

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



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



Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Anbarasu Mohanraj Speciality: CVD

Advised Date & Time: 08:40

Provisional Diagnosis: 08/01/24

CORONARY ARTERY DISEASE, CORONARY ANGIOGRAM DONE
ON 29/12/23 DISTAL LM AND TRIPLE VESSEL DISEASE.

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

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

Surgery / Procedure Name (if planned):

CABG

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

Expected Duration of Stay: 1-7 days

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

Payer: ☒ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Any other Instructions (if any):

Dr. Anbarasu Mohanraj
Reg No: 55476

Doctor's Signature

Name

Dr. Anbarasu Mohanraj

Reg. No.

55476

Date

8/1/24

Time

08:40

97576 (for)

For admission desk staff only:

Room Category:

☐ General Ward

☐ Single Room

☒ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others _____

Admission Intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

08/1/24

3.36 pm

8/1/24

3.36 pm

Source:

☐ OPD

☐ ER

☒ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time

S. Vignesh

S. Vignesh

0262

8/1/24

3.36 pm

Dr. Anand Mohan
Reg. No. 5545

ADMISSION FORM

Marital Status m	Full Address No. 3, Bharathiyar Street, Paraniyuthur, Teyyanpattangal, Chennai - 600122.		Telephone Number 97358446810 9940617755
Occupation 201	Referred from Dr. Narendra	Date of Time of Admission 8/1/24 3.36 pm	Date & Time of Discharge 15/1/24
UNIT Dr. Anbarasu cardiothoracic		Total No. of Days 8 days	
MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If Yes AR No. :	
FINAL DIAGNOSIS			ICD Code
TRIPLE VESSEL CORONARY ARTERY DISEASE			I25.1
LEFT MAIN DISEASE, EXERTIONAL ANGINA			I21.0
NORMAL LV SYSTOLIC FUNCTION - EF: 62%			I20.8
SYSTEMIC HYPERTENSION			I10.1
			I10
DATE	OPERATION / PROCEDURES		ICPM Code
10/1/24	OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OP CAB) X 3 GRAFTS. LIMATOLAD, SUBTOTALOM AND PDA (SEQUENTIAL) DONE ON (10.1/24)		36.13 99.00
DATE	TYPE OF ANESTHESIA		
10/1/24	<input checked="" type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL		
DISCHARGE STATUS			
<input type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input checked="" type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Signature of the Consultant Dr. Anbarasu Mohanraj No: 55476		Signature of Medical Records Officer	

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்

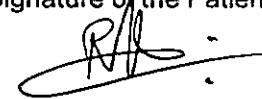
Signature of Admitting Nurse

தேதி

Date 08/01/2024

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian



R. HARISH PONSINGH

உறவுமுறை

Nature of Relationship



GENERAL CONSENT FOR ADMISSION



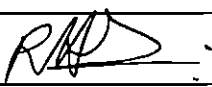
I, RAJA SINGH P the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.


- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.
- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.
- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient	For 	RAJA SINGH P	08/1/24	3:36pm
Surrogate/Guardian (if applicable #)		HARISH PONSINGH R (Write name and relationship with patient)	8/1/24	3:36pm
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		HARISH PONSINGH R	8/1/24	3:36pm
Interpreter (if applicable)				


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

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

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

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE			
8	Endocrine System and Metabolism related				
	Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis				
	Thyroid storm or myxedema coma with hemodynamic instability				
	Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl				
	Other endocrine problems such as adrenal crises with hemodynamic instability				
	Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring				
	Hypo or hypernatremia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered mental status				
	Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias				
	Hypo or hyperkalemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or muscular weakness				
	Hypophosphatemia with muscular weakness				
Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Parveen	112236	10/1/24	15.

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE			
1	Stable hemodynamic parameters	✓			
2	Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent	✓			
3	Minimal oxygen requirement (not more than 3 L by nasal prongs)	—			
4	Intravenous / Inotropic / Vasopressor support and vasodilators are no longer necessary	—			
5	Cardiac dysrhythmias are controlled	—			
6	Presence of distal pulses	✓			
7	No signs of bleeding and hematoma at puncture site	—			
8	End of life care pathway chosen	—			
Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. Parveen	112236	12/1/24	



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DISCHARGE SUMMARY

IP No. : IPH2024000068 D.O.A : 08/01/2024
UHID : MHI202381562 D.O.D : 15/01/2024
Name : Mr. RAJASINGH.P Room No. : 201
Age / Gender : 59Years / MALE
Consultant : (1). Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg)
Director and Clinical lead – Cardio Vascular and Thoracic Surgery

D.O.S: 10.01.2024

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE
LEFT MAIN DISEASE
EXERTIONAL ANGINA
NORMAL LV SYSTOLIC FUNCTION – EF: 62%
SYSTEMIC HYPERTENSION

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS:
LIMA TO LAD, SVG TO OM AND PDA (SEQUENTIAL) DONE ON 10.01.2024.

BRIEF HISTORY:

Mr. Rajasingh.P, 59 years old male, a known case of Systemic hypertension, exertional angina, CAG – Left main + Triple vessel disease, Normal LV systolic function, has come for CABG. Patient was apparently normal till 3 months ago when he developed chest pain on exertion which relieved at rest. H/o breathlessness on exertion NYHA class II. Initially, he went Dr. Narendran's clinic where he was advised Coronary angiogram. He then came to Medway Heart Institute and underwent Coronary angiogram on 29.12.2023 which showed left main + Triple vessel disease. He was advised early CABG. During the waiting period for surgery, he again developed one episode of chest pain with profuse sweating. He was brought to Medway Heart Institute ER where he was advised admission for further management. Currently, he is getting admitted for the same. No H/O Palpitations, Syncope or Swelling of Legs.

No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism

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94557 94557
1800 572 3003

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044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367

E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)

Heart Institute | Institute of Pulmonology
044 - 4310 8959 | 044-2473 4451

MHI/HOSP/2022/118

NAME : MR. RAJASINGH.P

UHID : MHI202381562

IPNO: IPH2024000068

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP - 97.8° F
HR - 80bpm
BP - 120/70mmHg
SPO₂ - 98% in room air
CVS - S1S2 (+)
RS - BAE (+)
Abdomen - Soft, BS (+)
CNS - NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	14.4	Male : 13.7 - 17.5 Female : 11.2 - 15.7	gms%
HAEMATOCRIT	42.5	39-52	%
TWBC	6680	4000 - 10000	Cells/Cumm
NEUTROPHILS	68	40-70	%
LYMPHOCYTES	23.6	20 - 40	%
EOSINOPHILS	3.6	0 - 6	%
MONOCYTES	4.4	0 - 6	%
BASOPHILS	0.4	0 - 2	%
PLATELET	298000	Male : 1.5 - 3.5 Female : 1.5 - 3.7	Cells/Cumm
Urea	19	14 - 40	mgs/dl
Creatinine	1.10	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mgs/dl
Sodium (Na ⁺)	141	135 - 145	mmol/l
Potassium (K ⁺)	4.65	3.4 - 5.5	mmol/l
T. Bilirubin	0.46	0.2-1.0	mg/dl
D. Bilirubin	0.21	0.00 - 0.4	mg/dl
I. Bilirubin	0.25	0.4-0.6	mg/dl
S.G.O.T	18	<38	U/L
S.G.P.T	17	<41	U/L
ALP	98	Adult: 42 - 141	U/L
GGT	45	Male : 10 - 45 Female : 5 - 32	U/L
Total Protein	6.8	6.0 - 8.0	gm/dl
S. Albumin	4.6	3.5 - 5.0	gm/dl

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PATIENT HELPLINE
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Heart Institute | Institute of Pulmonology
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MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED



Every heart beat counts
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NAME : MR. RAJASINGH.P

UHID : MHI202381562

IPNO: IPH2024000068

PROTHROMBIN TIME	12.1	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. Systemic Embolism: 3.0 - 4.5 INR	
INR	1.0		

T.S.H	2.310	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	uIU/ml
T3	125	"Adult : 60 - 152 New born - 4 days : 96 - 730 1 - 11 Months : 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	7.75	"Adult : 4.6 - 9.3 New born - 4 days : 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs : 6.3 - 13.16	ug/dl

ECG: HR – 78bpm, sinus rhythm, No significant ST –T changes.

ECHO : EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 108ML, ESV: 39ML, EF: 64%
AORTIC GRADIENT – MAX GRADIENT – 6 MM HG, MEAN GRADIENT – 3 MM HG, SIGMOID SEPTUM, ALL CHAMBERS NORMAL SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION, GRADE I DIASTOLIC DYSFUNCTION, NORMAL RV SYSTOLIC FUNCTION, IAS / IVS INTACT, AORTIC VALVE SCLEROSIS, NO AS / AR, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, IVC NORMAL IN SIZE AND COLLAPSING, NO CLOT / VEGETATION / EFFUSION.

CAROTID DOPPLER : INCREASED INTIMA MEDIA THICKNESS, NO FLOW LIMITING DISEASE, OTHERWISE NORMAL BILATERAL CAROTID AND VERTEBRAL DOPPLER STUDY.

CXR: PA film, lung fields clear

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Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118

NAME : MR. RAJASINGH.P

UHID : MHI202381562

IPNO: IPH2024000068

COURSE IN THE HOSPITAL:

Mr. Rajasingh.P, 59 years old male, was admitted with above mentioned complaints. He was admitted in the ward and was treated with LMWH, antianginals and other supportive medications. After stabilization, he then underwent **OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS: LIMA TO LAD, SVG TO OM AND PDA (SEQUENTIAL) ON 10.01.2024.** He was shifted to SICU with stable hemodynamics and Inj. Nor adrenaline 0.05µg/kg/min, Inj. Dopamine 5µg/kg/min supports. He was extubated on the same day (10/01/2024) at 19.45 pm Drains were removed on POD1 (11/01/2024). He was shifted to ward on POD 2 (12/01/2024). Suture removal was done on POD3 (13/01/2024). Patient course in the hospital was uneventful. His medications are optimized and he is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR - 88/min BP - 110/80mmHg
SPO2 - 94% in room air

POST OP INVESTIGATIONS:

ECG: HR : 84bpm, sinus rhythm, Q wave in leads III

ECHO : ALL CHAMBERS NORMAL IN SIZE, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION, EF: 61%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 9CM/S, AORTIC VALVE SCLEROSIS, OTHER VALVES STRUCTURALLY NORMAL, IAS/IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 5MMHG, MEAN GRADIENT – 2MMHG, GRADE I DIASTOLIC DYSFUNCTION, TRIVIAL MR, TRIVIAL TR, NO PAH, MILD LEFT, MINIMAL RIGHT PLEURAL EFFUSION, NO CLOT/VEGETATION/ PERICARDIAL EFFUSION.

CXR: PA film, sternal wires seen, lung fields clear, Minimal bilateral pleural effusion.

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PATIENT RELIEF
94557 94557
1800 572 3003

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Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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NAME : MR. RAJASINGH.P

UHID : MHI202381562

IPNO: IPH2024000068

ADVICE MEDICATIONS:

Sl. NO.	NAME OF THE DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP WITH MEAL	DURATION
				M	A	N			
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB.ROSUVAS (ROSUVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2 WEEKS
5	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
6	SYP. CREMAFFIN (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATION)
7	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	1 MONTH
8	SYP ALEX PLUS (DEXTROMETHORPHAN HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
9	TAB. ZOLFRESH (ZOLPIDEM)	1 TABLET	5MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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MHI/HOSP/2022/118



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NAME : MR. RAJASINGH.P

UHID : MHI202381562

IPNO: IPH2024000068

DISCHARGE ADVICE	
DIET	HIGH PROTEIN, LOW SALT AND LOW FAT DIET
PHYSICAL ACTIVITIES	RESTRICTED.
FLUID RESTRICTION	NIL
REVIEW	REVIEW WITH DR. ANBARASUMOHANRAJ AFTER 23/01/2024 WITH HB, UREA, CREATININE, SODIUM, POTASSIUM, CHEST X RAY

To report: If fever > 101 °F / Difficulty in breathing / Headache / Giddiness/chest pain/
Groin swelling/ bleeding / discharge at operated site/ Any other significant symptoms.

In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai

CONSULTANT SIGNATURE

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

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

"I understood the Content of the
discharge summary."

Shanthi Raj

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

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INPATIENT INITIAL ASSESSMENT

Date: 8/1/24

Time of arrival in ward: 16:50'

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 97.8°F | Pulse / HR: 80 (beats/min) | BP: 120/70 (mmHg)

Respiration: 20 (breaths/min) | SpO₂: 98 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 23.4 kg/m²

Pain: ☐ Yes ☒ No. If Yes, Score: 9/10

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

Duration: Location:

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

pt. H/o. Came to OPD for CABG plan.
chest pain x 1 1/2 months.
SOB x 1 1/2 months.
Dyspnea on exertion x past 1 year.

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☐ Yes ☒ No. If Yes, duration: Hypertension: ☒ Yes ☐ No. If Yes, duration: 1 month

Others:

MI/Kidney CKD/BA / thyroid disorders

Past Surgical History:

- Cardiotomy, 29/12/23 - distal LM (TUD)
- s/p (2) sided Deviated nasal septum done.
15yrs back.

Present Medication (for Medication Reconciliation):

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	T. ROSEDAY	20mg	plb	0-07	7/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2.	T. FLAVONOL MR	35mg	plb	1-07	8/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.	T. PROLOMBET XL	20mg	plb	1-00	8/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4.	C. CLOPIEGRETTA 75	75/100mg	plb	0-10	5/1/24	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5.	T. GTN SORBITRATE	2.6mg	plb	1-01	8/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6.	T. RANOLAZ	500mg	plb	1-01	8/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7.	T. RABLET	20mg	plb	1-01	8/1/24	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8.	T. SORBITRATE	5mg	plb	(500) 1-00		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.	Inj. FONDARE	20mg	plc	1-00	8/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Family History:

Personal / Social History (Tick whichever is applicable)

Lifestyle: ☐ Sedentary ☒ Active Occupation: _____
 Smoking: ☐ Yes ☒ No Alcohol: ☐ Yes ☒ No Recreational Drug Use: ☐ Yes ☒ No
 Others: _____

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

General Physical Examination:

Pallor: ☐ Yes ☒ No Icterus: ☐ Yes ☒ No Clubbing: ☐ Yes ☒ No
 Edema: ☐ Yes ☒ No Lymphadenopathy: ☐ Yes ☒ No

SYSTEMIC EXAMINATION

CVS:

S₁S₂ (P), NAS.

Respiratory System:

BAR (P), NAS

Gastrointestinal System:

Soft, NTND

Central Nervous System:

NRND, Able to move all 4 limbs

Urinary / Reproductive / Locomotor System:

Skin / Ophthalmic / ENT

Suspected of contagious disease: ☐ Yes ☒ No

Immuno compromised status: ☐ Yes ☒ No

Isolation required:

☐ Yes ☒ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☒ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

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

Weight loss within the last 3 months? ☐ Yes ☒ No

Is the patient severely ill? (e.g. in Intensive Therapy) ☐ Yes ☒ No

Reduced dietary intake in the last week? ☐ Yes ☒ No

Is the BMI < 20.5? ☐ Yes ☒ No

Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk

No: If the answer is "NO" to all questions, the patient is at Normal and not at risk

Provisional Diagnosis:

CAD-TUD, SHTN

Plan of Care:

- CABG plan weekly.

- Vital signs

- w/ R Gildner (SHTN)

- Follow by diet.

Investigations Advised:

- Investigation advised

Diet Advice:

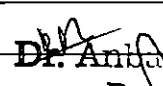
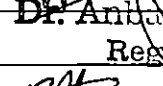

- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: low salt diet

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

PFE: Patient Family Education

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. Anbarasu Mohanraju	183573	8/1/24	12:25 PM
Consultant		DR. ANBARASU MOHANRAJU	55476	08/01/24	1:00:00
Patient Attendant		Relationship SON	-	8/1/24	1630

DOCTOR'S PROGRESS NOTES

DATE	NOTES
08/1/24	S/B Dr. Anusuya
21:30	A case of CAD - TVD / SHTN.
	patient reviewed.
	cl' chest pain on & off
	o/e patient conscious, oriented
Vitals stable	S/E: C/S - S, S2 ⊕
	RS - BAE ⊕
	C/S - no FND
	P/A - soft / non-tender.
	Advice
	- monitor vitals
	- continue the drugs as per chart
	- Plan: CABG on Wednesday.
	S/B Dr. Mohamed Hydross
9/1/24	Δ: CAD - TVD / HTN.
10am	Plan: CABG Tomorrow
	Patient conscious
	Oriented
	Afebrile
Vitals	C/S → S, S2 ⊕
PR - 82/min	RS → BAE ⊕
RR - 20/min	P/A → soft, NT
BP - 120/80 mmHg	
Spo2 - 97%	



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Mr. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IIPH2024000068

Dr. ANBARASU MOHANRAJ



MLH/ID/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
09/1/24	S/B Dr. Anusuyg
23:50	patient reviewed.
	clo' chest pain reduced now.
	0/5' patient conscious, oriented, Afebrile.
vitals stable	8/5' CUS - 5152 ⊕
	RS - BAS ⊕
	P/A - 60/40, non-tender.
	Advice
	monitors vitals
	- posted for CABG tomorrow 12 pm
	- NPO from 5 am tomorrow
	- consent
	- PAKS preparation
	- check pre - OPCBG
	- shift to OT on call.
K. M. 13/01/24	

MHI/IP/2022/041

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MR. RAJASINGH P

59/Malc/MHJ202381562

08/01/2024/IPH2024000068

Dr.ANBARASU MOHANRAJ



Every heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
10/01/2024 @15.05	Mr. Rajasingh 59 y/o underwent OPCABx3 grafts He was shifted to SICU & following hemodynamics HR - 80 Bpm AP - 132/50 mmHg CVP - 10 mmHg SpO ₂ - 96% on ventilator Ventilator: mode: SIMV FiO ₂ : 0.8 PEEP: 5 mmHg supporting inj. dopamine 2.5 µg/kg/min inj noradrenaline 0.04 µg/kg/min plan: Keep & extubate when fully awake
	For P 112256 Dr. Anbarase Prof. Dr. Karthika M H

DATE	NOTES
11/01/24, @8.10	S/B: Dr. Anbarasu / Dr. Rajesh / Dr. Praveen
P.O.D #1	S/P: DPLAB x 3 grafts . patient comfortable
Hb - 13.3	O/E: conscious, oriented, Afebrile
U - 15	. BP - 120/60 mmHg
Cr - 0.67	. HR - 104 bpm
Na - 134	. SpO ₂ - 96% on nasal prongs (4 litres O ₂)
K - 3.68	. I/O - 2515.5 mL / 2684 mL ; Bal → 168.5 mL
	. On ucab
RBS - 158 mg/dL	. Adequate urine output
	. tolerating feeds
BBV	. peripheries warm (+)
pH - 7.470	Supports: inj. Dopamine 2.5 µg/kg/min
pCO ₂ - 34.7	total drain: 320 mL
pO ₂ - 80.8	plan
HCO ₂ - 26.7	. RF - 2.4 litres/day
BE - 1.0	. Good chest physio
	. Remove drains by asst 11 AM
	. Inj. Dopamine started tapering & stop
	. mobilize
	. Nebulization
	. Spirometry
	. T. METOPROLOL 25mg 1-0-1
	Ganesh 11/2/20.



Mr. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IPH2024000068


Dr. ANBARASU MOHANRAJ



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DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/01/2024	S/P: Dr. Anbarasu / Dr. Rajesh / Dr. Praveen
@ 8.20	
	S/P: OPCAB x 3 grafts.
POD #12	• patient comfortable
Hb - 11.0	O/E: conscious, oriented, Afebrile
U - 28	• BP - 118/82 mmHg
Cr - 0.92	• HR - 84 Bpm
Na - 137	• SpO ₂ - 92% on room air
K - 3.83	• I/O - 236ml / 2275 ml ; Bal 1786ml
	• U cath removed
RBS - 161 mg/dl	• Adequate urine output
	plan
	• RF - 2.4 litres/day
	• Good chest physio
	• Mobilize
	• Nebulization
	• Spirometry
	• shift to Ward
	Spurven 12.2.24
	For
	Dr. Anbarasu
	Dr. Karthika
	Chief, (MHI0216)

DATE	NOTES
	S/S Dr. Mohamed Hydros
13/11/24.	Post OP case of OPCAB grafts
10pm	POD. II
	Patient Conscious
	Oriented
	Afebrile.
Vitals	W2 → S ₁ , S ₂ ⊕
Stable	M → BA ⊕
	P/A → Soft, NT
	ADW
	- Monitor vitals
	- No follow up
	chart
	- Plan: D/C tomorrow
	
	(KSSM)



PARASU MOHANRAJ

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DATE	NOTES
14/1/24	S/B Dr. G. Lakshmi durga.
10:30AM.	Pt. recovered.
	no new complaints.
	O/E: Conscious
	oriented
	afebrile
	vitals stable
	S/E: CUS - G ₂ +
	RS - BPE+
	PA soft.
	<u>Adv</u>
	Plan d/c today.
14/1/24	S/B Dr. Anbarasu.
10:30AM	
	D/c today evening
	mobilise.
	No weight bearing or driving for
	2 months
	<u>Adv</u>
	Reck.



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Thiruvudaimarudhur (Taluk), Kumbakonam - 61 2103. (Tanjore Dist). Ph: 0435 - 2412345 | Mob : 7397720491

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

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ

PRE-OPERATIVE CHECKLIST

Name :	Age : 59 Gender : M	UHID No. : 202381562	
Ward :	Bed No. :	B.S.	A.S.
Clinical Diagnosis :			
CORONARY ARTERY DISEASE - LEFT MAIN TRIPLE VESSEL DISEASE		✓	✓
Proposed Procedure :			
CORONARY ARTERY BYPASS GRAFTING		✓	✓
CHECKLIST			
1.	Identification Band on Hand Checked ?	✓	✓
2.	Surgical consent Signed? a. Special Consent signed if required.	✓	✓
3.	Anesthetist Consultation (If required?)	✓	✓
4.	History AND Physical Onchart? a. Height.....161 Cms..... b. Weight.....77.5 Kgs	✓	✓
5.	Allergic to drugs ? NOT KNOWN	✓	✓
6.	Surgical Preparation done ?	✓	surgical dressing
7.	Nill by Mouth From 5.00	✓	✓
8.	Blood Grouping & Rh Typing 'O' POSITIVE	✓	✓
9.	Investigation <input checked="" type="checkbox"/> X-Ray <input checked="" type="checkbox"/> ECG <input checked="" type="checkbox"/> LAB	✓	✓
10.	Blood Sugar 133 mg/dl Time 9.00	✓	✓
11.	TPR Chart Pulse 88 b/m Temp 98.2°F BP 110/70 mmHg RR 20 b/m	✓	✓
12.	Time Voided a. Retention <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	✓	✓
13.	Enema <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	✓	✓

MMC - POC - 2102

14.	a. Prosthesis Removed <input type="checkbox"/> Yes <input type="checkbox"/> No / <input checked="" type="checkbox"/> Not Applicable b. Plates present Removed <input type="checkbox"/> Yes <input type="checkbox"/> No / <input checked="" type="checkbox"/> Not Applicable c. Contact Lenses Removed <input type="checkbox"/> Yes <input type="checkbox"/> No / <input checked="" type="checkbox"/> Not Applicable d. Dentures Removed <input type="checkbox"/> Yes <input type="checkbox"/> No / <input checked="" type="checkbox"/> Not Applicable	✓	
15.	Valuables and Jewellery Removed <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Secured <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	✓	/
16.	Pre-Operative Medication Administered <u>T. PAN 40mg, T. ANXIT 0.25mg</u> a. Time <u>21.00</u> b. Nurse <u>F. Cathrine</u>	✓	/
17.	Blood Transfusion requisition Onchart	✓	/
18.	X-Ray <u>1</u> No <u>CAGT (2) → (1)</u>	✓	/
	ECG / ECHO <u>2/2</u>	✓	/
	Ultra Sound		
	C.T. Scan.....		
	MRI Scan		
	TMT		
	Medication		
9/1/24	T. PAN 40 MG } given @ 21.00 T. ANXIT 0.25 MG }	✓	
10/01/24	T. ANXIT 0.25 MG } given @ 06.00	✓	
	Others		

Verified by
F. Cathrine
02071
Nurse Signature

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name **MR - RAJASINGH** Age **59Y/M** UHID

Diagnosis **CAD - Right dominant #TVD** Plan **CABG**
normal LVP function / SHTN

Serology - **negative**

EURO Score / STS Score

PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):

Diabetes Mellitus (HB1AC) -

Associated Illness **SHTN**

Carotid Doppler **increased intima media thickness** Thyroid Enzymes **T3 -125 TSH -2.3/0**
normal blood flow limiting disease **T4 -7.75**
Sr. Creatinine **1.07** **carotid doppler study**

Any other illness of concern

Allen's Test

Myocardial viability if needed

Varicose Veins

Pulmonologist Clearance

Nephro Clearance: -

Neurology Clearance :

Dental Clearance: -

Mitral Regurgitation Assessment **Trivial MR**

Nursing:

Billing Clearance: -

Physiotherapy

Spirometry taught

Concerns from Surgical Team :

V. S. Srinivas
SIGNATURE :

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



CONSENT FOR SURGERY

1. Mr./Ms./Mrs Raja Singh P ☒ the Patient or ☒ Representative of patient have (Please tick correct option and below):

☒ Read

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

☒ Been explained this consent form in English, which I fully understand and understood the information provided about the disease Coronary Artery Disease - Distal Int. Tr. D.I.V. EF - 62%, HTN and about the procedure Coronary Artery Bypass Grafting (full name of operation / procedure given below in this consent form)

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

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

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

- I am aware that I may require administration of blood and / of 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. Arrhythmias ④. stroke ⑤. prolonged ICU stay /
ventilation ⑥. mild risk to life
- Benefits Relief from symptoms
- Alternatives pre-medical management
- The likelihood of success of the surgery (Percentage / Other comments) 97%
- Possible results of non-treatment Myocardial Infarction
Cardiac failure
- I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my sign this form.

Success rate: 97.5%

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	P. RAYASINGH	R. HARISH
Relationship	patient	Son
Signature	P. RAYASINGH	R. HARISH
Date & Time	9/1/24 at 18.00	9/1/24 at 18.00
Name & Signature of Doctor with Registration No.:		

Dr. Anbarasu Mohanraj
Reg No: 55476

55476

Doctor Seal

நோயாளி விவரங்கள்: (Affix Label here)

பெயர் :

UHID :

பிறந்த தேதி : பாலினம் :

அறுவை சிகிச்சை ஒப்புதல் படிவம்

நான்நோயாளி அல்லது நோயாளியின் பிரதிநிதி தயவுசெய்து மேலேயும் கீழேயும் பொருத்தமானதை தர்வு செய்யவும்

☐ படிபுங்கள்

☐ எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளன.

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

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

- சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்கள் _____
- நன்மைகள் _____
- மாற்றுவழிகள் _____
- அறுவை சிகிச்சையின் வெற்றி வாய்ப்பு (சதவீதம் / பிற கட்டளைகள்) _____
- சிகிச்சையின்றி சாத்தியமான முடிவுகள் _____
- செயல்பாடு / நடைமுறை மற்றும் வழங்கப்பட வேண்டிய கவனிப்புக்குப் பிறகு எதிர்பார்க்கப்படும் போக்கையும் நான் அறிவேன். நேரங்களில் தீவிரமான பராமரிப்பு அல்லது மருத்துவமனையில் அனுமதிக்கப்படும் கால அளவு தேவைப்படலாம் மற்றும் / அல்லது கூடுதல் மருந்துகள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம். இதன் மூலம் உடல் சிகிச்சையில் அதிகரிக்கும்.
- இந்த செயல்பாடு / நடைமுறையை நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய எந்தவொரு தீர் அல்லது உடல் பகுதியை அகற்ற மருத்துவமனையை நான் அங்கீகரிக்கிறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பட்ட தகவல்களை நான் பெற்றேன் மற்றும் முழுமையாகப் புரிந்து கொண்டேன் என்று அறிவிக்கிறேன். எனது வியாதி, செயல்பாடு / நடைமுறை தொடர்பான கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அதன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும் நோக்கம் கொண்ட நன்மைகள் மற்றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும் பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நான் கையெழுத்திடும் நேரத்தில் என் முன்னிலையில் செருகல் மற்றும் நிறைவு செய்ய வேண்டிய அனைத்து துறைகளும் (இந்த வடிவத்தில்) நிரப்பப்பட்டன என்று நான் மேலும் அறிவிக்கிறேன்.

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

CONSENT FOR ANAESTHESIA SERVICES

I, MR. RAJASINGH P ☐ the patient or ☐ the representative of patient have,
(please tick the correct option above and below)

☒ Read

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

☐ Been explained this consent form in English, which I fully understand and understood the information provided about Operation / Procedure

CORONARY ARTERY BYPASS GRAFTING

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

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

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

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

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

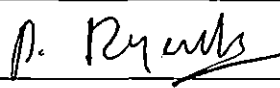
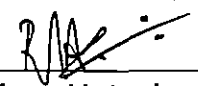
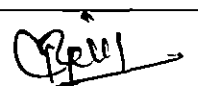
<input type="checkbox"/> Intravenous Regional Anaesthesia <input type="checkbox"/> With Sedation / GA <input type="checkbox"/> Without Sedation Alternatives <input type="checkbox"/> Major/Minor Nerve Block <input type="checkbox"/> GA <input type="checkbox"/> Others	Expected Results	Temporary loss of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

PRENATAL / EARLY CHILDHOOD ANAESTHESIA

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

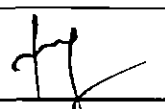
For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said operation / procedure on ☐ myself or ☐ my above named patient being fully aware of the nature, potential risks and complications, intended benefits and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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient		P. RAJASINGH	9/1/24	18:00
Surrogate/Guardian (if applicable #)		Son. (Write name and relationship with patient)	9/1/24	18:00
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		R. Sushma	9/1/24	18:00
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by		Dr. F. PRAVEEN Reg. No: 86510	86510	9/1/24	18:00

மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்

1. ☐ நோயாளிஅல்லது ☐ நோயாளியின் பிரதிநிதி,

மேலேயும் கீழேயும் சரியான விருப்பத்தைத் தேர்ந்தெடுக்கப் படித்தல்

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

இந்த ஒப்புதல் படிவத்தின் கீழே கொடுக்கப்பட்ட செயல்பாட்டு நடைமுறையின் முழு பெயர்

- * எனது அறுவை சிகிச்சை நிபுணர் நடைமுறையின் அபாயங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி என்னிடம் கூறினார். எனது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து சேவைகள் தேவை என்பதையும் நான் புரிந்து கொள்கிறேன். இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.
- * அனைத்து வகையான மயக்க மருந்துகளும் சில அபாயங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத கடுமையான சிக்கல்கள் ஏற்படலாம். தொற்று நோய், இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு செயல்பாடு, பக்கவாதம், மூளை பாதிப்பு அல்லது மரணம் போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.
- * இந்த அபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை நான் புரிந்து கொள்கிறேன்.
- * சில நேரங்களில் உள்ளூர் மயக்க மருந்துகளைப் பயன்படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் முழுமையாகப் பெறாமல், மற்றொரு நுட்பத்தை மயக்க மருந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.

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

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

விற்புக்கு முந்தைய / ஆரம்பகால குழந்தை பருவ மயக்க மருந்து

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

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

மேற்சுறிய செயல்பாட்டிற்கு (எஸ்) / நடைமுறை (கன்) எனக்கு தெரிந்துவிட்டது. நான் தானாக முன்வந்து எனது ஒப்புதலை வழங்குகிறேன்

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்	தேதி	நேரம்
பெறப்பட்ட ஒப்புதல்					

ANAESTHESIA RECORD

MHI/OT/2022/094

Mr. RAJASINGH P

S9/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Type of Surgery : ☐ Day Care ☒ Elective ☐ Emergency

Blood Group : O⁺ Height : 161 cms Weight : 72.5 Kgs

Pre-Operative Diagnosis: LM + TVD

Proposed Surgery:

CABG

Anaesthetic Plan

ETGA

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

History of Present Illness:

- ☒ ANGINA
- ☐ DYSPNOEA
- ☐ SYNCOPE
- ☐ MI
- ☐ CCF
- ☐ OTHERS

Previous Surgery :

COMORBIDITY

- ☒ HT ☐ SMOKING
- ☐ DM ☐ ALCOHOL
- ☐ ASTHMA / COPD ☐ GERD
- ☐ HYPO THYROID ☐ CKD / NEPHROPATHY
- ☐ STROKE / TIA ☐ DRUG ALLERGY
- ☐ EPILEPSY ☐

Present Medication :

Anti Platelet Stopped on :

6-1-24

Physical Examination :

- ☐ JAUNDICE ☐ PEDEL OEDEMA
- ☐ CYANOSIS ☐ CAROTID BRUIT
- ☐ CLUBBING

SYSTEMC EXAMINATION

CVS : 1 (2)
RS : 1 (2)

CNS : 1 (2)
Others : 1 (2)

HR : 82 NIBP : 120/80

SPO2 : 97 % TEMP : -

INVESTIGATION

HB : 14.2 T.BILIRUBIN : 0.4 T3 : 125 SEROLOGY
PLAT : 2.98 I.D. : 0.2 T4 : 7.75 Urine:
TC : 6680 D. : 0.2 TSH : 2.310
UREA : 17.9 T-PROTEINS : 6.8 HBA1C : - Others:
CREAT : 1.07 S.ALBUMIN : 4.6 RBS : -
Na⁺ : 141 PTT / INR : 12.1 / 1.0
K⁺ : 4.6 APTT : 30.6

ANGIO

LM + TVD

ECG

MR / WNL

CXR

(2)

ECHO

EF-63 %

AIRWAY

Teeth (2)
Mallampatti class III
Mouth Opening Adequate
Neck Movement Ext. restricted
TM Distance (2)

CAROTID DOPPLER

NO FLU

Other Opinions:

To do, blood grouping / typing

Pre OP Instruction :

NPO From: 5 AM

Pre Medication : T. par 40 mg
T. Anxiet 0.25 mg HS

Night Before Surgery :

Day of Surgery T. Anxiet 0.25 mg

Special Instruction :

Blood Reservation

PCV : 10 Platelet :
FFP : CRYO :
Whole Blood:

Remarks:

Anaesthetist Name with Reg.No. :

Dr. P. PRAVEEN
Reg No: 36510

Signature :

[illegible]

		START	STOP	FLUID TRANFUSED		BLOOD PRODUCTS	
ANAESTHESIA		9.40	15.00	CRYSTALOID	COLLOID	—	
PROCEDURE		10.40	14.45	KLX 4	—		
CPB — OR CAB —							
AXC							
CUF : MUF:							
HEPARIN				PRESSURE MONITOR			
DOSE	TIME	ACT		PRE OP			
125 mg	12.40	411 secs		PA	RV	PCWP	
				ABP —			
PROTAMINE				POST OP			
DOSE	TIME	ACT		PA	RV	PCWP	
75 mg	14.20	128					
INOTROPES & INFUSIONS				ABP —			
DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME	DRUG DILUTION	DOSE (RANGE)	START TIME	END TIME
NORAD (4mg/50ml)	0.05 mg	→ 2.4 ml/hr	→ ICU	DOPAMINE (200mg/100cc)	2.5-5 mcg/kg/min	14.00	→ ICU
NTG (25mg/25ml)	1 mg	→ 4 ml/hr	14.45				
REGIONAL ANAESTHESIA YES/NO DETAILS: B/L ESPB + ② FNB ↓ 0.2% Ropivacaine + 100 mg Dexmed				IABP: — ECMO: — TEE: —			
REMARKS / CRITICAL EVENTS							

IBW
60 kg

DR. PRAVEEN
 Reg. No: 86510

DR. PRAVEEN
 Reg. No: 86510

ANAESTHESIOLOGIST NAME :
 REG.NO.

SIGNATURE

POST OPERATIVE PLAN

Transfer to: ☒ SICU ☐ Others, specify: _____

Arrival in Recovery / ICU Time: 15.05

SpO₂: 100 % HR: 72 beats/min Rhythm: NSR RR: 14 breaths/min

ABP: 130/69 mmHg CVP: 8 mmHg PAP: _____ mmHg C.O: _____ L/min

Conscious state: sedated Pain score: _____

VENTILATOR SETTINGS:

MODE-SIMV (1/2) 15

T.V - 600

RR - 14

PEEP - 5

I:E = 1:2

FiO₂ - 0.8

IONOTROPES:

* DOPAMINE -

* NORADRENALINE - 0.05 µg/kg/min

POST OP ORDERS:

- ABG/AT/CXR
- vitals monitoring
- Review lab

MODIFIED ALDRETE'S SCORE (Score against each criteria)

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

Total Score: 10

Patient fit for discharge:

☒ YES ☐ NO

Anaesthetist Name & Reg.No. :

Dr. PRAVEEN
Reg. No: 86510

Dr. PRAVEEN
Reg. No: 86510

Signature

OPERATION NOTES

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Pre-Operative Diagnosis : CAD - LM + TVD , good LV , EF - 62%.

Post-Operative Diagnosis : - do -

Operation Procedure OPCAB x 3 grafts

LIMA → LAD

SVC → Last OM & PDA (seq)

D.O. Operation

1 0 0 1 2 0 2 4

Please tick the type of procedure :

Closed ☒

Open ☐

Operation

Commenced :

10.40

Operation

Completed :

14.45

Nature of

Anaesthetic : GA

Surgeons Dr. Anbarasu / Dr. Praveen / Dr. Sai / Dr. Kavitha

Anaesthetist Dr. Ajitha

Nurse MS. Sujatha

Incision Midline sternotomy

Cannulation

Arterial

Venous

Oxygenator

Median sternotomy, pericardiectomy. LIMA &

CPB Time

SVC harvested. Systemic heparinization. Heart

ACC Time

stabilized & myocardial stabilizer (Guidant). Distal

TCA Time

anastomosis done.

Findings and Relevant Details :

LIMA → LAD

Good myocardial contractions

SVC → Last OM & PDA (seq)

LIMA - 1.75mm, good quality
good flow

SVC - 4mm, from left leg, EVH
good quality

LAD - 1.75mm, intramyocardial
healthy vessel.

Last OM - 1.25mm, plaques

PDA - 1.5mm, healthy

aorta occluded partially. One 4mm hole was made
on the aorta. proximal anastomosis done &

6-0 prolene suture. protaminized. Hemostasis

secured. pericardium reapproximated partially.
LIMA vessel anastomosis

Routine chest closure done & two drain tubes
insite.

POST-BY PASS HAEMODYNAMICS

RA

LA

Cardiac Output

RV

LA

CI

SVS

SYS

PA

MEAN

BP

MEAN

DIAS

DIAS

PACW

Support:

Isoprin

Adrenaline

Dopamine

I A B P

Dobutrex

Others

POST-OPERATIVE INSTRUCTIONS :

Watch for: Bleeding, Hypotension

Blood loss: 250ml

Blood transfusion: Nil

Drains: Chest (Jt) - 1

Mediastinal - 1

Pericardial - 2

Others

Sponge Count: correct

Surgeon : Dr. Anbarasu Mohanraj

Reg No/55476

Date : 10/01/2024



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

OPERATION NOTES

NAME: Mr. RAJASINGH.P	AGE/GENDER: 59Years / MALE
UHD NO: MHI202381562	IP NO: IPH2024000068
DOA: 08/01/2024	DOS: 10/01/2024
SURGEON: DR. ANBARASU MOHANRAJ	ANESTHETIST: DR. AJEETHA
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	PHYSICIAN ASSOCIATE: MS. SAIKUMARI/MS.KARTHIKA
SCRUB NURSE: MS. SUJATHA	

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

LEFT MAIN DISEASE

NORMAL LEFT VENTRICULAR FUNCTION (EF – 62%)

SYSTEMIC HYPERTENSION

UNSTABLE ANGINA

SURGERY DONE:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3

LIMA TO LAD

SVG TO OM AND PDA (SEQUENTIAL)

FINDINGS:

Good myocardial contractions

No significant scarring

LIMA – 1.75mm, good flow, good quality

SVG – 4mm, Endoscopically vein harvested from left leg to mid thigh, Good quality

LAD – 2.0mm, Mid LAD deep intramyocardial, Healthy target

OM – 1.8mm, Healthy target

PDA – 1.6mm, mid PDA grafted, Mild plaques (+), Proximal PDA calcified

Good distal run off in all the grafts

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

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

**PATIENT
HELPLINE**
94557 94557
1800 572 3003

Medway Group of Hospitals

Kodambakkam | Mogappair | Chengalpattu | Villupuram | Kumbakonam | Kakinada
044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367

Medway Centre of Excellence (Chennai)

Heart Institute | Institute of Pulmonology
044 - 4310 8959 | 044-2473 4451

E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MHI/HOSP/2022/118



JCI ACCREDITED



NABH ACCREDITED



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

PROCEDURE:

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

Heart positioned and stabilized with myocardial stabilizer for PDA grafting. Arteriotomy was made and 1.55mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the PDA artery with 7-0 prolene suture. (SVG TO PDA)

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

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the Insitu LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture. (LIMA TO LAD)

Aorta occluded partially. One 4mm hole was made on the aorta with aortic punch. Proximal anastomosis of vein graft done onto aorta with 6-0 prolene suture. Protamine administered. Hemostasis secured. Pericardium reapproximated partially. Routine chest closure done with one mediastinal and one left pleural tubes insitu

SUPPORTS:

He was shifted to ICU with inj. Nor Adrenaline <0.04 µg/kg/min, inj. Dopamine <5 µg/kg/min supports

CONSULTANT SIGNATURE

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

Dr. ANBARASU MOHANRAJ
Reg. No: 55476

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

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1800 572 3003

Medway Group of Hospitals

Kodambakkam 044-2473 4455	Mogappair 044-26530011	Chengalpattu 044-27426829	Villupuram 04146-242000	Kumbakonam 044-2473 4455	Kakinada 0884-2333367
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118

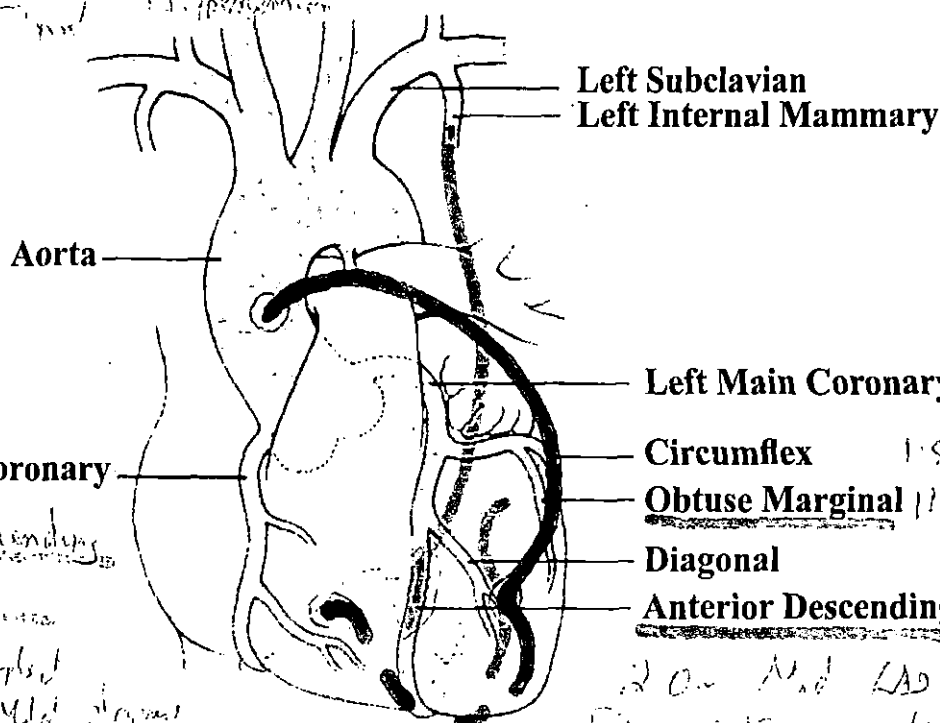
Simple Vessel covering Alleg. Cassare

Monday 24 November

4. 1. 1961

Unstable Regions

1. What is the purpose of the study?



Right Coronary

Left Main Coronary

Circumflex 1. C^{h}

Obtuse Marginal // *ca. 18* *1900*

Diagonal

Anterior Descending

Don't Mind LAD
Deep intramuscular
Healed target

Good muscular contraction.

No. 10000 and 10001

Prof. Richard Manning, Virginia Polytechnic Inst., Blacksburg, Va.

John Van Stry 5/24/15 conduct

Name Dr. Srinivas P. Srinivas Date of Surgery 16/01/2022 UHID. No. 441202781582

Operation Performed 501 Bomb Cal. cap. 1000 292100 (ANALYSE SAMPLES OF CAP)

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

59 Mod.

[illegible]

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SAFETY FIRST

MHI/ICU/2022/092



Mr. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IPH2024000068

S INFORMATION SHEET

NAME	Dr. ANBARASU MOHANRAJ	AGE / SEX	UHID NO
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CONSULTANT	SURGEON	ANAESTHETIST
DR. ANBARASU	DR. ANBARASU	DR. AJEETHA

DIAGNOSIS (In Capital Letters)	1. CAD - TVD + DISTAL LEFT MAIN
	2. NORMAL LV SYSTOLIC FUNCTION
	3. GRADE-I DIASTOLIC DYSFUNCTION
	4. AORTIC VALVE SCLEROSIS
	5. TRIVIAL MR, TR.
	6. EF = 63%
	7.
	8.

PRESENT PROCEDURE/ SURGERY	OPCAB X 3 GRAFTS LIMA → LAD SVG → LAST OM + PDA (SEQUENTIAL)
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PREVIOUS PROCEDURE/ SURGERY	SEPTOPLASTY DONE 15 YEARS BACK.
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CONTACT NO. & RELATIONSHIP	1. 9444697755 V.C [MR. BHARATHI] WIFE	2. 9940617755 [MR. RAJASINGH] SELF
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N. NO : 14/14

73584468100 V.C)
MR. HARISH [SON] SELF

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	08/01/24	Tab. ROSEDAY	20 mg	P/O	0-0-1	Continue
2	"	Tab. FLAVEDON MR	35 mg	P/O	1-0-1	
3	"	Tab. PROLOMET XL	25 mg	P/O	1-0-0	
4	"	Tab. GINT SORBITRATE	2.6 mg	P/O	1-0-1	
5	"	Tab. RANDEX	500 mg	P/O	1-0-1	
6	"	Tab. RABLET	20 mg	P/O	1-0-1	
7	"	INJ. FONDARED	2.5 mg	S/C	1-0-0	
8						
9						
10						



ANTIPLATELET STOPPED ON 06/01/24.

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	10/1/24	SUP. SUCRALFATE	10 ml	P/O	1-1-1	Continue
2	10/1/24	NEB. LEVOSALBUTAMOL	0.63 ml	P/W	Q6H	
3	11/1/24	T. FRUSEMIDE	40 mg	P/O	1-1-0	
4	11/1/24	T. SPIRANOLACTONE	85 mg	P/O	1-1-0	
5	11/1/24	T. BEPLEX FORTE	1 TAB	P/O	1-0-0	
6	11/1/24	T. CLOPIDOGREL ASPIRIN	75/75	P/O	0-1-0	
7	11/1/24	T. ROSUVASTATIN	40 mg	P/O	0-0-1	
8	11/1/24	T. PARACETAMOL	650 mg	P/O	1-1-1	Continue
9	11/1/24	SUP. LACTULOSE	15 ml	P/O	0-0-1	
10	11/1/24	T. METOPROLOL	85 mg	P/O	1-0-1	

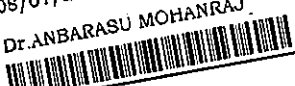
ANY RELEVANT INFORMATION:

Admission / OT Reveal Date and Time : 10/1/24 at 15:05 pm From : OT To : SICU.	Condition of the Patient : <div style="text-align: right; margin-bottom: 5px;">ON VENT</div> <div style="display: flex; justify-content: space-between;"> <div>1. Stable / Unstable ✓</div> <div>2. Oriented / Disoriented</div> </div> <div style="display: flex; justify-content: space-between;"> <div>3. Conscious / Semiconscious / Unconscious ✓</div> <div></div> </div> <div style="display: flex; justify-content: space-between;"> <div>4. Febrile / A febrile ✓</div> <div>5. Intubated / Extubated ✓</div> </div>		
Transfer Out Date and Time : 10/1/24 at 11:30 From : SICU To : 201	Condition of the Patient : <div style="display: flex; justify-content: space-between;"> <div>1. Stable / Unstable</div> <div>2. Oriented / Disoriented</div> </div> <div style="display: flex; justify-content: space-between;"> <div>3. Conscious / Semiconscious / Unconscious</div> <div></div> </div> <div style="display: flex; justify-content: space-between;"> <div>4. Febrile / A febrile</div> <div>5. Intubated / Extubated</div> </div>		
Transfer In Date and Time : From : To :	Condition of the Patient : <div style="display: flex; justify-content: space-between;"> <div>1. Stable / Unstable</div> <div>2. Oriented / Disoriented</div> </div> <div style="display: flex; justify-content: space-between;"> <div>3. Conscious / Semiconscious / Unconscious</div> <div></div> </div> <div style="display: flex; justify-content: space-between;"> <div>4. Febrile / A febrile</div> <div>5. Intubated / Extubated</div> </div>		
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD 4) Known Case Of Others	Year	Months	Days
	—		
	—	1 MONTH	
	—		
	—		
Denture	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Permanent Fixation <input type="checkbox"/> Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you means mention about Drug / Food Name :		
Pressure Ulcer Present	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you means mention about Grade : 1 / 2 / 3 / 4 & Site:		

ANY RELEVANT INFORMATION:

			Sign With Date	
Peripheral Cannulation	1. Site: <u>RE CUBITAL</u> 2. Site: 3. Site:	1. Inserted Date and Time <u>10/1/24 at 9:40</u> 2. Inserted Date and Time 3. Inserted Date and Time	1. Removed on : <u>11/1/24 at 16:30</u> 2. Removed on : 3. Removed on :	
Neck Line : IJL / EJL	Site: <u>RE IJV</u>	Inserted Date and Time <u>10/1/24 at 10:00</u>	Removed on <u>12/1/24 @ 9:30</u>	<u>Neha</u>
Arterial Line : Right /Left	Site: <u>RE RADIAL</u>	Inserted Date and Time <u>10/1/24 at 10:15</u>	Removed on <u>11/1/24 AT 11:10</u>	<u>Dr. 0229</u>
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 <u>+</u> 2. Pleural Right / Left : Inserted Date and Time <u>10/1/24 at 14:00</u>	Removed on <u>11/1/24 @ 16:10</u> Removed on <u>11/1/24 @ 16:10</u>		
Urinary Catheterization	Inserted Date and Time <u>10/1/24 at 10:30</u>	Removed on <u>12/1/24 @ 5:00</u>	<u>Dr. 0229</u>	
Nasal / Oral Gastric Tube	Inserted Date and Time <u>10/1/24 @ 15:05</u>	Removed on <u>10/1/24 @ 19:40</u>	<u>Dr. 0224</u>	
Intubation Date and Time <u>10/1/24 @ 15:05</u>	Extubation Date And Time <u>10/1/24 at 19:45</u>	Reintubation Date And Time <u>AHR Admin</u>	<u>Dr. 0224</u>	
Other Information.	<p>C/O CHEST PAIN [1 1/2 MONTH] AND SOB [1 1/2 MONTH]</p> <p>CAG DONE ON 29-12-24</p> <p>SCREENING ECHO DONE ON 30-12-23</p> <p>CAROTID DOPPLER DONE ON 30-12-23</p> <p>ECG DONE ON 08-1-24 [HR = 74 bpm]</p>			<u>Neha</u> <u>0224</u>

PATIENT'S INFORMATION SHEET

NAME Mr. RAJASINGH P. 59/Male/MHI202381562 08/01/2024/IPH2024000068 Dr. ANBARASU MOHANRAJ 	AGE / SEX	59Y/M	UHID NO	202381562
	SURGEON		ANAESTHETIST	
DR. ANBARASU	DR. ANBARASU		DR. PRAVEEN	
DIAGNOSIS (In Capital Letters)	1. CAD - RIGHT DOMINANT; DISTAL LM TWD			
	2. GOOD LV FUNCTION EF - 63%			
	3. SIGMOID SEPTUM TRIVIAL MR/TR			
	4. SHDN			
	5.			
	6.			
	7.			
	8.			
PRESENT PROCEDURE/ SURGERY	CABG			
PREVIOUS PROCEDURE/ SURGERY	H/O CABG done on 29.12.23 showed Right dominant distal LM & TWD S/P (L) sided Deviated nasal septum Plasty			
CONTACT NO. & RELATIONSHIP	1. MR. HARISH (SON) 9358446810		2. done 15 yrs back.	

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	29.12.23	C. CLOPITAB -A	75mg	P/O	0-1-0	01.1.24
2	"	T. ROSEDAY	20mg	P/O	0-0-1	}
3	"	T. FLAVEDON-MA	35mg	P/O	1-0-1	
4	"	T. PROLOMET XL	25mg	P/O	1-0-0	
5	"	T. GIMLISORBITRAT 2.6mg	P/O	1-0-1		
6	"	T. RANIZEX	500mg	P/O	1-0-1	
7	"	T. RABLET	20mg	P/O	1-0-1	
8						
9						
10						

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON	
1	08.1.24	T. ROSEDAY	20MG	P/O	0-0-1	}	
2	"	T. FLAVEDON-MR	35mg	P/O	1-0-1		
3	"	T. PROLOMETXL	25mg	P/O	1-0-0		
4	"	T. GIMLISORBITRAT	2.6mg	P/O	1-0-1		
5	"	T. RANIZEX	500mg	P/O	1-0-1		Continue
6	"	T. RABLET	20mg	P/O	1-0-1		
7	"	SPU. FONDARED	2.5mg	P/O	1-0-0	08.1.24	
8							
9							
10							

ANY RELEVANT INFORMATION:

Admission / OT Receival Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer Out Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
Transfer In Date and Time : From : To :	Condition of the Patient : 1. Stable / Unstable 2. Oriented / Disoriented 3. Conscious / Semiconscious / Unconscious 4. Febrile / A febrile 5. Intubated / Extubated		
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD 4) Known Case Of Others	Year	Months	Days
	—		
	1 month		
	—		
Denture	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Permanent Fixation <input type="checkbox"/> Temporary Fixation : Present / Absent		
Allergic Reaction : Drugs/Food	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you means mention about Drug / Food Name :		
Pressure Ulcer Present	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If you means mention about Grade : 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 Date and Time	2. Removed on :	
	3. Site:	3. Inserted Date and Time	3. Removed on :	
Neck Line : IJL / EIJL	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 / Left : Inserted Date and Time		Removed on	
Urinary Catheterization	Inserted Date and Time		Removed on	
Nasal / Oral Gastric Tube	Inserted Date and Time		Removed on	
Intubation Date and Time	Extubation Date And Time		Reintubation Date And Time	
Other Information	1. 6 per respiration done confirmed with MR. VENKAT			9/1/24 Sub

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086



Ev: **Mr. RAJASINGH P**
59/Male/MHI202381562
08/01/2024/IPH2024000068
Dr. ANBARASU MOHANRAJ



Name of the Procedure: OPCAB CLOSED HEART Location: COT-OT-2 Date & Time: 10/01/2024 @ 15:00

Does the Procedure involve Procedural Sedation: ☒ Yes ☐ No NA

SIGN IN: <u>9:35</u> Before Induction of Procedural Sedation		TIME OUT: <u>10:40</u> After procedural Sedation and before procedure		SIGN OUT: <u>15:00</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down	<input checked="" type="checkbox"/> Yes
Procedure	<input checked="" type="checkbox"/> Yes	Procedures	<input checked="" type="checkbox"/> Yes	OPCAB CLOSED HEART	
Side	<input type="checkbox"/> Rt <input checked="" type="checkbox"/> Lt <input type="checkbox"/> NA <u>chest, leg</u>	Side	<input type="checkbox"/> Rt <input checked="" type="checkbox"/> Lt <input type="checkbox"/> NA <u>chest, leg</u>	Name and site of all specimens / investigations	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA
Consent	<input checked="" type="checkbox"/> Yes	Expected Blood loss	<u>200-300ml</u>	confirms labeling and sent to lab	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NOT KNOWN If yes, please specify	Position	<u>- SUPINE</u>	Any recovery concerns:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify:	
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	14:40 - 2ND DOSE ANTIBIOTICS	
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	Any Equipment / instrument problem that needs to be addressed:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None
Pre OP medication taken	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Antibiotic prophylaxis within last 60 minutes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	If Yes, Pls. specify:	
Required equipment for procedure available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	Name of the Antibiotic given	<u>IN-CEFTURAXIME @ 1.5g 10:10 AM</u>	Corrective action:	
		Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input type="checkbox"/> Yes, NA		
		For procedural sedation cases			
		Any patient specific concerns:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
Anaesthetist / Doctor giving Procedural Sedation DR. ASEETHA Date: <u>10/01/2024</u> Time: <u>15:00</u>	Doctor performing the Procedure DR. ANBARASU MOHANRAJ Reg No: <u>55476</u> Date: <u>10/01/2024</u> Time: <u>15:00</u>	Nurse: SASTHANA <u>MA20031</u> Date: <u>10/01/2024</u> Time: <u>15:00</u>	Technician: RAJAKRISHNAN <u>0041</u> Date: <u>10/01/2024</u> Time: <u>15:00</u>	Others Please Specify: COT NURSE DR. CHRISTINA <u>0036</u> Date: <u>10/01/2024</u> Time: <u>15:00</u>	



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

Mr. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Every heart beat counts

CONSENT FOR BLOOD / BLOOD COMPONENTS

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

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

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

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

Witness.....

Doctor.....

Time.....

Date.....

Patients name.....

Patient signature.....

or Guardians name.....

Guardians signature.....

Relationship to patient.....

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: 18:00

Date: 9/1/24

Doctors signature.....

ஒப்புதல்:இரத்தம் / இரத்தத்தின் 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 கீழ்க்கண்டவை அடங்கும்:

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

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


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

நோயாளியின் பெயர்.....
சாட்சி..... நோயாளியின் கையொப்பம்.....
மருத்துவர் அல்லது பாதுகாவலரின் பெயர்.....
நேரம் பாதுகாவலரின் கையொப்பம்.....
தேதி..... நோயாளியுடனான உறைவு.....

உயிருக்கு ஆபத்தான/அவசரக்கால மருத்துவ நிலை காரணமாகத் தகவலறிந்த ஒப்புதல் பெறப்படவில்லை. தகவலறிந்த 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:
நோயாளியின் பெயர் மருத்துவரின் கையொப்பம்
தேதி:

Patient Details (Affix Label here)

Name: **Mr. RAJASINGH P**
UHID: 59 / Male / MH1202381562
DOB: 08 / 01 / 2024 / IPH2024000068
DOA: Dr. ANBARASU MOHANRAJ
Consultant: 

MHI/PHY/2022/050

CONSENT FORM - PHYSIOTHERAPY

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

☒ Read

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

☒ Been explained this consent form in TAMIL (Name of language) which I fully understand and understood the information provided about Operation / procedure

Post operative cardiac Pulmonary Rehabilitation

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

Brief description of the Operation / Procedure: DBx, Spirometry & Chest percussion
to B/c Chest wall, ARon to B/c U/LCL, Mobilization.

I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are:

To Improve Joint ROM, To improve lung capacity & function
To improve breathing, To clear out lung secretion

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

Pain

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

Nil

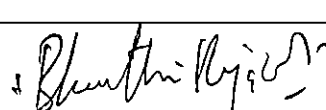

I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits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

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

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

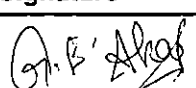
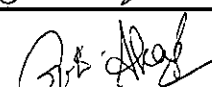
Dr. AKASH G.B (name of doctor performing the operation / procedure) for carrying out the said operation / procedure on ☒ myself or ☐ my above named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		BHARATHI RAJASINKU (Write name and relationship with patient)	10/1/24	16:00
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	R/KI 	GENIA FLORANCE S	10/1/24	16:00
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by		AKASH G.B	0256	10/1/24	16:00
Procedure performed by		AKASH G.B	0256	10/1/24	16:00

Name: **Mr. RAJASINGH P**
UHID: 59/Male/MHI202381562
DOB: 08/01/2024/PH2024000068
DOA: Dr. ANBARASU MOHANRAJ
Consultant:

IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints:

PT clo chest pain x 1 1/2 month
clo SOB x 1 1/2 month
Dyspnoea on exertion (lyrback)

Occupation: ☐ Heavy Activity ☐ Moderate Activity ☐ Light Activity

Past Medical / Surgical History:

K/C/O HTN x 1 month
CAG - (29/12/23) - Distal LM (TVS)
S/p - E coded dilatation nasal septoplasty done 15 yrs back.

On Observation:

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

On Palpation:

☐ INSIGNIFICANT

Tenderness: ☐ Yes ☐ No | Warmth: ☐ Yes ☐ No | Muscle spasm: ☐ Yes ☐ No
Oedema: ☐ Yes ☐ No | Crepitus: ☐ Yes ☐ No | Tone: ☐ Normal ☐ Abnormal

FALL RISK SCREENING NA

Fall Risk Screening for Adults: ☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem

In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.

Fall Risk Screening for Pediatrics: NA

☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged mobility

In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.

Respiratory Status:

☒ Room Air ☐ O₂ Support ☐ Ventilatory Support ☐ BIPAP
☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask
Intubated: ☐ Yes ☒ No
Tracheostomy: ☐ Yes ☒ No

Brain Injury (if applicable): NIL

☐ Traumatic ☐ Non Traumatic
☐ Mild ☐ Moderate ☐ Severe
☐ Conscious ☐ Unconscious

GCS: E +V +M = | RLA: levels

Spine Injury: ☐ Present ☒ Absent

AIS:ISNCSCI SCALE: NIL

☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx

Associated Injuries: Speech impaired: ☐ Yes ☒ No

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

ASHWORTH SCALE: NIL

☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit

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

Functional Activities

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

Transfers: ☒ Independent ☐ Dependent | Ambulation: ☒ Independent ☐ Dependent

FIM Score:

Breathlessness (if applicable):

Dyspnoea Grading Scale: Grade II

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

Abnormal Breathing Pattern: Abdominal breathing

Pain Assessment: Pain: ☒ Yes ☐ No

Pain Score: 8/10

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

☐ Pain Scale ☐ Critical Care Pain Observation Tool ☐ FLACC

Location: Chest

Duration: 1 1/2 month

Frequency: —

Character: —

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

☐ Sharp ☐ Cramping ☒ Stabbing ☐ Crushing

Aggravating Factors:

—

Relieving Factors:

—

Examination (Please tick and mention abnormal findings only):

☐ Range of Motion:

Normal

☐ Muscle Strength:

Normal

☐ Reflexes:

Normal

Plantar Response: ☒ Diminished ☐ Brisk ☐ Clonus

Biceps: ☒ Diminished ☐ Brisk ☐ Clonus

Triceps: ☐ Diminished ☐ Brisk ☐ Clonus

Supinators: ☐ Diminished ☐ Brisk ☐ Clonus

Knee: ☒ Diminished ☐ Brisk ☐ Clonus

Ankle: ☐ Diminished ☐ Brisk ☐ Clonus

Sensation: Good

☒ X-Ray

☒ ECG

☐ ECHO

☒ CAG

☐ SIP Surgery

CAD-TVD, SH7N

Physiotherapy Management Plan:

DBs, Spirometry as, chest percussion to BL chest wall,
Mobilization

Post OP Cardiothoracic rehabilitation Phase - I

AROM to BL UL & LL, Mobilize outside the room,
Stair climb encouraged.

	Signature	Name	Emp. No.	Date	Time
Physiotherapist	G. E. Akash	AKASH-G.E	0256	10/1/24	15:00

RE-ASSESSMENT FORM

Date &
Time

12/1/24
4
11:00

Fall Risk Score: -

Pain Score: 2/10

Surgical Site pain

Surgery / Procedure : OPCAB X3 Graft

Respiratory status Post OP :

- In Room Air

Post intention pain score :

2/10

Treatment case & plan :

- Doel
- symmetry ex
- chest percussion
- Mobilization
- ARON to B/E V/L

Post Intervention Pain Score: 2/10

Treatment Care & Plan:

Post operative cardiac Pulmonary
Rehabilitation

Signature

Name

Emp. No.

Physiotherapist

G.B. Gray

AKASHA G.B

0256



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Mr. RAJASINGH P

59 / Male / MH1202381562

08/01/2024 / IPH2024000068

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
10/1/24	17:30	<p>S/B <u>ABASIT</u></p> <ul style="list-style-type: none"> - ET/oral / Nasal Suctioning done yielded thick white secretions 	<p>GP: <u>Abas</u> MH10256</p>
10/1/24	19:45	<p>S/B <u>Ramanathan - P</u></p> <ul style="list-style-type: none"> - ET/oral / Nasal Suctioning done yielded thick secretions - Pt Extubated and Connected to Face mask (LOL-O₂) - Pt Voice Clear & Audible - DBE's encouraged - Chest Percussion to B/L Chest wall - AROM Gr's to B/L UL & LL - Spirometry Gr's encouraged Ins: 60cc Exp: 60cc 	<p>Dr. <u>Abas</u> MH10260</p>
11/1/24	6:00	<p>S/B <u>Ramanathan - P</u></p> <ul style="list-style-type: none"> - DBE's encouraged - Chest Percussion to B/L Chest wall - AROM Gr's to B/L UL & LL - Spirometry Gr's encouraged Ins: 60cc Exp: 60cc 	<p>Dr. <u>Abas</u> MH10260</p>



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Mr. RAJASINGH P

59/Malc/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
11/1/24	9:00	<p><u>S/B AKASH</u></p> <ul style="list-style-type: none"> - DBE's encouraged - Spirometry encouraged Ins: 6000 Exp: 6000 - Chest percussion to BL Chest wall - Arcom to BL UL EL 	<p>G. B. Akar</p> <p>MHI0256</p>
11/1/24	16:00	<p><u>S/B AKASH</u></p> <ul style="list-style-type: none"> - DBE's encouraged - Spirometry encouraged Ins: 6000 Exp: 6000 - Chest percussion to BL Chest wall - Arcom to BL UL EL - Chair mobilized 	<p>[Signature]</p> <p>MHI0260</p>
11/1/24	22:00	<p><u>S/B Ramanathan P</u></p> <ul style="list-style-type: none"> - DBE's encouraged - Chest Percussion to BL Chest wall - Arcom to BL UL EL - Spirometry encouraged Ins: 6000 Exp: 6000 	<p>[Signature]</p> <p>MHI0260</p>



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Mr. RAJASINGH P


59/Male/MHI202381562

08/01/2024/PH2024000068

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
12/1/24.	6:00	<p>S/B. <u>Ramanathan P</u></p> <ul style="list-style-type: none"> - DSE's encouraged - Chest percussion to BL chest wall - AROM Ab to BL M2L - Spirometry Ab encouraged In: 600cc Exp: 600cc - PT Chair mobilized 	 MH10260
12/1/24.	9:00	<p>S/B <u>AKASH</u></p> <ul style="list-style-type: none"> - DSE encouraged - Spirometry su encouraged In: 600cc Exp: 600cc - Chest percussion to BL chest wall - AROM to BL UL & LL 	<p>G. K. Akash</p> MH10256
12/1/24	16:00	<p>S/B <u>AKASH</u></p> <ul style="list-style-type: none"> - DSE encouraged - Spirometry su encouraged In: 600cc Exp: 600cc - Chest percussion to BL chest wall - AROM to BL UL & LL - PT Mobilized 	<p>G. K. Akash</p> MH10256



South Asia
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MH/ PRINT / 0096 / PHY

Mr. RAJASINGH P

59/Male/MH1202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
13/1/24	10:00	<p>S/B AIRASHU</p> <ul style="list-style-type: none"> - Dors encouraged - Sprometry encouraged Ins: bare exp: bare - Chest percussion to Bk Chest wall - AROM to Bk V/L - PT Mobilized 	<p>G.E. Rajas</p> <p>MH10256</p>
13/1/24	17:00	<p>S/B AIRASHU</p> <ul style="list-style-type: none"> - Dors encouraged - Sprometry encouraged Ins: bare exp: bare - Chest percussion to Bk Chest wall - AROM to Bk V/L - PT stair climb encouraged 	<p>G.E. Rajas</p> <p>MH10256</p>

DTANBARASO MONTANA

MICROBIOLOGY SHEET

MICROBIOLOGY-CULTURE REPORTS

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

DIABETIC CHART

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ

ACTUAL WEIGHT 77.3 kgs HbA_{1c}..... —

PREVIOUS DIABETIC MEDICATIONS —

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
9/01/24	18.00	131 mg/dl	—	<i>[Signature]</i>	<i>[Signature]</i>
9/01/24	9.00	133 mg/dl	NPO	<i>[Signature]</i>	<i>[Signature]</i>

INSTRUCTIONS FOR INSULIN INFUSIONS

<ul style="list-style-type: none"> * Mix 40u short acting Insulin in 40 ml. of normal Saline (I/J - 1 ml.) * Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.). * Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm. * Target Blood Sugar 150-200 mgs. * To monitor K⁺ separately. Urine Acetone <input type="text"/> 	BLOOD SUGAR mg / dl	INSULIN INFUSION
	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
	150-200	Adjust Infusion rate to 2u / hr.
	201-250	Adjust Infusion rate to 4u / hr.
	251-300	Adjust Infusion rate to 6u / hr.
	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
	>400	Adjust Infusion rate to 20u / hr.

DIABETIC CHART

Mr. RAJASINGH P
59 / Male / MHI202381562
08/01/2024 / IPH2024000068

Dr. ANBARASU MOHANRAJ

ACTUAL WEIGHT 77.3 kg HbA_{1c} -

PREVIOUS DIABETIC MEDICATIONS

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
10/1/24	15.10	202 mg/dl	my. H. ACTRAPID 4 IU / hr IV started	means 02/24	Dr. Ajeetha
	19.25	92 mg/dl	-	Dr. Ajeetha	Dr. Ajeetha
	21.15	40 mg/dl	-	Dr. Ajeetha	Dr. Ajeetha
11/1/24	6.45	158 mg/dl	-	Dr. Ajeetha	Dr. Ajeetha
12/1/24	5.00	161 mg/dl	-	Dr. Ajeetha	Dr. Ajeetha

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
* Mix 40u short acting Insulin in 40 ml. of normal Saline (I/J - 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 hourly when stable) and adjust Insulin rate according to the following Algorithm.	150-200	Adjust Infusion rate to 2u / hr.
	201-250	Adjust Infusion rate to 4u / hr.
	251-300	Adjust Infusion rate to 6u / hr.
* Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
* To monitor K ⁺ separately.	>400	Adjust Infusion rate to 20u / hr.
Urine Acetone <input type="text"/>		

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



BLOOD GROUP

O' POSITIVE

INVESTIGATION SHEET

Date	30/12/23					
HAEMATOLOGY						
Hb	14.4					
P.C.V	42.5					
Platelets	298000					
TLC	6680					
Polymorphs	68.0					
Lymphocytes	23.6					
Eosinophils	3.6					
Mono / Basophils	4.4/0.4					
E.S.R						
BIO-CHEMISTRY						
Urea	19					
Creatinine	1.10					
Sodium	141					
Potassium	4.67					
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.46					
D.Bilirubin	0.21					
I.Bilirubin	0.25					
S.G.O.T	18					
S.G.P.T	17					
ALP	98					
GGT	45					
Total Protein	6.8					
S.Albumin	4.6					
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

[illegible]

BLOOD GROUP

O POSITIVE

INVESTIGATION SHEET

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Date	30/12/23	10/1/2024	11/1/2024	12/1/24	14/01/24	
HAEMATOLOGY						
Hb	14.4	13.1	13.3	11.0	11.5	
P.C.V	42.5	38.6	39.6		34.3	
Platelets	298000	323500	344000		386000	
TLC	6680		9050		9820	
Polymorphs	68		87.7		77.8	
Lymphocytes	23.6		7.7		15.1	
Eosinophils	3.6		0.0		3.1	
Mono / Basophils	4.4/0.4		4.5/0.1		3.8	
E.S.R						
BIO-CHEMISTRY						
Urea	19		15	28	24	
Creatinine	1.10		0.67	0.92	0.83	
Sodium	141			127	136	
Potassium	4.65			3.83	3.73	
Bicarbonate						
Chloride						
Magnesium		2.0	1.9			
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.46		0.54			
D.Bilirubin	0.21					
I.Bilirubin	0.25					
S.G.O.T	18					
S.G.P.T	17					
ALP	98					
GGT	45					
Total Protein	6.8					
S.Albumin	4.6		3.8			
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK			284			
CK - M.B. MASS			14.0			
LDH						
Ntpro bnp						

[illegible]

ANTI PLATELET S TOPPED : 6/1/24



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59/Male/MHI202381562
08/01/2024/IPH2024000068

Dr.ANBARASU MOHANRAJ



MHI/IP/2022/074



Medway
Heart
Institute

Every heart beat counts

VITAL INFORMATION SHEET

BSA:
1.86 m²

BLOOD GROUP	O ⁺ ve
-------------	-------------------

ON ADMISSION

Height in CM

Weight in Kg.

161 cm

77.5 kg

Diagnosis: CAD - TVD + LEFT MAIN ADEQUATE LV EF = 68%.

Procedure : OPCAB X 3 GRAFTS

[illegible]

Mr. RAJASINGH P

59/ Male / MHI202381562

08/01/2024 / IPH2024000068

Dr. ANBARASU MOHANRAJ



Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name: _____

Age/Sex: _____

Patient Id No: _____

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

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

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



Mr. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IPH2024000068



MHI/IP/2022/066



Every heart beat counts

[illegible]

Date	From: 09/1/24	To: 10/1/24	Bed No: 201	INTAKE & OUTPUT CHART											
24 Hrs : Started Time :	7-00		Ended Time :											7-00	
NPO Started at :			NPO Over at :												
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)								
INTAKE	600ml		400ml		900ml										
OUTPUT	400ml		550ml		600ml										
Total Intake: 1900ml			Total Output: 1550ml			Difference: 350ml									
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
7:30	100					100	8:00	200					200		
9:30	200					300	12:00	200					400		
10:00	200					500	15:00	200					600		
12:00	100					600	16:00	150					750		
14:00	100					700	19:00	200					950		
15:00	150					850	21:00	200					1150		
16:00	50					900	2:00	200					1350		
18:00	100					1000	6:00	200					1550		
20:00	200					1200									
22:00	300					1500									
2:00	200					1700									
4:30	200					1900									
							TOTAL INTAKE - 1900ml								
							TOTAL OUTPUT - 1550ml								
							BALANCE - 350ml								

[illegible]



Date	From: 13/1/24	To: 14.1.24	Bed No: 20	INTAKE & OUTPUT CHART											
24 Hrs : Started Time : 7.00		Ended Time : 7.00													
NPO Started at :		NPO Over at :													
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)								
INTAKE	350 ml		400		900 ml		2.4 litres/day								
OUTPUT	950 ml		800		900 ml										
Total Intake: 1650 ml			Total Output: 2650 ml			Difference: 1000 ml									
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
9.15	100					100	9.20	500					500		
9.45	50					150	12.5	450					950		
9.5	100					250	1.40	300					1400		
12.10	100					350	5.40	300					1700		
1.35	200					550	20.10	300					2050		
4.20	100					650	00.00	300					2350		
6.00	100					750	6.00	300					2650		
8.20	50					800									
21.00	100					900									
23.00	100					1000									
23.15	50					1050									
2.30	200					1250									
4.30	200					1450									
6.30	200					1650									
							TOTAL INTAKE - 1650 ml								
							TOTAL OUTPUT - 2650 ml								
							BALANCE - 1000 ml								

Date		From: 14/01/24		To: 15/01/24		Bed No: 201									
24 Hrs : Started Time : 7-00				Ended Time : 7-00											
NPO Started at :				NPO Over at :											
SHIFT	Morning		Afternoon		Night		Restricted Fluid (RF)								
INTAKE	1100ml														
OUTPUT															
Total Intake:			Total Output:			Difference:									
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
7-00	100					100	10-20	300					300		
8-30	50					50									
10-00	50					300									
11-30	100					400									
discharged															

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAD - TUD / AVS / EF 63% / CABG /

Height: 161 cms Weight: 75 Kgs Food allergies: Yes/ No, if yes, specify.....

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



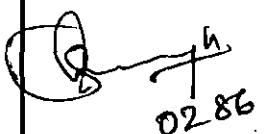
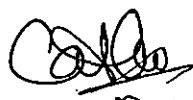
Diet Prescription: 1600 calories, low fat, low salt diet, high protein

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time:

9/1/24 16:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
8/1/24 18:00	<p>A 59 Years old gentleman came w/ c/o chest pain (1 month) was assessed to be well-nourished as evident by SGA.</p> <p>K/C/O - CAD - TVD</p> <p>Educated the patient & family on 1600 calories, low fat, low salt diet. Emphasized on small frequent meals.</p>	
10/1/24 16:00	<p>patient shifted to OT for surgery (CABG). kept on NBM. patient received to SICU. will initiate a liquid diet as per doctor's advice.</p>	
11/1/24 10:00 AM	<p>NBM over.</p> <p>patient tolerated liquid diet can initiate a soft solid, diet high protein diet</p>	
12/1/24, 12:00	<p>patient <u>void</u> bowel. Reemphasized on the diet restriction. Motivated to eat well</p>	 Maria Catherine John Senior Dietitian



Department of Dietetics

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
08/01/24, 00200.	<p>Diet intake is good. Diet modification and clarification done. Motivated to eat well.</p>	<p><i>[Signature]</i> Maria Catherine John Senior Dietitian</p>
15/1/24, 00200.	<p>Diet intake is good. Educated the patient and family on 1600 calories, low fat, low salt, high protein diet on discharge. Shipped a menu for meal. Diet modification and clarification done. <u>Diet chart given</u> on discharge.</p>	<p><i>[Signature]</i> Maria Catherine John Senior Dietitian</p>

INTRAOPERATIVE NURSING RECORD

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Consultant : DR. ANBARASU MOHANRAJ

Date of Surgery : 10/01/2024

Name of Surgery : OPCAB CLOSED HEART

Mode of Transfer to OR : ☐ Bed ☒ Stretcher ☐ Other ☐Anaesthesia Type : ☐ Epidural ☐ Spiral ☐ LOC ☐ MAC
☒ GEN ☐ Regional _____Position : ☐ Lithotomy ☐ Prone ☒ Supine ☐ Right Down ☐ Left down
☐ Lateral ☐ Other ☐Pressure Protection Pad : ☒ Headrest ☐ Sand Bag ☒ Pillow ☐ Axillary roll☒ Shoulder roll ☒ Eye protection ☐ Chest roll ☐ Cysto/Gyn☐ Sling ☐ Boot ☐ Stirrups/Leg Holder☐ L arm rest padded / Secured ☒ R Arms tucked / padded☐ Nil ☐ R ☐ L ☐ Other (Specify) _____Skin preparation in OT : ☒ Chlorhexidine Prep ☒ Povidone Iodine ☐ Iodophor scrub☐ Alcohol Prep ☐ Others (specify) _____Electrocautery : ☒ Monopolar ☒ Pad Location _____ ☐ Bipolar

Tourniquet

☐ Location _____☐ Applied Time _____ ☐ Released Time _____☐ Applied Time _____ ☐ Released Time _____☐ Applied Time _____ ☐ Released Time _____

Other equipment used : _____

Personal

: ☒ Surgeon DR. ANBARASU ☒ Asst. DR. PRAVEEN
☒ Anaesthetist DR. POETIA ☐ Asst. _____

Type of Specimen :

Lab

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

Packing / Drains / Catheters

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

Urinary catheterization had done by Mr. Harri with use of Foley's catheter

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

☒ Count Correct

Corrective action taken

Surgeon informed

done with sterile report by dressing done with hamjee pad + crepe bandage

Condition of patient at end of surgery : ☒ Stable

☐ Fair

☐ Critical

Transferred to : ICU

☐ Patient Room

☐ CCU

☐ Recovery Room

Scrub Nurse Signature

Name : RIN SUJATHA / 0125

Date & Time : 10/01/2024 @ 15.00

Circulating Nurse Signature SN/0031

Name ; RIN SARASWATHI / MA0031

Date & Time : 10/01/2024 @ 15.00



Patient Details (affix label here)
 Mr. Rajasingh, 59/M
 (Dr. Anbaram)

PSYCHOLOGICAL WELLBEING REPORT

Date: 09/01/24

Time: 2.40pm

Unit: 201A

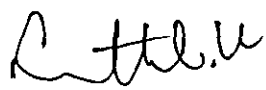
Clinical diagnosis: CAD - LM TVD

Surgery/ Procedure:

Impression: Functioning well, sleep ↓

- calm affect, oriented, responsive
- sleepless, appetite (N)
- no psychological distress reported.

Employee ID: MH1021654


 Signature of the Psychologist:

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 8/1/24 Time of Arrival: 16:30 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: MR. Harish

Relationship with Patient: Son Contact Person's Name: MR. Harish Relationship: Son

Contact No.: 7358446810 Primary language spoken: ☒ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☒ Yes ☐ No

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

Menstrual History : LMP : Menopause:

Medical History : DM / HTN / Co - Morbidity : 1 Month Yes If yes specify

Drugs History : Antiplatelet T-clopid - stopped - 6/1/24

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

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

If Yes, specify details:

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

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 78 (beats/min) | BP: 130/50 (mmHg)

Respiration: 18 (breaths/min) | SpO₂: 99 (%) | CBG: 134 (mg/dl) | Height: 161 (cms) | Weight: 77.5 (kgs)

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

If Yes, specify:

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10 Pain Scale Used: ☐ Wong-Baker FACES Pain Rating Scale (7-12 years)

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

Duration: Location:

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

Nutritional Screening:

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

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

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

Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: MRS. Cethrine Time: 16:30

Orient Patient if: ☒ Conscious Orient Patient Attendant if: ☐ Unconscious ☐ Disoriented

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

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

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Hearing Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Chewing Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Walking Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

Total Score: 28 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

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

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

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT):

Tick the score obtained (✓)

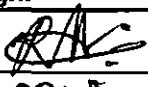
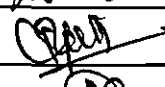

Final Score

		✓	Action Taken	Date	Time
Low Risk	-2 to 0		2 to 0	8/1/24	16:30
Moderate Risk	1 to 2				
High Risk	3 to 8				

Personal Belongings / Valuables:

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

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

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant		R. HARISH PORSINGHA	8021	8/1/24	16:30
Nurse		R. Sushma	0001	8/1/24	16:30
Unit In-Charge		Dr. Chennur	005	09/01/24	08:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/11/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

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

GCS:
POD:
Central line days:
VIP Score:

B

BACKGROUND

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

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 24 (breaths/min)
BP: 130/80 (mmHg) | SpO₂: 99 (%) | Height: 161 (cms) | Weight: 72.5 (kgs) | BMI: 24.2 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: ☐ Low ☒ Medium ☐ High
Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA Wound Dressing done: ☐ Yes ☒ No ☐ NA
Current diet: Normal diet Drains:

R

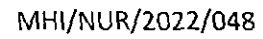
RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Rajasenthil	00201	8/11/24	16:30
Handover taken by		Sanjaya	00224	8/11/24	19:30
Document endorsed		Chandrasekar	0005	08/01/24	08:00

NURSES PROGRESS NOTES

[illegible]

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24

Shift: ☐ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - LMTVD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: ☒ Left: ☐

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS:

POD:

Central line days: -

VIP Score:

B

BACKGROUND

Type of surgery:

Allergies if any: NEDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.8 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 22 (breaths/min)

BP: 120/80 (mmHg) | SpO₂: 99 (%) | Height: 161 (cms) | Weight: 75 (kgs) | BMI: 24.26/m²

Others: -

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

Fall Risk Score: - Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Normal diet

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	Seni	Seni priya	0221	8/1/24	7:30
Handover taken by	S. Jay	S. Devachandini	0212	8/1/24	7:30
Document endorsed		Dheeraj	005	08/01/24	08:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - LM DVT

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: D2

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left: -

Day: -

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: -

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 24 (breaths/min)

BP: 130/80 (mmHg) | SpO₂: 99 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.2 kg/m²

Others: -

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

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

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: normal diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	S. D.	S. Douravharshini	0212	9/1/24	12:30
Handover taken by	A.	Agasthya	0116	9/1/24	12:50
Document endorsed	(Signature)	S. Chennur	005	09/01/24	14:00

NURSES PROGRESS NOTES					
Date & Time	Observations / Action			Signature with Emp. No.	
9/1/24	<u>Morning Duty Notes</u>				
7.30	Pt handing over taken from Night Duty Staff. ⇒ Pt conscious & oriented ⇒ pt V/S & I/O chart checked & recorded.			S.D. G.L.	
8.00	⇒ pt due medication given. ⇒ pt chest x-ray taken done & collected.				
9.00	⇒ pt urine routine sample sent to lab.			S.D. G.L.	
12.00	⇒ pt V/S & I/O chart checked & recorded.				
12.30	⇒ pt handing over given to evening duty staff.				
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	(Signature)	Dhananand	005	09/01/24	12.00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - LM DVT

NEWS / PEWS Score: 6

Ventilator day: -

Peripheral line day: Right: - Left: -

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: -

B

BACKGROUND

Type of surgery: NKA

Allergies if any: ON ROOM AIR

On room air / oxygen: -

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 25 (breaths/min)

BP: 100/70 (mmHg) | SpO₂: 94 (%) | Height: 169 (cms) | Weight: 54.5 (kgs) | BMI: 24.2 kg/m²

Others: -

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

Fall Risk Score: 5 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: Normal diet

Drains: Nil

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: Nil

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: to monitor plan cath.

	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>[Signature]</i>	Agasthian	006	9/1/24	12.30
Handover taken by	<i>[Signature]</i>	F. Catharine	0207	9/1/24	19.30
Document endorsed	<i>[Signature]</i>	Dhananarayanan	0005	9/1/24	08.00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/01/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - L.M.TVD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: D2 Left: -

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 15/15

POD: -

Central line days: -

VIP Score: 2/5

B

BACKGROUND

Type of surgery: -

Date of surgery: -

Allergies if any: NKDA

On room air / oxygen: -

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 84 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/70 (mmHg) | SpO₂: 99 (%) | Height: 169 (cms) | Weight: 77.5 (kgs) | BMI: 24.2 Kg/m²

Others: -

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: Normal diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: Tomorrow plan CABG

	Signature	Name	Emp. No.	Date	Time
Handover given by	<u>E. Carthy</u>	<u>E. Carthy</u>	<u>0207</u>	<u>10/01/24</u>	<u>7.30</u>
Handover taken by	<u>S. D.</u>	<u>S. Dhanasekaran</u>	<u>0212</u>	<u>10/01/24</u>	<u>7.30</u>
Document endorsed	<u>ADP</u>	<u>Dhanasekaran</u>	<u>005</u>	<u>10/01/24</u>	<u>08.00</u>

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/01/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - LM + TUD

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: D3 Left: -

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: -

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

GCS: 15/15

POD: -

Central line days: -

VIP Score: 0/5

B

BACKGROUND

Type of surgery: -

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: -

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 98 (%) | Height: 169 (cms) | Weight: 77.5 (kgs) | BMI: 24.2 kg/m²

Others: -

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

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Current diet: Normal Diet

Drains: -

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: TID plan (ABC, NPO 5 AM)

	Signature	Name	Emp. No.	Date	Time
Handover given by	S. D.	S. Devaraswami	0211	10/01/24	9.30
Handover taken by		shifted to OT			
Document endorsed	(R)	Devaraswami	005	10/01/24	10:00

NURSES PROGRESS NOTES

[illegible]

Date & Time	Observations / Action	Signature with Emp No.			
	CTOT RECEIVAL REPORT				
10/01/2024	Patient Received From _____ To _____ With Blue Op File And Case Sheet				
@	ECG: \ ECHO: @ X-RAY: ANGIO CD: with attender				
9-20	CT FILE: —				
	Patient Posted For Procedure: CABG				
	Under Anesthesia: WA	SK			
	Allergy Status: Not known drug & food allergy	0031			
	Known Case Of: CAD-DISTAL LM TVD, good LV function EF- 63%, SHUN- past 1 month				
	Past Surgical History: HD- (2) sided Nasal septoplasty - 15 yrs back				
	VITAL SIGN: TEMP: 37°C HR: 88bpm SPO2: 98% BP: 101/60mmHg				
	CTOT SHIFTING REPORT				
10/01/24	Patient Shifted From CTOT To SDU With Blue Op File And Case Sheet Along With				
@	*Surgery Safety Check List				
15:00	*Intra Operative Record				
	*Nurses' Record				
	*				
	ECG: \ ECHO: @ X-RAY: \ ANGIO CD: with attender	SK			
	CT FILE: —	0031			
	Patient Posted And Underwent For Procedure: CABG [closed]				
	Under Anesthesia: WA				
	Procedure: OPCABG 3 wires LIMA → LAD, heart				
	Drain tube size and placement: 28Fr → (2) → mediastinum				
	Pacing wire placement: Present/Absent / Site: left pectoral				
	Implants: —				
	Cautery burn/skin peeling/towel clip mark: Present/Absent				
	Site:				
	VITAL SIGN: TEMP: 37°C HR: 80bpm SPO2: 98% BP: 109/55 mm of Hg				
	Notes:				
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	SK 0031	M. SARDHUMAR	MHS0031	10/11/24	15:00

SAFETY FIRST



Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/048



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - GVD + Left Main

NEWS / PEWS Score: -

Ventilator day: D1

Peripheral line day: Right CUBIC Left: D1

Ryle's Tube: ☒ Yes ☐ No Day: 1

Urinary Catheter: ☒ Yes ☐ No Day: 1

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

GCS: F1VET M1P

POD: D03

Central line days: D1

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPLFB

Allergies if any: NIKDA

On room air / oxygen: ON VENTILATOR

Complaints / New Symptoms in last shift:

Date of surgery: 10/1/24

IV fluids on flow: KABILYIE

A

ASSESSMENT

Vital Signs: Temp: 98.1 (°F) | Pulse / HR: 77 (beats/min) | Respiration: 14 (breaths/min)

BP: 127/65 (mmHg) | SpO2: 96 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²

Others: CVP - 9mmHg, BSA: 1.86m²

Pain Score: 08 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 65 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High

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

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

Current diet: NPO

Drains: Mediastinal and pleural

R

RECOMMENDATION

Referral doctors: Dr. Agatha

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		ONIA FLORENCE S	0074	10/1/24	19:30
Handover taken by		ARUN	2355	10/1/24	19:30
Document endorsed		ARUN	2355	11/1/24	5:00

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: CUBITA Left: D1

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☒ Yes ☐ No Day:

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

GCS: 15/15

POD: D05

Central line days: D1

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCABX 3 GRAFTS

Date of surgery: 10/1/24

Allergies if any: NKA

On room air / oxygen: ON O2 mask - 10 lit

IV fluids on flow: LABILETE

Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 94.6°F | Pulse / HR: 102 (beats/min) | Respiration: 20 (breaths/min)

BP: 124/63 (mmHg) | SpO2: 94 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²

Others: CUP: 6 mmHg

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 65 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: liquid

Drains: mediastinal + Lt Pleural

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: 10/1/24

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		ARUN	2355	11/1/24	7.30
Handover taken by		ANBARASU	0919	11/1/24	7.30
Document endorsed		ANBARASU	2002	11/1/24	9.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
19.00	patient taken over from evening duty staff.	
19.45	patient was extubated. patient was hemodynamically in stable condition.	<i>[Signature]</i>
	with support IVS. DOPA = 5mls and IVS. NORAD = 20.04mls on flow.	
20.30	oral care was given	
21.00	rehabilitation and spirometry exercise given.	
21.30	DR. Aseeth came and seen the patient.	
	ABG Analysis Done. on O2 mask - 10 lit.	<i>[Signature]</i>
4.30	collected blood sample and sent to lab for further investigation.	
5.00	provided oral care & gives sponge bath. Back to Back care is given.	<i>[Signature]</i>
6.00	provided rehabilitation and spirometry exercise.	
6.45	ABG Analysis Done.	
7.10	patient handed over to morning duty staff.	<i>[Signature]</i>
Document endorsed by	Signature <i>[Signature]</i>	Name <i>[Signature]</i>
		Emp. No. 0003
		Date 11/12
		Time 9.00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

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

B

BACKGROUND

Type of surgery: OPCAB x 34 RAFIS Date of surgery: 10/1/24
Allergies if any: -
On room air / oxygen: ON NCPAP @ 2 Ltr
Complaints / New Symptoms in last shift: -
IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 108 (beats/min) | Respiration: 97 (breaths/min)
BP: 131/60 (mmHg) | SpO₂: 97 (%) | Height: 161 (cms) | Weight: 77.57 (kgs) | BMI: 29.9 kg/m²
Others: BSA 1.86 m²
Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: LIQUID Drains: MEDIASTINAL + LEFT PLEURAL

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Mahalingam M	0219	11/1/24	12:30
Handover taken by		S/N Bhavani R	0287	11/1/24	12:30
Document endorsed		Mahalingam M	0219	11/1/24	12:30

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: ☒ CUBITAL D2 Left:

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☒ Yes ☐ No Day:

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

GCS: 15/15

POD: I

Central line days: D2

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB X 3 GRAFTS.

Allergies if any: NOT KNOWN

On room air / oxygen: ON ROOM AIR

Complaints / New Symptoms in last shift:

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 97.2°F | Pulse / HR: 92 b/m (beats/min) | Respiration: 22 b/m (breaths/min)

BP: 122/76 (mmHg) | SpO₂: 100% (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²

Others: BSA = 1.86 m²

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

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

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

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

Wound Dressing done: ☒ Yes ☐ No ☐ NA OT

Current diet: LIQUID

Drains: MEDIASTINAL + LEFT PLEURAL

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:


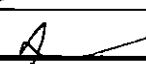
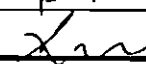
Critical value alert and its corrections:

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




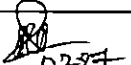
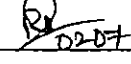
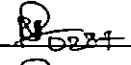
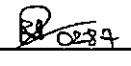
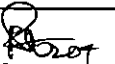
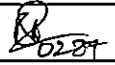

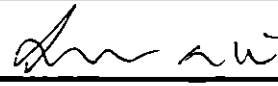
Pending follow-up orders:

Special instructions if any:

NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by	S/N R. BHAVANI	S/N R. BHAVANI	0287	11/1/24	19:30
Handover taken by		ASHA.C	0019	11/1/24	19:30
Document endorsed			2023	11/1/24	9:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	<u>Evening duty Report.</u>	
12:00 pm.	Handing over taken from Morning duty staff nurse.	
	While receiving patient was on Continuous Monitoring. patient was hemodynamically stable. patient is on Room air with $SpO_2 = 100\%$. C-line present in (RT) ITV. Flushed and checked. line was patent. peripheral line present over the (RT) anti-cubital line. Flushed and checked. line was patent. Chest Drain present over the pleural and Mediastinal. Dressing was placed over the Surgery site. Skin was intact. Abdomen was soft. peripheries are warm. pulses are felt.	
13:00 pm.	patient had lunch. Due drugs are given as per drug chart orders.	
14:00 pm	Due drugs given as per drug chart order. Hourly vitals are checked & recorded	
15:45 pm	Inj. para 1gm was given due to removal of drain.	
16:10 pm	Drain was removed by Mr. Saranya (PA).	
16:30 pm	After drain removal chest X-Ray was given taken and report was collected.	
17:15 pm	patient drunk Coffee	
18:00 pm	Mobilized to chair. patient felt comfortable. No More difficulties.	
19:00 pm	Handing over given to night duty staff nurse.	
Document endorsed by	Signature	Name
		
		Emp. No.
		0003
		Date
		11/1/24
		Time
		9.00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - TUD + Left main

NEWS / PEWS Score: -

Ventilator day:

Peripheral line day: Right: Central D-2 Left:

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☒ Yes ☐ No Day:

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

GCS: 15/15

POD: 1 pod

Central line days: D-2

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPCAB

Allergies if any: N/A

On room air / oxygen: On Room Air

Complaints / New Symptoms in last shift:

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 18 (breaths/min)

BP: 115/75 (91) (mmHg) | SpO₂: 94 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 (kg/m²)

Others: BSA: 1.86 m²

Pain Score: 4/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale (NRS) CPOT

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

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Soft diet

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		Aetha C	0019	12/1/24	07:15
Handover taken by		MAHALINGAM M	0019	12/1/24	7:15
Document endorsed		Anbarasu Mohanraj	2003	12/1/24	9:00

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-TVD + DISTAL LEFT MAIN - 15/15
NEWS / PEWS Score: -
Ventilator day: -
Peripheral line day: Right: CUBITAL Left: D3
Ryle's Tube: ☐ Yes ☒ No Day:
Urinary Catheter: ☒ Yes ☐ No Day:
Barrier nursing: ☒ Yes ☐ No MDR: ☐ Yes ☒ No. If Yes, specify organism:
GCS: 15/15
POD: POD-4
Central line days: D3
VIP Score: ds

B

BACKGROUND

Type of surgery: OPCAB X BYPASS Date of surgery: 10/1/24
Allergies if any: ALLER On room air / oxygen: On Room air IV fluids on flow: -
Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 96.0°F | Pulse / HR: 85 (beats/min) | Respiration: 16 (breaths/min)
BP: 119/65 (mmHg) | SpO₂: 94% | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²
Others: BSA: 1.86 m²
Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: SOFT DIET Drains: 2

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	Maha	Mahalinghi. M	0219	12/1/24	7.45
Handover taken by	Al	B. Vanish	0105	12/1/24	7.20
Document endorsed	X	Amur	0000	12/1/24	9.00



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-TVD + DISTAL LEFT MAIN

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: Cubiti Left: D3

Ryle's Tube: ☐ Yes ☒ No Day: -

Urinary Catheter: ☐ Yes ☒ No Day: -

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

GCS: 15/15

POD: II

Central line days: D3

VIP Score: -

B

BACKGROUND

Type of surgery: OPCABX. Bypass

Date of surgery: 10/1/24

Allergies if any: NDA

On room air / oxygen: on room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: NIL

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 85 / 61 (beats/min) | Respiration: 16 (breaths/min)

BP: 119/65 (mmHg) | SpO₂: 94 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.7 kg/m²

Others: -

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

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

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

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

Current diet: SOFT DIET

Drains: ☒

R

RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: NIL

Critical value alert and its corrections: -

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

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		<u>U. Devika</u>	<u>0182</u>	<u>12/1/24</u>	<u>12:30</u>
Handover taken by		<u>Jenipiya</u>	<u>0284</u>	<u>12/1/24</u>	<u>19:30</u>
Document endorsed		<u>S. ValPNP</u>	<u>0082</u>	<u>12/1/24</u>	<u>18:00</u>

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - TVD + DISTAL LEFT MAIN

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: Central Left: D₃

Ryle's Tube: ☐ Yes ☒ No Day:

Urinary Catheter: ☐ Yes ☒ No Day:

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

GCS: 15/15

POD: 4

Central line days: D₃

VIP Score: -

B

BACKGROUND

Type of surgery: OPCAB x 3UTRAFO

Allergies if any: NKDA

On room air / oxygen: on Room air

Complaints / New Symptoms in last shift: -

Date of surgery: 10/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 85 (beats/min) | Respiration: 16 (breaths/min)

BP: 100/80 (mmHg) | SpO₂: 94 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²

Others: -

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 80 Fall Risk Protocol: ☐ Low ☐ Medium ☐ High

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

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

Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: Soft DIET

Drains: -

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders: -

Special instructions if any: -

Nil

	Signature	Name	Emp. No.	Date	Time
Handover given by	Jen	Jen Priya	0284	12/1/24	7:30
Handover taken by	Hay	Hannah George	0105	12/1/24	7:30
Document endorsed	Uce	S. Kalpana	0024	12/1/24	16:30

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13.1.24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

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

B

BACKGROUND

Type of surgery: OPCAB x 3 Grafts Date of surgery: 10/1/24
Allergies if any: N/A
On room air / oxygen: On Room Air IV fluids on flow:
Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 88 (beats/min) | Respiration: 16 (breaths/min)
BP: 120/80 (mmHg) | SpO₂: 94 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²
Others :
Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: Soft diet Drains:

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Hannah Lixae	0105	13/1/24	12:30
Handover taken by		P. Sushma	0201	13/1/24	13:30
Document endorsed		S. Uthappa	0024	13/1/24	16:30

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD-TVD -

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☒ No Day: =

Urinary Catheter: ☐ Yes ☒ No Day:

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

GCS: 15/15

POD:

Central line days:

VIP Score: 0/5

B

BACKGROUND

Type of surgery: OPMB x 2 grafts

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift:

Date of surgery: 12/1/24

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 71 (beats/min) | Respiration: 22 (breaths/min)

BP: 120/75 (mmHg) | SpO₂: 99 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 29.9 kg/m²

Others:

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

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

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

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

Current diet:

Soft diet

Drains:

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any:

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0201	13/1/24	17.00
Handover taken by		M. Revathy	0225	13/1/24	19.30
Document endorsed		S. ValPNP	0024	13/1/24	10.20

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD-TVD

NEWS / PEWS Score: 0

Ventilator day: -

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism: -

GCS: 15/15

POD: 11

Central line days: -

VIP Score: 0.5

B

BACKGROUND

Type of surgery: OPCABx340abt

Allergies if any: NKDA

On room air / oxygen: RA

Complaints / New Symptoms in last shift: -

Date of surgery: 12/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 96.3°F | Pulse / HR: 84 (beats/min) | Respiration: 21 (breaths/min)

BP: 130/80 (mmHg) | SpO₂: 96 (%) | Height: 161 (cms) | Weight: 77.5 (kgs) | BMI: 27.9 kg/m²

Others: -

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

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

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

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

Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet:

Drains: -

Normal diet

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: Tomorrow plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by		N. Ravathi	0225	14/1/24	7:30
Handover taken by		A. Manabini	0170	14/1/24	7:30
Document endorsed		S. Nallappan	0024	14/1/24	10:00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - TVD

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right: ☐ Left: ☐

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Day:

Day:

Day:

MDR: ☐ Yes ☒ No. If Yes, specify organism:

GCS: 15/15

POD: IV

Central line days:

VIP Score: 6

B

BACKGROUND

Type of surgery: OPLABX 3 GRAFT

Allergies if any: 1/KAOA

On room air oxygen: on Room Air

Complaints / New Symptoms in last shift:

Date of surgery: 12/1/24

IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp: 97.2°F | Pulse/HR: 82 (beats/min) | Respiration: 22 (breaths/min)

BP: 110/72 (mmHg) | SpO₂: 97% | Height: 161 (cms) | Weight: 77.5 kgs | BMI: 27.9 kg/m²

Others:

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

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

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

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

Current diet:

Drains:

Normal diet

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any: Today. plan discharge.

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Nandhini	0170	14/1/24	12:30
Handover taken by		S. Vathini	0170	14/1/24	12:30
Document endorsed		S. Vathini	0170	14/1/24	16:20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
14/1/24	Morning July 14/24	
7-30	patient taken over from Night duty Staff Nurse	[Signature]
8-30	patient Conscious & oriented patient vital signs checked & Recorded Medication given as per drug chart patient mobilised well	[Signature]
11-30	Today plan discharge patient vital signs checked & Recorded	
12-30	patient handing over to Evening duty Staff Nurse	[Signature]
	Discharge notes	
19-15	pt can be discharged while pt conscious and oriented IV line removed Discharge Summary explained and given All Health Education given. ID Band removed	[Signature]
Document endorsed by	Signature [Signature]	Name S. Nalpan
	Emp. No. 0024	Date 14/1/24
	Time 14:00	

ADULT NURSING CARE PLAN

DR. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IPH2024000068
Dr. ANBARASU MOHANRAJ



MHI/NUR/2022/044




Every heart beat counts

Initial Date: 8/1/24 Time: 19:00		Modified Date: Time:	
Reason for Modification:		Diagnosis: CAD - LmTVD	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation
NUTRITION <input type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input checked="" type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input checked="" type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M E pt had @ diet N pt had @ diet
OXYGENATION <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input checked="" type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input checked="" type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt had @ diet E pt SpO ₂ 99% N pt SpO ₂ 99%
FLUID & ELECTROLYTES <input type="checkbox"/> Oral <input checked="" type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input checked="" type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M E pt 2l0 chart N pt 2l0 chart

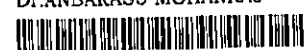
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input checked="" type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/>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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input checked="" type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input checked="" type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M E pt well communication N pt well communication	 P 6/20/1 S
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input checked="" type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input checked="" type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M E pt receiving meds given N pt receiving meds are given	 P 6/20/1 S
Endorsed by	Signature	Name	Emp. ID	Date	Time
		Dhananand	005	10/01/24	09:00

ADULT NURSING CARE PLAN

Patient Details: **Mr. RAJASINGH P**
59/Male/MHI202381562
08/01/2024/1PH2024000068
Dr. ANBARASU MOHANRAJ



Initial Date: <u>9/1/24</u> Time: <u>8-00</u>		Modified Date: _____ Time: _____		
Reason for Modification: _____		Diagnosis: <u>CAD - LMTUD</u>		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input checked="" type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M pt had @ diet. E pt had on Normal diet N pt had @ diet	S. J. S. S. J. S. S. J. S.
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt SpO2 99 pt on room air E pt on room air N pt is on room air	S. J. S. S. J. S. S. J. S.
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M pt I/O chart maintained E Monitored I/O was N pt I/O Chart maintained	S. J. S. S. J. S. S. J. S.

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt well mobilized	SJD 02/11
			E Pt well mobilized	Jus
			N Pt well mobilized	DC 02/07
ELIMINATION <input checked="" type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Pt normal Pattern	SJD 02/11
			E Pt self voiding	Jus
			N Pt self voiding	DC 02/07
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M Pt skin @ integrity	SJD 02/11
			E Maintained normal skin	Jus
			N —	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input checked="" type="checkbox"/> Bed-Bath <input checked="" type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M pt well groomed E pt well groomed N pt well groomed	3/22/21 Dub DC 02/07
SAFETY <input checked="" type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M pt I ID Band checked E check ID band N ID Band present	5/22/21 Dub DC 02/07
COMFORT AND SLEEP <input checked="" type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input checked="" type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M - E - N -	
OBSERVATION <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal range of vital parameters	<input type="checkbox"/> Monitor vital signs regularly <input checked="" type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M pt v/s checked E monitored vital signs N pt v/s checked	5/22/21 Dub DC 02/07
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input checked="" type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input checked="" type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M - E provided psychological support N -	Dub


Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input checked="" type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M pt well commynl cmti on. E pt well communication N pt well communicated	S.DZ JUB DC 0207	
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:	<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M pt medicine given. E due drug given N pt due drugs are given	S.DZ JUB DC 0207	
Endorsed by	Signature	Name	Emp. ID	Date	Time
	(Signature)	Jhanvanti.	005	09/01/24	08:00

ADULT NURSING CARE PLAN

Initial Date: 10/01/24		Time: 8.00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD - LM + RVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input checked="" type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt NPO 5AM E N	5 Jan 24			
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on room air E N	5 Jan 24			
FLUID & ELECTROLYTES <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Pt out pat monitored E N	5 Jan 24			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input checked="" type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input checked="" type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embolic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt mobilized well E N	S.D. 02.1
ELIMINATION <input type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input checked="" type="checkbox"/> Urination <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal elimination pattern <input type="checkbox"/> Patient will control of urinary in-continance or urinary retention, control of bowel incontinence, and regular elimination patterns	<input type="checkbox"/> Encourage fluid intake <input type="checkbox"/> Encourage fibre diet intake <input type="checkbox"/> Encourage early ambulation <input type="checkbox"/> Report any abnormalities to physician <input type="checkbox"/> Observe voiding accessories as foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemesi as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M pt self voided E N	S.D. 02.1
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <input type="checkbox"/> GRADE 1 <input type="checkbox"/> GRADE 2 <input type="checkbox"/> GRADE 3 <input type="checkbox"/> GRADE 4 <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury <input type="checkbox"/> Healing Status <input type="checkbox"/> PUSH Decreased <input type="checkbox"/> PUSH Increased <input type="checkbox"/> Intermittent Assisted <input type="checkbox"/> Dermatitis <input type="checkbox"/> Pressure injury / blisters site care given <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" type="checkbox"/> Minimize / Eliminate friction and shear <input type="checkbox"/> Minimize pressure (off-loading) with special beds <input type="checkbox"/> Make sure wrinkles free bed / comfort surfaces and devices <input type="checkbox"/> Early skin inspection and treatment <input type="checkbox"/> Keep position changing 2 hourly and manage pain <input type="checkbox"/> Manage moisture, clean and dry skin <input type="checkbox"/> Maintain adequate nutrition and hydration <input type="checkbox"/> Proper application of medications and dressing <input type="checkbox"/> Follow doctors and TVN order properly <input type="checkbox"/> Monitor the healing status <input type="checkbox"/> Educate patient and family members about further skin care	M pt skin is (N) - Integrity E N	S.D. 02.1

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


Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M pt communication well E N	S.D. 02-
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		D Chennaraj	005	10/01/24	10:00



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 10/1/24 Time: 15:05		Modified Date: — Time: —		
Reason for Modification: —		Diagnosis: CAD - IVD + left main.		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN <input type="checkbox"/> Comfortable Position <input checked="" type="checkbox"/> Pain Scale <input type="checkbox"/> Pain Score <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have less pain	<input type="checkbox"/> Evaluate location, character, quality and severity of pain <input checked="" type="checkbox"/> Administer pain medication as prescribed and as needed <input checked="" type="checkbox"/> Observe for any changes in vital signs <input type="checkbox"/> Maintain proper positioning of patient <input type="checkbox"/> Assist or turn patient every two hours <input type="checkbox"/> Assess incision area for redness, heat, induration, swelling, separation and drainage <input type="checkbox"/> Non-Pharmacological therapy	M E Administered analgesics as per order. N Pain score 1/10	Jais 0074 S2
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Hood <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Nebulizer <input type="checkbox"/> Ventilator <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have no shortness or difficulty of breathing	<input type="checkbox"/> Provide well ventilated environment <input checked="" type="checkbox"/> Check oxygen saturation <input type="checkbox"/> Perform suctioning if needed <input checked="" type="checkbox"/> Ventilator settings as per physician orders <input type="checkbox"/> Monitor rate, depth of respiration <input checked="" type="checkbox"/> Administer oxygen and nebulizer therapy if needed <input type="checkbox"/> Encourage spirometry, deep breathing and coughing exercises <input type="checkbox"/> Monitor amount, viscosity, colour and odour of sputum if present	M E SpO ₂ 97% on ventilatory support N O ₂ mask - 10lit	Jais 0074 S2
ANXIETY <input type="checkbox"/> Increased Pulse Rate <input type="checkbox"/> Anxious Look	<input type="checkbox"/> Patient will cope properly with his illness and react positively to his surroundings	<input type="checkbox"/> Explain all procedures to patient or family member in simple language they understand <input type="checkbox"/> Encourage and support patient while increasing anxiety level <input type="checkbox"/> Help patient to cope with outcomes of surgery <input type="checkbox"/> Keep patient in comfortable position in bed to enhance sleep	M E N	
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Apply Anti-Embolic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input checked="" type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E ON bed rest N on bed rest	Jais 0074 S2

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input checked="" type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input checked="" type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M	
			E	Jv line patent & healthy Monitored I/O Jais 00/24
			N	monitored intake & output Jais 00/24
RISK OF INFECTION <input type="checkbox"/> Prevent Infection <input type="checkbox"/> Others:	<input type="checkbox"/> The patient will be discharged with no hospital acquired infection	<input checked="" type="checkbox"/> Use aseptic technique in all aspect of patient care <input type="checkbox"/> Restrict visitors and use appropriate PPE <input type="checkbox"/> Meticulous hand washing before and after patient's care <input type="checkbox"/> Inspect wound for signs of infection, purulent drainage or discoloration <input type="checkbox"/> Administer antibiotics as ordered <input type="checkbox"/> CVC dressing changing every 24 hours and surgical site dressing to be changed by surgeons	M	
			E	Aseptic precautions followed. Jais 00/24
			N	Administer antibiotics as ordered. Jais 00/24
RISK OF FALL <input type="checkbox"/> Giddiness <input type="checkbox"/> Independent State <input type="checkbox"/> Dependent State	<input type="checkbox"/> The patient will have safe, free from fall hospitalization	<input checked="" type="checkbox"/> Keep bed on low position <input checked="" type="checkbox"/> Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed <input type="checkbox"/> Remove clutter, keep items patient needs within reach <input type="checkbox"/> Avoid movement out of bed after surgery for 46 hours <input type="checkbox"/> Review patients' medication like narcotics and hypotensive agents <input type="checkbox"/> Offer urinal or bedpan to the patient if needed	M	
			E	fall risk precaution followed. Jais 00/24
			N	keep bed on low position Jais 00/24
SKIN & WOUND CARE <input type="checkbox"/> Observe REEDA <input type="checkbox"/> Oozing <input type="checkbox"/> Foul Smell	<input type="checkbox"/> The patient will have intact skin while staying in the hospital and on discharge	<input checked="" type="checkbox"/> Check all drains from the operation site more frequently <input type="checkbox"/> Provide wound care as ordered <input type="checkbox"/> Minimize pressure <input type="checkbox"/> Provide adequate nutritional support <input type="checkbox"/> Report signs of poor healing or trauma to doctor	M	
			E	drain empty. Jais 00/24
			N	no oozing in surgical site Jais 00/24
DIET & NUTRITION <input type="checkbox"/> NPO <input type="checkbox"/> Soft Diet <input type="checkbox"/> Semisolid Diet <input type="checkbox"/> Solid Diet <input type="checkbox"/> RT Feeds	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting	<input type="checkbox"/> Encourage patient to consume prescribed diet <input type="checkbox"/> Record amount of food consumed <input type="checkbox"/> Provide high calories, high protein diet as prescribed <input type="checkbox"/> Monitor patient's weight <input type="checkbox"/> Administer supplemental vitamins and minerals as prescribed <input checked="" type="checkbox"/> Administer parenteral or TPN per protocol if dietary needs are not met through oral intake <input type="checkbox"/> Report abdominal distention, large gastric residual volume or diarrhea to doctor	M	
			E	ON IVF 100ml/hr Jais 00/24
			N	patient had liquid diet Jais 00/24

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		<input type="checkbox"/> Patient will have patent, properly maintained catheters, drains etc	<input checked="" type="checkbox"/> Check the catheters, drains etc frequently <input checked="" type="checkbox"/> Observe I/O Chart <input type="checkbox"/> Watch for any symptoms related to kinked or blocked tubes <input type="checkbox"/> Maintain adequate cleaning and dressing	M	
				E ON CBD u cath put adequate	
				N observe I/O chart	2
DISTURBED BODY IMAGE		<input type="checkbox"/> The patient will demonstrate initial acceptance and to newly body image	<input type="checkbox"/> Note non verbal body language, negative attitude and self talk <input type="checkbox"/> Note emotional reaction (grieving, depression, anger) <input type="checkbox"/> Acknowledge and accept expression of feeling of grief and hostility	M	
				E	
				N	
OBSERVATION <input type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient	M	
				E hemodynamically stable	data
				N monitored vital signs and status	Dr
HEALTH EDUCATION <input type="checkbox"/> Patient <input type="checkbox"/> Family / Guardian <input type="checkbox"/> Diet <input type="checkbox"/> Disease process <input type="checkbox"/> Infection control / PPE <input type="checkbox"/> Medication <input type="checkbox"/> Educate about TAC level and immunosuppressant <input type="checkbox"/> Personal Safety <input type="checkbox"/> Treatment Regimen <input type="checkbox"/> Others:		<input type="checkbox"/> Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	<input type="checkbox"/> Provide proper education regarding follow-up diet <input checked="" type="checkbox"/> Insist on importance of hand hygiene <input type="checkbox"/> Explore action, reactions and adherence about medication <input type="checkbox"/> Provide clear, thorough, and understandable explanations regarding safety precautions. <input type="checkbox"/> Explain to perform activities / skin care that recommended by concerned doctor <input type="checkbox"/> Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M	
				E gained knowledge on importance of hand hygiene	data
				N explained about the treatment plan.	Dr
ANY OTHER NEEDS				M	
				E	
				N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		Donna	0003	12/1/24	9:00



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 11/1/2024		Time: 10:00		Modified Date: —		Time: —	
Reason for Modification:				Diagnosis:			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
PAIN <input checked="" type="checkbox"/> Comfortable Position <input type="checkbox"/> Pain Scale <input type="checkbox"/> Pain Score <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have less pain	<input checked="" type="checkbox"/> Evaluate location, character, quality and severity of pain <input type="checkbox"/> Administer pain medication as prescribed and as needed <input type="checkbox"/> Observe for any changes in vital signs <input checked="" type="checkbox"/> Maintain proper positioning of patient <input type="checkbox"/> Assist or turn patient every two hours <input type="checkbox"/> Assess incision area for redness, heat, induration, swelling, separation and drainage <input type="checkbox"/> Non-Pharmacological therapy	M Maintained proper positioning E Evaluated location, quality & severity of pain N Pain Score 4/10	Di 0229 0207 0207			
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Hood <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Nebulizer <input type="checkbox"/> Ventilator <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have no shortness or difficulty of breathing	<input type="checkbox"/> Provide well ventilated environment <input checked="" type="checkbox"/> Check oxygen saturation <input type="checkbox"/> Perform suctioning if needed <input type="checkbox"/> Ventilator settings as per physician orders <input type="checkbox"/> Monitor rate, depth of respiration <input type="checkbox"/> Administer oxygen and nebulizer therapy if needed <input type="checkbox"/> Encourage spirometry, deep breathing and coughing exercises <input type="checkbox"/> Monitor amount, viscosity, colour and odour of sputum if present	M On Room air SpO2: 95% E checked saturation level of the patient on Room air N On Room air SpO2 94%	Di 0229 0207 0207			
ANXIETY <input type="checkbox"/> Increased Pulse Rate <input type="checkbox"/> Anxious Look	<input type="checkbox"/> Patient will cope properly with his illness and react positively to his surroundings	<input type="checkbox"/> Explain all procedures to patient or family member in simple language they understand <input type="checkbox"/> Encourage and support patient while increasing anxiety level <input type="checkbox"/> Help patient to cope with outcomes of surgery <input type="checkbox"/> Keep patient in comfortable position in bed to enhance sleep	M NA E NA N NA	Di 0229 0207 0207			
MOBILITY <input checked="" type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input checked="" type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Apply Anti-Embolism stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M On Bed Rest E used safety measures to minimize injury provided side rails N Patient mobilized well at 3.45	Di 0229 0207 0207			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input checked="" type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Monitors intake and output	Di 0219
			E Monitored Intake and output chart.	Di 0219
			N Monitored I/O chart	Di 0219
RISK OF INFECTION <input checked="" type="checkbox"/> Prevent Infection <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> The patient will be discharged with no hospital acquired infection	<input checked="" type="checkbox"/> Use aseptic technique in all aspect of patient care <input type="checkbox"/> Restrict visitors and use appropriate PPE <input type="checkbox"/> Meticulous hand washing before and after patient's care <input type="checkbox"/> Inspect wound for signs of infection, purulent drainage or discoloration <input type="checkbox"/> Administer antibiotics as ordered <input type="checkbox"/> CVC dressing changing every 24 hours and surgical site dressing to be changed by surgeons	M Aseptic technique followed	Di 0219
			E Followed aseptic techniques followed Moments of hand hygiene	Di 0219
			N Aseptic technique followed	Di 0219
RISK OF FALL <input type="checkbox"/> Giddiness <input type="checkbox"/> Independent State <input checked="" type="checkbox"/> Dependent State	<input checked="" type="checkbox"/> The patient will have safe, free from fall hospitalization	<input checked="" type="checkbox"/> Keep bed on low position <input type="checkbox"/> Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed <input type="checkbox"/> Remove clutter, keep items patient needs within reach <input type="checkbox"/> Avoid movement out of bed after surgery for 46 hours <input type="checkbox"/> Review patients' medication like narcotics and hypotensive agents <input type="checkbox"/> Offer urinal or bedpan to the patient if needed	M Fall risk precautions followed	Di 0219
			E kept bed on low position	Di 0219
			N Fall risk precautions followed	Di 0219
SKIN & WOUND CARE <input type="checkbox"/> Observe REEDA <input checked="" type="checkbox"/> Oozing <input type="checkbox"/> Foul Smell	<input checked="" type="checkbox"/> The patient will have intact skin while staying in the hospital and on discharge	<input checked="" type="checkbox"/> Check all drains from the operation site more frequently <input type="checkbox"/> Provide wound care as ordered <input type="checkbox"/> Minimize pressure <input type="checkbox"/> Provide adequate nutritional support <input type="checkbox"/> Report signs of poor healing or trauma to doctor	M No oozing - skin intact	Di 0219
			E checked all drains from the operation site more frequently	Di 0219
			N Drains removed & skin is intact	Di 0219
DIET & NUTRITION <input type="checkbox"/> NPO <input checked="" type="checkbox"/> Soft Diet <input type="checkbox"/> Semisolid Diet <input type="checkbox"/> Solid Diet <input type="checkbox"/> RT Feeds	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting	<input checked="" type="checkbox"/> Encourage patient to consume prescribed diet <input type="checkbox"/> Record amount of food consumed <input type="checkbox"/> Provide high calories, high protein diet as prescribed <input type="checkbox"/> Monitor patient's weight <input type="checkbox"/> Administer supplemental vitamins and minerals as prescribed <input type="checkbox"/> Administer parenteral or TPN per protocol if dietary needs are not met through oral intake <input type="checkbox"/> Report abdominal distention, large gastric residual volume or diarrhea to doctor	M on liquid diet followed well	Di 0219
			E Encouraged patient to consume prescribed diet	Di 0219
			N Patient Consumed adequate diet	Di 0219


Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		<input checked="" type="checkbox"/> Patient will have patent, properly maintained catheters, drains etc	<input checked="" type="checkbox"/> Check the catheters, drains etc frequently <input type="checkbox"/> Observe I/O Chart <input type="checkbox"/> Watch for any symptoms related to kinked or blocked tubes <input type="checkbox"/> Maintain adequate cleaning and dressing	M <i>ON CPD - Occlusal</i> <i>adequate</i> E <i>checked the catheters, drains etc frequently</i> N <i>U-Cath removed at 5:00</i>	
DISTURBED BODY IMAGE		<input type="checkbox"/> The patient will demonstrate initial acceptance and to newly body image	<input type="checkbox"/> Note non verbal body language, negative attitude and self talk <input type="checkbox"/> Note emotional reaction (grieving, depression, anger) <input type="checkbox"/> Acknowledge and accept expression of feeling of grief and hostility	M <i>NA</i> E <i>NA</i> N <i>NA</i>	
OBSERVATION <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient	M <i>Vitals stable</i> <i>hemodynamically</i> E <i>Monitored vit every hour</i> N <i>Hemodynamically stable</i>	
HEALTH EDUCATION <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Family / Guardian <input type="checkbox"/> Diet <input type="checkbox"/> Disease process <input type="checkbox"/> Infection control / PPE <input type="checkbox"/> Medication <input type="checkbox"/> Educate about TAC level and immunosuppressant <input type="checkbox"/> Personal Safety <input type="checkbox"/> Treatment Regimen <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	<input checked="" type="checkbox"/> Provide proper education regarding follow-up diet <input type="checkbox"/> Insist on importance of hand hygiene <input type="checkbox"/> Explore action, reactions and adherence about medication <input type="checkbox"/> Provide clear, thorough, and understandable explanations regarding safety precautions. <input type="checkbox"/> Explain to perform activities / skin care that recommended by concerned doctor <input type="checkbox"/> Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M <i>Gained knowledge</i> <i>regarding diet.</i> E <i>provided proper education regarding follow-up diet.</i> N <i>Gained knowledge on medications</i>	
ANY OTHER NEEDS				M E N	
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>[Signature]</i>	<i>Shirley</i>	<i>0003</i>	<i>12/1/24</i>	<i>9:10</i>



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 12/1/24		Time: 8:00		Modified Date: —		Time: —	
Reason for Modification:				Diagnosis:			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
PAIN <input type="checkbox"/> Comfortable Position <input type="checkbox"/> Pain Scale <input type="checkbox"/> Pain Score <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have less pain	<input type="checkbox"/> Evaluate location, character, quality and severity of pain <input type="checkbox"/> Administer pain medication as prescribed and as needed <input type="checkbox"/> Observe for any changes in vital signs <input type="checkbox"/> Maintain proper positioning of patient <input type="checkbox"/> Assist or turn patient every two hours <input type="checkbox"/> Assess incision area for redness, heat, induration, swelling, separation and drainage <input type="checkbox"/> Non-Pharmacological therapy	M Administered pain medication as ordered E pt has normal diet N pt normal diet	Di 049 8 an ss			
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Hood <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Nebulizer <input type="checkbox"/> Ventilator <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have no shortness or difficulty of breathing	<input type="checkbox"/> Provide well ventilated environment <input type="checkbox"/> Check oxygen saturation <input type="checkbox"/> Perform suctioning if needed <input type="checkbox"/> Ventilator settings as per physician orders <input type="checkbox"/> Monitor rate, depth of respiration <input type="checkbox"/> Administer oxygen and nebulizer therapy if needed <input type="checkbox"/> Encourage spirometry, deep breathing and coughing exercises <input type="checkbox"/> Monitor amount, viscosity, colour and odour of sputum if present	M On Room air patient stable E pt room air N pt on room air	Di 049 8 an ss			
ANXIETY <input type="checkbox"/> Increased Pulse Rate <input type="checkbox"/> Anxious Look	<input type="checkbox"/> Patient will cope properly with his illness and react positively to his surroundings	<input type="checkbox"/> Explain all procedures to patient or family member in simple language they understand <input type="checkbox"/> Encourage and support patient while increasing anxiety level <input type="checkbox"/> Help patient to cope with outcomes of surgery <input type="checkbox"/> Keep patient in comfortable position in bed to enhance sleep	M n/a E — N —	Di 049 8 an ss			
MOBILITY <input type="checkbox"/> Mobile / Immobile <input type="checkbox"/> Walk with assistance <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will mobilize freely <input type="checkbox"/> Patient will perform physical activity independently or within limits of disease <input type="checkbox"/> Patient will use safety measures to minimize potential for injury <input type="checkbox"/> Patient will demonstrate the use of adaptive devices to increase mobility	<input type="checkbox"/> Apply Anti-Embolic stocking / SCD <input type="checkbox"/> Evaluate the need for assistive devices <input type="checkbox"/> Assess the safety of the environment <input type="checkbox"/> Consider the need for home assistance (e.g., physical therapy, visiting nurse) <input type="checkbox"/> Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M patient mobilized to chair E patient mobilized to chair N pt mobilized to chair	Di 049 8 an ss			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE <input checked="" type="checkbox"/> Oral <input checked="" type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input checked="" type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Monitor intake and output.	Di 02/19
			E Pt electrolytes fluid	Di 02/19
			N Pt electrolytes fluid.	Di 02/19
RISK OF INFECTION <input type="checkbox"/> Prevent Infection <input type="checkbox"/> Others:	<input type="checkbox"/> The patient will be discharged with no hospital acquired infection	<input type="checkbox"/> Use aseptic technique in all aspect of patient care <input type="checkbox"/> Restrict visitors and use appropriate PPE <input type="checkbox"/> Meticulous hand washing before and after patient's care <input type="checkbox"/> Inspect wound for signs of infection, purulent drainage or discoloration <input type="checkbox"/> Administer antibiotics as ordered <input type="checkbox"/> CVC dressing changing every 24 hours and surgical site dressing to be changed by surgeons	M Aseptic techniques followed	Di 02/19
			E Pt Aseptic techniques followed	Di 02/19
			N Pt Aseptic technique followed.	Di 02/19
RISK OF FALL <input type="checkbox"/> Giddiness <input type="checkbox"/> Independent State <input type="checkbox"/> Dependent State	<input type="checkbox"/> The patient will have safe, free from fall hospitalization	<input type="checkbox"/> Keep bed on low position <input type="checkbox"/> Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed <input type="checkbox"/> Remove clutter, keep items patient needs within reach <input type="checkbox"/> Avoid movement out of bed after surgery for 46 hours <input type="checkbox"/> Review patients' medication like narcotics and hypotensive agents <input type="checkbox"/> Offer urinal or bedpan to the patient if needed	M Fall risk precautions followed	Di 02/19
			E Fall risk precautions followed	Di 02/19
			N Fall risk precautions followed	Di 02/19
SKIN & WOUND CARE <input type="checkbox"/> Observe REEDA <input type="checkbox"/> Oozing <input type="checkbox"/> Foul Smell	<input type="checkbox"/> The patient will have intact skin while staying in the hospital and on discharge	<input type="checkbox"/> Check all drains from the operation site more frequently <input type="checkbox"/> Provide wound care as ordered <input type="checkbox"/> Minimize pressure <input type="checkbox"/> Provide adequate nutritional support <input type="checkbox"/> Report signs of poor healing or trauma to doctor	M No oozing. Skin intact.	Di 02/19
			E No oozing. Skin intact.	Di 02/19
			N No skin intact.	Di 02/19
DIET & NUTRITION <input type="checkbox"/> NPO <input type="checkbox"/> Soft Diet <input type="checkbox"/> Semisolid Diet <input type="checkbox"/> Solid Diet <input type="checkbox"/> RT Feeds	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting	<input type="checkbox"/> Encourage patient to consume prescribed diet <input type="checkbox"/> Record amount of food consumed <input type="checkbox"/> Provide high calories, high protein diet as prescribed <input type="checkbox"/> Monitor patient's weight <input type="checkbox"/> Administer supplemental vitamins and minerals as prescribed <input type="checkbox"/> Administer parenteral or TPN per protocol if dietary needs are not met through oral intake <input type="checkbox"/> Report abdominal distention, large gastric residual volume or diarrhea to doctor	M on soft diet. tolerated well	Di 02/19
			E on soft diet. tolerated well	Di 02/19
			N Pt. on soft diet	Di 02/19

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.		<input type="checkbox"/> Patient will have patent, properly maintained catheters, drains etc	<input type="checkbox"/> Check the catheters, drains etc frequently <input type="checkbox"/> Observe I/O Chart. <input type="checkbox"/> Watch for any symptoms related to kinked or blocked tubes <input type="checkbox"/> Maintain adequate cleaning and dressing	M Observed the chart	Di ora
				E pt self care	\$
				N pt self care	Jen son
DISTURBED BODY IMAGE		<input type="checkbox"/> The patient will demonstrate initial acceptance and to newly body image	<input type="checkbox"/> Note non verbal body language, negative attitude and self talk <input type="checkbox"/> Note emotional reaction (grieving, depression, anger) <input type="checkbox"/> Acknowledge and accept expression of feeling of grief and hostility	M —	Di ora
				E —	
				N —	
OBSERVATION <input type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will have normal range of vital parameters	<input type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient	M vitals stable neurologically	Di ora
				E vitals stable well oriented	San
				N Vitals are stable	Jen son
HEALTH EDUCATION <input type="checkbox"/> Patient <input type="checkbox"/> Family / Guardian <input type="checkbox"/> Diet <input type="checkbox"/> Disease process <input type="checkbox"/> Infection control / PPE <input type="checkbox"/> Medication <input type="checkbox"/> Educate about TAC level and immunosuppressant <input type="checkbox"/> Personal Safety <input type="checkbox"/> Treatment Regimen <input type="checkbox"/> Others:		<input type="checkbox"/> Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	<input type="checkbox"/> Provide proper education regarding follow-up diet <input type="checkbox"/> Insist on importance of hand hygiene <input type="checkbox"/> Explore action, reactions and adherence about medication <input type="checkbox"/> Provide clear, thorough, and understandable explanations regarding safety precautions. <input type="checkbox"/> Explain to perform activities / skin care that recommended by concerned doctor <input type="checkbox"/> Use the teach-back technique to determine the patient's understanding regarding importance of treatment	M Gained knowledge regarding diet	Di ora
				E pt gained regarding diet	San
				N pt gained regarding diet	Jen son
ANY OTHER NEEDS				M —	
				E —	
				N —	
Endorsed by	Signature	Name	Emp. ID	Date	Time
		Human	0003	12/1/24	9:00

ADULT NURSING CARE PLAN

Dr. RAJASINGH P
59 / Male / MHI202381562
08/01/2024 / IPH2024000068

Dr. ANBARASU MOHANRAJ

Consultant

MHI/NUR/2022/044



Every heart beat counts

Initial Date: 13/1/24		Time: 8.00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD-TVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input checked="" type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M Pt had @ diet E pt had @ diet N Pt had @ diet	Hay 207			
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input checked="" type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on room air E pt on room air N Pt is on room air	Hay 207			
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M Pt take oral fluid. E pt follow may fluid N Pt I/O chart maintained	Hay 207			

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input checked="" type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CBD Care (if present) <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input checked="" type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M Pt well groomed E Pt well groomed N Pt well groomed	Hay olo b F.C. 0807
SAFETY <input checked="" type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have no life-threatening situations	<input checked="" type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M Pt ID Band checked E Pt ID Band checked N Pt ID Band	Hay olo S P.C. 0807
COMFORT AND SLEEP <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize / or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M — E — N —	
OBSERVATION <input checked="" type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have normal range of vital parameters	<input checked="" type="checkbox"/> Monitor vital signs regularly <input checked="" type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M Pt V/S checked E Pt V/S checked N Pt V/S checked	Hay olo B F.C. 0807
PSYCHOLOGICAL / SPIRITUAL SUPPORT <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M — E — N —	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M D+ good Communication E pt good commuicate N pt well communicated	Hay 1/2/24 8/2 PC 5/2/24
SPECIAL INTERVENTIONS <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M morning medication given E Morning medication given N due drugs are given	Hay 1/2/24 8/2 PC 5/2/24
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Nae	S. Nae/PA	0024	1/2/24 13/1/24	16:00

ADULT NURSING CARE PLAN




Mr. RAJASINGH P
59 / Male / MHI202381562
08/01/2024 / IPH2024000068
Dr. ANBARASU MOHANRAJ






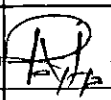
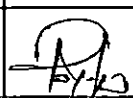

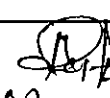
MHI/NUR/2022/044



Every heart beat counts

Initial Date: 14/1/24		Time: 7.00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: CAD-TVD			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M patient had @D diet E N				
OXYGENATION <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Nasal Cannula / High Flow O ₂ <input type="checkbox"/> Mask <input type="checkbox"/> BIPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O ₂ saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M patient is on Room Air E N				
FLUID & ELECTROLYTES <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input checked="" type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M I/O Chart Monitored E N				

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M Good communication E N	PL
SPECIAL INTERVENTIONS <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	Medication M given as per drug E Chart N	PL
Endorsed by	Signature	Name	Emp. ID	Date	Time
	Wae	S. Walpna	0024	14/1/24	16:20



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IVs for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4		
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3		
					TOTAL SCORE	23	23	
					Initial & Emp. No. of Staff Nurse:	86	81	
					Initial & Emp. No. of Sr. Staff Nurse:	15	10	

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



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4	4	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4	4	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3	
					TOTAL SCORE	23	23	23
					Initial & Emp. No. of Staff Nurse:	54	4	22
					Initial & Emp. No. of Sr. Staff Nurse:	100	100	100

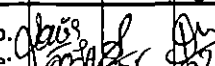
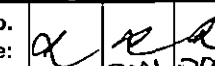
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

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ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4		
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					TOTAL SCORE	23	
					Initial & Emp. No. of Staff Nurse:	S9	
					Initial & Emp. No. of Sr. Staff Nurse:	10	

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

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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 IVs for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation				
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					TOTAL SCORE	6	6	6
					Initial & Emp. No. of Staff Nurse:	 		
					Initial & Emp. No. of Sr. Staff Nurse:	 		

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

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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	2	2	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	2	2	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 IVs for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	2	2	2	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		2	2	2	
					TOTAL SCORE	12	15	15
					Initial & Emp. No. of Staff Nurse:	Bar	PR	DR
					Initial & Emp. No. of Sr. Staff Nurse:	DR	DR	DR

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

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IVs for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4		
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3		
					TOTAL SCORE	23	23	
					Initial & Emp. No. of Staff Nurse:	2024	2024	
					Initial & Emp. No. of Sr. Staff Nurse:	2024	2024	

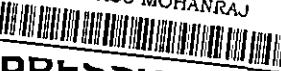
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4	4
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4	4
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
TOTAL SCORE					23	23	23
Initial & Emp. No. of Staff Nurse:					11/11/2024	11/11/2024	11/11/2024
Initial & Emp. No. of Sr. Staff Nurse:					11/11/2024	11/11/2024	11/11/2024


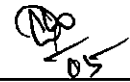




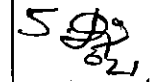



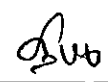



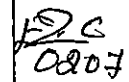

Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6



BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK

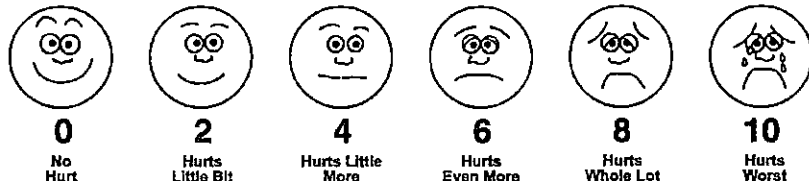
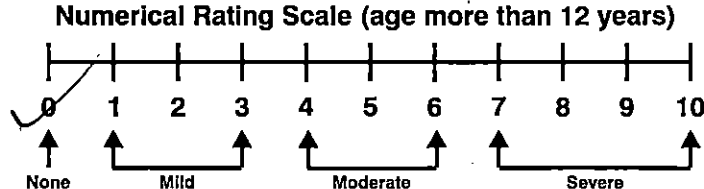
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	7
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	7
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	7
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	7
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	7
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	7
					TOTAL SCORE 23	
					Initial & Emp. No. of Staff Nurse: 15/7	
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: 15/7	

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.
16:30	0/10	NO pain	—	—	—	 08/01	 05
22:00	0/10	NO pain	—	—	—	 08/01	 05
6:00	0/10	NO pain	—	—	—	 08/01	 05
10:00	0/10	NO pain	—	—	—	 08/01	 05
14:00	0/10	NO pain	—	—	—	 08/01	 05
18:00	0/10	NO pain	—	—	—	 08/01	 05
22:00	0/10	NO pain	—	—	—	 08/01	 05
10/01/24 2:00				PATIENT - SLEEPING			
6:00	0/10	NO pain	—	—	—	 08/01	 05

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
6:00							

PAIN SCALES

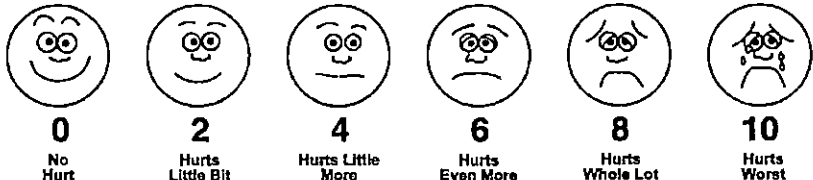
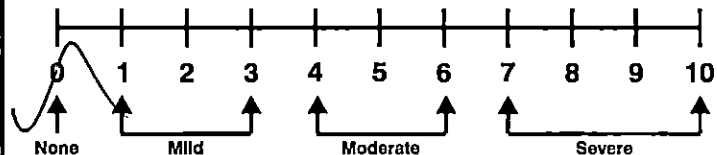
PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention	
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible.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

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.
10/1/24 16:00	0/8	By cpo	-	-	-	Panis 0024	K
17:00	0/8	By cpo	-	-	-	Panis 0024	K
19:00	0/8	By cpo	-	-	-	Panis 0024	K
21:00	1/10	Dull Pain	10sec	sternum	provided comfortable position.	Shr	K
23:00	-	-	-	-	patient was sleeping	Shr	K
01:00	-	-	-	-	patient was sleeping	Shr	K
03:00	-	-	-	-	patient was sleeping	Shr	K
05:00	1/10	Dull Pain	10sec	sternum	provided comfortable position.	Shr	K
07:00	1/10	Dull Pain	15sec	sternum	provided comfortable position	Shr	K






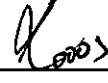





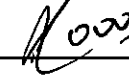

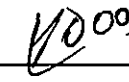


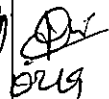

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9:00 4/10		Achy pain	40sec	Sternum	Non Pharmacological intervention given	Di 0289	✓ 000
11:00 4/10		Achy pain	40sec	Back	Pharmacological intervention given.	Di 0289	✓ 000
13:00 4/10		Achy pain	45sec	Sternum	Non-pharmacological intervention given.	Di 0289	✓ 000
15:00 4/10		Achy pain	40sec	Sternum	pharmacological intervention given	Di 0289	✓ 000

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 <p>0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst</p>
	Numerical Rating Scale (age more than 12 years)  <p>0 None 1 Mild 2 Mild 3 Mild 4 Moderate 5 Moderate 6 Moderate 7 Severe 8 Severe 9 Severe 10 Severe</p>
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	Distraction: A - Relaxation-conductive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

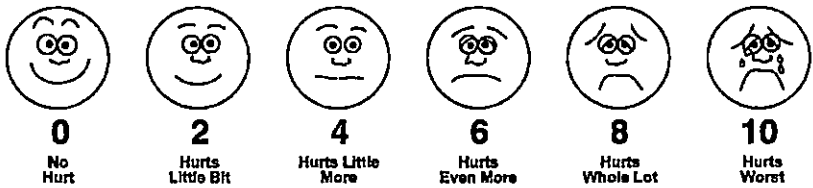
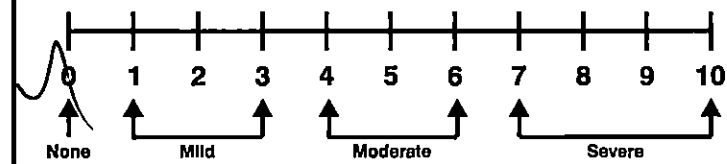


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
11/1/24 @ 17:00	1/10	Achy pain	25 sec	Back pain	Non-pharmacological Intervention	 2023	 2023
19:00	4/10	Achy pain	10 sec	Stomach	Non-pharmacological management done	 2023	 2023
21:00	4/10	Dull pain		Stomach	Pharmacological management done	 2023	 2023
23:00	4/10	Dull pain		Stomach	Non-pharmacological Intervention done	 2023	 2023
12/1/24 01:00	-	-	-	-	patient is sleeping	 2023	 2023
03:00	-	-	-	-	patient is sleeping	 2023	 2023
05:00	4/10	Dull pain	40 sec	Back pain	patient mobilised to chair	 2023	 2023
07:00	0/10	-	-	No Complaints of pain		 2023	 2023
09:00	4/10	Achy pain	10 sec	Stomach	Pharmacological intervention given	 2023	 2023

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
12/1/24 11:00	1/10	Achy pain	10 sec	sternum	Non pharmacological intervention given	Qu 0919	L 0003
15:00	1/10	Achy pain	20 sec	sternum	Non pharmacological intervention given	Qu 0919	Nice 1524
19:00	1/10	Achy pain	2 sec	sternum	Non pharmacological intervention given	Qu 0919	Nice 1524
20:00	1/10	Achy pain	20 sec	sternum	Non pharmacological	Qu 0919	Nice 1524

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention	
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.	
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both	
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 <p>0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst</p>	Numerical Rating Scale (age more than 12 years)  <p>None Mild Moderate Severe</p>
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain	
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counseling: K - Individual Counseling; L - Family counseling	
Pharmacological Interventions as per doctor's prescription		









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.
21/1/24 6:00	1/10	Dull pain	on & off	sternum	provide comfortable position	See	Not
10:00	1/10	Dull pain	on & off	Surgical site	Pharmacological Intervention Given	Hay	Not
14:00	1/10	Dull pain	on & off	Surgical site	pharmacological Intervention Given	See	Not
18:00	1/10	Dull pain	on & off	Surgical site	Pharmacological intervention Given	See	Not
22:00	1/10	Dull pain	on & off	Surgical site	pharmacological intervention Given	P.C 0207	Not
24/1/24 2:00		Patient is sleeping					
6:00	1/10	Dull pain	on & off	Surgical site	pharmacological intervention Given	P.C 0207	Not
10:00	0/10	No pain	-	-	-	See	Not

DVT RISK ASSESSMENT






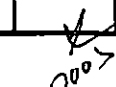




Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

		Date	8/1	9/1	10/1				
		Time	16:30	6:00	6:00				
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0					
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0					
5	Entire leg swollen (Assess for both legs)	0	0	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0					
9	Previously documented DVT (Assess for both legs)	0	0	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction, Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0					
FINAL SCORE				0					
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		0	0	Low					
DVT prophylaxis started		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									



DVT RISK ASSESSMENT

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

		Date	10/1/24	11/1/24	12/1/24	13/1/24	14/1/24		
		Time	15.05	6.00	6.00	6.00	6.00		
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0			
2	Bedridden recently >3 days or major surgery within four weeks	+1	+1	+1	+1	+1			
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0			
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0			
5	Entire leg swollen (Assess for both legs)	0	0	0	0	0			
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0			
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0	0	0			
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0	0			
9	Previously documented DVT (Assess for both legs)	0	0	0	0	0			
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0	0	0			
FINAL SCORE		+1	+1	+1	4	+1			
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		Mod	mod	mod	mod	MOD			
DVT prophylaxis started		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									

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Mr. RAJASINGH P
Patient Name: 59 / Male / MHI202381562
UHID: 08/01/2024 / IPH2024000068
DOB: DR. ANBARASU MOHANRAJ



MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	8/1	8/12/24	9/1/24	9/1/24	9/10/24	10/1/24			
	Time	16:30	20:00	8:00	14:00	20:00	8:00			
History of falling (immediate or within 6 months)	No	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 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		<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	<input checked="" type="checkbox"/> 0	<input checked="" type="checkbox"/> 0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		0	0	35	35	35	35			
Low Risk (0 - 24)		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>							
Medium Risk (25 - 44)				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

INTERVENTIONS <i>Tick as per the Risk Score</i>	Date	8/1/24	8/1/24	9/1/24	9/1/24	9/1/24	9/1/24		
	Time	16:00	20:00	8:00	14:00	20:00	8:00		
Low Risk Interventions (0 - 24)									
Familiarize the patient with the immediate surroundings		/	/	/	/	/	/		
Remind the patient to use call bell before getting out of bed		/	/	/	/	/	/		
Keep the two side rails in the raised position at all times for all patients regardless of age		/	/	/	/	/	/		
Keep the call bell, bedside table, water, glasses within the patient's easy reach		/	/	/	/	/	/		
Remove excess equipment or furniture to make a clear path		/	/	/	/	/	/		
Keep the patient's bed in the low position at all times except during procedure		/	/	/	/	/	/		
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		/	/	/	/	/	/		
Bed wheels should be locked		/	/	/	/	/	/		
Encourage family participation in the patient's care		/	/	/	/	/	/		
Ensure that floor of the bathroom is dry and not slippery		/	/	/	/	/	/		
Review medications for potential side effects that can promote falls		/	/	/	/	/	/		
Use safety belts during movement in wheelchair		/	/	/	/	/	/		
The patients are not ambulated by themselves. They are to be ambulated only with assistance		/	/	/	/	/	/		
Medium risk interventions (25 - 44)									
Apply all the low risk interventions				/	/	/	/		
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher				/	/	/	/		
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat				/	/	/	/		
Use restraints and bed monitors as ordered by the doctor				/	/	/	/		
Allow the patient to ambulate only with assistance				/	/	/	/		
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care				/	/	/	/		
Do not leave patients unattended in diagnostic or treatment areas				/	/	/	/		
Accompany the patient while going to bathroom				/	/	/	/		
Advise the patient to use grab bars near the toilet, bathtub, and shower				/	/	/	/		
Make sure the family and other visitors understand the restrictions mentioned above				/	/	/	/		
High-risk interventions (45 or above)									
Apply all the low and medium risk interventions				/	/	/	/		
Tie red fall risk tag in the bed, wheel chair and stretcher				/	/	/	/		
Locate the high-risk patients in a room close to the nurses' station				/	/	/	/		
Answer these patients call bells as quickly as possible				/	/	/	/		
Provide a commode at bedside (if appropriate)				/	/	/	/		
Urinal/bedpan should be within easy reach (if appropriate)				/	/	/	/		
Encourage family members or other visitors to stay with them				/	/	/	/		
If appropriate, consider using protection devices: safety belts				/	/	/	/		
Signature & Emp. No. of RN		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Signature & Emp. No. of Sr. RN		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		

05/05 05/05 05/05 05/05 05/05 05/05



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	10/1/24	10/1/24	11/1/24	11/1/24	11/1/24	12/1/24	12/1/24	12/1/24	13/1/24
	Time	15:05	20:00	8:00	12:30	20:00	8:00	14:00	20:00	8:00
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
Yes		15	15	15	15	15	15	15	15	15
Total Score		65	65	50	50	50	50	50	50	50
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓	✓	✓
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

00/24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

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MHI/NUR/2022/046

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ



Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	12/11/23	13/11/23	14/11/23	15/11/23	16/11/23	17/11/23	18/11/23	19/11/23	20/11/23
	Time	14:00	20:00	8:00						
History of falling (Immediate or within 6 months)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	15	15	15	15	15	15	15	15	15
Total Score		65	50	15						
Low Risk (0 - 24)				<input checked="" type="checkbox"/>						
Medium Risk (25 - 44)										
High Risk (45 or above)		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>							
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

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[illegible]

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance	8/1												Dietician
<input checked="" type="checkbox"/> Diet Instruction for patients at Nutritional risk			OD	V									Marie E. [Signature] Senior Dietitian
<input type="checkbox"/> Diet advice for home													Nurse
Discharge Planning													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													
<input type="checkbox"/> Smoking Cessation													Doctor
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> Other Risks													

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse _____ Signature : _____



Mr. RAJASINGH P	
Patient ID	59/Male/MH1202381562
Name:	08/01/2024/IPH2024000068
UHID:	Dr. ANBARASU MOHANRAJ
DOB:	
DOA:	
Consultant:	

MHI/IP/2022/055



Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input checked="" type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input checked="" type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions
Completed By : Date <u>10/1/24</u> Time <u>18:00</u>		Nurse Signature : <u>R/A [Signature]</u>

Learning Record

Need	Date 10/1/24	Visit 1			Date 11/1/24	Visit 2			Date 12/1	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Disease													Doctor
<input type="checkbox"/> Information on Disease / Diagnostics		S	OD	✓		S	OD	✓					
<input type="checkbox"/> Treatment		S	OD	✓		S	OD	✓					
Medications		S	OD	✓		S	OD	✓					Doctor / Nurse
<input type="checkbox"/> Information on Safe and Effective use of medicines		—	—	—		—	—	—					
<input type="checkbox"/> Information on drug / drug and drug / food interactions		—	—	—		—	—	—					
<input type="checkbox"/> Discharge Medications		—	—	—		—	—	—					
Surgical Instructions						—	—	—					Nurse
<input type="checkbox"/> Pre - Operative Instructions		S	OD	✓		—	—	—					
<input type="checkbox"/> Post - Operative Instructions (Wound / Dressing Care)		S	OD	✓		S	OD	✓					
Pain Management		S	OD	✓		S	OD	✓					Nurse
<input type="checkbox"/> Reporting of pain		S	OD	✓		S	OD	✓					
<input type="checkbox"/> Pain Management		—	—	—		—	—	—					
Safe and effective use of medical Equipment (if required)		S	OD	✓		S	OD	✓					Doctor / Nurse
Name of Equipment													
Rehabilitation Techniques		—	—	—		—	—	—					

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance	10/11				11/11								Dietician
<input checked="" type="checkbox"/> Diet Instruction for patients at Nutritional risk		S	ODV		S	ODV							
<input type="checkbox"/> Diet advice for home		-	-	-	-	-	-						Nurse
Discharge Planning													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													
<input type="checkbox"/> Smoking Cessation													Doctor
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> Other Risks													

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

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

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

Written Material given and explained (if any)

NIL

Reports Given :

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

Name of Attendant / Patient : _____ Signature : _____

Name of Discharge Nurse

Signature :

PATIENT AND FAMILY EDUCATION RECORD

Assessment

To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions
Completed By : Date <u>12/01/24</u> Time <u>8:00</u>		Nurse Signature : <u>S. H. S. Smith, RN</u>

Learning Record

[illegible]

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

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

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

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

Written Material given and explained (if any)

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	<input checked="" type="checkbox"/>			Diet Advice	<input checked="" type="checkbox"/>		
ECG Report	<input checked="" type="checkbox"/>			CT Scan Report			
Doppler Report				CT Scan Film			
X-Ray Report	<input checked="" type="checkbox"/>			ECHO Report	<input checked="" type="checkbox"/>		
X-Ray Film	<input checked="" type="checkbox"/>			Ultrasound Report			
Compact Disk				Any Other Report	old @ given		

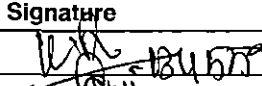

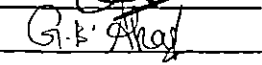

Name of Attendant / Patient : BHARATHI RAJASINHA Signature : Bharathi Rajasini

Name of Discharge Nurse : e. L. duffy

Signature : [Signature]

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 8/1/24 Time: 16.30

Checklist	Yes	No	NA	Action / Remarks	
MEDICAL					
Daily Consultant Visit	✓				
Plan of care discussed	✓				
Discharge Planning	✓	✓			
Others if any	✓				
NURSING					
Safety Precautions Ensured	✓				
Care of Lines and Tubes	✓				
Infection Control Measures	✓				
Skin Care	✓				
Response to assistance	✓				
Others if any	✓				
DIETICIAN					
Diet Adequate	✓				
Special Request	✓				
PHYSIOTHERAPIST					
Available for Assistance for Activities of Daily Living	✓				
Others if any	✓				
PATIENT CARE SERVICES					
Room Cleaning satisfactory	✓				
Room Amenities Adequate					
Billing Update available					
Non-Availability of any service					
Spiritual Needs (if yes specify)					
Others if any					
Inter Disciplinary Team Members					
	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		DR. ANBARASU MOHANRAJ	134577	08/01/24	
Nursing Staff		R. Sathya	0201	8/1/24	16:30
Dietician		ivisha Catherine John Senior Dietician	2401	8/1/24	17:00
Physiotherapist		AKASH G. K.	0256	10/1/24	16:00
Patient Care Service Staff					

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	Syp. SUCRALFATE SUSPENSION	10ml	PO	1-1-1	12/1/24 @ 7:30	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	NEB. LEVOSALBUTAMOL	0.63 mg	INH	1-1-1-1	12/1/24 @ 10:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	T. FROSEMIDE	40mg	PO	1-1-0	12/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	T. SPIRONOLACTONE	25mg	PO	1-1-0	12/1/24 @ 10:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	T. BEPLEX FORTE	1 TAB	PO	1-0-0	12/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	T. CLOPIDOGREL + Aspirin	75/75	PO	0-1-0	11/1/24 @ 14:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	T. ROSUVASTATIN	40mg	PO	0-0-1	11/1/24 @ 20:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	T. PARACETAMOL	650mg	PO	1-1-1	12/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	S. LACTULOSE	15ml	PO	0-0-1	11/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	T. METAPROLOL	25mg	PO	1-0-1	12/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details (if any):

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

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	<i>[Signature]</i>	Dr. Jorauen	112236	12/1/24	11:00
Receiving Doctor	<i>[Signature]</i>	DR. ANUSUYA	134579	12/1/24	11:10

Part C (to be filled by Nurses)

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

Additional Details (if any):

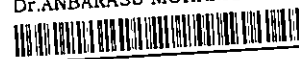
	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	<i>[Signature]</i>	Mahalaughiy	0219	12/1/24	11:30
Receiving Nurse	<i>[Signature]</i>	Ngastaya	006	12/1/24	11:30

FAMILY COUNSELLING FORM

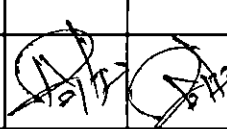
CONSULTANT- DR. ANBARASU			DIAGNOSIS- CAD - IVD + left main.			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
10/1/24	Dr. Anbarasu	BIHARATHI RAJA SINGH [Sign]	Explained about the general condition, Need of ICU stay, medicinal supports and visitors policy.	Dr. Anbarasu	-	<u>f</u> 11/2/24
11/1/24	Dr. Anbarasu	BHARATHI RAJA SINGH	Explained about the condition of the patient, Need of ICU stay, medicinal supports and visitors policy.	Dr. Anbarasu	-	<u>f</u> 11/2/24



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Heart
Institute

[illegible]

WOUND ASSESSMENT CHART

EXUDATE AMOUNT								
none	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
evidence of some moisture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
evidence of significant flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXUDATE								
serous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sero - sanguinous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purulent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ODOUR								
none	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
some evidence of odour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
significantly malodorous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PAIN AT WOUND SITE (nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)	1-2	1-2						
INFECTION SUSPECTED*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SWAB SENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANTIBIOTIC THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD GLUCOSE / URINE ANALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PATIENT / CARER TO DO DRESSING	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SIGNATURE								

***SIGNS & SYMPTOMS OF WOUND INFECTION :**

- Pyrexia
- localised pain
- erythema
- localoedema
- excess exudate
- pus
- offensive odour

***SUSPECT WOUND INFECTION IF :**

- granulation tissue bleeds easily
- fragile bridge of epithelium occurs
- odour increases
- healing is slower than anticipated
- wound breakdown

[illegible]



Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Ward / Bed No. Q1W-4

ANY SCORE>0 SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.
10/1/24	15:05	Ⓡ cubital	0/5	IV line patent	flushed	No signs of phlebitis	10/1/24
	20:00	Ⓡ cubital	0/5	IV line patent	flushed	No signs of phlebitis	10/1/24
11/1/24	8:00	RT cubital	0/5	IV LINE PATENT & HEALTHY	FLUSHED C NS	ON OBSERVATION	11/1/24
	12:30 pm	Ⓡ cubital	0/5	IV LINE PATENT & HEALTHY	FLUSHED & CHECKED	ON OBSERVATION	11/1/24
	20:00	RIGHT CUBITAL	0/5	IV LINE IS PATENT	FLUSHED & OK	No signs of phlebitis	11/1/24
12/1/24	8:00	RIGHT CUBITAL	0/5	IV LINE PATENT & HEALTHY	FLUSHED C NS	No signs of phlebitis	12/1/24
	14:00	RT cubital	0/5	IV line patent	flushed OK	No signs of phlebitis	12/1/24
	20:00	RT cubital	0/5	IV line patent	flushed OK	observation	12/1/24
13/1/24	8:00	RT cubital	0/5	IV line patent	flushed	observation	13/1/24
	14:00	RT cubital	0/5	IV line patent	flushed	observation	13/1/24
	20:00	RT cubital	0/5	IV line patent	flushed	observation	13/1/24
				IV LINE REMOVED			

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given									
			Time ↓	8	11	10							
DRUG NAME T. ROSE DAY													
Dose 200	Route po	Frequency o-b7											
Dr. Sign & Reg. No. / Seal <i>RL</i> 183573		Start Date & Time 8/1/24 @ 18:00	20:00	8/1	9/1	10/1							
		Stop Date & Time											
Additional Info:													
DRUG NAME T. FLAVENON MR			8:00										
Dose 300	Route po	Frequency 1-07											
Dr. Sign & Reg. No. / Seal <i>RL</i> 183573		Start Date & Time 8/1/24 @ 18:00	20:00	8/1	9/1	10/1							
		Stop Date & Time											
Additional Info:													
DRUG NAME T. PROLOMET XL			8:00										
Dose 200	Route po	Frequency 1-00											
Dr. Sign & Reg. No. / Seal <i>RL</i> 183573		Start Date & Time 8/1/24 @ 18:00											
		Stop Date & Time											
Additional Info:													
DRUG NAME T. CITRUS SORBATE			8:00										
Dose 2.00	Route po	Frequency 1-07											
Dr. Sign & Reg. No. / Seal <i>RL</i> 183573		Start Date & Time 8/1/24 @ 18:00	16:00	8/1	9/1	10/1							
		Stop Date & Time											
Additional Info:													
DRUG NAME T. RANDOX			8:00										
Dose 5000	Route po	Frequency 1-07											
Dr. Sign & Reg. No. / Seal <i>RL</i> 183573		Start Date & Time 8/1/24 @ 18:00	20:00	8/1	9/1	10/1							
		Stop Date & Time											
Additional Info:													
Area in-charge Nurse Signature:													





DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
8/1/24	7:00 PM	Low salt diet, B diet	[Signature]	183573					
9/1/24	8 AM	Low salt, Low fat	[Signature]	134579					
10/1/24	8:00	NPO	[Signature]	134579					

NURSE IDENTIFICATION RECORD

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


Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
8/1/24	Night	A. ALBINUS	0088	A		Night			
9/1/24	Morning	M. Lueck	2208			Morning			
9/1/24	Evening	Agasthiga	0116	J		Evening			
9/1/24	Night	E. Cathrine	0207	E.C		Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

201



Every heart beat counts.

Drug Chart: 2 of 1 Height (cms): 161cm Weight (kg): 77.5kg

Drug Details	Description of Allergy	Doctor's Sign:
NKDA	NIL	<div>  </div> Name: DR. PRAVEEN JAYAKUMAR Reg. No. 112236

1. Check entries in every section to avoid omissions
2. Nurse in-charge should verify drug chart on daily basis
3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings
4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

10/1/24 11/1/24 12/1/24 13/1/24 14/1/24

DRUG NAME

INJ. PARACETAMOL

Dose

1gm

Route

2v

Frequency

Q 6th hourly

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

10/1/24 at 19:00

Stop Date & Time

11/1/24 at 10:30

Additional Info:

DRUG NAME

SUP. LUCRALFATE SUSPENSION

Dose

10ml

Route

p/o

Frequency

1-1-1

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

10/1/24 at 21:00

Stop Date & Time

Additional Info:

DRUG NAME

NGB. LEVOSALBUTAMOL

Dose

0.63mg

Route

2v

Frequency

Q 6th hourly

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

10/1/24 at 18:00

Stop Date & Time

Additional Info:

DRUG NAME

TAB. PRUSEMIDE

Dose

40mg

Route

p/o

Frequency

1-1-0

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 6:30

Stop Date & Time

13/1/24 at 9:00

Additional Info:

DRUG NAME

TAB. SPIRANOLACTONE

Dose

25mg

Route

p/o

Frequency

1-1-0

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 10:00

Stop Date & Time

13/1/24 at 9:00

Additional Info:

Area In-charge

Nurse Signature:

3:00

11:00

19:00

7:30

13:30

19:30

5:00

11:00

17:00

23:00

8:00

16:00

10:00

17:00

3:00

10:00

19:00

7:30

13:30

19:30

5:00

10:45

17:00

23:00

8:30

15:00

16:30

10:00

17:00

17:00

17:00

17:00

3:00

10:00

19:00

7:30

13:30

19:30

5:00

10:45

17:00

23:00

8:30

15:00

16:30

10:00

17:00

17:00

17:00

17:00

3:00

10:00

19:00

7:30

13:30

19:30

5:00

10:45

17:00

23:00

8:30

15:00

16:30

10:00

17:00

17:00

17:00

17:00

3:00

10:00

19:00

7:30

13:30

19:30

5:00

10:45

17:00

23:00

8:30

15:00

16:30

10:00

17:00

17:00

17:00

17:00

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

TAB. BEPLEX FORTE

Dose

Route

Frequency

1 tab

PO

1-0-0

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 8:30

Stop Date & Time

Additional Info:

DRUG NAME

TAB. CLOPIDOGREL + ASPIRIN

Dose

Route

Frequency

75/75mg

PO

0-1-0

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 14:00

Stop Date & Time

Additional Info:

DRUG NAME

TAB. ROSUVASTATIN

Dose

Route

Frequency

20mg

PO

0-0-1

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 21:00

Stop Date & Time

Additional Info:

DRUG NAME

TAB. PARACETAMOL

Dose

Route

Frequency

650mg

PO

1-1-1

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 14:00

Stop Date & Time

Additional Info:

DRUG NAME

SYP. LACTULOSE

Dose

Route

Frequency

15mL

PO

0-0-1

Dr. Sign & Reg. No. / Seal

Dr. PRAVEEN JEYAKUMAR

Reg. No: 112236

Start Date & Time

11/1/24 at 21:00

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

2005 2005 2005 2005

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

T. METOPROLOL (BERNOL)

Dose

25mg

Route

PO

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

Start Date & Time

13/1/24 8:00

Stop Date & Time

Additional Info:

DRUG NAME

T. FRUSEMIDE

Dose

40mg

Route

PO

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

Start Date & Time

13/1/24 10:00

Stop Date & Time

Additional Info:

DRUG NAME

T. SPIRONOLACTONE

Dose

25mg

Route

PO

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

Start Date & Time

13/1/24 10:00

Stop Date & Time

Additional Info:

DRUG NAME

T. ZOLFRESH

Dose

0.5/10

Route

PO

Frequency

13/1/24 21:00

Dr. Sign & Reg. No. / Seal

Start Date & Time

13/1/24 @ 8:00

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

24/12/24 8:00
24/12/24 8:00
24/12/24 8:30
24/12/24 9:00

8:00

20:00 20:00 21:00 21:00

20:00

8:00

10:00

21:00

2002 2002 2002

Clinical Pharmacist
Medway Heart Institute

ANTIMICROBIALS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given										
			Time ↓	11/1/24										
DRUG NAME Inj. Cefuroxime Sodium			2:10	2:20										
Dose 1.5gm	Route iv	Frequency q12h b.i.d		D2										
Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236		Start Date & Time 11/1/24 at 2:10	14:10	14:10										
		Stop Date & Time 11/1/24 at 14:30												
Additional Info:														
DRUG NAME														
Dose	Route	Frequency												
Dr. Sign & Reg. No. / Seal		Start Date & Time												
		Stop Date & Time												
Additional Info:														
DRUG NAME														
Dose	Route	Frequency												
Dr. Sign & Reg. No. / Seal		Start Date & Time												
		Stop Date & Time												
Additional Info:														
DRUG NAME														
Dose	Route	Frequency												
Dr. Sign & Reg. No. / Seal		Start Date & Time												
		Stop Date & Time												
Additional Info:														
DRUG NAME														
Dose	Route	Frequency												
Dr. Sign & Reg. No. / Seal		Start Date & Time												
		Stop Date & Time												
Additional Info:														
DRUG NAME														
Dose	Route	Frequency												
Dr. Sign & Reg. No. / Seal		Start Date & Time												
		Stop Date & Time												
Additional Info:														
Area In-charge Nurse Signature:														

2023

[illegible]

10/1/24	15:05	KABILYIC	500ml	100ml/box	IV	-	-	-	F	112236	15:05	18:00	<i>[Signature]</i>
---------	-------	----------	-------	-----------	----	---	---	---	---	--------	-------	-------	--------------------

10/1/24	18:00	KABILYTE	500u	100u	Pr	1v	—	—	—	112+36	18:00	00:00	2019
---------	-------	----------	------	------	----	----	---	---	---	--------	-------	-------	------

11/1/24	00:00	KABILSTE	Scout	100ml/HR	1V	—	—	—	8	112256	00:00	04:00	22
---------	-------	----------	-------	----------	----	---	---	---	---	--------	-------	-------	----

11/1/24	21:00	CABLYTE	550ml	100 ml/hr	1V	-	-	-	L	112-36	21:00	01:00	11/8/19
---------	-------	---------	-------	-----------	----	---	---	---	---	--------	-------	-------	---------

12/1/24	01.00	CABLYTE	50ml	100ml/hr	IV	—	—	—	5	112236	01.00	05.00	$\frac{74}{2013}$
---------	-------	---------	------	----------	----	---	---	---	---	--------	-------	-------	-------------------

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

[illegible]

mean
'6276

Moody
G286

Meat
0286

2
opp 3

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
10/1/24	15:05	NPO	8	112232					
11/1/24	8:00	LIQUID DIET	8	112236					
12/1/24	9:00	Soft diet.	8	112236					
13/1/24	8:00	normal diet	12/11	134559					
14/1/24	8:00	normal diet	12/11	134559					

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning				14/1/24	Morning	B. Mani Sri	0195	By
10/1/24	Evening	SANTA FLORANCE S	0054	SA		Evening			
10/1/24	Night	ARUN	235	AR		Night			
11/1/24	Morning	MAHALAKSHMI M	0219	DM		Morning			
11/1/24	Evening	ASHA C BHAVANI	0051	AS		Evening			
11/1/24	Night	ASHA C	0019	AS		Night			
12/1/24	Morning	Mahalakshmi M	0219	DM		Morning			
12/1/24	Evening	A. ALBINUS	0082	AL		Evening			
12/1/24	Night	F. Catherine	0207	F-C		Night			
13/1/24	Morning	Indu	0088	IN		Morning			
13/1/24	Evening	A. ALBINUS	0088	AL		Evening			
13/1/24	Night	F. Catherine	0207	F-C		Night			

OPCABX 3 GRAFTS

LIMA → LAD

SV4 → LAST OM & PDA [SEQ]



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



JCI ACCREDITED NABH ACCREDITED



Every heart beat counts

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/1PH2024000068

Dr. ANBARASU MOHANRAJ

Name

UHID No.

Blood Group

O+ve

Height

161cm

Weight

77.5kg

BSA

1.86m²

MHI/ICU/2022/076

Sheet No.

1

A

SURGICAL PROCEDURE:

DATE OF SURGERY:

10/1/24

POST-OP DAY:

Day

DATE	TIME	VENTILATORS PARAMETERS											BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO ₂		pH	PCO ₂	PO ₂	HCO ₃	SAT%	BE
10/01 2024	15.05	Smv (frc) ps	14		22.0	5.0	9.0	8.4	600	596.	80		7.432	36.9	84.3	24.0	96.6	-0.3
	15.00										60%							
	18.00	PSV	12			5.0					60%							
	18.25	PSV	10			5.0					60		7.380	43.1	103.7	24.9	97.6	0.2
	19.45	PATIENT EXTUBATED																
	20.00										100%	PEO ₂	7.428	40.7	129.7	26.3	98.7	1.9
	22.00			on		02	mask				8lit							

CRITICAL CARE FLOWCHART

RECEIVED THE PATIENT FROM OT AT: 15.05

OT URINE: 0150ml

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

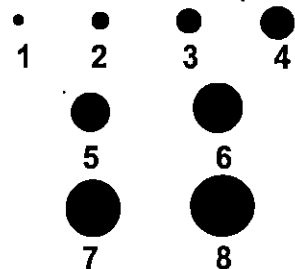
MOTOR

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

MOTOR ARMS/LEGS

S-Strong
Wk-Weak
O-Absent
A-Anaesthesia
CP-Chemical paralysis

PUPILS SCALE (mm)



PUPILS REACTION

Br-Brisk
Sl-Sluggish
O-Absent

CARDIOVASCULAR

CAPILLARY REFILL

Br-Brisk
Sl-Sluggish
O-Absent

EDEMA

D-Dependent
G-Generalised
O-Absent

HEART SOUNDS

S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS

JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced /
Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING

Ab-Abdominal
TA-Thoraco-abdomial
L-Laboured

SUCTION

ET-Endotracheal
N-Nasal
Or-Oral

BREATH SOUNDS

CL-Clear
Ro-Ronchi
Wh-Wheezes
CR-Crackles
BECL-Bilat
equal & clear

SECRECTIONS

COLOUR
CL-Clear
Y-Yellow
W-White
Pk-Pink

CHARACTER

M-Moderate
Sc-Scanty
Th-Thin
Tk-Thick
Cs-Copious
R-Red

GASTROINTESTINAL

BOWEL SOUNDS

+Present
O-Absent

NGT POSITION

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

ABDOMINAL TONE

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

GASTRIC RESIDUAL

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

LIVERSIZE

N-Normal
E-Enlarged

OP CAB X 3 GRAFTS

LIMA → LAD

SVG → LAST OM & PDA [SEQ]

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ

MHI/ICU/2022/076

Name

UHID No

Blood Group

O +ve

Height

161cm

Weight

72.5kg

BSA

1.86m²

Sheet No.

2

A

SURGICAL PROCEDURE:

DATE OF SURGERY:

10/1/24

POST-OP DAY:

DOS

DATE	TIME	VENTILATORS PARAMETERS										BLOOD GAS					
		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FIO ₂	pH	PCO ₂	PO ₂	HCO ₂	SAT%	BE
10/1/24	01:00	ON	ON		ON		mask				8lit						
	05:00	ON	ON		nasal		prongs				4lit						
											6.30	7.470	34.7	80.8	24.7	96.6	1.0

CRITICAL CARE FLOWCHART

NEURO

EYES

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

VERBAL

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

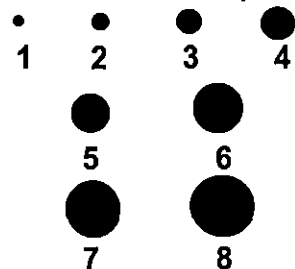
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Obeys commands-6
Localise pain-5
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EDEMA

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G-Generalised
O-Absent

HEART SOUNDS

S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

NECK VEINS

JVP
N-Normal
In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced /
Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING

Ab-Abdominal
TA-Thoraco-abdominal
L-Laboured

SUCTION

ET-Endotracheal
N-Nasal
Or-Oral

BREATH SOUNDS

CL-Clear
Ro-Ronchi
Wh-Wheezes
CR-Crackles
BECL-Bilat
equal & clear

SECRETIONS

COLOUR
CL-Clear
Y-Yellow
W-White
Pk-Pink

CHARACTER

M-Moderate
Sc-Scanty
Th-Thin
Tk-Thick
Cs-Copious
R-Red

GASTROINTESTINAL

BOWEL SOUNDS

+Present
O-Absent

NGT POSITION

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

ABDOMINAL TONE

So-Soft
F-Firm
Tn-Tender
Ob-Obese
D-Distended

GASTRIC RESIDUAL

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

LIVERSIZE

N-Normal
E-Enlarged

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

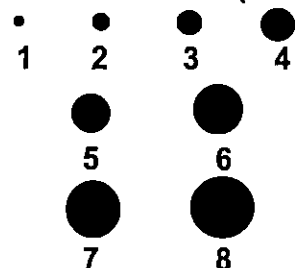
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CAPILLARY REFILL

Br-Brisk
Sl-Sluggish
O-Absent

EDEMA

D-Dependent
G-Generalised
O-Absent

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S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

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Valve Replaced /
Shunt
+Present
O-Absent

PULMONARY

WORK OF BREATHING

Ab-Abdominal
TA-Thoraco-abdomial
L-Laboured

SUCTION

ET-Endotracheal
N-Nasal
Or-Oral

BREATH SOUNDS

CL-Clear
Ro-Ronchi
Wh-Wheezes
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BECL-Bilat
equal & clear

SECRETIONS

COLOUR
CL-Clear
Y-Yellow
W-White
Pk-Pink

CHARACTER

M-Moderate
Sc-Scanty
Th-Thin
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Cs-Copious
R-Red

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BOWEL SOUNDS

+Present
O-Absent

NGT POSITION

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

ABDOMINAL TONE

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

GASTRIC RESIDUAL

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

LIVERSIZE

N-Normal
E-Enlarged

Sheet No. 1	Name	Mr. RAJASINGH P 59/Male/MHI202381562 08/01/2024/IPH2024000068 Dr. ANBARASU MOHANRAJ	
	UHID No.		
B	Blood Group	O+ve	Sex
	Height	161cm	Weight
			BSA
			1.86m ²





DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd™G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
10/01 2024	15.10	13.0	138	3.65	1.09 2.02		15.05		cl	96%	Simy 14								
							16.00		cl	98%	14mt		93.1°F						
							17.00		cl	97%	14mt								
	19.05	12.1	136	3.61	1.06 2.2		18.00		cl	97%	13mt								
							19.00		cl	99%	15mt								Start 100%
							20.00		cl	98%	18mt		94.6°F						
	21.15	13.2	138	3.91	0.95 2.0		21.00		cl	99%	22mt								
							22.00		cl	100%	20mt								
							23.00		cl	100%	17mt								
							00.00		cl	100%	11mt								

CRITICAL CARE FLOWCHART

18.00 NE GOT FULLY AWAKE AND MOVED ALL LIMBS

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME			15.05	16.00	22.00	00.00
	EYES			CP	A	4	4
	VERBAL			CP	ET	5	5
	MOTOR			CP	F	6	6
	ARMS R/L			CP	ST	ST	ST
	LEGS R/L			CP	ST	ST	ST
PUPILS	R.SIZE/REACTION			3/B1	3/B1	3/BR	3/BR
	L.SIZE/REACTION			3/B1	3/B1	3/BR	3/BR
CARDIO-VASCULAR	HEART SOUNDS			S1S2	S1S2	S1S2	S1S2
	VALVE CLICK				-		
	CAPILLARY REFILL			B1	B1	BR	BR
	EDEMA			0	0	0	0
	NECK VEINS			N	N	2	2
PULMONARY	WORK OF BREATHING			TA	TA	TA	TA
	SUCTION			-	-		
	SECREATIONS			-	-		
GASTRO INTESTINAL	BOWEL SOUNDS			+	+	+	+
	ABDOMINAL TONE			SO	S	S	S
	N/G POSITION			in situ	INSITU	LOC	
	GASTRIC RESIDUAL			4	4		
	LIVER			N	N	2	2

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE			4	4	4	4
	PD - FUNCTION			-	-		
	DRAINAGE			-	-		
	PD - SITE			-	-		
SKN	COLOUR			e	-		
	Sx WOUND-CHEST			4	4	4	4
	LEG			4	4	4	4
	DRESSING			OT	OT	OT	OT
	PRESSURE SORE-SITE			Neck	NH	W1	W1
	AREA			-	-		
	DRESSING CONDITION			-	-		
MISCELL	POSITION CHANGE			Q2H	Q2H	Q2H	Q2H
	CHEST-PHYSIO			Q2H	Q2H	Q2H	Q2H
	ACTIVITY			CP	PE	PE	PE
				ABP	ABP	ABP	ABP
	S/N NAME			Deeper	Deeper	ARND	ARND
	TIME			15.05	16.00	22.00	00.00
	SIGNATURE			K. Arndt	Deeper	Deeper	Deeper

Sheet No. 	Name	Mr. RAJASINGH P 59/Male/MHI202381562 08/01/2024/IPH2024000068	
	UHID No.	Dr. ANBARASU MOHANRAJ 	
B	Blood Group	O+ve	Height
			Weight
			BSA



MHI/ICU/2022/076




Every heart beat counts

DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd™G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
							01:00		cl	100%	23mt								
							02:00		cl	100%	20mt								
							03:00		cl	100%	18mt								
							04:00		cl	100%	19mt								
							05:00		cl	100%	21mt								
							06:00		cl	94%	24mt		94.9°F						
11/1/24	6:30	11.7	134	3.68	1.01 58		07:00		cl	97%	23mt								

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING		NIGHT	
NEURO	TIME						04.00
	EYES						4
	VERBAL						5
	MOTOR						6
	ARMS R/L						st
	LEGS R/L						st
PUPILS	R.SIZE/REACTION						3/BR
	L.SIZE/REACTION						3/BR
CARDIO-VASCULAR	HEART SOUNDS						S.S2
	VALVE CLICK						
	CAPILLARY REFILL						BR
	EDEMA						0
	NECK VEINS						2
PULMONARY	WORK OF BREATHING						TA
	SUCTION						
	SECREATIONS						
GASTRO INTESTINAL	BOWEL SOUNDS						+
	ABDOMINAL TONE						S
	N/G POSITION						
	GASTRIC RESIDUAL						
	LIVER						2

	SHIFT	DAY		EVENING		NIGHT	
G.U.	DESCRIP.OF URINE						cl
	PD - FUNCTION						
	DRAINAGE						
	PD - SITE						
SKN	COLOUR						
	Sx WOUND-CHEST						cl
	LEG						cl
	DRESSING						OT
	PRESSURE SORE-SITE						P11
	AREA						
	DRESSING CONDITION						
MISCELL	POSITION CHANGE						02.44
	CHEST-PHYSIO						web SPIRO
	ACTIVITY						FE
							ABP CUP
	S/N NAME						ARUN
	TIME						04.00
	SIGNATURE						2

Sheet No. 3	Name	Mr. RAJASINGH P S9/Male/MHI202381562 08/01/2024/1PH2024000068	
	UHID No.	Dr. ANBARASU MOHANRAJ 	
B	Blood Group	Height	Weight
	O+ve	161cm	72.5kg
		BSA	
		1.86m²	



MHI/ICU/2022/076



Every heart beat counts

DATE	TIME	BIOCHEMISTRY					VITAL PARAMETERS								CARDIAC ASSIST DEVICE				
		Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd ^{mm} G	TIME	IABP		PACEMAKER SETTING	
																RATIO	DURATION	RATE	MODE
11/1/24							8:00		cl	97%	21mt								
							9:00		u	97%	20mt		97.1F						
							10:00		u	95%	22mt								
							11:00		u	100%	24mt								
							12:00		u	100%	24mt	117							
							13:00		clear	100%	22 blm	122	76 (97)	97.2F					
							14:00		clear	95%	24 blm	113	73 (86)						
							15:00		clear	95%	22 blm	110	70 (87)						
							16:00		clear	95%	24 blm	104	70						
							17:00		clear	96%	22 blm	111	73 (86)						

CRITICAL CARE FLOWCHART

	SHIFT	DAY		EVENING	NIGHT	
NEURO	TIME	8:00	12:00	16:00		
	EYES	4	4			
	VERBAL	5	5			
	MOTOR	6	6			
	ARMS R/L	ST	ST			
	LEGS R/L	ST	ST			
PUPILS	R.SIZE/REACTION	3/BR	3/BR			
	L.SIZE/REACTION	3/BR	3/BR			
CARDIO-VASCULAR	HEART SOUNDS	S1S2	S1S2			
	VALVE CLICK	-	-			
	CAPILLARY REFILL	BR	BR			
	EDEMA	-	-			
	NECK VEINS	-	-			
PULMONARY	WORK OF BREATHING	-	-			
	SUCTION	-	-			
	SECREATIONS	-	-			
GASTRO INTESTINAL	BOWEL SOUNDS	+	+			
	ABDOMINAL TONE	SD	SD			
	N/G POSITION	-	-			
	GASTRIC RESIDUAL	-	-			
	LIVER	N	N			

	SHIFT	DAY		EVENING	NIGHT	
G.U.	DESCRIP.OF URINE	4	4	4		
	PD - FUNCTION	-	-	-		
	DRAINAGE	-	-	-		
	PD - SITE	-	-	-		
SKN	COLOUR	-	-	-		
	Sx WOUND-CHEST	4	4	4		
	LEG	4	4	4		
	DRESSING	-	-	-		
	PRESSURE SORE-SITE	-	-	-		
	AREA	-	-	-		
	DRESSING CONDITION	-	-	-		
MISCELL	POSITION CHANGE	Q2H	Q2H	Q2H		
	CHEST-PHYSIO	NEB SPIRO	NEB SPIRO	NEB SPIRO		
	ACTIVITY	PE	PE	PE		
		ABP WUP	ABP	NIBP		
	S/N NAME	Mah	Mah	Mah		
	TIME	8:00	12:00	16:00		
	SIGNATURE	Di	Di			

Name		Mr. RAJASINGH P		MHI/ICU/2022/076	
UHID No.		59/Male/MHI202381562		Sheet No.	
Blood Group		0+ve		1	
Height		161cm		Sex	
Weight		77.5kg		BSA	
BSA		1.86m ²		C	

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	POS	Dopa 200/50	NORAD 4/50		
10/01/2024	15:05																5.0	2.0	ACRA	
	16:00	150	150			50		50	50			7.0	7.0	207	KABLYE 200	200	5.0	2.0	4.0	
	17:00	50	200						50			7.0	257	257	100	300	5.0	2.0	4.0	
	18:00	75	275			20		20	70			7.0	352	352	200	500	5.0	2.0	4.0	
	19:00	150	425			20		20	90			7.0	522	522	100	600	5.0	2.0	4.0	
	20:00	200	625			40		40	130			7.0	762	762	100	700	5.0	2.0	-	
	21:00	110	735			20		20	150			1.0	893	893	100	800	5.0	2.0		
	22:00	200	935			20		20	170				8.0	1112	100	900	5.0	2.0		
	23:00	180	1115			20		20	190				8.0	1313	100	1000	5.0	2.0		
	00:00	200	1315			10		10	200				8.0	1523	KABLYE 100	1100	4.5	2.0		

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

det: 113 qe at 15:10

CRITICAL CARE FLOWCHART

GENITOURINARY (GU)**PD****URINE**

CL-Clear
T-Turbid
Stained
HC-High Coloured

FUNCTION

Dr-Draining
B-Blocked

DRAINAGE

CL-Clear
BS-Blood

SITE

C-Clean
R-Redness
BD-Block discoloration

MISCELLANEOUS**POSITION CHANGE**

Su-Supine
RL-Right lateral
LL-Left Lateral

ACTIVITY

PE-Passive exercise
Am-Ambulated

CHEST PHYSIO

V-Vibrator
CP-Chest percussion
DC-Deep breath & cough
N-Nebulizer

TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

SKIN**COLOUR**

Pk-Pink
F-Flushed
P-Pale
Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

DRESSING

B-Betadine
AI-Antibiotic
Irrigation

PRESSURE SORE**SITE**

S-Sacrum
Sc-Scapular
Oc-Occiput

AREA

R-Redness
BD-Black discoloration
BL-Blister
SP-Skin Peeling
D-Deep

DRESSING / Rx

IR-Infra Red
DU-Dueodem
E-Eptoin dressing
B-Betadine dressing
EU-Eusol sitz bath
ST-Sofra Tulle

CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

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

Mr. RAJASINGH P

59/Male/MHI202381562

08/01/2024/IPH2024000068

Dr. ANBARASU MOHANRAJ

MHI/ICU/2022/076

Name

UHID No.

Blood Group

Height

Age

Sex

Weight

BSA

Sheet No.

2

C

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	101	DOPH 20/50	MORAD 2/50		
11/1/24	01:00	150	1465			10		10	210				8.0	1683	100	1200	4.0	2.0		
	02:00	180	1645						210				8.0	1863	100	1300	3.5	2.0		
	03:00	160	1805			20		20	230				8.0	2043	100	1400	3.0	2.0		
	04:00	200	2005			10		10	240				8.0	2283	100	1500	2.5ms 2.5	2.0		
	05:00	150	2155			30		30	270				8.0	2433	-	1500	2.5	1.0		
	06:00	100	2255			40		40	310				8.0	2573		1500	2.5	-	25.0 POTASSIUM 20/50	
	07:00	100	2355			10		10	320			1.0	9.0	2684		1500	2.5		25.0	

CRITICAL CARE FLOWCHART

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)**PD****URINE**

CL-Clear
T-Turbid
Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

Dr-Draining
B-Blocked

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BD-Block discoloration

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BS-Blood

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Su-Supine
RL-Right lateral
LL-Left Lateral

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TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
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F-Flushed
P-Pale
Cy-Cyanotic
M-Mottled
D-Dusky
J-Jaundice

SURGICAL (SX) WOUND

C-Clean
Oz-Oozing
G-Gaping
Op-Open
I-Infected

DRESSING

B-Betadine
AI-Antibiotic
Irrigation

PRESSURE SORE**SITE**

S-Sacrum
Sc-Scapular
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IR-Infra Red
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CONDITION

H-Healing
SCo-Status quo
S-Sloughing

LINES / TUBES CONDITION

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Dr-Draining
D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

Mr. RAJASINGH P 59 / Male / MHI202381562 08/01/2024 / IPH2024000068		MHI/ICU/2022/076	
Name	Dr. ANBARASU MOHANRAJ	Sheet No. 3	
UHID No.		Age	Sex
Blood Group	O+ve	Height	Weight
	161cm	77.5kg	BSA 1.86m ²

DATE	TIME	URINE		CHEST DRAINAGE						GASTRIC		LAB SAMPLE		TOTAL OUTPUT	VOLUME		INFUSIONS			
		AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL		AMT	INF	DOPPA 20/50	INS. KEL 20/50		
11/1/24	8:00	100	100		20			20	20					120			2.5	25.0		
	9:00	100	200		10			10	30					230			1.0	-		
	10:00	100	300						30					330			-			
	11:00	70	370		20			20	50					420						
	12:00	75	445		10			10	60					505						
	13:00	70	515		70 (TUBE EMPTIED)			70	130					645						
	14:00	50	565						130					695						
	15:00	70	635						130					765						
	16:00	50	685					CHEST DRAIN REMOVED @ 16:10	-					815						
	17:00	100	785											915						

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME	
11/1/24	11:10	ARTERIAL LINE REMOVED BY (DR. ANBARASU)
11/1/24	16:10	CHEST DRAIN REMOVED.

GENITOURINARY (GU)**PD****URINE**

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Stained
HC-High Coloured

BS-Blood Stained
HA-Haematuria

FUNCTION

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TRANSDUCER ZERO

PARAMETER
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SURGICAL (SX) WOUND

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IR-Infra Red
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CONDITION

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D/c-Discontinued
P-Positional
HL-Heparin Lock
B-Blocked

Name		Mr. RAJASINGH P		59/Male/MHI202381562		Sheet No.	
UHID No.		08/01/2024/IPH2024000068		Dr. ANBARASU MOHANRAJ		Sex	
Blood Group		O +ve		Height 161cm		Weight 77.5kg	
				BSA 1.86m ²		D	



MHI/ICU/2022/076



FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: O +ve.

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
						H18x		AMT.	TOTAL														
1d	15:00											75	SINUS	0.01	134/63	87	8		COOL	++			
	16:00					2.0	13.0			213	+6	69	SINUS	0.01	125/62	84	9		COOL	++			
	17:00					2.0	13.0			326	+69	72	SINUS	0.03	125/69	89	8		COOL	++			
	18:00					2.0	13.0			539	+187	68	SINUS	0.08	126/68	86	7		COOL	++			
	19:00					2.0	13.0			652	+130	82	SINUS	0.10	117/63	81	9		COOL	++			
	20:00					2.0	9.0			761	-1	99	SINUS	0.02	116/66	81	5		WARM	++			
	21:00					2.0	9.0			870	-23	100	SINUS	0.01	138/74	83	4		WARM	++			
	22:00					2.0	9.0	CPIC		979	134	99	SINUS	0.02	148/72	98	7		WARM	++			
	23:00					2.0	9.0	150	150	1238	-75	100	SINUS	0.00	154/79	104	4		WARM	++			
	00:00					2.0	8.5	50	200	1397	126	97	SINUS	0.01	150/72	94	3		WARM	++			

CRITICAL CARE FLOWCHART

STAT DRUGS TIME

18:05 my. MYOPYROLATE ENL IV STAT GIVEN [Dr. JEEHAN]

PREVIOUS DAY HRS

DRAINAGE:

TOTAL INTAKE:

URINE :

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

Name		Mr. RAJASINGH P		59/Male/MHI202381562		Sheet No. ②	
UHID No.		08/01/2024/IPH2024000068		Dr. ANBARASU MOHANRAJ		Sex	
Blood Group		O+ve		Height 161cm		Weight 72.5kg	
				BSA 1.86m ²		D	



MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: O+ve

DATE	TIME	INFUSIONS (contd.)					TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/RAP	PERI	PP R/L	CO	CI	SVR
								AMT.	TOTAL														
11/11/24	01:00					2.0	8.0	100	300	1605	78	100	sinus	0.00	144/75	97	4		warm	++			
	02:00					2.0	7.5		300	1712.5	50.5	101	sinus	0.04	146/74	86	5		warm	++			
	03:00					2.0	7.0	150	450	1969.5	73.5	98	sinus	0.06	126/60	84	6		warm	++			
	04:00					2.0	6.5	100	550	2176	77	100	sinus	0.01	136/69	93	4		warm	++			
	05:00					2.0	5.5		550	2181.5	251.3	96	sinus	0.00	138/70	92	6		warm	++			
	06:00					2.0	4.5	150	700	2236	237	94	sinus	0.01	135/68	90	7		warm	++			
	7:00					2.0	29.5	150	850	2515.5	168.5	98	sinus	0.00	136/70	92	8		warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME

PREVIOUS DAY HRS

DRAINAGE:

TOTAL INTAKE:

URINE :

TOTAL OUTPUT:

TOTAL BALANCE:

P.T.O.

Name		Mr. RAJASINGH P		59/Male/MHI202381562		08/01/2024/IPH2024000068		Sheet No.	
UHID No.		Dr. ANBARASU MOHANRAJ		ex		3		D	
Blood Group		O+ve		Height		Weight		BSA	
		161cm		77.5kg		1.86m ²			



MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: O+ve

DATE	TIME	INFUSIONS (contd.)				TOTAL	N/G/ORAL		TOTAL INTAKE	TOTAL BALANCE	HR/mt	RHYTHM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	CO	CI	SVR
							AMT.	TOTAL														
11/1/24	8:00					2.0	50	50	139	61	104	SINUS	0.01	130	62	9		Warm	++			
	9:00					2.0	100	150	182	68	102	SINUS	0.01	133	67	12		Warm	++			
	10:00					2.0	150	300	334	74	106	SINUS	0.02	111	73	8		Warm	++			
	11:00					2.0	75	375	411	79	100	SINUS	0.01	132	69	7		Warm	++			
	12:00					2.0	100	475	511	76	Ab sinus	0.01	132					Warm	++			
	13:00					-	50	525	561	84	92	SINUS	0.02	-				Warm	++			
	14:00					-	100	625	661	84	96	SINUS	0.02	-				Warm	++			
	15:00					-	50	675	711	84	92	SINUS	0.03	-				Warm	++			
	16:00					-	150	825	861	86	92	SINUS	0.03	-				Warm	++			
	17:00					-	75	900	936	81	92	SINUS	0.03	-				Warm	++			

CRITICAL CARE FLOWCHART

STAT DRUGS
TIME

PREVIOUS DAY 16 HRS 555mls HRS

DRAINAGE: 320ml

TOTAL INTAKE: 2515.5ml

URINE: 2355ml

TOTAL OUTPUT: 2684ml

TOTAL BALANCE: 680.5ml

P.T.O.

OPCAB X 3 GRAFTS
LIMA → LAD
SVB → LAST OM AND, PDA [SEA]



INTERMEDIATE CARE FLOWCHART

A

NAME : Mr. RAJASINGH P
59/Male/MHI202381562
08/01/2024/IPH2024000068
SURGIC : Dr. ANBARASU MOHANRAJ

UHID NO : AGE : SEX :


POSTOP DAY : POD - 1

FLUID REQUIREMENT : 2.4 litres

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS			ORAL/ R.T.			TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
11/12/23 18:00	100	885				130	1015					50	950	986	-29
19:00	50	935				130	1065					75	1025	1061	-4
20:00	75	1010				130	1140			keep			1025	1061	-79
21:00	75	1085				130	1215			100		100	1125	1261	+46
22:00	100	1185				130	1315			100		75	1200	1436	+121
23:00	120	1305				130	1435			100			1200	1536	+101
00:00	200	1405				130	1635			100			1200	1636	+100
01:00	150	1555				130	1785			100			1200	1736	-49
02:00	150	1705				130	1935			keep 100		50	1250	1886	-49
03:00	100	1805				130	2035			100			1250	1986	-49
04:00	120	1925				130	2155			100			1250	2086	-69
05:00	120	2045				130	2275			100		75	1325	2261	-14
06:00		2045				130	2275			-		100	1425	2361	+86
7:00		2045				130	2275							2361	+86

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
AT 5.00 U. CATH REMOVED BTO DR. ANBARASU	

Mr. RAJASINGH P
 59/Male/MHI202381562
 08/01/2024/IPH2024000068
 Dr. ANBARASU MOHANRAJ



INTERMEDIATE CARE FLOWCHART

B

UHID NO :

AGE :

SEX :

BLOOD GROUP : O^{+ve}

HEIGHT : 161 Cm

WEIGHT : 77.5 Kg


B.S.A : 1.86 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
97.1° F	94 bpm	SINUS	0.02	103/71 (82)		Warm	++	18	clear	95%	On Room Air
97.2° F	88 bpm	SINUS	0.03	111/77 (86)		Warm	++	16	clear	95%	
	89	SINUS	0.04	123/74	90	Warm	++	18	cl	94%	
	88	SINUS	0.07	110/74	86	Warm	++	19	cl	92%	
	91	SINUS	0.01	124/72	89	Warm	++	21	cl	93%	
	90	SINUS	0.01	119/74	88	Warm	++	25	cl	93%	
98° F	90	SINUS	0.01	115/72	85	Warm	++	15	cl	92%	
	82	SINUS	0.01			Warm	++	19	cl	93%	
	84	SINUS	0.01	112/79	85	Warm	++	19	cl	93%	
	86	SINUS	0.02			Warm	++	21	cl	93%	
	86	SINUS	0.01	106/74	85	Warm	++	23	cl	92%	
	85	SINUS	0.01	107/74	85	Warm	++	18	cl	92%	
	86	SINUS	0.01	116/78	91	Warm	++	19	cl	93%	
	85	SINUS	0.01	123/85	98	Warm	++	21	cl	94%	10/1/2019

PREVIOUS DAY - HOURS

DRAINAGE

URINE



TOTAL INTAKE

TOTAL OUTPUT

BALANCE

OPCAB X 3 GRAFTS
LIMA → LAD
SVG → LAST OM AND PDA



Every heart beat counts

A

59/Malc/MH202381562

UHD NO :

AGE: 59 yrs SEX: Male

Dr.ANBARASU MOHANRAJ

SURGIC

FLUID REQUIREMENT : 2.4 litres.

[illegible]

[illegible]

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



Pa **Mr. RAJASINGH P**
Ni 59/Male/MHI202381562
UI 29/12/2023/IPH2023002633
D **Dr. NARENDRA M**
D
Consent

MHI/IPD/2022/002



ADMISSION SLIP

Admitting Doctor: **Dr. Narendran/Dr. Giranvelu** Speciality: **Cardiology**

Advised Date & Time: **29/12/2023 12:32PM**

Provisional Diagnosis:

CAO/CA II/ @ LV Function

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

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

Surgery / Procedure Name (if planned):

RL

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

Expected Duration of Stay:

Daycare

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

Payer: ☒ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Admission in GR

Any other Instructions (if any):

[6000-]

Doctor's Signature

[Signature]

Name

Dr. Giranvelu

Reg. No.

39468

Date

29/12/23

Time

12:32 PM

For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☒ Others PL

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

29/12/2023

12.39 pm

29/12/2023

12.39 pm

Source: ☒ OPD

☐ ER

☐ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time

[Signature]

Prathiba K.S

0192

29/12/23

12.39

ADMISSION FORM

Marital Status M	Full Address No. 478/3, Bharathiyar Street, Kamatchi Arman Nagar, Pasaniputhur, Kundrathur, Chennai - 600122		Telephone Number 7358446810 9940617755
Occupation RL			
Referred from Dr. Narendran Dr. Anandavelu	Date of Time of Admission 29/12/23 at 12:00	Date & Time of Discharge 29/12/23 at 18:30	Total No. of Days 6 hr 30 min
UNIT RL	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
CORONARY ARTERY DISEASE			I25.1
EXERTIONAL ANGINA CLASS III			I20.8
NORMAL LV FUNCTION			I50.1
SYSTEMIC HYPERTENSION			T10
DATE	OPERATION / PROCEDURES		ICPM Code
29/12/23	CORONARY ANGIOGRAM		88.50
DATE	TYPE OF ANESTHESIA		
29/12/23	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL		
DISCHARGE STATUS			
<input checked="" type="checkbox"/> Cured <input type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input checked="" type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Signature of the Consultant [Signature]		Signature of Medical Records Officer [Signature]	

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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


மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.


செவிலியர் கையொப்பம்
Signature of Admitting Nurse

தேதி
Date 29/12/23


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

FATHER SON
உறவுமுறை
Nature of Relationship



GENERAL CONSENT FOR ADMISSION



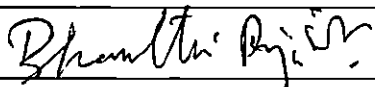
I, RAJASINGH P the ☐ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.
- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.
- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient		P. RAJASINGH	29/12/23	12:32
Surrogate/Guardian (if applicable #)		R. HARISH PONSINGH (Write name and relationship with patient)	29/12/23	12:32
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		BHARATHI	29/12/23	12:32
Interpreter (if applicable)				

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



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

DAY CARE DISCHARGE SUMMARY

IP No.	IPH2023002633	D.O.A	: 29/12/2023
UHID	MHI202381562	D.O.P	: 29/12/2023
Name	Mr. RAJASINGH .P	Room No.	: RL
Age / Gender	59 Years /MALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 29/12/2023

DIAGNOSIS:

**CORONARY ARTERY DISEASE
EXERTIONAL ANGINA CLASS III
NORMAL LV FUNCTION
SYSTEMIC HYPERTENSION**

PROCEDURE: CORONARY ANGIOGRAM DONE ON 29.12.2023 – DISTAL LM AND TRIPLE VESSEL DISEASE.

BRIEF HISTORY:

Mr. Rajasingh .P, 59years old male, presented with complaints of chest pain on exertion. He was advised Coronary angiogram and referred to Medway Heart Institute on 29.12.2023 for which he has been admitted.

ON EXAMINATION:

HR: 74bpm ; BP: 128/92mmHg ; SPO₂: 99% in room air
CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: Hb- 14.2gm/dl, Urea – 17.9mg/dl, Creatinine – 1.07mg/dl.

ECG: sinus rhythm, HR – 82 bpm.

ECHO: No RWMA. Normal LV systolic function. EF – 60%. Normal valves and chambers. Normal chamber dimensions. Mild concentric LVH. Mild MR. Normal RV function. Normal PA pressure.

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

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



94457 94457
1800 572 3003

Medway Group of Hospitals

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

Medway Centre of Excellence (Chennai)

Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

MHI/HOSP/2022/118



NABH ACCREDITED

Mr. RAJASINGH .P

UHID: MHI202381562

IP.NO: IPI 2023002633



Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

CORONARY ANGIOGRAM FINDINGS:

Right dominant system; **DISTAL LM AND TRIPLE VESSEL DISEASE.** (reports enclosed)

ADVICE : CABG x grafts to LAD, MAJOR OM & PDA/PLV .

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	CAP. CLOPILET-A (ASPIRIN & CLOPIDOGREL)	75/150 MG	0	1	0	ORAL	AFTER FOOD	TO STOP 5 DAYS BEFORE SURGERY
2	TAB. ROSEDAY (ROSUVASTATIN)	20 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. PROLOMET XL (METOPROLOL SUCCINATE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
5	TAB. GTN SORBITRATE (NITROGLYCERIN)	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	TAB. RANOZEX (RANOLAZINE)	500 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7	TAB. RABLET (RABEPRAZOLE)	20 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE

DISCHARGE ADVICE

DIET	LOW FAT, SALT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH DR. NARENDRAN.M.

To report: If temp > 101 °F / Difficulty in breathing / chest pain / Giddiness/ palpitations.

In case of emergency Contact: Medway Hospitals @ 4310 8959.

[Signature]

"I understood the Content of the discharge summary."

Typed by: Ezhilarasi.

[Signature]

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

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

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

f @MedwayHospitals

@medwayhospitals

in @medway-hospitals

@medwayhospitals



1800 572 3003

Medway Hospitals
Trustpuram, Chennai
Tel : 044-2473 4454

Medway Hospitals
Kodambakkam, Chennai
Tel : 044 - 2473 4455

Medway Hospitals
Mogappair, Chennai
Tel : 044- 26530011

Medway Hospitals
Kumbakonam
Tel: 0435 - 2412345

Medway JSP Hospitals
Chengalpattu
Tel: 044-27426829

E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MHI/MGT/LH/202109/001

DAY CARE INITIAL ASSESSMENT FORM

Date: 29/12/23 Time of arrival: 12.40.

Part A (to be filled by Nurses)

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 94 (beats/min) | BP: 128/92 (mmHg)
Respiration: 20 (breaths/min) | SpO₂: 99% (%) | Height: 167 (cms) | Weight: 75.5 (kgs) | BMI: 27.1 kg/m²

Any Language Barrier: ☐ Yes ☒ No If yes, please call Language Coordinator / Translator

Allergies: ☐ Yes ☒ No If Yes, specify: _____

Psychosocial Assessment:

Alcohol Intake: ☐ Yes ☒ No **Substance Abuse:** ☐ Yes ☒ No **Smoking:** ☐ Yes ☒ No

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

If Yes, specify details: _____

Pain Screening

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

Pain Scale used: ☐ PIPPS (28 weeks to < 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☒ Numerical Rating Scale (Age more than 12 years)

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

Fall Risk Screening for adults:

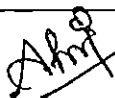
☒ No Risk
☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem

In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

Fall Risk Screening (for pediatrics)

☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ☒ No Risk

In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

	Signature	Name	Emp. No.	Date	Time
Nurse		<u>Aouthi</u>	<u>0282.</u>	<u>29/12/23</u>	<u>12-45</u>

Part B (to be filled by Physicians)**Chief Complaints**

c/o of chest pain on exertion.

Past Medical History**Personal History****Significant Family History****Current Medication**

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	T. CLOPILLET-A	75mg	p/o	0-1-0	28/12/23 at 2pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T- ROSELAGY	20mg	p/o	0-0-1	28/12/23 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T- FLAVESON MR	35mg	p/o	1-0-1	29/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T- PROLOMET XL	55mg	p/o	1-0-0	29/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T- GININ SORBIRATE	2.5mg	p/o	1-0-1	29/12/23 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T- RANOLAX	500mg	p/o	1-0-1	29/12/23 at 8am	<input type="checkbox"/> Yes <input type="checkbox"/> No
	T- RABLET	20mg	p/o	1-0-1	29/12/23 at 8pm	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Clinical Examination / Investigation

Cvs - S1 S2 ⊕
Normal vs.
Abdomen Soft

HB - 14.2.
Creat - 1.07
Crea - 17.9
Serology - Negative

Provisional Diagnosis

CAD
EXERTIONAL ANGINA CLASS III
NORMAL LV FUNCTION
SYSTEMIC HYPERTENSION

Plan of Care (including Investigations Ordered)

CAG

Doctor's Signature

[Signature]

Name

Dr. Kashiraj

Reg. No.

88851

Date

29/12/23

Time

12.00



DOCTOR'S PROGRESS NOTES

DATE	NOTES
29/12/23 4:15 PM	<p>• CAG</p> <p>— Rt radial access</p> <p>— SF chest</p> <p>— SF TIA → CAG done</p> <p>— SF EBU 30</p> <p>Rt dominant / LAD</p> <p>Adv: CABG</p> <p>9721</p>
18.55	<p>pt received</p> <p>vital stable</p> <p>oral feeds.</p> <p>observation</p> <p>85851</p>
18.30	<p>plan for CAG</p> <p>85851</p>

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Affix label here)
Name: Mr. [Signature]
UHID: 2023002628
DOB: 43y Sex: male
DOA: 29/12/23
Consultant: Dr. Jaishankar

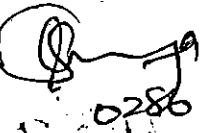

Diagnosis: CAD - OLD ASW / SHTN / EF - 60%
Height: 167 cms Weight: 78.5 Kgs Food allergies: Yes/ No, if yes, specify: _____
Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain
Diet Prescription: 1600 calories, low fat, low salt diet

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time:

[Signature] 29/12/23 6:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>29/12/23</p> <p>13:00</p>	<p>A 59 years old gentleman came to c/o chest pain. was assessed to be well-nourished as evident by SGA KLOD - SHIN.</p> <p>patient <u>shifted</u> to cath lab for procedure (CAG). kept on NBM.</p> <p>patient <u>received</u> to Radial lounge. NBM over, patient tolerated liquid diet. Can initiate soft solid diet.</p>	 <p>0286</p>
<p>29/12/23.</p> <p>16:00</p>	<p>Educated the patient & family on 1600 calories, low fat, low salt diet <u>on discharge</u>.</p> <p>emphasized on small frequent meals. diet modifications & clarifications done.</p> <p><u>Diet chart</u> given on discharge</p>	 <p>0286</p>

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD, EXERCUTIONAL ANGINA CLASS III Allergies if any: N/A
NORMAL LV FUNCTION, S4T

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
RL	Cathlab	29/12/23	14.55	CAG.

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

ASSESSMENT OF PATIENT:

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

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

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.6	22 b/m	74 b/m	97.1	128/92	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☒ Numerical Rating Scale (> 12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
Handed over to		Pragna S	0233	29/12/23	15.00

After Procedure:

Procedure completed: ☒ Yes ☐ No | Any critical information: Nil

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
98.6	20 b/m	79 b/m	100%	117/80 mmHg	1/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☒ Numerical Rating Scale (> 12 years) ☐ CPOT (ventilator / comatose)

Handover by	Signature	Name	Emp. No.	Date	Time
Handed over to		Pragna S	0233	29/12/23	17.15

Mr. RAJASINGH P

59 / Male / MHI202381562

29 / 12 / 2023 / IPH2023002633

Dr. NARENDRA M



CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr. Narendran has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with blood. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

- (i) The nature of coronary artery disease (ii) The pumping status of the heart (iii) Your age and general health

These are some of the more serious risks that can happen, but are not the only risks:


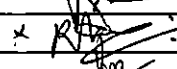

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	(i) the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

I acknowledge that Dr. Narendran has explained my medical condition and the proposed procedure. I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment. He has explained my prognosis and the risks of not having the procedure. I have been explained that some reprocessed items might be used once its sterility and integrity is confirmed. I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		Mr. Rajasingh P	29/12/23	12-45
witness		Mr. Mohish (son)	29/12/23	12-45
Doctor		Dr. Lalit Sudhan	29/12/23	12-45
Interpreter				

Patient Details (Affix Label here)

Name:

UHID:

DOB:

Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனாரி ஆக்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ள காண்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த காண்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர் சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புலூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள கிப்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள கிப்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர கிப்பாடுகள் விவரமானது. ஆனால் கிவைகள் மட்டுமே முழுமையான கிப்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டைட்) ஆபத்தான விளைவுகள். இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடப்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(i) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) காண்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமல் அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிடான சிராய்ப்பு அல்லது வீக்கம்
வரும்பாலான மக்களுக்கு	(n) சிறிய அளவிடான சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள கிப்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் கிப்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் கிப்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணியப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள கிப்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கவந்தாரோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு இரத்தமேற்றாதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார், கிச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				



JCI ACCREDITED



NABH ACCREDITED



Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mr. RAJASINGH.P	ID:	MHI202381562
Age/Gender :	59 M	IPH:	IPH2023002633
Cath No. :	3506	DOP:	29.12.2023
Done by	Assisted by	Technician	Physician assistant
Dr.M.Narendran	Ms. Sandhiya	Mr. Prathap	Ms. Shalini

DIAGNOSIS: CAD; EXERTIONAL ANGINA CLASS III; HBP; NORMAL LV FUNCTION

Access: Right radial artery

Total exposure time: 1126"

Hardware used: 5F sheath, 5F TIG, 5F EBU 3.0

DAP : 101.33 Gy.cm²

Contrast used: CONTRAPAQUE 50ml

Total RAK: 263.30 mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Aortic pressure 117/88(99) mmHg; HR 80 bpm; SpO2 100%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Distal LM has 70% tubular stenosis. Bifurcates into LAD & LCX.
LAD	Type 3 vessel. Ostioproximal LAD has 80% long segment stenosis. Mid LAD has 80% tubular stenosis. Distal LAD has luminal irregularities. Gives 2 major diagonals which have luminal irregularities.
LCx	Non Dominant. Proximal LCX before OM1 shows 95% tubular stenosis. Distal has luminal irregularities with TIMI I flow. Gives 2 major OMs. OM1 proximal part shows 95% long segment disease. OM2 proximal part shows 95% tubular stenosis.
RCA	Dominant. Proximal RCA has 50% tubular stenosis. Mid RCA has luminal irregularities. Distal RCA near bifurcation has 99% discrete stenosis. PDA proximal part has diffuse disease upto 70% stenosis. PLV mid part has 70% tubular stenosis.
IMA	LIMA & RIMA are normal.

FINDINGS: RIGHT DOMINANT; DISTAL LM AND TRIPLE VESSEL DISEASE**ADVICE: CABG X Grafts to LAD, Major OM & PDA/PLV**

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

DR. M.NARENDRA, MD, DM

Chief Cardiologist

Reg. No: 39469

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

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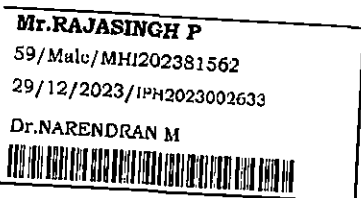
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1800 572 3003**Medway Group of Hospitals**

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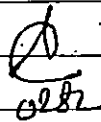

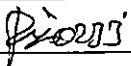
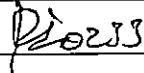
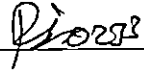


E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)Heart Institute
044 - 4310 8959Institute of Pulmonology
044-2473 4454

MHI/HOSP/2022/118



1/048

DATE & TIME	Observation / Action	Signature with Emp.No			
29/12/23 12.40	Patient Received from RL. Patient is conscious & Oriented Pl- vitals are monitoring Skin preparation done. CATH	 028			
29/12/23 15.00	CATH LAB. ⇒ patient received From RL to cath lab. pt conscious and oriented	 Pioris			
15.10	⇒ vitals stable. Dr line right side patient	 Pioris			
16.15	⇒ Sterile drapping done. procedure CAG started	 Pioris			
16.20	⇒ Rt Radial artery approach, under local anesthesia	 Pioris			
16.20	⇒ INJ: NTG 200 mcg + INJ: Heparin 2500 ²⁰ IU given o/b Dr. GG (sr)	 Pioris			
16.35	⇒ HR: 71 b/min BP: 118/88 mmHg spo2: 100%. vitals stable ⇒ procedure CAG done. Rt Radial artery sheath removed. Tight plaster bandage	 Pioris			
Document endorsed by	Signature	Name	Emp . No.	Date	Time
Jayl	JAYARIS,	000	29/12/23	12.30	

[illegible]

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Mr. RAJASINGH P
S9 / Male / MH1202381562
29 / 12 / 2023 / IPH2023002633
Dr. NARENDRA M

I/OT/2022/086
Medway Heart Institute
Every heart beat counts

Name of the Procedure : CAG Location : cath lab II Date & Time : 29/12/23

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>16.15</u> Before Induction of Procedural Sedation		TIME OUT <u>16.20</u> After procedural Sedation and before procedure		SIGN OUT <u>16.45</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures <u>CAG</u>	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>CAG</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input type="checkbox"/> Yes <input type="checkbox"/> NA confirms labeling and sent to lab	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt Radial artery approach</u>	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		
		Expected Blood loss <u>NA</u>			
Consent	<input checked="" type="checkbox"/> Yes	Position <u>supine</u>	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify :	
		Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
		Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :	
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
<input type="checkbox"/> SpO2 <input type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>		Anticipated blood loss briefed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input type="checkbox"/> Yes	Corrective action : <u>[Signature]</u>	
Required equipment for procedure available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	For procedural sedation cases			
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure : <u>[Signature]</u> Date : <u>29/12/23</u> Time : <u>16.55</u>	Nurse : <u>R/N Sardhiya</u> Date : <u>29/12/23</u> Time : <u>16.55</u>	Technician : <u>Mr. Prathap</u> Date : <u>29/12/23</u> Time : <u>16.55</u>	Others Please Specify : <u>[Signature]</u>	

Procedure Monitoring Sheet (Cath Lab)

Patient Name **Mr. RAJASINGH P**
59/Male/MHI202381562
UHID / IP : 29/12/2023/IPH2023002633
Consultant : Dr. NARENDRA N M

Age / Sex :

Ward Unit :

Diagnosis :

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 128/72 Temp: 98.6 Pulse: 74 RR: 22 SPO2: 99%			
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered		✓	
Procedure site marked	✓		
Skin preparation done	✓		
NPO : 9.30 am.			
Loose Tooth removed		✓	
Contact lenses / Eye glasses removed	✓		
Prosthesis present		✓	
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food)	✓		
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse <i>[Signature]</i>	Date & Time : 29-12-23 @ 12.45		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
16.20	83b/min	20b/min	115/77 (95)	100%	—	P2023
16.30	79b/min	20b/min	127/93 (97)	100%	—	P2023
16.40	80b/min	20b/min	114/52 (84)	100%	—	P2023
procedure got over						

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

Time : 16.50 Route : Rt Radial artery approach

Complication : Nil

BP : 136/83 (97) mmHg, HR : 82 b/min, RR : 20 b/min SpO2 : 99%

Brachial
Distal Pulse: Felt, Puncture Site: No oozing no hematoma

Advise:

- ◆ Shift To: Ward / ICU / ICU
- ◆ Bed rest up to 12 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt Radial artery.
- ◆ Diet Normal diet
- ◆ Inform Duty Medical Officer SOS
 - a) If patient complains of any Discomfort
 - b) If dressing is Loose or Socked with Blood
 - c) If limbs are Cold / Absent Pulse
- ◆ Remove Rt Radial artery dressing on 20/12/23 at 16.30 AM / PM after informing to the consultant.
- ◆ Special instruction if any: Nil


Name & Signature of Consultant

POST PROCEDURE OBSERVATION

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

Nurses Notes :

procedure CAG done. Rt Radial artery sheath removed. Tight plaster bandage applied. no oozing no hematoma.

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time : 29/12/23





BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	3	3	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
					TOTAL SCORE		
					19		
					Initial & Emp. No. of Staff Nurse:		
					022		
					Initial & Emp. No. of Sr. Staff Nurse:		
					022		

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

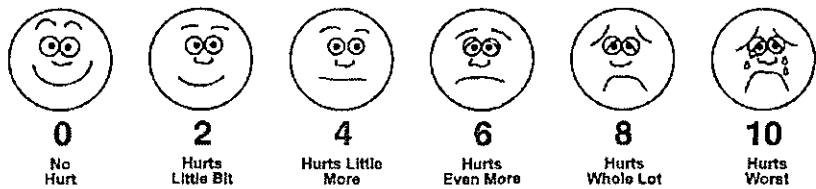
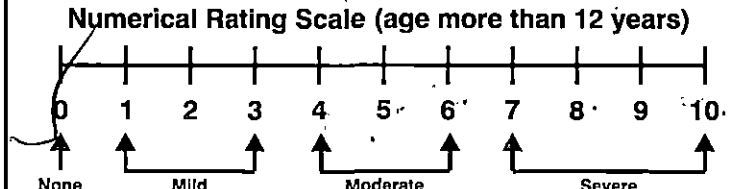


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
29/12/23 10-40	0/10	No pain	-	-	-	[Signature]	[Signature]
12-40	0/10	No pain	-	-	-	[Signature]	[Signature]
		pt shifted to cath lab at 14:55 Received pt from cath lab at 17:15					
17-15	0/10	No pain	-	-	-	[Signature]	[Signature]
18-15	0/10	No pain	-	-	-	[Signature]	[Signature]
19-15	0/10	No pain	-	-	-	[Signature]	[Signature]
				D/C			

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



PAIN SCALES

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

Pharmacological Interventions as per doctor's prescription

DVT RISK ASSESSMENT



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

Date		29/12/23						
Time		12.42						
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0						
5	Entire leg swollen (Assess for both legs)	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0						
9	Previously documented DVT (Assess for both legs)	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						
FINAL SCORE		0						
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8								
DVT prophylaxis started		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	29/12/23	29/12/23							
	Time	10:40	17:00							
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		80	50							
Low Risk (0 - 24)		—	—							
Medium Risk (25 - 44)		—	—							
High Risk (45 or above)		✓	✓							
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

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

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

1, 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, In

044-2473 4455

care@medwayhospitals.com

Registration No : MHI202381562

Patient Name : RAJASINGH P

Age : 59

Gender : Male

IP Number : MMH/HM/IPH2023002633

Discharge Date : 29/12/2023 6:57:00PM

Bill No : MMH/HM/IPH00648

Bill Date : 29/12/2023 5:56:07PM

Ward Name : RADIAL LOUNGE

Bed Name : V_RL-9

NO DUE

