302423				٠	Sheet No.		
UHID No.	Dr.RAJESH.V		A	ge	Sex	<b>3</b>		
Blood Grou		Height	^	Weight 32 Kg	BSA I-Im <sup>2</sup>	Α		

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#### **NEURO**

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•	•	•	
1	2	3 4	
	5	<u>6</u>	
	7	8	

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**EDEMA** 

SI-Sluggish O-Absent	G-General O-Absent
HEART SOUNDS	NECK VE
S1 S2	JVP ·
M-Murmur	N-Normal
Rb-Rub	In-Increase
G-Gallop	
SM-Sound muffled	

## **ECK VEINS**

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/P -Normal -Increased

#### VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

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**NGT POSITION** 

**BOWEL SOUNDS** 

+Present

**LIVERSIZE** 

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+Present O-Absent		
ABDOMINAL TONE So-Soft F-Firm Tn-Tender Ob-Obese D-Distented	GASTRIC G-Green Y-Yellow	RESIDUAL B-Bleeding C-Coffee ground

# AVR & 21mm - ST JUDE MASTER SERIES VALVE







	Master.SIVAGURU.S 13/Malc/MHI20238107	5	]_		M	HI/ICU/2022/076
Name	02/12/2023/IPH2023024 Dr.RAJESH.V	123 .	:	_	,	Sheet No.
UHID No.			ge	Sex	(3)	
Blood Grou	p Bave	Height	ე ე	Weight 33 kg	BSA 1-1002	Ą

SURGICAL PROCEDURE:

DATE OF SURGERY: O升(い)2022

POST-OP DAY: 74 POD

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DATE		VENTILATORS PARAMETERS										BLOOD	GAS					
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	IΤV	ETV	FiO <sub>2</sub>		pН	PCO <sub>2</sub>	PO <sub>2</sub>	HCO₂	SAT%	BE
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#### **NEURO**

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#### **VERBAL**

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#### MOTOR

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SI-Sluggish

O-Absent

Obev commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

**CAPILLARY REFILL** 

#### **MOTOR ARMS/LEGS**

S-Strona Wk-Weak O-Absent A-Anasthesia **CP-Chemical paralysis** 

#### **PUPILS SCALE (mm)**

•	•	• (	
1	2	3	4
	5	6	
	7	8	

#### **PUPILS REACTION**

Br-Brisk SI-Sluggish O-Absent

#### CARDIOVASCULAR

**D-Dependent** 

G-Generalised

**EDEMA** 

O 7 1000111
HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

## **NECK VEINS**

O-Absent

JVP N-Normal In-Increased

#### **VALVE CLICK/** SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

#### **PULMONARY**

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Ab-Abdominal	ET-Endotracheal
TA-Thoraco-abdomial	N-Nasal
L-Laboured	Or-Oral

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

#### **GASTROINTESTINAL**

BOWEL SOUNDS	
+Present	
O-Absent	

+Heard in Abd O-Absent GA-Gastric contents aspirated Dr-Dependent Drainage

#### **ABDOMINAL TONE**

So-Soft F-Firm Tn-Tender Ob-Obese **D-Distented** 

#### LIVERSIZE

N-Normal E-Enlarged

**NGT POSITION** 

Air injected

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

#### Master.SIVAGURU.S

13/Male/MHI202381075 02/12/2023/iPH202302423

Dr.RAJESH.V

Sheet No

В

|--|

Blood Group Height

Age

Weight

3349

Sex

BSA

1.1m2

Medway Hospitals

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



MHI/ICU/2022/076



				ВІОСНІ	MISTRY		•			VITA	L PARAI	METER	S	-		CARDIA	AC ASSIST	DEVICE	
DATE	TIME	Нь	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	NRP	TEMP°E	Abd <sup>∞n</sup> G	TIME	IABP			R SETTING
	ļ	1.5	'\"	"	SUGAR	BECOB	1		SOUNDS	0002	10000	14101	1 Elvii 1	ADG O	1 11411	RATIO	DURATION	RATE	MODE
#10123	13:46	11.3	137	346	1.12		13,46		Q	א טטו.	VW 12		<b>9</b> 3F			_			
l <del></del>							14-30	II.	Cl	106'\	91mV								
	15.00	12.8	13%	8.72	1.14		15-30		66	1001	23/								
							16-30		CL	100%	266								
	16-30	11.01	13p	3.62	141,1		17-30		cl		delle.	1	97F						
							18:30		CL	1001	<b>ી</b> 4ક્રીમ								
		٠				<u> </u>	19-30		ci	997	366/ht						_		
							80,30		L	1001.	Odlmi		99F						
							91.3·		cl	00%	19m+								
_							22.3n		и	1 <del>00</del> 1.	20/m+		Clot-						\ 
				ī															
								1											

	SHIFT	DAY	EVENING	NIGHT
	TIME	13'40	16.00	20100
	EYES	CP	4	Ч
NEURO	VERBAL	BI	الح	4
	MOTOR	cp	6_	Ь
	ARMS R/L	op	18	ST
	LEGS R/L	cp	. 281	37
PUPILS	R.SIZE/REACTIION	ср	3/BR	3 BR
PUF	L.SIZE/REACTION	CP CP	3/1	3 BR
4R	HEART SOUNDS	915-	8,82	2152
CUL	VALVE CLICK	-		J
CARDIO-VASCULAR	CAPILLARY REFILL	9x	BR	BR
RDIC	EDEMA	Ó	p	٥
ু ১	NECK VEINS	Ν	N	H
IARY	WORK OF BREATHING	-da	TH	TA _
PULMONARY	SUCTION	Bulon	,	
PU	SECREATIONS	puld		_
 	BOWEL SOUNDS	4	+	4
STIN	ABDOMINAL TONE	Lor	SUFT	Sqt
NTE	N/G POSITION	(1000)	Mitu	
GASTRO INTESTINAL	GASTRIC RESIDUAL	d	a	_
GAS	LIVER	~	N	Н

	SHIFT	DA	Υ	EVE	NING	NIC	3HT
	DESCRIP.OF URINE		13:40		JCL	امل	
G.U.	PD - FUNCTION		d			_	
	DRAINAGE		1		ſ	1	
	PD - SITE		_			-	
	COLOUR		<b>-</b> -		)	_	
	Sx WOUND-CHEST		d		CL	J	
	LEG		υl		CL	cL	
SKN	DRESSING		דו		20	OT	_
	PRESSURE SORE-SITE	Y	y. C		WIL		
	AREA		•		1	1	
	DRESSING CONDITION				ł		
	POSITION CHANGE		الدل		Q2H	. <u> </u>	
MISCELL	CHEST-PHYSIO	1	200 200 200 200 200 200 200 200 200 200		200 L	NEB Spire	
MIS	ACTIVITY		PE		195	PE	
			器		CVP CVP	ABP	
	S/N NAME		gran	-	\$1000 \$1000	Paret	_
	TIME		13,500		16-06	৯০ ১০০	
	SIGNATURE	C	por		Sto	Pant	

Master.SIVAGURU.S

13/Malc/MHI202381075 02/12/2023/IPH202302423

Name

Blood Group

Sheet No.

В

Dr.RAJESH.V UHID N

BARE

Sex Age

Height Weight BSA 33-69





MHI/ICU/2022/076



				BIOCHI	EMISTRY					VITA	L PARAI	METER	S			CARDIAC ASSIST		DEVICE	
DATE	TIME	Hb	Na	К	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao <sub>2</sub>	RR/MT	N DD	TEMP°F	Λhd <sup>cm</sup> C	TIME	IABP	•	PACEMAKE	RSETTING
~		110	1144	<u> </u>	SUGAR	BLOOD	111012		SOUNDS	Jau	KIVIVI	IN <sub>1</sub> DF	I FIAIL 1	ADU G	INVIL	RATIO	DURATION	RATE	MODE
		_	_	<u> </u>			23,30		ci_	1001	341m	 	वर्षम						
প্রীস্থ							<u> ઝેમાં 30</u>		cl	100.	Belmi								
	_						1.30		<u>c</u>	100 1.	asim								
	•			ļ			2-30		cl	100%	18mt								
_							3.36	_	cl	1004.	26mt		98°F						,
	,						4.30		cl	100%	21mt								
							5.30		cl	100%	300								
	6.46	12.3	130	3.72	1.09	_	b.30	ı	u	1001.	28/m		98°F						
														_					\
	,																		

	SHIFT	DAY	EVENING	NIC	3HT
	TIME			જીમૃત્80	4,00
	EYES			4	4
NEURO	VERBAL			5	5
Ä	MOTOR			<u>6</u>	لم
	ARMS R/L			72	<b>ST</b>
	LEGS R/L			57	51
PUPILS	R.SIZE/REACTIION			श्रध	\$BR
ana l	L.SIZE/REACTION			<i>ने</i> छिक	3/88
4R	HEART SOUNDS			S, 52	SiS2
CUL	VALVE CLICK				
CARDIO-VASCULAR	CAPILLARY REFILL			PU	BR
RDIC	EDEMA			0	0
გ	NECK VEINS			Ю	N
IARY	WORK OF BREATHING			7 0	αA
PULMONARY	SUCTION				
PUI	SECREATIONS				
AL	BOWEL SOUNDS			+	+
STIN	ABDOMINAL TONE			٤	<u>\$</u>
INTE	N/G POSITION				
GASTRO INTESTINAL	GASTRIC RESIDUAL				
GAS	LIVER			N	2

	SHIFT	DAY	EVENING	NIC	GHT
	DESCRIP.OF URINE			00.00	objec
G.U.	PD - FUNCTION				
	DRAINAGE				
	PD - SITE				
	COLOUR				
	Sx WOUND-CHEST			ct	cı
	LEG			cı	Сl
SKN	DRESSING			OT	ОТ
}	PRESSURE SORE-SITE			MI	1011
	AREA				
	DRESSING CONDITION				
	POSITION CHANGE			Ø2H_	6124
MISCELL	CHEST-PHYSIO			SPIRO	<u>oeb</u> saro
MIS	ACTIVITY			PE	PE
				ABP CVP	CUP
	S/N NAME			KRUN	ARUR
	TIME			00.00	Oh·oz
	SIGNATURE			B	2

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MHI/ICU/2022/076



				BIOCH	EMISTRY					VITA	L PARA	METER:	S			CARDIA	AC ASSIST	DEVICE	
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	N DD	TEMP°E	Abd <sup>∞</sup> G	TIME	IABP			R SETTING
		טה	ING.		SUGAR	BLOOD	TIIVIE	ETCO <sub>2</sub>	SOUNDS	Sau	KROWII	NIDE	TEMP	ADO G	THAIR	RATIO	DURATION	RATE	MODE
8/12/23							7:30		<b>c</b> )	99%	38 m	 	190.FJ						
							8:30		cl	998	32/ml								
							O'57C		()		zajni		age F						
							10:30		J	1001	35/m	96 66	1b)						
							1:30	•	U	100%	32 mi	•					_	<u> </u>	
				-			(&.30	-	cl	wor	-30/n	- • .`							
							13-30		Cr	99%	28/mt	,	99.6	<b>e</b>					
							१५.५०		디	98%	22/2	168¢	<b>(</b> 3)						
					<u></u> :		15-30		6	9 F.Y.	20/n	90	(23)						
				٠			16.30		2	981	22/1								k.

	SHIFT	D	AY	EVE	NING	NIGHT		
	TIME	වැන	12. හ					
	EYES	14)	14					
NEURO	VERBAL	<u>.</u>	hg -					
Ä	MOTOR	B	b					
	ARMS R/L	St	ঞ					
	LEGS R/L	5+	SF					
PUPILS	R.SIZE/REACTIION	3/80	8/20					
PUF	L.SIZE/REACTION	3/2	2/8			_		
X	HEART SOUNDS	3,52	S152			_		
CUL	VALVE CLICK					_		
CARDIO-VASCULAR	CAPILLARY REFILL	Bo	Br				_	
RDIC	EDEMA	O	0.					
	NECK VEINS	N	7					
PULMONARY	WORK OF BREATHING	AT	ΤÅ					
NOM-	SUCTION							
P	SECREATIONS							
AF	BOWEL SOUNDS	+	7					
STIN	ABDOMINAL TONE	art	Soff			· 		
INTE	N/G POSITION	, , <u> </u>	1 '					
GASTRO INTESTINAL	GASTRIC RESIDUAL				_		_	
GA	LIVER	7/	$V_I$					

	SHIFT	D.	AY	EVE	NING	NIC	3HT
	DESCRIP.OF URINE	0	d				
G.U.	PD - FUNCTION	'	, <u> </u>				
	DRAINAGE						
	PD - SITE	.=.	-				_
	COLOUR						
	Sx WOUND-CHEST	c/	cľ				
	LEG		_				
SKN	DRESSING	70	10				
	PRESSURE SORE-SITE	MIL	WIC				
	AREA						_
	DRESSING CONDITION						
	POSITION CHANGE	Q241	Q>+1				
MISCELL	CHEST-PHYSIO	Rojago Mep	2000				
MIS	ACTIVITY	PE	Pe	-			
		CUP	ALB END2	-			
	S/N NAME	Rathyr	Situya				
	TIME	21.45 21.45	12:w				
	SIGNATURE	Je.	6				







Master.SIVAGURU.S	1		М	HI/ICU/2022/076
13/Male/MHi202381075 02/12/2023/iPH202302423	Ī			Sheet No
Dr.RAJESH.V		<b>∖</b> ge	Sex	$\bigcirc$
Bioda Group BAve	Height	Weight 33kg	BSA I+ Im2	С

		UR	INE		CI	IEST D	RAINAG	E .		GAS	TRIC	LAB S	AMPLE	J		MB		USIONS	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	IMK	TOTAL		· ·	 
1/12/23	13:45														(	, <u> HTE</u>			
	14.30	150	150	_		_			-			5.0	5-0	thn	75	*	AOME9	-	
	15.30	923	350			20		₹D	20				5,0	325	<b>7</b> 5	1500	25	,	
	16-30	100	H50			20		20	40				5-0	445	45	225			
	17-30	75	525	_		to		lo	50				5-0	530	扩	300		ra.smiq FENTA	
	18-30	wo	625			Ì			50				5-0	630	75	375		FENTA FOOLIO	
	19-30	75	700			to		10	60				5.0	715	75	450	<u> </u>	0.4	
	20,30	80	780			מו		10	<del>7</del> 0				1	805	l γ-AB	HITE .		0.7	
	21.30		250			10		10	20				₹.0	935	75	600		0.7	
	<b>პ</b> გ,ვგ	130	980			ટ્રેઇ		ત્રેઇ	00				5.0	1085	#5	b75		0.7	

SP	FCIFIC	<b>OBSERVATIONS/PROBL</b>	<b>FMS</b>
JF	COILIC	OBSERVATIONS/LICOBE	

DATE	TIME	iopw	TRANSTUS BD	IN	07
		r			

ACT: - 110 sec

# **GENITOURINARY (GU)**

•	JENI I OURINART	(GU)		ORIN					
	PD		<b>COLOUR</b> Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine				
URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale	Oz-Oozing G-Gaping	Al-Antibiotic Irrigation				
CL-Clear T-Turbid Stained	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	mgallon				
HC-High Coloured	SITE		D-Dusky J-Jaundice						
BS-Blood Stained HA-Haematuria	C-Clean R-Redness	l4:		PRESSURE SORE					
	BD-Block dis	coloration	SITE	AREA	DRESSING / Rx				
	MISCELLANEO	us	S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E-Eptoin dressing				
<b>OISITION CHANGE</b>	CH	HEST PHYSIO	Oc-Occiput	SP-Skin Peeling	B-Betadine dressing				
Su-Supine RL-Right lateral LL-Left Lateral	CF DC	Vibrator P-Chest percussion C-Deep breath & cough Nebulizer	CONDITION	D-Deep	EU-Eusol sitz bath ST-Sofra Tulle				
ACTIVITY									
PE-Passive exercise Am-Ambulated	PA	RANSDUCER ZERO ARAMETER BP-Arterial BP	H-Healing SCo-Status quo S-Sloughing						
		AP-Right Arterial Pressure AP-Pulmonary Arterial Pressure	LINES / TUBES	CONDITION					
	L.A	AP-Left Arterial Pressure	R-Redness at si Sw-Swelling at s Dr-Draining D/c-Discontinued P-Positional	D/c-Discontinued P-Positional HL-Heparin Lock					

SKIN

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





	Master.SIVAGURU.S 13/Malc/MHi20238107	5		M	HI/ICU/2022/076	
Name UHID No.	02/12/2023/IPH202302 Dr.RAJESH.V	2423	\_\jge	Sex	Sheet No.	
Blood Grou	Btre	Height	Weight	BSA	С	

	1	7								T		r		,	-		17.5mh			
		UR	INE		Cł	EST D	RAINAG	E		GAS	TRIC	LAB S	AMPLE		VOL	1 MB	INFU	SIONS		
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED /4	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	MK	TOTAL	PENTA 50941			
7 12 23	23.30	too	امدوا						100				50	1185	75	750	4.0			
8/12/28	જીમ∙૩૦	45	1155			<i>බ</i> ත		20	120				50	1880	ने5	825	0.7			- ',
112/23	1.30	75	1230						120				50	1355	75	900	0.4			
	2.30	80	1310			20		20	140				5.0	14 55	75	975	v·7		:	
	3,30	100	· ` `						140				5.0	1555	75	1050	0-7			_
	k.30	90	1500			૧્ર૦		ર્ર૦	160				5.0	1665	75	1125	0.7			
	5.30	70	1570	_		(o		10	176				5.0	1745	75	1200	0-7			
	630	70	Ibho			10		10	180			bio	11.0	1831		1200	_			
																				•

## SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME
	_
i	

# CENITOLIDINADY (CLI)

G	ENITOURINARY (GU)			SKIN	
	PD		COLOUR	SURGICAL (SX) WOUND	DRESSING
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	ingulor.
Stained HC-High Coloured	SITE	,	D-Dusky J-Jaundice		
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discoloration		SITE	PRESSURE SORE AREA	DRESSING / Rx
	MISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem
<b>OISITION CHANGE</b>	CHEST PHY	SIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral	V-Vibrator CP-Chest pe DC-Deep bre N-Nebulizer		CONDITION	D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
ACTIVITY		ED 7ED0	CONDITION		
PE-Passive exercise Am-Ambulated	<b>TRANSDUC</b> PARAMETEI ABP-Arterial	₹	H-Healing SCo-Status quo S-Sloughing		
	PAP-Puľmon	rterial Pressure ary Arterial Pressure	LINES / TUBES	CONDITION	
	LAP-Left Arte	erial Pressure	O-No redness, sw	velling, no leak, no air	

O-No redness, swelling, no leak, no air R-Redness at site Sw-Swelling at site Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked







	Masi IVAGURU.S 13/Malc/MHI202381075 02/12/2023/IPH2023024				М	HI/ICU/2022/076
Name UHID No.	Dr.Rajesh.v		Δ.	ge	Sex	Sheet No.
OTHE NO.			10%		COA	
Blood Group	Bhe	Height	n	Weight 33 Kg	BSA 1+Im <sup>2</sup>	С

		UR	INE		CI	IEST D	RAINAG	E		GAS	TRIC	LAB S	AMPLE		NOL	) MR	INF	JSIONS	 	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	Mrt	WAL				
8/12/23	11:30	<u>0</u> 01	100						•		,			100				•		
	8:30	50	150											150	ن	والمدار المستمانية	CDRD4			
	9:30	50	200°	_	-	R								200	S. Carlotte	A 4	50			
	10:3 O		260									سيم بر	200	200						1
	11:30		320						_		, ·		A Paragraphy	320						;   
	1.2.50	50	370										7.4	370						
	13.30	150	B											સ્કૃ						
	14-30	200	720			)								720						]
	15,30	071	870											870						
	16.91	00)	970											970						

SPECIFIC OBSE	RVATIONS/PRO	BLEMS 9:20	REMOVED	MEDIASTN	IAC DRA	414
DATE	TIME	9120	Dealate	PIGHT.	Aptraige	EABIAL LINE

E Joslo DR. PRAVEEN.

	GENITOURINARY (GU)			SKIN	
	PD		COLOUR	SURGICAL (SX) WOUNI	D DRESSING
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing	B-Betadine Al-Antibiotic
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	G-Gaping Op-Open I-Infected	. Irrigation
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice		-
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discoloration	on	SITE	PRESSURE SORE	DRESSING / Rx
	MISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem
OISITION CHANGE	CHEST P	HYSIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral		percussion breath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
ACTIVITY			CONDITION		
PE-Passive exercise	TRANSD	UCER ZERO	H-Healing SCo-Status quo		
Am-Ambulated	PARAMET ABP-Arte		S-Sloughing		

RAP-Right Arterial Pressure PAP-Pulmonary Arterial Pressure LAP-Left Arterial Pressure

## **LINES / TUBES CONDITION**

O-No redness, swelling, no leak, no air R-Redness at site Sw-Swelling at site Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked

		IVAGURU.S MHI202381075		·		
Name		23/12H202302423				Sheet No.
	Dr.RAJES	H.V	ì			
UHID No.			AUUS	Age	Sex	$\Box$
Blood Gro	up	· -	Height	Weight	BSA	
		Btre	161 cm	32140	1.100	<b>D</b> .





MHI/ICU/2022/076



HATMODYNAMICS Plant Court

		FLUID ASSES	SMENT (co	ntd.)				HAEN	MODYNA	MICS						Blo	od Gre	oup:				_
_ :		INFU	SIONS (conto	l.) _		N/G	/ORAL	TOTAL	TOTAL	LIDI	DVTINAL					LAP/	DED!	PP		<u></u>	0) (D	I
DATE	TIME			Misc	TOTAL	AMT.	TOTAL	INTAKE	BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	RAP	PERI	R/L	CO	CI	SVR	
13-45	_									વા	Sinu	001	113/ 15-7	<b>%</b> D	٦		tao,	717-				]_
14.30				2.0	2.0			77	-48	98	enu	0.01	崙	95	7_		Cool	‡ <b>-</b>	•			  음
15.30				2-0	27.0			179	146	100	stnu	<u> </u>	136 75	93	6		ceam	++				CRITICAL
16-30				2.0	20			256	31	98	2 Thus	8-02	12)	71	6		nam	++				CARE
17.3व	<u></u>			2-0	20			333	+33	١.,	sinu		113	+	귝	1	nam.	4-1-				
18-30				0.0	J-D			710	<i>ఏ</i> ఎం	Qh	RINKA	1.02	112	72	6	l	uson					֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֓֡֓
19.30				20	20	দD	50	531.7	177.3	96	Smu	Q-01	끸	bo	હ		TIVOJ.	++				FLOWCHARI
20:30				2.0	ઝ <del>.</del> =	50	100	590H	214.6	114	Sinu	0.02	Wy	72_	8		Wash	4				]^
21.30				2.0	2.7	50	(50	718.]	216.9	113	حاسامح	0.01	120	<b>હ</b> Ι	7		√asm	F+	_			
8813				2.0	એ, <del>≒</del>		150	<del>1195</del> , &	289,2.	120	SILU	001	MY.	मुल	8		warh	↑ 村·				

DRAINAGE:

**TOTAL INTAKE:** 

**URINE:** 

**TOTAL OUTPUT:** 

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET		]	
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE	_	946Int	<u> </u>
B.P.		113/66 mm	<u>.                                    </u>

• •

DATE	TIME	REMARKS / PLAN

INFUSION PU	MPS					-	
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
Fires as BI, WIZB	(名cm) (5) (6)	7/12/23	1		P	R	R
Ny trubo	Ns-		1	·	P	R	R
DJL	₽1 21√	7/12/2029	1	: 	ρ	P	P
APT. LWB	RAD RAD	7/12/2028	1_1_		P	P	P
PROLLINE	ρ1	7/12/2029	1		P	P	P
IV BARN		41212022	1		ρ	P	P
MEDIA		4/12/12/23	1	<b></b>	ρ	P	b.
Pieven	U	+41212003	1		P	P	P
V-CATH		F112/2023			ρ	P	P
S-TUBING		7/12/2023.	i		ρ	P	P
V-TUBIN		Modera	,		P	P	P
02 Wary		7 (12/2023			<u> </u>	P	P
Te-DOMB	<u>.                                    </u>	7/12/218-3	1		P_	P	P
MARW rent		7/10/2023	1		P	4	4
				<b></b> _			
	_						
				_ <del></del>			

#### Master.SIVAGURU.S 13/Malc/MHI202381075 02/12/2023/14202302423 Name Dr.RAJESH.V Sheet No. NA ARABANIA MARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA BARANA Sex UHID No. Height Weight **Blood Group** BSA D BARE 33 kg <u>lolom</u>





MHI/ICU/2022/076



### FLUID ASSESSMENT (contd.)

#### **HAEMODYNAMICS**

### **Blood Group:**

				(								_							<u> </u>			
DATE	TIME	INFL	ISIONS	(contd.)	)	TOTAL	N/G	/ORAL	TOTAL	TOTAL	HR/mt	RYTHYM	QT	ABP	МАР	RAP	LAP/	PERI	PP	СО	CI	SVR
- DAIL	INVIL				Nie	IOIAL	AMT.	TOTAL	INTAKE	BALANCE	I II VIII	1(1111111	31	ADF	IVIAF	IVAF	RAP	1 5131	R/L		<u> </u>	
커 <u>비2</u> 2	<u> સેકે,ક</u> ્રહ				20.	みす		150	873.5	- -311/5-	119	SING	CI CO.	112/8	刊		44	Want	+}_			
	<u>बिमाञ्</u> य				వి.0	a-7-	50	don	1001.2	<u>.</u> 공취 8-8		Simi		110/	3F		7	Warth	#			
	1.30				8,0	2,7	50			2261		کا			73	1		waan	#+			
	2.30				2.00	2-7		Ī	1206-6	1 -	1	SACHY	l	۱ ـ .	70	5		war	+ 1			
	3.30				ე-0	2-7		250	128403	270.7	1	SINUS	000	1 -	68	ک		woom	++			
	H'39				2-0	2.7	100	350	1462	203	117	S12125	اقاه	95	67	ی		2025	++			
	6 <sup>30</sup>				2.0	2-7	100	<b>450</b>	1659.7	105.3	120	TACH!	p-01	108	74	7		مهججت	++			
	b:30				ನಿ. ರ	2,0	100	550	- निमान	89.3	1HD	Sim		12%	82_	ե		luboim	4			
			_l	<u> </u>	L				<del></del>	<u> </u>		l	<u> </u>	1	<u> </u>	l	l					—

STAT	DRUGS
Т	IME

PREVIOUS DAY ..... HRS

DRAINAGE:

**TOTAL INTAKE:** 

**URINE:** 

**TOTAL OUTPUT:** 

TOTAL BALANCE:

P.T.O.

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED		]	
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES	_		
ALARMS VERIFIED	_		
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE			110 mt-
B.P.			1261sty 1941

DATE	TIME	REMARKS / PLAN							

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
IJv	E Y	07/12/03	1				P
ART- LINE		07/12/03	١		ļ 		P
PERI- LINE	chem-		١		<u> </u>		P
DV EXTN		7/12/63	j			·	P
MEDIA		711263	1			ļ	P
U - UFTH		#112/23	١				P
9-TUBINO		7-112-63	1			ļ	P
OJ_TURING		7/12/03	١			<u> </u>	P
TR-DOME		7/12/23	١				P
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#### Master.SIVAGURU.S 13/Male/MHI202381075 02/12/2023/IPH202302423 Name Dr.RAJESH.V Sheet No. NEW YORK CONTROL AND A STATE OF THE STATE OF 3 Sex UHID No. Weight Blood Group Height BSA D RAVE I From 33 kg 1, 1003





MHI/ICU/2022/076



Bite (Bigh) 3	3,22 11.110-1	(A Unit of United Afflance Healthcare Pvt Ltd)	Every heart beat counts
<b></b>	•	,	

		FL	UID ASSESSI	MENT (contd.)				HAE	ANYGON	MICS						Bloc	od Gro	up:	Bir	<u></u>		
			INFUSIO	ONS (contd.)			/ORAL	TOTAL	TOTAL	110/4	DVTINA					LAP/	DEDI	PP	-00	~	0)./[2]	
	DATE	TIME		M	I TOTA	AMT.	TOTAL	INTAKE	BALANCE	HK/MI	RYTHYM	SI	ABP	MAP	RAP	RAP	PERI	R/L	CO	CI	SVR	
8	2/23	7,80		2	ত হত	50	500	52	48	151	974US 74CHY	tol	109	Ŧ	7		Warm	44				
		8:30		2	0 2.0	. 50	100	104	46		1 1 1		101	41	b		warm	++				CRIT
		9:30		2	· 0 2-C	40	140	196	· H	132	TACAI	(J.01	102	44	Ц	u	/W.M	+1-				CRITICAL
		10:30			}_	65	205	261	+ 1	119	Sing	<b>₽.</b> 0	· 	-	-	t	(1)m	11-				CARE
		Niau				50	255	311	t.a	loï	EILLA	0.00				<u> </u>	lym	7-1	<b>&gt;</b>			E FL
		12.30				350	305			109	SINX	: 0:00					wan	44				FLOWCHART
		13-30					305	361	159	no	sinus	Ð- <u>o</u> l					100m	1-1				HAF
		14.30				log	405	461	259	97	Irabil	0.01					war					~
		12.90			_	100	202	561	309	101	ให้เกา	0.01					war.	4 )				
		16.70					501	561	409	99	Sulus	ان٠٥				ı	warr	44				

STAT DRUGS TIME PREVIOUS DAY 16HKS 30MB HRS

DRAINAGE: 180ml

TOTAL INTAKE: 計出, 平mu

URINE: 16 Homi

TOTAL OUTPUT: 1831m1

TOTAL BALANCE: - 89,3 m)

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE	·		
DRESSING/EQUIPMENT			_
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O	·		
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE			
B.P.			

,

DATE	TIME	REMARKS / PLAN								
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	-									
		•								

INFUSION PU	MPS				-		
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
T.Jr	127 127	04/12/03	2		P		
ART-LINE	RED	07/12/03	2		4		
PERI-LINE	CDRUH KJ	०म १२ ४३	عا		P		
AN EXIN		7/1263	2		P		
MEDIA		7/12/23	2		P		ļ
D-CATH		4/12/23	2_	<u></u>	P		
8. TORMU		4 115/93	2_		P		
OS. TURINA		7/12/13	2		P_		
TR-DOM		7/12/2	2		P		
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Master.SIVAGURU.S 13/Malc/MHI202381075

02/12/2023/IPH202302423

POSTOP DAY:

Or.RAJESH.V ARRIVARIAN NO DELL'ARRIVA DELL'ARRIVA

# INTERMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

**SURGICAL PROCEDURE:** 

AVR & 21 MM ST JUDG MASTER SCRIES VALVE

FLUID REQUIREMENT: 1-5 Litores

1	DATE	UR	INE	CH	IEST D	RAIN	AGE	TOTAL	I.V. FLUIDS				ORAI	_/ R.T.	TOTAL	TOTAL
	& Time	н.т.	G.T.		AIR LEAK	н.т.	G.T.	OUTPUT				н.т.	н.т.	G.T.	INTEKE	BALANCE
	<b>ल</b> ्डिक म.३०												50	50	FO	tho
	8-30								-					50	50	50
<b> </b>	9.3b						_			_			too	120	150	4 50
	10-30	પ્જ	Heo					400					100	250	वेऽठ	150
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									<del></del>							
	SPECI	FIC OE	SERVA	TIONS/	REMAR	KS			MEDI	CATION	I / DRUG	SS				
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Master.SIVAGURU.S

13/Malc/MHI202381075

02/12/2023/IPH202302423

Dr.RAJESH.V 

# INTERMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

**SURGICAL PROCEDURE:** 

AVRE 21 mm ST JUDG

MASTER PERILES VALICE

POSTOP DAY :  $\bigcirc$ 

FLUID REQUIREMENT: 1.J L'19405

	DATE	UR	INE	Cŀ	IEST D	RAINA	AGE	TOTAL		I.V. FL	LUIDS		ORAL	_/ R.T.	TOTAL	TOTAL
	& Time	H.T.	G.T.		AIR LEAK	н.т.	G.T.	OUTPUT	rapity	Tilda	y ` 	н.т.	н.т.	G.T.	INTEKE	BALANCE
	17.30	150	UL O			_		1120					50	222	611	509
	[8.30	100	1220					1220					loo	615	411	509
				•				1295				1	50	705	761	534
	20,30	100	[395					1395			-		50	755	811	584
	7\ <sup>30</sup>	100	1495					1995	15				50.	805	936	559
	33,70	150	(645					1645	75				-	605	1011	634
	27	00/	1745	•	-			1745	15				!	805	1086	659
9/1	h\0/> 1	/D) ;	(guy				- '	1845	15	Caring	)			805	1161	684
	01:30	775	1020					1920	16	(30m)				805	1286.	- 634
								1990	15			-		805	1361	-629
			2065					2065	75					ક્ષેત્ર	1436	629
	04,30	15	2149					2140	15				50	855	1561	-579
	07:30	permi	2140					2140	15					355	1636	504
	06:30		2140					2140	15				රි	905	1161	-379
							-					_				
							ı			-						

SPECIFIC OBSERVATIONS/REMARKS

01:00: Patient TR: 140 Blinin,

Intermitent. Informat to DR, Planson

adviced to give II - cardalono 12 mg DU

Rolous given.

OH.45: Catholel Ramined.

**MEDICATION / DRUGS** 

01:00: If condender (somy IV : 00:10

Ol:00: If, Palacetamol Frong EU given.







Master.SIVAGURU.S

13/Malc/MHI202381075

02/12/2023/IPH202302423

Dr.RAJESH.V

# INTERMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

**BLOOD GROUP:** 

Btre

HEIGHT: ISTOM

WEIGHT: 38Kg

B.S.A: 1 1 1 M2 .

			НА	EMOD	YNAN	iics	<del>-</del> ,		RES	P. PARAME	ERS	INVESTIGATIONS /
TE	MP	H.R.	RHY.	ST.	в.р.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
58	94	110	ourth Fachy	0.02	93 66	(Fr)	poom	++	20	CL	99%	on Room Air.
			Sinu	0-01	有	98	<u>(lbam</u>	1+	26	<u>C</u> L	99 %	
		115	<u>sthul</u>	D-01	1 -	76	team	<u></u>	Эy	ci	99%	
L		120	sinus Tadiy	0-01	100	#	toom	- 4	ථ	CL	98%	
		<u> </u>										
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	-		_									
<u> </u>												
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										. ,		; ·
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PREVIOUS DAY - HOURS

DRAINAGE -

TOTAL INTAKE 1761 mL

URINE 2140 ML

TOTAL OUTPUT 2140mL

BALANCE \_ 379 mb