Medway Hospitals ®
The way to better health

MH/ PRINT / 0075 / MRD

MRD CHECKLIST

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

SAFETY FIRST

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

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/IPD/2022/002

Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

Admitting Doctor: DR. GNANAVELU **Speciality:** CARDIAC

Advised Date & Time: 7/1/24 @ 12.50

Provisional Diagnosis: Acut pulm. edema.
HTN.
CAB on BPJ

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

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

Surgery / Procedure Name (if planned): MM

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

Expected Duration of Stay: 4-5 days

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

Payer: ☑ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):
ABG.
CXR.
Admission to CCU.

Any other Instructions (if any): —

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr. Kanthan	88857	7/1/24	12.50

For admission desk staff only:

Room Category:

- ☐ General Ward
- ☐ Single Room
- ☐ Twin Sharing
- ☐ Deluxe Room
- ☐ Suite Room
- ☑ Others ECG

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
7/1/24	01-1 Pm	7/1/23	01:1 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.T	0192	7/1/23	01.1 Pm

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81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status: M Occupation: Cu	Full Address: No. 102, Sadasivam Street Manali Chennai	Telephone Number: 9962405666

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
Dr. G. G	7/1/24 01.1PM	12/1/24	6 days

UNIT: ward.

MLC ☐ Yes ☑ ~~No~~ If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
COPD - ACUTE EXACERBATION S/P	J44.9
PPI MEDTRONIC MODE: VVI FOR CHB (7/24)	I50.0
DILUTIONAL HYPONATREMIA - CORRECTED	
NORMAL LV FUNCTION MODERATE PAH	I50.1
SYSTEMIC HYPERTENSION TYPE II	I27.2
DIABETES MELLITUS	I10
	E11.9

DATE	OPERATION / PROCEDURES	ICPM Code
—	—	

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

DISCHARGE STATUS

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

Dr. G. GNANAVELU
Reg No. 39469
Signature of the Consultant

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date	Signature of the Patient / Relative / Gurdian
	07-1-24	

Son.

உறவுமுறை

Nature of Relationship

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

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/IP/2022/008

Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

I, LAKSHMI K the ☑ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

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

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

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

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

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient		LAKSHMI K	7/1/24	1:01
Surrogate/Guardian (if applicable #)		Kanirajan *(Write name and relationship with patient)*	7/1/24	1:01
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness		Kanirajan.	7/1/24	1:01
Interpreter (if applicable)				

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

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICU/2022/114

Medway Heart Institute
Every heart beat counts

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

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

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

Doctor	Signature	Name	Reg. No.	Date	Ti
		Dr. Karthikeyan	81851	7/1/24	18:

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	Tim
	923625	DR. BALAJI	923625	9/1/24	18:00

DISCHARGE SUMMARY

IP No.	: IPH2024000051	**D.O.A**	: 07/01/2024
UHID	: MHI202481668	**D.O.D**	: 12/01/2024
Name	: Mrs. LAKSHMI.K	**Room No.**	: 114
Age / Gender	: 81Years / FEMALE		
Consultant	: **Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist**		

DIAGNOSIS:

COPD- ACUTE EXACERBATION
S/P PPI MEDTRONIC MODE: VVI FOR CHB (07/2016)
DILUTIONAL HYPONATREMIA – CORRECTED
NORMAL LV FUNCTION
MODERATE PAH
SYSTEMIC HYPERTENSION
TYPE II DIABETES MELLITUS

BRIEF HISTORY:

Mrs. Lakshmi.K, 81years old Female, Presented with complaints of breathlessness since 2 days. History of pain in right hip. She came to Medway heart institute on 07.01.2024 for evaluation and further management.

No H/O diarrhea.

Known case of Type II diabetes mellitus, systemic hypertension on medication.

N/K/C/O hypothyroidism, seizure disorder.

ON EXAMINATION:

Patient conscious, oriented, afebrile
HR : 69pm
BP : 174/84mmHg
SPO_2 : 99% on room air
CVS : S1S2 (+)
RS : BAE(+), B/L crepts(+)
Abd : Soft
CNS : NFND

PAST SURGICAL HISTORY:

S/P PPI Medtronic – 2016.

INVESTIGATIONS:

BLOOD(07.01.2024) : HB – 10.2g/dl, TWBC – 10990 cells/cumm, PLT – 392000cells/cumm, Sodium - 115mmol/l, Potassium – 3.90 mmol/l, Urea – 19 mg/dl, Creatinine – 0.52 mg/dl, Trop I – 12.7 ng/l.

BLOOD(08.01.2024) : HB – 10.0g/dl, TWBC – 10080 cells/cumm, PLT – 355000cells/cumm, Sodium - 118mmol/l, Potassium – 3.75 mmol/l, Urea – 20 mg/dl, Creatinine – 0.59 mg/dl.

BLOOD(08.01.2024) : Sodium – 122 mmol/l.

BLOOD(09.01.2024) : Sodium - 132mmol/l, Potassium – 3.52 mmol/l.

BLOOD(11.01.2024) : Sodium - 132mmol/l, Potassium – 3.91 mmol/l,

ECG: V paced rhythm @ 69bpm.

URINE CULTURE & SENSITIVITY (08.01.2024): No growth in culture.

DEVICE INTERROGATION: Battery longetivity- 22 months, battery and leads parameters are satisfactory.

ECHO(08.01.2024): Concentric LVH. Sigmoid septum. No RWMA. Normal LV systolic function. EF – 50%. Grade II diastolic dysfunction. Normal RV systolic function. Aortic valve sclerosed & mildly calcified. Mild AS/ Mild AR. Other valve are normal. IAS / IVS intact. Mild MR. Mild TR. Moderate PAH. Mild right, minimal left pleural effusion. IVC normal in size & collapsing. No clot / vegetation / pericardial effusion. RV lead insitu.

COURSE IN THE HOSPITAL:

Mrs. Lakshmi.K, 81years old Female, admitted with above mentioned complaints. Baseline investigation was done. ECHO showed Mild right, minimal left pleural effusion. RFT showed decreased sodium level and correction was given. She was diagnosed as COPD, acute pulmonary edema and DR.ELAKIYA (pulmonologist) opinion was obtained and orders followed. She was treated with oxygen support, IV diuretics, bronchodilators, statin, antiplatelet and other supportive measures. Device interrogation was done suggestive of battery & leads status were satisfactory. Serial sodium levels were monitored. DR.ELAKIYA (pulmonologist) reviewed and advised to continue overnight bipap and nebulization. In view of severe lower backpain Dr. Arunkumar (orthopedic surgeon) opinion was obtained and orders followed. She advised to undergo FOT test which revealed small airway obstruction. She symptomatically improved with above line of treatment. Her medications were optimized and she is being discharged in a clinical stable condition.

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. CLOPITAB CV	75/10 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. LASIX	40MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ALDACTONE	25 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
5	TAB. ACTON OR	1000MG	1	0	1	ORAL	AFTER FOOD	X 5 DAYS
6	NEB. FORACORT	400MCG	1	0	1 PUFF	P/N	AFTER FOOD	X 10 DAYS
7	NEB. GLUCOHALE	25 MCG	0	1	0	P/N	AFTER FOOD	X 10 DAYS
8	NEB. LEVOLIN	0.63MG	1	1	1	P/N	AFTER FOOD	X 10 DAYS
9	TAB. AB PHYLLINE N	1 TAB	1	0	1	ORAL	AFTER FOOD	X 10 DAYS
10.	TAB. MONDESLOR	1 TAB	0	0	1	ORAL	AFTER FOOD	X 10 DAYS
11	TAB. PREDNISOLONE	40MG	1	0	0	ORAL	AFTER FOOD	X 5 DAYS
12	TAB. PREDNISOLONE	20MG	1	0	0	ORAL	AFTER FOOD	X NEXT 5 DAYS
13	SYP. BROZEDEX	5ML	1	1	1	ORAL	AFTER FOOD	X 10 DAYS
15	NEB. DUOLIN	1 RESP	1	1	1	1	P/N	6 HOURLY
16	TAB. MYORIL	8 MG	1	0	1	ORAL	AFTER FOOD	X 1 WEEK
17	TAB. CISSOL	1 TAB	1	0	0	ORAL	AFTER FOOD	X 1 WEEK
18	TAB. PAN	40MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE

DIABETIC MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	**TAB. OXRA**	10MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT, SALT & DIABETIC DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH **DR. G. GNANAVELU / DR. ELAKIYA AFTER 10 DAYS**

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

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

Typed by: Ezhilarasi.

"I understood the Content of the discharge summary."

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

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Paf Mrs.LAKSHMI K
Na 81/Female/MHI202481668
UH 07/01/2024/IPH2024000051
DO Dr.G. GNANAVELU
DO
Cor

MHI/IP/2022/107

Medway Heart Institute
Every heart beat counts

INPATIENT INITIAL ASSESSMENT

Date: 7/1/24 **Time of arrival in ward:** 1:01pm

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 69 (beats/min) | BP: 174/84 (mmHg)
Respiration: 24 (breaths/min) | SpO_2: 99 (%) | Height: ±155 (cms) | Weight: ±90 (kgs) | BMI: 37.5 kg/m²

Pain: ☑ Yes ☐ No. If Yes, Score: 05/10
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

C/O Breathlessness since 2days progressively aggravating not relieved with medications
H/O fall 2days back. not able walk since then
H/O pain in (R) hip.

PAST MEDICAL HISTORY (with duration of illness):
Diabetes Mellitus: ☑ Yes ☐ No. If Yes, duration: >15y Hypertension: ☑ Yes ☐ No. If Yes, duration: >15y

Others:
COPD.
TLDT
HTN.
CHB — on PPI.

Past Surgical History: PPI - implanted for CHB. - 2016.

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. Beplex Forte	1	PO	O—O—1	06/1/24@2000	☑ Yes ☐ No
2.	T. Betaserc	8mg	PO	1—0—1	07/1/24@8:30	☑ Yes ☐ No
3.	T. Elacar L	10mg	PO	0—1—0	06/1/24@14:00	☑ Yes ☐ No
4.	T. Glycomet GP	1/850		1—0—1	07/1/24@8:30	☑ Yes ☐ No
5.	T. Omez	20mg	PO	1—0—1	07/1/24@8:30	☑ Yes ☐ No
6.	T. SPORLA DS.	1	PO	1—0—0	07/1/24@8:30	☑ Yes ☐ No
7.	T. Tricinod	10/12.5	PO	1—0—0	07/1/24@8:30	☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

—

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

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

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

Others: _____

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

menopause.

General Physical Examination:

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

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

SYSTEMIC EXAMINATION

CVS: S1 S2 (+) -

Respiratory System:
NVBS.
Basal creps (+)

Gastrointestinal System:
Soft.

Central Nervous System: NFND.

Urinary / Reproductive / Locomotor System:
(R) Hip. ROM restricted.

Skin / Opthalmic / ENT
NAD.

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

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

Nutritional Screening *(ESPEN Guidelines for Nutritional Screening - NRS 2002)*:
Weight loss within the last 3 months? ☐ Yes ☑ No   Is the patient severely ill? *(e.g. in Intensive Therapy)* ☐ Yes ☑ No
Reduced dietary intake in the last week? ☐ Yes ☑ No   Is the BMI < 20.5? ☐ Yes ☑ No

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

Provisional Diagnosis:
? # NOF (R).
Acute pulm-edema
T2DM, HTN, COPD

Plan of Care:
O_2 - nasal.
Diuretics.
NIV + SOS
Analgesics
X-ray - Hip & chest.

Investigations Advised:

CBC, RFT, TropI,

CXR pelvis
Xray for hips.

Diet Advice:

- [ ] Nil per Oral
- [ ] Clear liquid diet
- [ ] Normal liquid diet
- [ ] Diabetic liquid diet
- [ ] Semisolid diet
- [ ] Soft solid diet
- [x] South Indian normal diet
- [ ] North Indian normal diet
- [ ] Neutropenic liquid diet
- [ ] Others: ____________

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

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor	[signature]	Dr. [illegible]	85851	7/1/24	13:20
Consultant	Dr. G. GNANAVELU Reg. No: 39469 [signature]	Dr. Gnanavelu	39469	7/1/24	13:20
Patient Attendant	[signature]	Relationship SON	-	7/1/24	13:20

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU
Consultant:

MHI/ICU/2022/036

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CONSENT FORM FOR CRITICAL CARE (ICU)

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

☑ Read

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

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

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

CENTRAL VENOUS CATHETER INSERTION

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

Intended benefits:
Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

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

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

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		*(Write name and relationship with patient)*		
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness				
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Doctor					

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

MHI/ICU/2022/036

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உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

□ வாசித்திருக்கிறேன்

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

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

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

மைய சிரையில் கதீட்டர் உட்செருகல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

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

	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
நோயாளி				
பதிலாள் / பாதுகாவலர் (பொருந்துமானால் #)		Senthil Kumar (Son) (பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)	7/1/24	13:30
பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்லை; ஏனெனில்:			
சாட்சி		Senthil Kumar (Son)	7/1/24	13:30
மொழிபெயர்ப்பாளர் (பொருந்துமானால்)				

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்		Dr. Karthik	45851	7/1/24	13:30

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NABH ACCREDITED

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
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ICU PROGRESS NOTES

Date : 8/1/24
Time : 2.30 pm
Doctor's Name : T. madhukar

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

ICU Day Background
COPD
SHT
CHB (d6) ↓ WI/PPI.
Herpes zoster mandibular division

Issues last 24 hours
↑RR on O2 support
division Hypertension.

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E V M 4 5 6
Pupils
Pain score
Drains

Cardiovascular system
HR - 69/
Rhythm -
Cardiac Output -
BP - 150/60
CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – 3/L O2 ncc support
Saturation / PaO2-
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

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

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

Microbiology
Invasive lines Peripheral lines
1. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports
Antimicrobials with days
1.
2.
3.

Labs
Hb 10.21 TC 10,990 Platelets 392k
Urea 19 Creatinine 0.52
Na 115 K 3.9
Bilirubin AST ALT
INR
Others

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD
Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

Plan

→ SpO_2 Target 88–92%.
→ ABG q/m
→ Ur/Cr/K/Na – q/m
→ I/O charting
→ Other of chart.
→ NIV (SOS)
→ ABG @ 3.00 Am, 6.00 Am
→ Overnight BIPAP – 12/6

J. madh
[illegible]

7.10 Am

Increased UOP – 180 ml/hour – since 3 hours
Stop lasix
I/O charting
Follow Sr. [illegible] levels

J. madh
10376?

Doctor	Signature	Name	Reg. No.	Date	Time
	J. madh	J. madh	[illegible]	8/11/24	2.00

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81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICU/2022/040

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ICU PROGRESS NOTES

Date : 8/1/24
Time : 8.50
Doctor's Name : Dr. Karthon

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

ICU Day Background
→ Act. pul. Edema.
→ Hyponatremia
COPD.
T2DM
[illegible]

Issues last 24 hours
- Hyponatremia.
- Tachypnea.

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

Cardiovascular system
HR - 69.
Rhythm -
Cardiac Output -
BP - 160/70
CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – BAE (E)
Saturation / PaO2- SpO2 - 98% RA.
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -

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

Nutrition & Fluids
Oral feeds / NG feeds oral feeds.
TPN – formula used
Supplements
Calories / Proteins achieved : I 1040 / O 1640.
IV fluids -
24 hour Urine output -600.
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

Microbiology
Invasive lines peripheral line.
1.
2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports
Antimicrobials with days
1. CEFOL -3.
2.
3.

Labs
Hb 10.0.
TC 10,900.
Platelets 3,55,000
Urea 20.
Creatinine 0.59.
Na 118.
K 3.75.
Bilirubin
AST
ALT
INR
Others

DVT prophylaxis – Y / (N)
Drugs :
Mechanical – TEDS / SCD
Stress Ulcer Prophylaxis – (Y) / N
Drugs
Pressure sore Y / (N)
Alpha bed Y / (N)

Plan for the day

Adv

Drugs as charted

Oral feeds

I/O chart.

Monitoring

Na+ - 8th hrly

Cont. Abx.

Ur. C/S.

[illegible]

(signature)

Doctor	Signature	Name	Reg. No.	Date	Time
	(signature)	Dr. Karthe	85851	8/1/23	8:00

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/IP/2022/041

Medway Heart Institute
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/2024	s/b Dr G. Gnanavelu
9.45.	COPD Acute exacerbation
	Fluid retention
	Dilutional hyponatremia
	S/p AVR for CHD 7/2016
	Ⓐ [illegible]
	PAH [illegible]
	H/o HZ Ⓐ [illegible] disorders
	Deferred — Inj Hydrocort 100mg IV bd
	Edema — Inj Deriphylline [illegible] IV bd
	P70 120/[illegible] — Inj Lasix 20mg IV [illegible]
	CVS [illegible] — Clopidogrel [illegible]
	RS [illegible] — [illegible]
	Inj Pan 40mg IV OD
	ECG [illegible] — T. Aldactone 25mg OD
	Antibiotics
	[illegible]
	[signature]
	19469

MHI/ICU/2022/040

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Medway Heart Institute
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ICU PROGRESS NOTES

Date : 8/1/2024
Time : 2:10pm
Doctor's Name : Dr. G. Akilan

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

ICU Day D2
Background
AE of COPD.
Acute pul. edema.
Hyponatraemia.
T2DM / SHT.
S/P PPI implanted for CHB - 2016

Issues last 24 hours
SOB ↓.

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E4V5M6 15/15
Pain score
Pupils B/L PERL
Drains NFND.

Cardiovascular system
HR - 70 | Rhythm - Paced rhythm | Cardiac Output -
BP - 140/80 CVP -
Cardiac Medications: S1S2 ⊕.

Respiratory system
Oxygen supplementation –
Saturation / PaO2- 92% č 2L O2
Ventilator : Spontaneous / Controlled
Last C x R -
Drains -
BGAE ⊕.
RR = 24/min.

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

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

Microbiology
Invasive lines
1. Peripheral line 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports
Antimicrobials with days
1. Inj. Cefoperazone 1.5g iv bd.
2.
3.

Labs
Hb 10.0 TC 10,010 Platelets - 355000
Urea 20 Creatinine 0.59.
Na 118 K 3.75
Bilirubin AST ALT
INR
Others

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

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

Plan for the day

- Drug as per chart.
- I/O chart.
- Vitals Monitoring.
- to Do S.Ngt Q8H.
- Intermittent bipap - day time & over Night Bipap.

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr. [illegible]	90810	8/1/24	2:20 pm.

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
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ICU PROGRESS NOTES

Date : 8/1/24
Time : 20.00
Doctor's Name : BALAJI

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

ICU Day
Background

ALCOPD, T.E
Hyponatremia

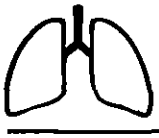
Issues last 24 hours

Ketto L SOB.

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

Cardiovascular system
HR - 68 Rhythm - Cardiac Output -
BP - 130/90 CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – 100 % · EZLO2.
Saturation / PaO2-
Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

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

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

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

Antimicrobials with days
1.
2.
3.

Labs
Hb 10 TC 10,800 Platelets
Urea 70 Creatinine 0.5
Na 118 K 3.7
Bilirubin AST ALT
INR
Others

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

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

Plan for the day

Rx

~~[illegible]~~

overnight B IPAP support.

Doctor	Signature	Name	Reg. No.	Date	Time
	[illegible]	13ACA01	123612	8/1/24	9:05

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
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Date : 9/1/24.
Time : 8:00
Doctor's Name : Dr. Balaji

ICU PROGRESS NOTES

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

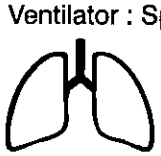
ICU Day
Background
ACS, P.E, AGWPD

Issues last 24 hours
overnight BIPAP.

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

Cardiovascular system
HR - 72 Rhythm - Cardiac Output -
BP - 130/80 CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – 100% - 2 L O_2
Saturation / PaO2-
Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

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

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

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

Antimicrobials with days
1.
2.
3.

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

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

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

Plan for the day

R
cont the same

Doctor	Signature	Name	Reg. No.	Date	Time
	✓	BALAJI	123672	9/11/24	9:00

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/IP/2022/041

Medway Heart Institute
heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES

DATE	NOTES
9/1/24	Device Interrogation:
1PM	S/P PPI - 2016. Battery Longevity = 22 months.
	Medtronic Relia. R ES01. 2.72 V.
	S. No : 031336. VS - 4 mV.
	mode: VVI. VP - 86 %.
	LR : 70 bpm.
	RV.
	Impedence 580 Ω.
	Sensing. -
	Threshold. 1.0 V @ 0.4 ms.
	Output 2.0 V.
	New NSVT Episode noted < 5 seconds.
	Final Impression: Battery & Leads Parameters are satisfactory.
	Dr. Bhatia.

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
9/1/24 4.00pm	S/B. Dr. Sujith.B. (DMO)
	Case of Acute pulmonary edema / COPD / SHTN / DM.
	Pt. reviewed - no complaints.
BP-140/80mmHg HR-70bpm SpO2-99% ē 5L of Nasal prongs	O/E - Pt. concious, oriented, Afebrile.
	S/E - CVS - S_1S_2 (+) RS - BAE (+) PA - soft, NTND
	Adv - vitals monitoring - follow daily chart - BIPAP SOS - w/F desaturation - Inj. [illegible] SOS
	183573

DATE	NOTES
09/1/24	S/B Dr. Anusuya
22-00	patient reviewed.
	C/o breathlessness reduced now.
	O/E patient conscious, oriented
	S/E: CVS - S1S2 (+)
	RS - BAE (+) B/L minimal crepts (+).
Vitals stable	CNS - NFND.
	P/A - soft, non-tender.
	Advice
	- monitor vitals
Device interrogation done today	- continue drugs as per chart.
	- BIPAP SOS.
D/M 12mm	

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art beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
10/1/24 9 AM	< S/B Dr-Gnanavelu team
	- Pt reviewed
	O/E : Conscious, oriented
	PR-70/min, BP-140/70.
	SpO2 92% RA, 96% on 2L O2
CBG-205	CVS : S1S2 (+)
	RS : BAE (+)
I 1230 / O 1810	Scattered crepts (+)
	Adv
Device interrogation	- Cont the same.
- RVP 96%	- plan: Intermittent BiPAP
- Life - 22 months	
- Few NSVT episodes <5 sec.	
	9/1/24
Pul mahog ...	
Chair sitting	

DATE	NOTES
10/1/24 9AM	S/B. Dr. Sujith S (DMO)
	Case of Acute pulmonary edema ƒ PM/AN.
	Pt reviewed:
	- No complaints
SpO2 - 97% ƒ 2L O2	O/E Pt. conscious, oriented, Afebrile.
	S/R - CVS - S1, S2 (+)
	RS - BAE (+)
	Adv:
	- vitals monitoring
	- follow up dry chart
	- Pulmo (O)
	Plan - Intensification ? IPAA
	[signature]
	183573

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
10/01/24 5pm	S/B Dr. [illegible]
	- 81/F
	- Known CHD/S/P PPI / HTN ABG - 7.4[illegible]/45/39/34 - VBG
	- Admitted Acute pulmonary edema.
	- Attender gives H/o seasonal variation / No H/o [illegible]
	- No prev H/o TB/COVID
	- Now presented c H/o Breathlessness / cough / wheeze x 3 days. - No fever.
	- Tc - 10,000 CXR — B/L pulmonary vascular [illegible] (+)
	O/E? conscious / oriented afebrile / mildly tachypneic at rest
	SpO2 - 94% (RA) - 98% (O2)
	HR ? 72/min
	Mr - B/L [illegible] (+) scattered wheeze (+)
	Imp 1) Continue Diuretics / Target Negative Balance
	2) Inj. Hydrocort 100mg IV TDS → BD (from tomorrow)
	3) Neb. FORACORT 0.5mg BD
	Neb. Duolin 1resp Q6H.
	Inj. [illegible] IV BD
	T. Montelukast 10mg P/O BD
	4) plan PFT / For pulmonologist D/C.
	6) 10mm Daytime intermittent / overnight BiPAP < [illegible]

DATE	NOTES
10.01.24	S/B Dr. Anusuya
23.00	Patient reviewed.
	C/o: Shortness of breath reduced now.
	O/E: Patient conscious, oriented,
	S/E: CVS - S1S2 (+)
	RS - BAE (+) B/L minimal crepts (+)
	CNS - NFND
Inj. hydrocort D3	P/A - soft, non-tender.
Inj. ~~Forderal~~ vitals.	HR - 84 b/m
D1	BP - 120/80 mmHg
Inj cotol-S D3	RR - 20/min
	SpO2 - 93-95% RA
	Advice
	- monitor vitals
	- continue the drugs as per chart & nebulisation
	- check CBG tds
K.dn (134579)	- continue overnight BiPAP 12/6 8)
	Daytime intermittent
	- to change Inj. hydrocort 100mg IV TDS
	→ 100mg IV BD (from tomorrow)

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
10/1/24 9:30am	S/B. Dr. Sujith. B. (DM)
	pt. reviewed.
	- No complaints
	- pt. feels better now.
	O/E - pt. conscious, oriented, Afebrile
	S/E - CVS - S1S2 (+)
	RS - BAE (+), minimal B/L creps (+)
	Adv.
	- vitals monitoring -
	- follow drug chart
	cont. overnight BiPAP.
	FOR K. [signature] (134/3…) 12/6

DATE	NOTES
11/1/24 @ 8 AM	S/B Dr. Gnanavelu team —
	- pt reviewed
	O/E = Conscious, oriented
CBG - 318	PR - 70/m, BP - 110/80.
	SpO2 98% RA.
T 7.25 / 11.50 / O	CVS = S1 S2 (+)
	RS = BAE (+).
	Adv
	- Cont the same.
	- pt on intermittent BiPAP
	- plan Rpt Na/K.
	9/1/24

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
11/1/24 10:15AM	S/B. Dr. Sujith. B. (DMO)
	- Acute pulmonary edema / COPD /
	DM / SHT.
Input 1200	pt. reviewed.
output 1100	pt. feels better
BP - 110/80 mm	O/E - pt. conscious
HR - 70 bpm	oriented,
SpO2 - 98% RA	Afebrile
	S/B - CVS - S1S2 ⊕
	RS - BAE ⊕
	Adv
	- vitals monitoring
	* - Todo : Na⁺, K⁺
	- Follow dry chart
	- Intermittent BIPAP
	- Difen SOS
	- w/f desaturation
	(signature) 183573

DATE	NOTES
12/1/24	S/B Dr. Anusuya
23:50	Patient reviewed
	c/o: shortness of breath reduced now.
	O/E: Patient conscious, oriented,
	S/E: CVS - S1S2 (+)
	RS - BAE (+)
Vitals stable	Advice
	- monitor vitals
	- Continue the drugs as per chart
Inj. hydrocort (D3)	- Check CBG 4 tds
Inj. Cefo-S (D3)	- Continue overnight BIPAP 12/6 & Day time intermittent BIPAP
K/D (BUBM)	

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Mrs. Lakshmi

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81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Medway Heart Institute
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/01/2024 09:20 AM	S/B Dr. Elalaye
	Case seen
	clinically better
	Clo munitilen / whey
	I/O - 1020 / 2700
	O/E: conscious / oriented / afebrile
	SpO2 97% (RA)
	PR: 72/min
	RR: 20/min
	m-clear,
	Sugg 1) Stop inj. Hydrocort 100mg WBD
	inj. Deri 2cc IV BD
	2) start T. PRED 40mg OD x 5 days,
	T. PULMOCLEAR 1 BD.
	3) may stop daytime BIPAP
	continue overnight BIPAP
	4) PFT - prior to D/C.
	(signature)

DATE	NOTES
11/11/2024	S/B Dr ARUNKUMAR
1 hr 00'	H/o fall, and Now c/o pain lumbar region
	O/E mild tenderness lumbar region Right side
	No radiating
	possible osteoporotic # lumbar spine
	Adv
	Xray L spine AP/Lat
	Tab [illegible] 1—0—1 — 10 days
	Nano fast gel topical application
	Tab Cissdol 1—0—0 90 days
11/1/24. 4:40PM	C/D/w. Dr. Arunkumar.
	- Reviewed LS Spine xray.
	- No abnormal findings.
	- Physio & previous Advice.
	- Nil ortho intervention needed
	for
	[signature]
	183583

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/1/23 10:00	S/B: Dr. G.G team.
	pt slightly better.
	SOB ↓
	No fever
	CVS: S1S2 (+)
	SpO2 98% (RA) RS: B/L BS ... wheeze
	BP: 130/80
	PR: 92
	Tachypnea
	Ambulate pt. Remove CBD. Plan discharge
	4302

Dr ELAKIYA MATHIVARAN MBBS.,MD
(Respiratory Medicine)
Consultant Pulmonologist
Reg No : 108445
MEDWAY INSTITUTE OF PULMONOLOGY

DATE	NOTES
12/01/24	S/B Dr. Elakiya
12:45 am	
	- Clinically improved
	- FOT - small airway obstruction. No BDR
	- planned for D/C
	Advice:
	Rx
	- Neb. FORACORT 0.5mg tds ⎫
	Neb. ULUOHALE 25mcg OD. ⎬ 10 days
	Neb. LEVOLIN 0.63mg tds ⎭
	T. ABphylline N tds ⎫ 10 days.
	T. Montelukast OD ⎭
	T. PREDNISOLONE 40mg OD - 5 days
	↓ ↓ followed by,
	20mg OD 5 days
	Syp. Duoxaclix 5ml TDS - 10 days.
	- Continue overnight BiPAP 12/6 till review,
	- Review in OPD in 10 days / SOS.
	[signature]
	Dr ELAKIYA MATHIMARAN MBBS.,MD
	(Respiratory Medicine)
	Consultant Pulmonologist
	Reg No : 108445
	MEDWAY INSTITUTE OF PULMONOLOGY

MHI/ICU/2022/098

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PRE/POST OPERATIVE ECHO

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Screening Echo

Date & Time	S/P PPI (VVI)
08/01/2023	
@ 9.10	· Concentric LVH
	· Sigmoid septum
	· No RWMA
	· Normal LV systolic function
	· Grade II diastolic dysfunction
	· Normal RV systolic function
	· Aortic valve sclerosed & mildly calcified
	· Mild AS / Mild AR
	· Other valves are normal
	· IAS / IVS intact
	· Mild MR
	· Mild TR · Moderate PAH (RVSP: 45mmHg)
	· Mild right, minimal left pleural effusion
	· IVC normal in size & collapsing
	· No clot / vegetation / pericardial effusion
	· RV lead in situ
	HR: 69 bpm
	IVS: 13mm — TAPSE: 19mm
	PW: 11mm — Pul. Acc time: 74ms
	LVIDD: — E/A: 1.21
	LVIDS: — Med E/E': 28.61
	EF: — Lat E/E': 16.6
	EDV: 71ml — AR PHT: 570ms
	ESV: 35ml — AV max: 2.27m/s
	EF: 50% — Peak PG: 20mmHg
	Mean PG: 10mmHg
	Done by: Ushiah (PA, RES)

MHI/10053/AD

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81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

DATE	7/1/24		
COLOUR	PALE YELLOW		
REACTION			
SPECIFIC GRAVITY			
APPEARANCE	SLIGHTLY TURBID		
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	10 – 12		
EPITHELIAL CELLS	2 – 4		
RBC	6 – 8		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL.		

MICROBIOLOGY-CULTURE REPORTS

DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY
8/1/24 @ 00	URINE c/s		

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DIABETIC CHART

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

ACTUAL WEIGHT ~90Kg. HbA1c —

PREVIOUS DIABETIC MEDICATIONS —

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
7/1/24	13:20	89 mg/dl	—	0208	DR. Kautick
7/1/24	19:00	60 mg/dl	Inj. 25% Dextrose *	2205	DR. Kautick
7/1/24	20:00	90 mg/dl	—	2040	DR. Kautick
8/1/24	5:30	86 mg/dl	—		Dr. madhukar
8/1/24	8:30	89 mg/dl	—	0240	Dr. madhukar
8/1/24	6.00	93 mg/dl.	—	0400	DR. MADHUKAR.
8/1/24	12.00	203 mg/dl.	* 13.00 Inj. H.A 6 units.	1015	DR. KARTHICK.
8/1/24	18:30	254 mg/dl	19.30 Inj. HA 8 units.	19.45	Dr. Akilan.
11	21:30	176 mg/dl	—	0159	DR. BALAJI
9/1/24	6.30	201 mg/dl	Inj. H-A 4units * @9:10	0158	DR. BALAJI
	12:00	325 mg/dl	Inj. H.A 20 units	@ 13:50 Hay 0105	DR. BALAJI
	18:00	58 mg/dl	DNS IVF		

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone

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

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

DIABETIC CHART

ACTUAL WEIGHT ± 90 kg HbA1c —

PREVIOUS DIABETIC MEDICATIONS —

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
10.1.24	6.30	205 mg/dl	Inj. HM 10U	[illegible]	K 134559
	12.30	250 mg/dl	Inj. HA 8U.	[illegible] 12.15	[illegible] 45802
	18:30	165 mg/dl	[illegible] (6U)	[illegible] 20:30	Dr. [illegible] 183573
11.1.24	6.30	218 mg/dl	Inj. HA-12U	[illegible]	K 134559
	12.40	273 mg/dl	Inj. H. Actrapid. 8units	[illegible]	Dr. Salai 183573
	18.30	212 mg/dl.	Inj. H Actrapid 6units	[illegible] at 19.40	Dr. Salai [illegible]
12.1.24	6.30	208 mg/dl.	Inj. HA – 6U	[illegible]	K 134559
	18:30	168 mg/dl	—	[illegible]	K 134559

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

Urine Acetone [ ]

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

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

BLOOD GROUP

INVESTIGATION SHEET

Date	7/1/24	8/01/24	8/1/24	9/1/24	11/1/24	
HAEMATOLOGY						
Hb	10.2	10.0				
P.C.V	30.7	20.7				
Platelets	392000	355000				
TLC	10990	10080				
Polymorphs	90.4	84.9				
Lymphocytes	5.0	8.0				
Eosinophils	0.7	1.3				
Mono / Basophils	3.8/0.1	5.5/0.3				
E.S.R						
BIO-CHEMISTRY						
Urea	19	20				
Creatinine	0.52	0.59				
Sodium	115	118	122	132	132	
Potassium	3.90	3.75		3.52	3.91	
Bicarbonate	25	22				
Chloride	78.5	76.1				
Magnesium						
Calcium	8.6	7.9				
Phosphorus	2.5	3.5				
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I	12.7					
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

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

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

SAFETY FIRST

NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

VITAL INFORMATION SHEET

BLOOD GROUP	
ON ADMISSION	
Height in CM	**Weight in Kg.**
± 155 Cm	± 90 Kg

Diagnosis: Acute pulmonary edema, COPD **Procedure :**

NO. OF DAYS	DAY-1	DAY-2	DAY-3	DAY-4	DAY-5	DAY-6
DATE	7/1/24	8/01/24	9/1/24	10/1/24	11/1/24	12/1/24
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10
PULSE	69	69, 70	69, 70	70, 80	70, 70	70
RESP	24	20, 20	19, 20	20, 20	20, 20	20
B.P.	174/84	155/69, 140/63	140/90, 140/90	140/70, 130/80	110/80, 120/60	120/60
SPO2	99%	95%, 97%	99, 98	100, 96%	98%, 93%	93
DAILY WEIGHT	± 90 Kg.	± 90 kg	± 90 Kg	± 90 kg		
24 HRS INTAKE	1048 ml	1420	1230 ml	~~1720~~ 725	1027 ml	
24HRS OUTPUT	1680 ml	3045	1810 ml	1150	2700 ml	
BALANCE	- 632 ml	1625	580 ml	550 ml	1680 ml	
MOTION	x	x				

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

On Admission

MHI/IP/2022/103

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07/01/2024/IPH2024000051
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EARLY WARNING S[illegible]G CHART

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

NEWS key 0 1 2 3	DATE / TIME													DATE / TIME
A+B Respirations Breath/ min	>25													>25
	21-24						2							21-24
	18-20													18-20
	15-17													15-17
	12-14													12-14
	9-11						1							9-11
	<8													<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96													>96
	94-95						1							94-95
	92-93						2							92-93
	<91													<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % *In hypercapnic* respiratory failure only scale 2 under the direction of qualified clinician	>96 on oxygen													>96 on oxygen
	95-96 on o2						2							95-96 on o2
	93-94 on O2						1							93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87						1							86-87
	84-85						2							84-85
	<83%													<83%
Air or Oxygen ?	A= Air													A= Air
	O2litre/ min						2							O2litre/ min
	Device													Device
C Blood Pressure	>220													>220
	201-219													201-219
	181-200						2							181-200
	161-180													161-180
	141-160													141-160
	121-140													121-140
	111-120													111-120
	91-100						1							91-100
	81-90						2							81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	<50													<50
[illegible]astolic BP	mmHg											70 60	60	mmHg
Pulse Beats / min	>131													>131
	121-130						2							121-130
	111-120						2							111-120
	101-110						1							101-110
	91-100						1							91-100
	81-90													81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	41-50						1							41-50
	31-40													31-40
	<30													<30
D Consciousness Score for New onset of *confusion* (no score if chronic)	Alert													Alert
	Confusion													Confusion
	V													V
	P													P
	U													U
E Temperature Degree Celsius	>39.1 degree Celsius						2							>39.1 degree Celsius
	38.1-39.0						1							38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0													36.1-37.0
	35.1-36.0						1							35.1-36.0
	< 35.0													< 35.0
NEWS Total		2	2	2	2	0	5	3	2	2	0	0	0	
Monitoring Frequency		4hr	4hr	4hr	4hr	4hr	4hr	4hr	4hr	4hr	4hr	4hr	8hr	
Escalation of Care Y/N		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
Initials by RN		[illegible]												
Initials by Sr. RN		[illegible]												

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

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

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EARLY WARNING SCORE MONITORING CHART

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

	DATE	11/1/24	12/1/24	12/1/24										DATE
	TIME	22:00	6:30	10:07										TIME
	>25													>25
	21-24						2							21-24
	18-20													18-20
	15-17													15-17
	12-14													12-14
	9-11						1							9-11
	<8													<8
A+B Small Scale 1 Oxygen Saturation (%)	>96													>96
	94-95						1							94-95
	92-93						2							92-93
	<91													<91
Small scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % ie in hypercapnic respiratory failure only scale 2 under the direction of qualified clinician	>96 on oxygen													>96 on oxygen
	95-96 on o2						2							95-96 on o2
	93-94 on O2						1							93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87						1							86-87
	84-85						2							84-85
	<83%													<83%
Air or Oxygen ?	A= Air													A= Air
	O2litre/ min						2							O2litre/ min
	Device													Device
C Blood Pressure	>220													>220
	201-219													201-219
	181-200						2							181-200
	161-180													161-180
	141-160													141-160
	121-140													121-140
	111-120													111-120
	91-100						1							91-100
	81-90						2							81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	<50													<50
Systolic BP	mmHg	60	40	58										mmHg
Pulse Beats / min	>131													>131
	121-130						2							121-130
	111-120						2							111-120
	101-110						1							101-110
	91-100						1							91-100
	81-90													81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	41-50						1							41-50
	31-40													31-40
	<30													<30
D Consciousness Score for new onset of confusion (no previous record)	Alert													Alert
	Confusion													Confusion
	V													V
	P													P
	U													U
E Temperature Degree centigrade	>39.1 degree Celsius						2							>39.1 degree Celsius
	38.1-39.0						1							38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0													36.1-37.0
	35.1-36.0						1							35.1-36.0
	< 35.0													< 35.0
NEWS Total		0	0	0										
Monitoring Frequency		4HR	4HR	4HR										
Escalation of Care Y/N		No	No	No										
Initials by RN		[illegible]	[illegible]	[illegible]										
Initials by Sr. RN		[illegible]	[illegible]	[illegible]										

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

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

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INTAKE & OUTPUT CHART

Date	From: 9/1/24	To: 10/1/24	Bed No: 113
24 Hrs : Started Time : 7:00		Ended Time : 7:00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE			500	
OUTPUT			600	

Total Intake: 1800 Total Output: 1230 Difference:

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
				Total intake = 1180 ml											
				Total output = 610 ml @ 12.00											
12-00	UP Tot	8.30	250m			730	19.40	700					1310		
8.00	200					930	22.00	300					1610		
23.30	200					1280	6.00	200					1810		

Total Intake - 1280 ml
Total output - 1810 ml
Balance - 580

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Date	From: 10/1/24	To: 11/1/24	Bed No: 113	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	275	150	300 ml	
OUTPUT	150	600ml	400 ml	

Total Intake: Total Output: Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
8.00	50					50
9.30	150					200
10.50	75					275
11:30	50					325
14:00	50					375
16:00	50					425
17.30	100					525
20.00	50					575
22.00	50					625
5.00	50					675
6.50	50					725

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
12.00	150					150		
17:30	600					750		
6.00	400					1150		
			TOTAL	INTAKE		725		
			TOTAL	OUT	PUT	1050		
					BALANCE	-325		Nu
								002

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INTAKE & OUTPUT CHART

Date	From: 11/1/24	To: 12/1/24	Bed No: 213
24 Hrs : Started Time : 7.00		Ended Time : 7.00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	400	580 mL	350 ml	
OUTPUT	1000	600 mL	1100 ml	

Total Intake: 1020 ml   Total Output: 2700   Difference: 1680 ml

INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion: Type of Fluid	Additions	Amount	Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
8.00	280					280	12.00	1000					1000		
9.30	100					380	18.40	600					1600		
11.00	50					400	6.00	1000					2700 ml		
13.00	30					430									
14.00	20					450									
15.00	100					550			Total Intake - 1020 ml						
16.00	30					580			Output - 2700 ml						
20.00	100					680 ml				Balance - 1680 ml				[signature]	
21.00	100					780 ml									
22.30	50					920 ml									
6.00	100					1020 ml									[signature]

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: Acute pulmonary edema / T2DM / HTN / COPD / PPI (2016) / Anaemia (10g/dl)

Height: 155 cms | Weight: 90 Kgs | Food allergies: Yes/No, if yes, specify .... EF - 50%

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

Diet Prescription: 1500 calories, Low Fat, Low salt, Diabetic diet, 1000ml fluid restricted

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Nutritional Status : Based on this patient is		
	Well Nourished	☑ (7 to 14) 9
	Moderately Malnourished	☐ (15 to 18)
	Severely Malnourished	☐ (19 to 35)

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

Dietitian Signature / Name / Date / Time: [signature] 0286 · 14:00 7/1/24

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
7/1/24 14:00	A 81 years old Female came c c/o Breathlessness (2days) was assessed to be well-nourished as evidently SGA.	8286
	K/C/O - T2DM / HTN.	
	Educated the patient & family on 1600 calories, low fat, low salt, Diabetic diet. Emphasized on small frequent meals & low glycemic control.	
8/1/24 10:00	Oral intake is better. Re emphasized on diet restriction	8286
09/1/24. 13:00	patient received ward. Reemphasized on diet restrictions	8286
12/1/24 10:00	Oral intake is good. Educated the patient and family on 1600 calories, low fat, low salt 1000ml fluid restricted, diabetic diet on discharge. Emphasized on small frequent meals & low glycemic control. Diet modifications and clarifications done. Diet chart given on discharge.	Maria Catherine John Senior Dietitian

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81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

PSYCHOLOGICAL WELLBEING REPORT

Date: 09/01/24. Time: 3.25pm.

Unit: 113

Clinical diagnosis: Acute pulmonary edema, COPD, DM, HTN

Surgery/ Procedure:

Impression:

- calm affect, oriented, responsive & (easily impairment)
- sleep & appetite (N).
- couldn't interact further due to easily difficulty.

Employee ID: MH10275/54

Signature of the Psychologist:

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CONSENT FOR HIV TESTING

Pa Mrs.LAKSHMI K
81/Female/MHI202481668
Cc 07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Age : 81 Sex : M / F

UHID 20248165

- I _____ have been given verbal and written educational information for HIV antibody testinq.
- I have been informed that a sample of my blood will be drawn and tested and tested to detect HIV antibodies I have been informed of the purpose, potential uses of the test and the consequences of not having the test done
- I hereby acknowledge that I have read or have had read to me this information regarding HIV antibody testing.
- I have been given the opportunity to ask questions and all the questions have been answered to my satisfaction.
- I acknowledge that I have given consent for performance of this blood test to detect HIV antibodies. This has been explained to me in TAMIL language. which I can understand.

	Signature	Name	Date	Time
Patient		LAKSHMI I.	8/1/24	9.00
Doctor / Nurse / Counsellor	9.00	Dr-G-Anu	8/1/2024	9.00
Interpreter				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

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

	Signature	Name	Date	Time
Patient Representative with relationship				
Doctor / Nurse / Counsellor				
Interpreter				

CONSENT OF PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to consent because _____

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

	Signature	Name	Date	Time
Patient Representative				
Witness				
Doctor				
Interpreter				

SAFETY FIRST

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NABH ACCREDITED

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/053

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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 7/1/24 Time of Arrival: 13:01 Mode of Admission: ☐ Walking ☐ Wheelchair ☑ Stretcher

Accompanied by Relative: ☑ Yes ☐ No If Yes, Name of the Relative: MR. JANI RAJAN.

Relationship with Patient: SON Contact Person's Name: 9962405666 Relationship: SON.

Contact No.: 9962405666 Primary language spoken: ☑ Tamil ☐ English ☐ Indian ☐ International

Interpreter needed: ☐ Yes ☑ No

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

Menstrual History : LMP : — Menopause: —

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

Drugs History : Antiplatelet T. Clopitab (Specify)

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

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

If Yes, specify details: —

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

Vital Signs: Temp: 98 F (°F) | Pulse / HR: 69 (beats/min) | BP: 114/66 (mmHg)

Respiration: 28 (breaths/min) | SpO_2: 100 (%) | CBG: 89 (mg/dl) | Height: 155 (cms) | Weight: 90 (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: Low salt diet.

Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: MRS. CATHERINE Time: 13:15

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

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

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

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	☐ Yes ☑ No		
Hearing Impairment	☐ Yes ☑ No		
Chewing Difficulty	☐ Yes ☑ No		
Walking Difficulty	☑ Yes ☐ No		

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

Total Score: 16 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

Variables		Numeric Value
History of falling (immediate or within 6 months)	No	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
Ambulatory Aid None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait Normal / Bed Rest / Wheel Chair		0
Weak		10
Impaired		20
Mental Status Oriented to own stability		0
Overestimated or forgets limitations		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics	No	0
	Yes	15
Score Interpretation: *0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk* **Total Score**		85

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

Risk Score Interpretation (Probability of DVT): **Final Score** 2

Tick the score obtained (✓)

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**				
Moderate Risk	**1 to 2**	2	~	7/12/23	13:05
High Risk	**3 to 8**				

Personal Belongings / Valuables:

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

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

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	[signature]	Santhil Kumar	Relationship (SON)	7/12/23	13:35
Nurse	[signature]	Umamaheshwari.	0258	7/12/23	13:15
Unit In-Charge	[signature]	JAYADEVI J	0258	7/12/23	13:15

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Dr.G. GNANAVELU
Consultant:

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 1/12/23 Shift: ☐ Morning ☐ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: — Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: on O2 @ lit on FM IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 69 (beats/min) | Respiration: 24 (breaths/min)
BP: 174/84 (mmHg) | SpO_2: 99 (%) | Height: 155 (cms) | Weight: 190 (kgs) | BMI: 37.5 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 85 **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: Low salt 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: To collect urine routine report.

	Signature	Name	Emp. No.	Date	Time
Handover given by		SUMA MAHESWARI	0708	7/1/24	19:30
Handover taken by		Nathiya	0240	7/1/24	19:30
Document endorsed		Jacintha	0021	7/1/24	19:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/24 @ 13:05	=> pt Got admission to CCU pt is Conscious & oriented pt BP- 174/78 HR- 69 SpO2 - 99% RR-28b/mit => Inj LASIX Started, pt on Face mask O2 - 2 litres, pts on PPI proceed.	0208
13:30	=> Catherization done pt under the monitoring	0208
14:00	=> pt I/O chart maintained. pt had oral Rice Kanchi, Inj PARA 1gm IV given	
15:00	=> pt was stable, Chest x-ray done. under the monitoring	0208
16:00	=> pt I/O chart maintained, pelvis x-ray done	
17:00	=> Inj Cefol 3gm IV given, Tab Azee 500mg p/o given orders by Dr. Karthick.	0208
18:00	=> pt Attender seen the pt.	
19:00	=> Urine routine sended to Lab Advised by Dr. Karthick Sir	0208
19:30	pt handed over to the Night duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYASRI S	008	8/1/24	20:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 7/1/24 Shift: ☐ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: Acute
NEWS / PEWS Score: —
Ventilator day: —
Peripheral line day: Right: Left:
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☐ Yes ☑ No Day: 0
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 SpO_2 - 2/9 onflow
Complaints / New Symptoms in last shift: —

Date of surgery: —
IV fluids on flow: —

A — ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 70 (beats/min) | Respiration: 23 (breaths/min)
BP: 153/65 (mmHg) | SpO_2: 100 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: _____ **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Dm diet Drains: —

R — RECOMMENDATION

Referral doctors:
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		Nathiya	0240	8/1/24	7:30
Handover taken by		S. Premalatha	0241	8/1/24	7:30
Document endorsed		JAYADEVI	0007	8/1/24	7:30

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NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No:
7/1/24 @ 19:30	Night duty Notes	
	→ pt taken over from Evening duty staff, pt concious & oriented, pt vitals are stable	0240
	→ pt NP - 2 lit on flow	
	→ pt kept on diet.	
20:00	→ medicine given as per drug chart.	0240
21:00	→ pt Inj. Lasix 2mg/hr on flow, pt IVF NS 30cc/hr on flow	0240
23:00	⇒ pt concious & oriented, VICS recorded the Notes, No compline of patient, continue the same	0240
3:00	Patient concious oriented, VICS recorded the Notes, Dr. madhukar advice to Bipap 12:6 started. No compline of patient, continue the same	0240
4:30	Patient concious Oriented, VICS recorded the notes, morning Investigation urea, creat, Na+, K+ done reports due.	0240
5:30	Patient concious Oriented, VICS recorded the Notes ECG, ABG done No compline of patient	0240
7:30	Patient concious Oriented, VICS recorded pt Hand over to morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAGADEESH S	002	8/1/24	9:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: Acute Pulmonary Edema / STEMI GCS: 15/15
NEWS / PEWS Score: – POD: –
Ventilator day: – Central line days: –
Peripheral line day: Right: – Left: Brachial
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☑ Yes ☐ No Day: D2 VIP Score: 0/5
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: – Date of surgery: –
Allergies if any: NKDA
On room air / oxygen: Pt. on NPO2 2 litres IV fluids on flow:
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 98 F(°F) | Pulse / HR: 69 (beats/min) | Respiration: 20 (breaths/min)
BP: 152/60 (mmHg) | SpO_2: 99 (%) | Height: 151 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 85 **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: Low salt 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. Rekha.	S. Premalatha	0211	8/1/24	13:00
Handover taken by	Arif	Lavanya.	0158	8/1/24	13:00
Document endorsed	Jain	Jayadevi.S	0002	8/1/24	14:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8/1/24	Morning Duty Note.	
@ 7:30	⇒ Pt taken over from night duty Staff. Pt is Conscious & Oriented. Pt haemodynamically Stable & recorded.	024
7:40	⇒ T-98°F, P-69b/mt, R-20b/mt, BP-145/80 mmHg, SPO2-94%.	024
7:50	⇒ Pt on BIPAP: 12:6 Oxyflow.	
8:00	⇒ Pt had diet no other complaints.	024
8:30	⇒ Pt medication given as per drug chart	
8:45	⇒ Pt Budecort & Duolin given as per drug chart.	
9:45	⇒ Dr. G. Gnanavelu Sir seen the Pt Add. inj. Hydrocortt & inj. pan., to given.	024
	⇒ Pt hourly I/O Chart maintained & recorded.	024
	⇒ Pt Screening Echo done.	
10:30	⇒ Pt T Hbtactone given as per drug chart	024
11:00	⇒ Pt haemodynamically Stable & recorded.	024
12:00	⇒ Pt CBG checked & recorded.	024
12:30	⇒ Pt blood investigation not send to lab.	
13:00	⇒ Pt hand over to evening duty Staff.	024

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	HAYAGREEV. J	0002	8/1/24	14:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24 Shift: ☐ Morning ☑ Evening ☐ Night

S

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

B

BACKGROUND
Type of surgery: — Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: NP O2 2L onflow IV fluids on flow: IVF NS 30cc/hr
Complaints / New Symptoms in last shift: —

A

ASSESSMENT
Vital Signs: Temp: 97.8°F | Pulse / HR: 69 (beats/min) | Respiration: 28 (breaths/min)
BP: 145/62 (mmHg) | SpO_2: 94 (%) | Height: 151 (cms) | Weight: 59 (kgs) | BMI: 25.5 kg/m²
Others: —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 85 **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 Solid diet. Drains: —

R

RECOMMENDATION
Referral doctors:
Pending medications:
Pending medication indent: NIL.
Pending lab reports / Investigations: Urine CFS report to be collect.
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 check Na+ 8th hrly.

	Signature	Name	Emp. No.	Date	Time
Handover given by		Lavanya.	0158	8/1/24	19:30
Handover taken by		Pavya	0159	8/1/24	19:30
Document endorsed		JAYAPRAVI. J	0002	9/1/24	

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8/1/24 @19.30	NIGHT DUTY NOTES	
	→ pt taken over from evening duty staff, pt on conscious & oriented & v/s checked & recorded pt on BiPAP < 12/6 on flow IV line patent, CBD ⊕ , back clear, no complaints	[signature]
20.15	→ pt on insulin given	
20.30	→ pt had dinner done / medication given as per drug chart ppt CBD after 11aly onflow	[signature]
23.00	→ pt on comfortable sleep	
23.30	→ pt on Neb given as per drug chart / v/s checked & recorded.	[signature]
9/1/24	ppt ABG done pt on BiPAP < 12/6 onflow	
@ 00.30	→ pt on comfortable sleep, v/s checked & recorded	
1.10	→ pt on IV line removed.	
4.30	→ pt on lab. investigation on kt & nat send, pt on overnight BiPAP	[signature]
5.30	→ pt on morning care & oral back & catheter care given	[signature]
	→ pt on v/s checked & recorded	
6.30	→ pt on ECG, CBG done	
	→ pt on IV line inserted. & patent & urine c/s ⓔ due	[signature]
7.00	→ Inj. pan 40mg IV given as per drug chart	
7.30	→ pt handing over to morning staff	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	JAYADEVI. S	0002	9/1/24	9.00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

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

B — BACKGROUND

Type of surgery: — Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: Pt on ROOM AIR IV fluids on flow: IVF 30 cc/hr
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98° (°F) | Pulse / HR: 69 (beats/min) | Respiration: 24 (breaths/min)
BP: 140/80 (mmHg) | SpO_2: 100 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : —
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT
Fall Risk Score: 85 Fall Risk Protocol: ☐ Low ☐ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Diabetic diet. Drains: —

R — RECOMMENDATION

Referral doctors: ortho opinion.
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Urine C/S report due.
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: BIPAP (SOS)

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Poornalatha.	0211	9/1/24	12:00
Handover taken by	[signature]	Hannah Grace	0105	9/1/24	12:30
Document endorsed	[signature]	S. [illegible] PNP	0024	9/1/24	12:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/1/24 @ 7:30	⇒ Patient took over from night duty staff. patient was haemodynamically stable. On O2 support 2L via Nasal prongs. she was conscious & oriented	0211
	⇒ IVF NS 30 cc/hr onflow.	0211
8:30	⇒ Patient had breakfast in diabetic diet.	
9:00	⇒ Due medication given as per chart.	
	⇒ Neb. Duolin + Budecort administered as per chart.	0211
10:40	⇒ S/B Dr. Gnanavelu & Co add T. Opton, Inj. Para 1g tds.	
11:15	⇒ Inj. Para 1g IV given as per chart.	0211
	⇒ Patient shifted to ward (103).	
12:00	⇒ Pt hand over to Ist floor staff. Pt file reports hand over to Ist floor staff.	0211

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Valpari	0024	9/1/24	16:20

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

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

B — BACKGROUND

Type of surgery: — Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: on NP O_2 1 litre IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 97 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : _____
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 25 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent: 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: NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		Hannah Grace	0105	9/1/24	19:30
Handover taken by		Soni Priya	0384	9/1/24	19:30
Document endorsed		S. Nalini	0024	9/1/24	19:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8/11/24	Receiving notes	
13:00	patient Received from CCU to room NO: 113 in a hemodynamically Stable Condition	Hay 0105
14:00	Patient on U-cath, Skin Intact IV line @ on NP Ringer D2	Hay 0105
14:30	Vital Signs checked & Recorded	Hay 0105
15:00	Due drugs are given as per drug chart	Hay 0105
16:00	Nebulization was given	Hay 0105
17:00	patient was Stable, had no Complaints	Hay 0105
18:00	patient Vital Signs checked and Recorded	Hay 0105
	I/O chart Maintained	
19:00	patient handing over given to Night duty staff	Hay 0105

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0084	9/11/24	20:0

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S — SITUATION

Diagnosis: Acute Pulmonary edema
GCS: 15/15
NEWS / PEWS Score:
POD:
Ventilator day:
Central line days: –
Peripheral line day: Right: Left: ✓
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☑ Yes ☐ No Day: P3
Barrier nursing: ☑ Yes ☐ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: –
Date of surgery: –
Allergies if any: NKAD
On room air / oxygen: on NPO2 1 litres
IV fluids on flow: –
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 97.8°F) | Pulse / HR: 80 (beats/min) | Respiration: 21 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 99 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : –
Pain Score: 1/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT
Fall Risk Score: 85 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM diet Drains: –

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: } 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	Sen	Soniya	0284	9/1/24	19.30
Handover taken by	Pdk	Pavithra	0072	9/1/24	19.30
Document endorsed	Nal	S. Nalini	0024	10/1/24	8:0

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
9/1/24 @ 19.15	Pt hand over taken from evening duty staff. Pt on NP O_2, litres on flow. Pt was hemodynmically stable.	
20.00	Pt oral diuresis taken.	
20.30	Pt medication given as per drug chart.	
22.00	Pt was comfortable to sleep.	
6.00	Pt B/O was maintained Pt V/S are checked and recorded.	
7.30	Pt hand over taken to from morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		E-Nailoh	0084	10/1/24	8:00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: Acute pulmonary edema
GCS: 15/15
NEWS / PEWS Score:
POD:
Ventilator day:
Central line days: —
Peripheral line day: Right: Left: ✓
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 015
Urinary Catheter: ☑ Yes ☐ No Day: D3
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☒ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery:
Date of surgery: —
Allergies if any: NKAD
On room air / oxygen: on NPO2 : 4litres
IV fluids on flow: —
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 21 (breaths/min)

BP: 120/80 (mmHg) | SpO_2: (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5kg/m2

Others : — —

Pain Score: 11/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / (NRS) / CPOT

Fall Risk Score: 55 **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: gm diet Drains: —

R — RECOMMENDATION

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

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

Pending follow-up orders: —

Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by	Rajesh	Rajesh	0052	10/1/24	13:30
Handover taken by	Hannah	Hannah Grace	0105	10/1/24	12:30
Document endorsed	Nalini	S. Nalini	0024	10/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/1/24 7.30	Morning Duty Notes	
	- patient taken over from night duty staff	Pathm
	- while take over patient is hemodynamically stable	
8.30	- Due medications given as per orders	Pathm
9.00	- Pt S/B Dr. Sabiseelan sir advised to keep in intermittent Bipap	Pathm
10.00	- vital signs stable.	Pathm
12.30	- patient handed over to evening duty staff	Pathm

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S Nalini	0024	10/1/24	13:30

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☐ Morning ☐ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: —
Date of surgery: —
Allergies if any: NKDA
On room air / oxygen: on NP @ O_2 litres
IV fluids on-flow: —
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 96 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 85 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Dm diet Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications: NIL
Pending medication indent:
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	Hay	Hannah Grace	0105	10/1/24	19:00
Handover taken by	Sen	Seniya	0284	10/1/24	19:20
Document endorsed	Nal	S. Nalini	0024	10/1/24	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10/11/24	Evening duty notes	
12:30	patient handing over taken from Morning duty Staff in a hemodynamically Stable Condition	Hay 0005
13:00	Vital Signs Checked & Recorded	Hay 0005
14:00	Due drugs are given as per drug chart	Hay 0005
15:00	S/B Dr. Gnanavelu, to do ABG now, Pulmonology Opinion	Hay 0005
15:30	ABG taken, Pulmo Infoormed	
17:00	S/B Dr. Elakiya. Drugs are added	Hay 0005
17:30	Chair Mobilized, Pt Stable on O2 2 litres	Hay 0005
18:00	patient Vital Signs are checked and Recorded I/O chart Maintained.	Hay 0005
19:00	patient handing over given to night duty staff	Hay 0005

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nur	R. Nalini	0024	10/11/24	20:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 10/1/24 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

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

B

BACKGROUND

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

A

ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 96 (%) | Height: 165 (cms) | Weight: 90 (kgs) | BMI: 34.5 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 85 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: DM Diet Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: } 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	Jeni	Jeni Priya.	0284	10.1.24	7.30
Handover taken by	[signature]	A. Nandhini	0170	11/1/24	7.30
Document endorsed	Nalini	L. Nalini	0024	11/1/24	8.20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
10.1.23	NIGHT DUTY NOTES	
19.30		
	=> Pt hand over taken from morning duty staff.	Jem
	=> Pt consciousness and orientation.	
20.00	=> Pt vitals checked and recorded.	
	=> Pt oral drugs are given as per drug chart.	Jem
22.00	=> Pt Mobilized well	
	=> Pt Nebulization given.	
23.00	=> Pt sleep well.	
6.00	=> Pt vitals checked.	Jem
	=> Pt I/O chart Maintain.	
7.00	=> Pt hand over given to morning duty staff.	Jem

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0024	11/1/24	8:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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

S

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

B

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

A

ASSESSMENT
Vital Signs: Temp: 97 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 20 (breaths/min)
BP: 180/72 (mmHg) | SpO_2: 95 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 85 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Drains: –

R

RECOMMENDATION
Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
(all above: Nil)
Changes in nursing care plan: ☐ Yes ☑ No If Yes, modified care plan date: –
Pending follow-up orders: –
Special instructions if any: Morning intermitten BiPAP, Night over night BiPAP

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	A. Nandhini	0770	11/1/24	12:30
Handover taken by	[signature]	R.W. Bharathi	0271	11/1/24	12:30
Document endorsed	[signature]	S. Nalini	0024	11/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
11/1/24 @ 7.30	Morning duty Notes => patient taken over from Night duty Staff Nurse => patient conscious & oriented => patient vital Signs checked & recorded	
8.30	=> Medication given as per drug chart => pulmo opinion done. over night BiPAP done. => I/O chart monitored	
11.30	=> patient Signs checked & Recorded	
12.30	=> patient handing over to Evening duty Staff Nurse	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0024	11/11/24	13:30

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MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 11/11/24 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: Acute pulmonary edema GCS: 15/15
NEWS / PEWS Score: POD:
Ventilator day: Central line days:
Peripheral line day: Right: Left: (L) Antecubital
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 015
Urinary Catheter: ☑ Yes ☐ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

B — BACKGROUND

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

A — ASSESSMENT

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 22 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 97 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5kg/m2
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA *Wound Dressing done:* ☐ Yes ☐ No ☐ NA
Current diet: DM diet Drains:

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		RN Bhuvaneshwari	0074	11/11/24	19.30
Handover taken by	Jeni	Jenifer	0024	11/11/24	19.30
Document endorsed	Nil	S. Nalini	0024	11/11/24	20.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
11/1/24	Evening duty Notes	
7:00	Patient hand over from morning duty staff.	
13:30	Afternoon dose Medication given as per.	
5.00	Vitals Checked & recorded Vitals are stable.	
6.00	Doctors rounds done.	
16:20	Ortho opinion done dr. Arun kumar Sir seen the patient to do X-ray Spine.	
16:35	X-ray Lsspine done	
18-30	Monitor Intake & Output Chart.	
19-30	Patient hand over by night duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0024	11/1/24	20:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/2024 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

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

B — BACKGROUND

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

A — ASSESSMENT

Vital Signs: Temp: 97.2 (°F) | Pulse / HR: 78 (beats/min) | Respiration: 22 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 97 (%) | Height: [illegible] (cms) | Weight: 90 (kgs) | BMI: 37.5 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ☑ NRS / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: DM DIET. Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Janipriya.	0084	12.1.2024	19:30
Handover taken by	[signature]	A. Nandhini	0170	12/1/24	7:30
Document endorsed	Nil	S. Nalini	0024	12/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
11/1/24 @ 19.30	NIGHT DUTY NOTES => Pt hand over taken from evening duty staff.	Jeni om.
	=> Pt conscious and orientation	
20.00	=> Pt vitals checked and recorded	
	=> Pt due drugs are given as per drug chart.	Jeni om.
23.00	=> Pt MOBILized well	
	=> Pt Nebulization was given.	
	=> Pt Sleep well.	
6.00	=> Pt vitals checked and recorded.	Jeni om.
	=> Pt I/O Chart Monitored.	
7.00	=> Pt hand over to Morning duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nai	S. Nalini	0024	12/1/24	8:0

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Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: Acute pulmonary edema GCS: 15/15
NEWS / PEWS Score: POD: –
Ventilator day: Central line days: –
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:
VIP Score: 0/5

B

BACKGROUND

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

A

ASSESSMENT

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 130/72 (mmHg) | SpO_2: 96 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5 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: 10M 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		A. Nandhini	0170	12/1/24	12.30
Handover taken by	Hay	Hannah Grace	0105	12/1/24	12:30
Document endorsed		S. Nalini	0024	12/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12/1/24 @	Morning duty Notes	
7.30	⇒ patient taken over from Night duty S/N	[signature] 3322
	⇒ patient v/s checked and recorded.	
	⇒ patient had ⓝ diet	
8.30	⇒ patient Drugs are given.	[signature] 172
	⇒ I/O monitor & maintain.	
	⇒ CBD ⊕	
	⇒ patient Today D/s plan	
	⇒ Before D/S FOT plan	
	⇒ patient today discharge	
	⇒ patient Shifted to pulmo department plan for FOT done.	
	⇒ patient Received, patient conscious & oriented.	
15.25	⇒ patient vital & checked & Recorded	[signature] 17
15.30	⇒ patient handing over to Evening duty Staff Nurse	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0024	12/1/24	13:00

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MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

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

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/80 (mmHg) | SpO_2: 97 (%) | Height: 155 (cms) | Weight: 90 (kgs) | BMI: 37.5kg/m² ✓
Others :
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Dm diet Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	Hay	Hannah Grace	0105	12/1/24	16:00
Handover taken by		A. Aishwarya			
Document endorsed	Vee	S. Vel PNS	0024	12/1/24	16:20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
12/1/24	Evening duty notes	
12:30	patient handing over taken from Morning duty staff in a hemodynamically stable condition	Hay 0105
13:00	Vital Signs checked & Recorded	Hay 0105
14:00	U-cath Removed	
18:00	Discharge notes	
⇒	Patient stable and conscious	Hay 0105
⇒	Patient Vital signs are stable	
⇒	I V line Removed	
⇒	Discharge Summary explained	Hay 0105
⇒	ID band Removed	
⇒	patient got discharged @ 18:30	Hay 0105

	Signature	Name	Emp. No.	Date	Time
Document endorsed by	[signature]	S valPnP	0074	12/1/24	16:00

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Mrs. LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICN/2022/102

Medway Heart Institute
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HAI BUNDLE

Date & Time of Intubation	Date of extubation:	Date of Reintubation:	Total Days

	DATE																
S.no	VAE Bundle	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Elevate HOB 30° - 45° & patient not sliding down															
2	Perform hand hygiene before & after each respiratory care															
3	Perform regular oral care with antiseptic oral rinse if needed															
4	Review sedation target daily															
5	Assess readiness to wean and extubate to daily															
6	Drain condensate of the ventilator circuit before repositioning of patients															
7	Check and maintain appropriate ETT cuff pressure 25 - 30 cmH2o															
8	verify correct placement of the NG tube at regular interval															
9	Regular assessment of patient's tolerance to NG tube feeding															
10	Stress ulcer prophylaxis															
11	DVT prophylaxis															

Date & Time of Insertion	**Date of Removal:**	**Date of Reinsertion:**	**Total days:**

	DATE																
S.no	**CLABSI Bundle**	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Perform hand hygiene															
2	Dressing intact and labelled properly															
3	Site inspected															
4	Catheter stabilized/no tension on line															
5	Dormant lumens clamped															
6	Caps changed-administering blood & if there is visual observation of blood in the caps															
7	Caps sanitized with alcohol before & after each use. "scrub the hub".															
8	Lumens flushed with minimum volume 10cc every 12 hours															
9	Iv bags and tubing's labelled properly															
10	All tubing changed every 24 hours															

Date & Time of Insertion	**Date of Removal:**	**Date of Reinsertion:**	**Total days:**
7/1/24 @ 13:30	12/1/24 @14:30		

	DATE	7/1/24	8/1/24	9/1/24	10/1/24	11/1/24											
S.no	**CAUTI Bundle**	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Maintain sterlity of closed urinary drainage		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	Wash hands prior to handling the urinary drainage system & catheter		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3	Maintain unobstructed urinary flow & specimens from sampling port		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4	Keep collection bag below the bladder & off the floor		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5	Don't change indwelling catheter or collection bag routinely		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6	Tie/secure catheter to patient tubing to bed		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	RN SIGNATURE / E. NO:															

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

MHI/ICN/2022/102

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SURGICAL SITE INFECTION

Ward :	Contact No :	Consultant Name :
Diagnosis :		Surgeon Name :
Surgery / Procedure :		ASA GRADE : 1 2 3 4 5 E
DOA :	DOS :	DOD :
Diabetes :	HB A1C	Pre op FBS : mg/dt Time :
Weight / BMI :		

PRE OPERATIVE PREPARATION

S.NO:	CRITERIA	DATE	TIME	RN NAME
1	Pre operative chlorhexidine bath (Previous day of surgery) - 1			
2	Pre operative skin preparation (Previous day of surgery)			
3	Pre operative chlorhexidine bath (On the day of surgery) - 1			
4	Pre operative chlorhexidine mouth wash gargle (on the day of surgery)			
5	Sterile preparation (before shifting to OT)			

TO BE FILLED BY OT NURSE

Incision Time :	Duration of Surgery :

1ST DOSE OF ANTIBIOTICS DETAILS

IF SURGERY EXCEEDING MORE THAN 4 HOURS INTRA OPERATIVE ANTIBIOTICS DETAILS

TIME	DRUG NAME	DOSE	TIME	DRUG NAME	DOSE

POST OPERATIVE ANTIBIOTICS DETAILS

DRUG NAME	DOSE	FREQUENCY	FROM	TO	TOTAL DOSAGES

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MHI/ICN/2022/102

Medway Heart Institute
Every heart beat counts

VAP BUNDLE

Date & Time of Intubation	Date of extubation:	Date of Reintubation:	Total Days

	DATE																
S.no	VAE Bundle	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Elevate HOB 30° - 45° & patient not sliding down															
2	Perform hand hygiene before & after each respiratory care															
3	Perform regular oral care with antiseptic oral rinse if needed															
4	Review sedation target daily															
5	Assess readiness to wean and extubate to daily															
6	Drain condensate of the ventilator circuit before repositioning of patients															
7	Check and maintain appropriate ETT cuff pressure 25 - 30 cmH2o															
8	verify correct placement of the NG tube at regular interval															
9	Regular assessment of patient's tolerance to NG tube feeding															
10	Stress ulcer prophylaxis															
11	DVT prophylaxis															

Date & Time of Insertion	Date of Removal:	Date of Reinsertion:	Total days:

	DATE																
S.no	CLABSI Bundle	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Perform hand hygiene															
2	Dressing intact and labelled properly															
3	Site inspected															
4	Catheter stabilized/no tension on line															
5	Dormant lumens clamped															
6	Caps changed-administering blood & if there is visual observation of blood in the caps															
7	Caps sanitized with alcohol before & after each use. "scrub the hub".															
8	Lumens flushed with minimum volume 10cc every 12 hours															
9	Iv bags and tubing's labelled properly															
10	All tubing changed every 24 hours															

Date & Time of Insertion 7/1/24 at 13:30	Date of Removal: 12/1/24	Date of Reinsertion:	Total days: 5 days

	DATE																
S.no	CAUTI Bundle	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
1	Maintain sterlity of closed urinary drainage	✓														
2	Wash hands prior to handling the urinary drainage system & catheter	✓														
3	Maintain unobstructed urinary flow & specimens from sampling port	✓														
4	Keep collection bag below the bladder & off the floor	✓														
5	Don't change indwelling catheter or collection bag routinely	✓														
6	Tie/secure catheter to patient tubing to bed	✓														
	RN SIGNATURE / E. NO:															

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

MHI/ICN/2022/102

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SURGICAL SITE INFECTION

Ward :	Contact No :	Consultant Name :
Diagnosis :		Surgeon Name :
Surgery / Procedure :		ASA GRADE : 1 2 3 4 5 E
DOA :	DOS :	DOD :
Diabetes :	HB A1C	Pre op FBS : mg/dt Time :
Weight / BMI :		

PRE OPERATIVE PREPARATION

S.NO:	CRITERIA	DATE	TIME	RN NAME
1	Pre operative chlorhexidine bath (Previous day of surgery) - 1			
2	Pre operative skin preparation (Previous day of surgery)			
3	Pre operative chlorhexidine bath (On the day of surgery) - 1			
4	Pre operative chlorhexidine mouth wash gargle (on the day of surgery)			
5	Sterile preparation (before shifting to OT)			

TO BE FILLED BY OT NURSE

Incision Time :	Duration of Surgery :

1ST DOSE OF ANTIBIOTICS DETAILS			IF SURGERY EXCEEDING MORE THAN 4 HOURS INTRA OPERATIVE ANTIBIOTICS DETAILS		
TIME	DRUG NAME	DOSE	TIME	DRUG NAME	DOSE

POST OPERATIVE ANTIBIOTICS DETAILS

DRUG NAME	DOSE	FREQUENCY	FROM	TO	TOTAL DOSAGES

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ADULT NURSING CARE PLAN

Patient Details (Affix Label here)
Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
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Initial Date: 7/1/24	Time: 13:01pm	Modified Date:	Time:
Reason for Modification:		Diagnosis: Acute pulmonary edema.	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M	
			E Pt on (N) diet	[signature]
			N Pt on Dm diet	[signature]
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☑ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☑ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M	
			E Pt on O_2 SpO_2 - 99%	[signature]
			N Pt on O_2 SpO_2 - 100%	[signature]
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M	
			E Encourage oral intake.	[signature]
			N Pt IVF NS - 30cc/hr on flow	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	**M** **E** Pt mobilized in bed freely. **N** Pt mobilise on bed	 [signature] 0700 [signature] 0240
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistent / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	**M** **E** Pt (N) elimination pattern **N** Pt (N) Elimination Pattern	 [signature] 0700 [signature] 0240
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	**M** P' **E** Pt had (N) skin integrity. **N** Pt had (N) Skin Integrity	 [signature] 0700 [signature] 0240

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jayl	JAYASRI	0002	8/1/24	10:00

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K
81/Female/MH1202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
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Initial Date: 8/1/24	Time: 8:00	Modified Date:	Time:
Reason for Modification:		Diagnosis: Acute Pulmonary Edema	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt had regular diet	[illegible]
			E pt Had a DM diet	[illegible]
			N → Pt on DM diet	[illegible]
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt NPO2 2 liters onflow	[illegible]
			E pt NPO2 2 litre O2	[illegible]
			N → Pt on BC 12/6 onflow	[illegible]
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt IVF 30cc/hr onflow	[illegible]
			E Pt IVF NS 30ml/hr going to Flow	[illegible]
			N → Pt on IVF NS 30ml/hrs onflow	[illegible]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt on bed mobilized. E pt on Bed Mobilization N ~~p~~ pt on bed rest	[illegible] 021 [illegible] 23[illegible] [illegible]
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt CBD Present Day-2 E pt on CBD ⊕ DL N ~~p~~ pt on CBD ⊕ - DL	[illegible] 021 [illegible] 23[illegible] [illegible]
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☑ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Pt (N) skin integrity elimination Pattern E pt Maintain (N) skin integrity N ~~p~~ pt on skin integrity	[illegible] 021 [illegible] 23[illegible] [illegible]

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	**M** Pt Communication well	[illegible] 0211
			E pt good verbal communication	[illegible] 2302
			N often Good communication	[illegible]
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	**M** Pt Medication given as Per drug chart	[illegible] 0211
			E administered the medication as per drug chart	[illegible] 2302
			N medication given as per drug chart	[illegible]

	Signature	Name	Emp. ID	Date	Time
Endorsed by	[signature]	JAYAPRAKASH	000[illegible]	8/1/24	

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 9/1/24 **Time:** 8.00 **Modified Date:** **Time:**

Reason for Modification:

Diagnosis: Acute pulmonary edema / T2DM / SHTN

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☑ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M patient had breakfast E Pt had DM diet N Pt had PM diet	AL 0158 Hay 0105 @2AM
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M on O_2 support spo2 maintained E on O_2 1 litres Nasal prongs N Pt on 1 litres NP	AL 0158 Hay 0105 @2AM
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M IVF NS 30 cc/hr. onflow. E I/O chart Maintained N Pt I/O was maintained	AL 0158 Hay 0105 @2AM

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M patient was bed mobilized E patient on bed N Pt on bed mobilized	M [illegible] 0158 E [illegible] 0800 N [illegible] @2HH
ELIMINATION ☑ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M patient elimination pattern E pt had normal elimination pattern N Pt [illegible] voided CBD [illegible] D.S.	M [illegible] 0158 E [illegible] 0800 N [illegible] @2HH
SKIN INTEGRITY ☐ Maintain normal skin integrity ☑ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☑ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Maintained Skin integrity (N) E Patient had normal skin Integrity N Pt maintain (N) skin integrity	M [illegible] 0158 E [illegible] 0800 N [illegible] @2HH

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☑ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	**M** Patient stay cleaned **E** Pt groomed well **N** Pt clean & well groomed	M: 0158 E: Hay 0105 N: 02HH
SAFETY ☐ Check ID Hand, ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	**M** patient ID band (+) **E** ID band present **N** Pt ĉ ID band (+)	M: 0158 E: Hay 0105 N: 02HH
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	**M** provided privacy. **E** — **N** Pt comfortable position	M: 0158 E: N: 02HH
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	**M** vitals stable **E** Pt vital signs are stable **N** Pt V/S are checked and recorded	M: 0158 E: Hay 0105 N: 02HH
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	**M** — **E** — **N** —	M: — E: N:

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	Maintained good rapport	[signature] 0152
			E	Pt communicated well	Hay 0105
			N	Pt well communication	[signature] 02HH
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☑ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M	patient medications given as per chart	[signature] 0152
			E	Due drugs are Given	Hay 0105
			N	Pt medication given as per drugchart	[signature] 02HH

Endorsed by	Signature	Name	Emp. ID	Date	Time
	[signature]	S. Nalini	0024	09/4/24	18:00

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 10/1/24	**Time:** 8.00	**Modified Date:**	**Time:**
Reason for Modification:		**Diagnosis:** APE	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☑ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M pt had DM diet.	[illegible]
			E Pt had DM diet	Hay 0105
			N pt had DM diet	Jer
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☑ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on room air	[illegible]
			E Patient was stable on ~~room~~ O_2 NP 2litres	Hay 0105
			N pt on Room air	Jer 00:4
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt oral fluid taken.	[illegible]
			E I/O chart Maintained	Hay 0105
			N I/O chart maintained.	Jer

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

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt communication well. E Pt Communicated well N Pt communicated well	[signature] Hay 5105 [signature]
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Pt medication given. E Due drugs are Given N Due drugs are given	[signature] Hay 0105 [signature]

	Signature	Name	Emp. ID	Date	Time
Endorsed by	[signature]	E-Nalini	0024	16/11/24	1310

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH202400051
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 11/1/24 **Time:** 8:00 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** SOB S/P PDA

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Patient had DM diet E Pt had DM diet N Pt had DM Diet.	07/1/24
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M patient is on Room Air E patient is on room air N Pt is on Room air	07/1/24 07/1/24
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☑ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/o Chart monitored E I/O Chart monitored N I/o chart Monitored	07/1/24 07/1/24

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

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by		S. Nalini	0024	11/1/24	16:00

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 12/1/24 **Time:** 8:00 **Modified Date:** **Time:**

Reason for Modification:

Diagnosis: Acute pulmonary edema

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

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

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	Good communication	2753
			E		
			N		
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M	Medication was given	2753
			E		
			N		

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nal	S-nalini	0024	12/1/24	1400

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NABH

Patient Details (Affix Label here)
Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date:	4	1	24
					Time:		E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals		3	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours		1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance		2	2
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		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		16	16
				Initial & Emp. No. of Staff Nurse:		0208	0240
Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**			

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NABH ACCREDITED

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 8	1	24
					Time: M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	(4) **No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	(4) **Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	(1) **Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	(2) **Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	2	2	2
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	(3) **Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	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	3
				TOTAL SCORE	17	12	17
				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*

S.No. : 22

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NABH

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07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 9	1	24
					Time: 14	8	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	3	3	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	3	3
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	3	4	4
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	2	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	3
				TOTAL SCORE	17	20	20
				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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Dr.G. GNANAVELU

MHI/NUR/2022/045

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Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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

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

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 10		
					Time: M	A	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	2	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	3	3
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	4
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	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	3
				TOTAL SCORE	23	20	20
				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*

S.No. : 22

Medway Hospitals®
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NABH

Mrs.LAKSHMI
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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

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

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Dr.G. GNANAVELU

MHI/NUR/2022/052

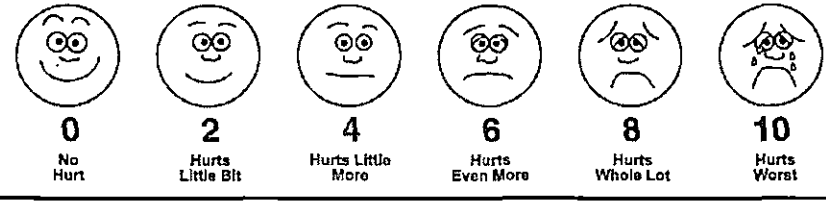
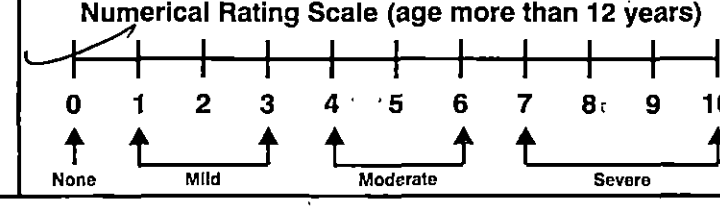
Medway Heart Institute
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7/1/24 13:00	5/10	Dull	1hr	HIP	Pharmacological action	0206	
13:30	3/10	Dull	30min	HIP	Pharmacological action	0206	
14:00	1/10	Dull	30min	HIP	Pharmacological action	0206	
14:30	0/10	No pain	–	–	–	0206	
15:00	0/10	No pain	–	–	–	0206	
16:00	0/10	No pain	–	–	–	0206	
17:00	0/10	No pain	–	–	–	0206	
18:00	0/10	No pain	–	–	–	0206	
19:00	0/10	No pain	–	–	–	0206	

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.
7/1/24 20:00	0/10	No pain	–	–	–	02410	
21:00	0/10	No pain	–	–	–	02410	
22:00	0/10	No pain	–	–	–	02410	
23:00	0/10	No pain	–	–	–	02410	

PAIN SCALES

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

Pharmacological Interventions as per doctor's prescription

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Dr.G. GNANAVELU

MHI/NUR/2022/052

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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7/1/24 24:00	0/10	No pain	—	—	—	0240	
8/1/24 1:00	0/10	No pain	—	—	—	0240	
2:00	0/10	No pain	—	—	—	0240	
3:00	0/10	No pain	—	—	—	0240	
4:00	0/10	No pain	—	—	—	0240	
5:00	0/10	No pain	—	—	—	0240	
6:00	0/10	No pain	—	—	—	0240	
7:00	0/10	No pain	—	—	—	0240	
8:00	0/00	No Pain	—	—	—	0241	

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
8/1/24 9:00	0/10	No Pain	–	–	–	0240	24
10:00	0/10	No Pain	–	–	–	0241	24
11:00	0/10	No Pain	–	–	–	0241	24
12:00	0/10	No Pain	–	–	–	0241	24

PAIN SCALES

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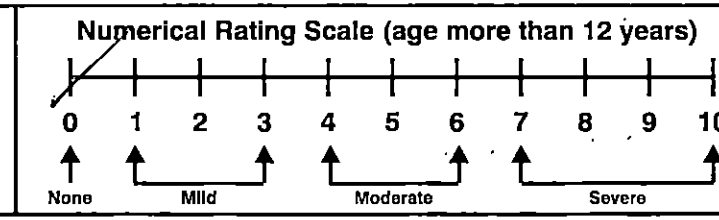
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	
	
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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.
8/1/24 13:00	0/10	No Pain	—	—	—	0411	Nurse 24
14.00	0/10	No pain	—	—	—	0158	Nurse 24
15:00	0/10	No pain	—	—	—	0158	Nurse 24
16.00	0/10	No pain	—	—	—	0158	Nurse 24
17.00	0/10	No pain	—	—	—	0158	Nurse 24
18.00	0/10	No pain	—	—	—	0158	Nurse 24
19:00	0/10	No pain	—	—	—	0158	Nurse 24
20.00	0/10	No pain	—	—	—	[illegible]	Nurse 24
21.00	0/10	No pain	—	—	—	[illegible]	Nurse 24

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.
8/12							
12:00	0/10	no pain	—	—	—		
20:00	0/10	no pain	—	—	—		
00:00	0/10	no pain	—	—	—		
4:00	0/10	no pain	—	—	—		

PAIN SCALES

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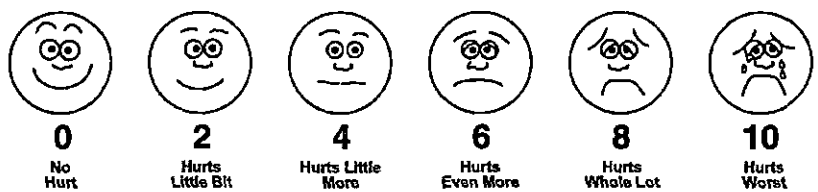
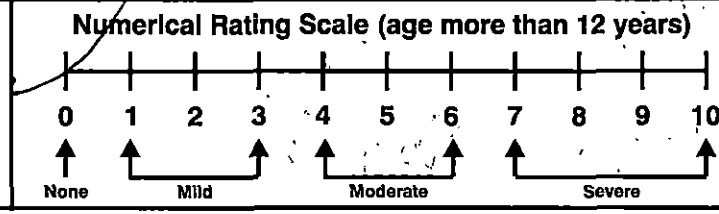
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9/1/24 @ 2:00	0/10	no pain	—	—	—	[signature]	Na 024
3:00	0/10	no pain	—	—	—	[signature]	Na 024
4:00	0/10	No pain	—	—	—	[signature]	Na 024
5:00	0/10	No pain	—	—	—	[signature]	Na 024
6:00	0/10	No pain	—	—	—	[signature]	Na 024
7:00	0/10	No pain	—	—	—	[signature]	Na 024
8:00	0/10	No pain	—	—	—	[signature] 0158	Na 024
9:00	0/10	No pain	—	—	—	[signature] 0158	Na 024
10:00	0/10	No pain	—	—	—	[signature] 020	Na 024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
9/1/24 11:00	0/10	No Pain	-	-	-	024	Nad 024
12:00	0/10	No Pain	-	-	-	024	Nad 024
16:00	0/10	No pain	-	-	-	Hay 024	Nad 024
20:00	0/10	no Pain	-	-	-	02HH	Nad 024

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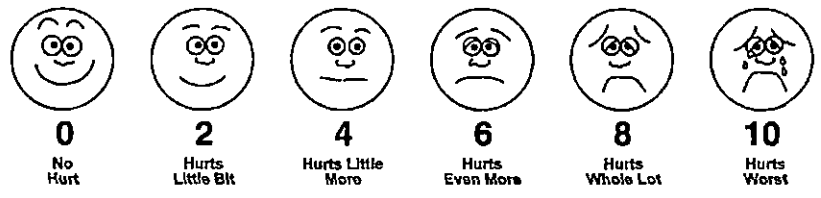
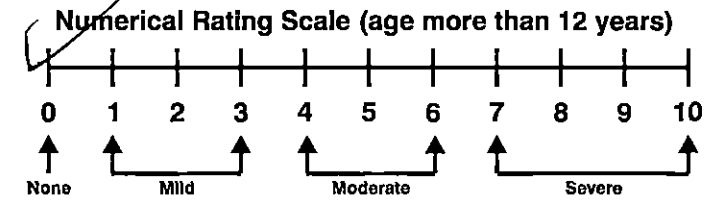
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

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Consultant:

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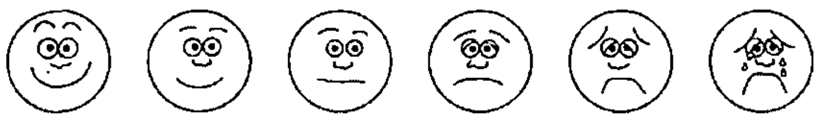
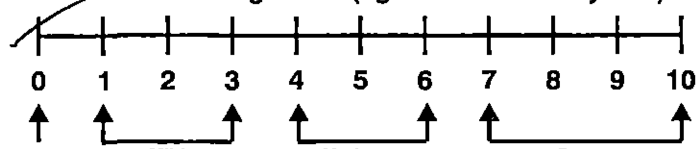
PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10/1/24 20:00	0/10	No pain	—	—	—	[signature] 0184	Nua 024
06:00	0/10	No pain	—	—	—	[signature]	Nua 024
10:00	0/10	No pain	—	—	—	[signature]	Nua 024
14:00	0/10	No pain	—	—	—	Hay 0105	Nua 024
18:00	0/10	No pain	—	—	—	Hay 0105	Nua 024
22:00	0/10	No pain	—	—	—	[signature]	Nua 024
11/1/24 6.00	0/10	No pain	—	—	—	[signature]	Nua 024
10.00	0/10	No pain	—	—	—	[signature]	Nua 024
14:00	0/10	NO Pain	—	—	—	[signature] 0225	Nua 024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
18.00	0/10	NO Pain	–	–	–	[illegible] 0525	Nca 024
20.00	0/10	No pain	–	–	–	Jem on.	Nca 024
6.00	0/10	NO pain	–	–	–	Jeni on.	Nca 024
10.00	0/10	NO pain	–	–	–	[illegible] 0333	Nca 024

PAIN SCALES

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

Pharmacological Interventions as per doctor's prescription

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Patient Details (Affix Label here)
Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/NUR/2022/047

Medway Heart Institute
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DVT RISK ASSESSMENT

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

	Date	7/1/24	8/1/24	9/1/24	10/1/24	10/1/24	11/1/24	12/1/24
	Time	13:10	6:00	6:00	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	0	
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	0	0	0	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	0	0	0	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	0	0	0	
5	Entire leg swollen (Assess for both legs)	1	1	1	0	1	1	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	1	0	0	0	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0	0	0	
9	Previously documented DVT (Assess for both legs)	0		0	0	0	0	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0 0	0	0	0	0	
	FINAL SCORE	0	0	+0	+1	+1	+1	
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	0	2	Mod.	Mod	Mod	Mod	
	DVT prophylaxis started	☐Yes ☐No	☑Yes ☐No	☐Yes ☑No	☐Yes ☑No	☐Yes ☑No	☐Yes ☑No	☐Yes ☐No
	Signature & Emp. No. of RN	0208		0158				
	Signature & Emp. No. of Sr. RN			24	24	24	24	

MHI/NUR/2022/046

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Medway Heart Institute
Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	7/1/24	7/1/24	8/1/24	8/1/24	8/1/24	9/1/24	9/1/24	9/1/24	10/1/24
	Time	13:05	20:00	8:00	14:00	20:00	8:00	14:00	20:00	8:00
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		85	85	85	85	85	85	85	85	85
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓	✓	✓	✓	✓	✓	✓	
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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

INTERVENTIONS *Tick as per the Risk Score*	Date	8/1/24	9/1/24	8/1/24	8/1/24	8/1/24	9/1/24	9/1/24	10/1/24	
	Time	13:05	20:00	8:00	14:00	20:00	R:00	14:00	8:00	
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓	✓	✓	
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓	✓	✓	
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓	✓	✓	
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓	✓	✓	
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓	✓	✓	
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓	✓	✓	
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓	✓	✓	
Bed wheels should be locked		✓	✓	✓	✓	✓	✓	✓	✓	
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓	✓	✓	
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓	✓	✓	✓	✓	✓	
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓	✓	✓	✓	
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓	✓	✓	
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓	✓	✓	
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓	✓	✓	✓	✓	✓	✓	✓	
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓	✓	✓	✓	✓	✓	
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓	✓	✓	✓	✓	
Use restraints and bed monitors as ordered by the doctor		✓	✓	✓	✓	✓	✓	✓	✓	
Allow the patient to ambulate only with assistance		✓	✓	✓	✓	✓	✓	✓	✓	
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓	✓	✓	
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓	✓	✓	✓	✓	✓	
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓	✓	✓	
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓	✓	✓	✓	✓	✓	
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓	✓	✓	
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓	✓	✓	✓	✓	✓	✓	
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓	✓	✓	✓	✓	✓	✓	
Locate the high-risk patients in a room close to the nurses' station		✓	✓	✓	✓	✓	✓	✓	✓	
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)		N/A	N/A	✓	✓	✓	✓	✓	✓	
Encourage family members or other visitors to stay with them		N/A	✓	N/A	N/A	N/A	N/A	✓	✓	
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓	✓	✓	
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH202400005!
Dr.G. GNANAVELU

Medway Heart Institute
Where heart beat never stops...

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			
		Time	14:00	20:00	8:00	14:00	20:00	8:00			
History of falling (immediate or within 6 months)	No		0	0	0	0	0	0	0	0	0
	Yes		25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No		0	0	0	0	0	0	0	0	0
	Yes		20	20	20	20	20	20	20	20	20
AMBULATORY AID None / Bed Rest / Nurse Assist			0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker			15	15	15	15	15	15	15	15	15
Furniture			30	30	30	30	30	30	30	30	30
GAIT Normal / Bed Rest / Wheel Chair			0	0	0	0	0	0	0	0	0
Weak			10	10	10	10	10	10	10	10	10
Impaired			20	20	20	20	20	20	20	20	20
MENTAL STATUS Oriented to own stability			0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations			15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Total Score			85	85	85	85	85	85			
Low Risk (0 - 24)											
Medium Risk (25 - 44)											
High Risk (45 or above)			✓	✓	✓	✓	✓	✓			
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN											

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

INTERVENTIONS *Tick as per the Risk Score*	Date	10/1/24	10/1/24	11/1/24	11/1/24	12/1/24	12/1/24			
	Time	14:00	20:00	8:00	14:00	20:00	8:00			
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓			
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓			
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓			
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓			
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓			
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓			
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓			
Bed wheels should be locked		✓	✓		✓	✓	✓			
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓			
Ensure that floor of the bathroom is dry and not slippery				✓	✓	✓	✓			
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓	✓			
Use safety belts during movement in wheelchair				✓	✓	✓	✓			
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓			
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓	✓	✓	✓	✓	✓			
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher					✓	✓	✓			
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓	✓	✓			
Use restraints and bed monitors as ordered by the doctor		✓	✓		✓	✓	✓			
Allow the patient to ambulate only with assistance					✓	✓	✓			
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓			
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓	✓	✓	✓			
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓			
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓	✓	✓	✓			
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓			
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		✓	✓	✓	✓	✓	✓			
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓	✓	✓	✓	✓			
Locate the high-risk patients in a room close to the nurses' station		✓	✓	✓	✓	✓	✓			
Answer these patients call bells as quickly as possible				✓	✓	✓	✓			
Provide a commode at bedside (if appropriate)		✓	✓	✓	✓	✓	✓			
Urinal/bedpan should be within easy reach (if appropriate)		✓	✓	✓	✓	✓	✓			
Encourage family members or other visitors to stay with them		✓	✓	✓	✓	✓	✓			
If appropriate, consider using protection devices: safety belts		✓	✓	✓	✓	✓	✓			
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			

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NABH

Mrs.LAKSHMI K
Pa 81/Female/MHI202481668
Na 07/01/2024/IPH2024000051
UI
DI Dr.G. GNANAVELU
DI
Consultant:

MHI/IP/2022/055

Medway Heart Institute
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PATIENT AND FAMILY EDUCATION RECORD

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

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instuctions
Completed By : Date 7/1/24 Time 13:01		Nurse Signature : 0208

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	7/1/24	L	P	O	8/1/24	L	P	O	9/1/24	L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics		P	OD	U		P	OD	U		P	OP	U	
☑ Treatment		P	OD	U		P	OD	U		P	OP	U	25851
Medications													Doctor / Nurse
☑ Information on Safe and Effective use of medicines		P	OD	U		P	OD	U		P	OP	U	0208
☑ Information on drug / drug and drug / food interactions		P	OD	U		P	OD	U		P	OP	U	
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☐ Reporting of pain													
☐ Pain Management													
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient :_____Signature :_____

Name of Discharge Nurse

Signature :

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81/Female/MHI202481668
07/01/2024/IPH2024000051
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MHI/IP/2022/055

Medway Heart Institute
Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☑ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instuctions
Completed By : Date 12/12/24 Time 8.00 Nurse Signature : Pavithra		

Learning Record

Need	Date 12/12/24	Visit 1 L	P	O	Date 13/12/24	Visit 2 L	P	O	Date 14/12/24	Visit 3 L	P	O	Signature
Disease													Doctor
☐ Information on Disease / Diagnostics		P	D	V		P	DD	U		P	DD	V	KBG 134559
☑ Treatment		P								P			
Medications		P	DD	V		P	DD	U		P	DD	V	Doctor / Nurse
☐ Information on Safe and Effective use of medicines		P	DD	V		P	DD	U		P	DD	V	
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☑ Reporting of pain		P	DD	V		P	DD	O		P	DD	V	
☑ Pain Management		P	DD	V		P	DD	V		P	DD	V	
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient :_____Signature :_____

Name of Discharge Nurse

Signature :

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NABH ACCREDITED

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/ICU/2022/056

Medway Heart Institute
Every heart beat counts

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 7/1/24 Time: 13:05

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor	[signature]	Dr. Karthik	35851.	7/1/24	13:05
Nursing Staff	[signature]	Jayapriya	002	7/1/24	13:05
Dietician	[signature]	Catherine John, Senior Dietitian	[illegible]	7/1/24	14:00
Physiotherapist					
Patient Care Service Staff					

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/IP/2022/054

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IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 9/1/24 Time: 12:00 Transferred from: CCU To: (103) 1st floor, 81.

Diagnosis: Acute pulmonary edema / T2DM / SHTN

Vital Signs: Temp: 98 (°F) | Pulse / HR: 69 (beats/min) | BP: 154/63 (mmHg) | Respiration: 20 (breaths/min)

Part B *(to be filled by Physicians)*

Any Critical Investigations: _____

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

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. Clopitab CV	75/10	P/O	0—0—1	8/1/24@20:00	☑ Yes ☐ No
2	T. Tricor	10/145	"	1—0—0	9/1/24@8:00	☐ Yes ☐ No
3	Neb ⊂ Duo		P/N	1—1—1	9/1/24@8:00	☑ Yes ☐ No
4	Neb ⊂ Budet		P/N	1—0—1	9/1/24@8:30	☐ Yes ☐ No
5	Inj. Dexi	2cc	IV	1—0—0	9/1/24@8:30	☑ Yes ☐ No
6	T. Nutrin	15	P/O	1—0—0	9/1/24@8:30	☑ Yes ☐ No
7	Inj. Hydrocortison	100	IV	1—1—1	9/1/24@8:30	☐ Yes ☐ No
8	Inj. Lasix	20	IV	1—0—0	9/1/24@8:30	☐ Yes ☐ No
9	T. Aldactone	25	P/O	1—0—0	9/1/24@8:30	☑ Yes ☐ No
10	Inj. Pantop	40	IV	TDS	9/1/24@11:15	☐ Yes ☐ No
11	T. Dytor	40	P/O	BB.	-	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

—

Patient Condition: [✓] Stable [ ] Sick-need urgent care [ ] Others: ____

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	[signature]	BALAJI	123619	9/1/24	12:00
Receiving Doctor	[signature]	Dr [illegible]	16032	9/1/24	12:00

Part C *(to be filled by Nurses)*

Check for	Transferring Nurse	Receiving Nurse
Drains	[ ] Chest [ ] Abdominal [ ] Others: —	[✓] Yes [ ] No
Respiratory	Air Way Type: [✓] Patent [ ] Tracheostomy [ ] Others: ____ Oxygen Therapy: [ ] No [✓] Yes via: Nasal prongs Rate: 1 li/min	[✓] Yes [ ] No
NG Tube / Oral	[ ] Yes [✓] No [ ] For Feeding [ ] Gastric Suction [ ] Fluid Restriction	[✓] Yes [ ] No
Foley's Catheter	[✓] Yes [ ] No	[✓] Yes [ ] No
Intravenous Access	[✓] Peripheral Line [ ] Central Venous Line [ ] Others: ____	[✓] Yes [ ] No
Pressure Injury	[ ] Yes [✓] No If Yes, give details: ____	[✓] Yes [ ] No
Score	Fall Risk: 85 WELLS: NEWS / PEWS:	[✓] Yes [ ] No
Patient Belongings	[ ] Yes [✓] No If Yes, give details: ____	[✓] Yes [ ] No
Handover Details	Medication Administration Record explained: [✓] Yes [ ] No Lab & Diagnostic Reports handed over: [✓] Yes [ ] No	[✓] Yes [ ] No
Patient Attendant Informed	[✓] Yes [ ] No If No, give details: ____	[✓] Yes [ ] No

Additional Details *(if any)*:

—

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	[signature]	Premalatha	0211	9/1/24	12:00
Receiving Nurse	[signature]	Hannah Grace	0105	9/1/24	12:30

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Patient Details
Nam Mrs.LAKSHMI K
UHI 81/Female/MHI202481668
DOB: 07/01/2024/IPH2024000051
DOA: Dr.G. GNANAVELU
Consu

MHI/IP/2022/051

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FAMILY COUNSELLING FORM

CONSULTANT- DR. Gnanavelu | DIAGNOSIS- Acute pulmonary edema.

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
7/1/24	Doctor	Son	Pt condition explained to family members	-		
8/1/24	Doctor	Son	Pt condition explained to attenders	-		
9/1/24	Doctor	Son	Pt Condition explained to attenders	-		

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NABH ACCREDITED

Mrs.LAKSHMI K
81/Female/MH1202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/HOSP/2022/032

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PHONE / VERBAL ORDER FORM / CRITICAL VALUE REPORTING FORM

☐ Telephone order ☐ Verbal order ☑ Critical value reporting form

Name of the Drug ☑ N/A	Dose	Route	Additional information if any

Lab / Radiology Critical result reporting *(if any)*: ☐ ~~N/A~~ **Informed to Dr.:** Karthik

SODIUM - 115

Non Medication Order *(if any)*: ☑ N/A

Order Recipient Response: *Please Tick*

Write Down ☐ Yes ☑ No **Read Back** ☑ Yes ☐ No **Confirm** ☑ Yes ☐ No

Received by	**Ordering Physician / Informing Staff**
Signature: [signature]	**Signature:**
Name: S UMA MAHESWARI **Date:** 7/1/24	**Name:** Indhumathi **Date:** 7/1/24
Emp. No.: 0206 **Time:** 15:35	**Emp. No.:** 2480 **Time:** 15:35

Action Taken *(only in Cases Of Critical Value)*: [illegible] ? dilutional hyponatremia

	SIGNATURE	NAME	REG. NO.	DATE	TIME
Doctor	[signature]	Dr. Karthon	65851	7/1/24	18:35

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

IP No. / UHID No 2024816 68

AGE / SEX :

Ward / Bed No. CCU

ANY SCORE SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
7/1/24	13:00	(R) Brachial	0/5	Inserted	flushed	followed	
	20:00	(R) Brachial	0/5	Patient	flushed	followed	
8/1/24	8:00	Rt Brachial	0/5	Patent	Flushed	followed	
	14.00	Rt Brachial	0/5	patent	Flushed	followed	
	20:00	(R) Brachial	0/5	patent	Flushed	followed	
				None removed @ 9/1/24 1.10			
9/1/24	7.00	Rt cephalic	0/5	Inserted	Flushed	followed	
			(LA)	cephalic line	removed		
9/1/24	8:00	(R) cephalic	0/5	patent	flushed	followed	
	14:00	Rt cephalic	0/5	Patent	flushed	—	
	20:00	(R) cephalic	0/5	Patient	flushed	followed.	
10/1/24	8:00	R cephalic	0/5	Patent	flushed	followed.	
	14:00	Rt cephalic	0/5	Patent	flushed	—	
	20.00	Rt cephalic	0/5	Patent	flushed	—	
11/1/24	8:00	Rt cephalic	0/5	patent	flushed	—	
	14:00	RT cephalic	0/5	Patent	flushed	—	
	20.00	Rt cephalic	0/5	Patent	flushed	—	
12/1/24	8:00	Rt cephalic	0/5	patent	flushed	—	
				Iv line	Removed	—	

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient : Mrs. Lakshmi
Age / Sex : 81 y / F
Consultant Name : Dr. Gnanavelu.
IP No. : 2024/0004
DOA : 8/1/24.
UHID No. : 20248166?
Room No. : CCU.

S. No.	Date	Medicine Name	Qty.
1.	9/1/24	T. Pantop 40 mg.	6.
2	9/1/24	Nebulization	10
3	9/1/24	Normal saline	10
4	9/1/24	inj Ampicillin 2ml	2.

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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CCU - 1H:25

REQUISITION FOR MEDICINE

Name of Patient : Mrs.LAKSHMI K
Age / Sex : 81/Female/MHI202481668
Consultant Name : 07/01/2024/IPH2024000051
Dr.G. GNANAVELU

IP No. :
DOA : 8/1/24.
UHID No. :
Room No. : CCU

S.No.	Date	Medicine Name	Qty.
1.	8/1/24	Lunch Food	01
2.	"	Easy Bath	1
3.	"	Hydrocort 100mg	3

Nurse Name 8/1

Pharm Bill & Name

MHI/PHARM/2022/060

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10.02

REQUISITION FOR MEDICINE

Name of Patient : Mrs. [illegible]
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : CCU

No.	Date	Medicine Name	Qty.
1	3/1/24	Inj. Pan 40 mg	3
2	"	[illegible] ondansetron 2 ml	10
3	"	[illegible]	5
4	"	[illegible]	5

Nurse Name

Pharm Bill & Name

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REQUISITION FOR MEDICINE

IP No. :
Name of Patient :
DOA :
Age / Sex :
UHID No. :
Consultant Name :
Room No. : CCU

Sl. No.	Date	Medicine Name	Qty.
	8/11/24	T. Natrico 175 mg	5

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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7:35 - (11)

REQUISITION FOR MEDICINE

Name of Patient : Mrs. LAKSHMI.K

Age / Sex :

Consultant Name :

IP No. :

DOA :

UHID No. :

Room No. : (10)

Sl. No.	Date	Medicine Name	Qty.
1	28/1/24	BIRAP (INJ)	1
2	"	BIRAP MOUTH	1

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : CCU

No.	Date	Medicine Name	Qty.
16	7/11/24	4" Cartridge	2
17	"	Neb. Duolin (4 resp)	1 pack.
18	"	Neb. Budecort 4 resp	1 pack.
19	"	T. clopitab - cv 10g	1 Strip.
20	"	T. TAPcin cd 10/12.5mg	1 Strip.
21	"	Inj. Deriphylline 2cc	2
22	"	Inj. Cefti 1.5g	2
23	"	Easy bath	2
24	"	Underpad	2
25	"	Gloves 20 pairs	20.

Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA :
UHID No. :
Room No. : CCU.

S No.	Date	Medicine Name	Qty.
1	7/1/24	50 ml Syringe	1
2	"	Pmo line	1
3	"	IV Set	1
4	"	Nasal prongs	1
5	"	O2 face mask	1
6	"	venflon 20 G	1
7	"	Foxhil fluid	1
8	"	20 cm extension	1
9	"	Easy fix	1
10	"	Inj. Lasix 40 mg	2
11	"	100 ml NS	2
12	"	20 ml syringe	2
13	"	10 ml syringe	2
14	"	5 ml syringe	4
15	"	2 ml syringe	4

Nurse Name: [illegible]

Pharm Bill & Name

MHI/PHARM/2022/060

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REQUISITION FOR MEDICINE

Name of Patient : Mrs. Lakshmi
Age / Sex : 81 Y / F.
Consultant Name : Dr. Gnanavelu.
IP No. : 2024000051
DOA :
UHID No. : 20218166 8
Room No. : CCU.

S.No.	Date	Medicine Name	Qty.
1	7/1/24	Inj. Cefop. S 2g	1
2	"	20 ml Syringe	1
3	"	T. Pacco 500 mg	1 tab
4	"	Foley's catheter 16 F	1
5	"	Uro meter	1
6	"	Povidone 100 ml	1
7	"	Sterile glove 7 size	1
8	"	Xylocaine gel (Lox)	1
9	"	Sterile water	2
10	"	10 ml Syringe	2
11	"	Under pad	2
12	"	Inj. Pora 4 g	1

01458
Nurse Name

Pharm Bill & Name

MHI/PHARM/2022/028

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NABH ACCREDITED

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

Medway Heart Institute
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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 **of** 1 **Height (cms):** ±155 **Weight (kg):** ±90Kg

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

Drug Details	Description of Allergy	Doctor's Sign:
—	NKDA	Name: Dr. Keerthi Reg. No. 85851.

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. *For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings* 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor Sign.	Doctor Reg. No.	Administered Sign.	Administered Emp. No.	Administered Time
7/1/24	13:15	Inj LASIX	20mg	IV	[signature]	85851.	[signature]	0208	13:15
7/1/24	14:00	Inj PARA	1g	IV	[signature]	85851.	[signature]	0208	14:00
7/1/24	17:05	Inj CEFOL-S	3g	IV	[signature]	85851.	[signature]	0208	17:05
7/1/24	17:05	T. Azee	500	PO	[signature]	85851.	[signature]	0208	17:05
7/1/24	19:00	Inj 25% DEXTROSE *	100	IV	[signature]	85851.	[signature]	0208 0184	19:00
8/1/24	11:00	T. Natrilo	1.5mg	P/O	[signature]		STAT	0240	11:00

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. DUOLIN.

Dose	Route	Frequency
1 resp.	PIN	1-1-1.

Dr. Sign & Reg. No. / Seal
3585L.

Start Date & Time: 7/1/24 @ 14:00
Stop Date & Time: 10/1/24 @ 18:00

Additional Info:

Clinical Pharmacist Medway Heart Institute

8:00 → 8:30 8:30 9:55
16:00 → 16:30 16:00 16:00 16:00
00:00 →

DRUG NAME
Tab. DUOFLORT.

Dose	Route	Frequency
1 tab.	PIN	1-0-1.

Dr. Sign & Reg. No. / Seal
3585L.

Start Date & Time: 7/1/24 @ 13:00
Stop Date & Time: 10/1/24 @ 18:00

Additional Info:

Clinical Pharmacist Medway Heart Institute

8:00 → 8:30 8:30 9:50
16:30
20:00 → 20:40 20:40

DRUG NAME
T. CLOPITAB-CV.

Dose	Route	Frequency
75/10 mg	PO	0-0-1.

Dr. Sign & Reg. No. / Seal
3585L.

Start Date & Time: 7/1/24 @ 14:00
Stop Date & Time:

Additional Info:

Clinical Pharmacist Medway Heart Institute

20:00 → 20:40 20:40 20:40 20:40

DRUG NAME
T. TRICINOD

Dose	Route	Frequency
10/12.5	PO	~~0-0-1~~ 1-0-0

Dr. Sign & Reg. No. / Seal
3585L.

Start Date & Time: 7/1/24 @ 14:00
Stop Date & Time: 8/1/24 @ 10:00

Additional Info:

8:00 →

DRUG NAME
Inj. DERIPHYLLIN

Dose	Route	Frequency
2cc	IV	1-0-0

Dr. Sign & Reg. No. / Seal
3585L

Start Date & Time: 7/1/24 @ 14:00
Stop Date & Time: 10/1/24 @ 18:00

Additional Info:

Clinical Pharmacist Medway Heart Institute

8:00 → 8:30 8:30 10:20

Area In-charge Nurse Signature:

NEO 24

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date → / Time ↓ — To be filled by Nursing Staff only. Sign and time given

Prescription	Time	8/1/24	9/1/24	10/1/24	11/1/24	12/1/24			
DRUG NAME T. NATRISB Dose: 15 g / Route: P/O / Frequency: 1-0-0 Dr. Sign & Reg. No. / Seal: 35851 Start Date & Time: 8/1/24 @ 9:40 Stop Date & Time: Additional Info:	10:00	10:00	10:00	10:10	9:50	10:05			
DRUG NAME Inj. HYDROCORT. Dose: 100 g / Route: IV / Frequency: 1-1-1 Dr. Sign & Reg. No. / Seal: 35851 Start Date & Time: 8/1/24 @ 9:40 Stop Date & Time: 10/1/24 @ 10:00 Additional Info:	8:00	9:45	8:30	9:00	8:50				
	14:00	14:00	14:20	14:00					
	20:00	20:00	20:10	20:00					
DRUG NAME Inj. LASIX Dose: 20 g / Route: IV / Frequency: 1-0-0 Dr. Sign & Reg. No. / Seal: 35851 Start Date & Time: 8/1/24 @ 9:40 Stop Date & Time: Additional Info:	8:00	→	8:30	9:00	8:50	8:55			
DRUG NAME T. ALDACTONE Dose: 25 g / Route: P/O / Frequency: 1-0-0 Dr. Sign & Reg. No. / Seal: 35851 Start Date & Time: 8/1/24 @ 9:40 Stop Date & Time: Additional Info:	8:00	10:30	8:20	8:50	8:50	9:20			
DRUG NAME Inj. PAN Dose: 40 g / Route: IV / Frequency: 1-0-0 Dr. Sign & Reg. No. / Seal: 35851 Start Date & Time: 8/1/24 @ 9:40 Stop Date & Time: 9/1/24 @ 11:00 Additional Info:	8:00	→	8:00		ordered change				
Area In-charge Nurse Signature:		[signature]	[signature]	[signature]	[signature]	[signature]			

Clinical Pharmacist Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only ↓

Date → / Time ↓ — To be filled by Nursing Staff only. Sign and time given

Drug details	Time	9/1	10/1/24	11/1/24	12/1/24
DRUG NAME: INJ. PARACIP	8:00	11:15	9:56		
Dose: 1g **Route**: IV **Frequency**: ~~stat~~ (TDS)	14:00	14:30	14:00		
Dr. Sign & Reg. No. / Seal: 112236 **Start Date & Time**: 9/1/24 @ 11:00 **Stop Date & Time**: 10/1/24 @ 15:00	20:00	20:10			
Additional Info:					
DRUG NAME: T. OPTON	8:00	→	7:30		
Dose: 40mg **Route**: PO **Frequency**: 1-0-1					
Dr. Sign & Reg. No. / Seal: 112236 **Start Date & Time**: 9/1/24 @ 11:00 **Stop Date & Time**: 10/1/24 @ 18:00	19:00	19:00			
Additional Info:					
DRUG NAME: Acon on	8:00	→		8:30	
Dose: 1000mg **Route**: PO **Frequency**: 1-0-1					
Dr. Sign & Reg. No. / Seal: 29469 **Start Date & Time**: 10/1/24. 18:00 **Stop Date & Time**:	20:00	→	20:00	20:00	
Additional Info:					
DRUG NAME: IA fondacef	8:00			8:50	8:50
Dose: 2.5 **Route**: PO **Frequency**: OD					
Dr. Sign & Reg. No. / Seal: 29469 **Start Date & Time**: 10/1/24 18:00 **Stop Date & Time**:			19:45	18:05	
Additional Info:					
DRUG NAME: Inj. PAN	8:00	→		7:30	7:30
Dose: 40mg **Route**: IV **Frequency**: 1-0-1					
Dr. Sign & Reg. No. / Seal: 16600 **Start Date & Time**: 10/1/24. 18:00 **Stop Date & Time**:					
Additional Info:	19:00		19:30	19:30	
Area In-charge Nurse Signature:		(signed)	(signed)	(signed)	(signed)

Clinical Pharmacist Medway Heart Institute

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

DRUG	Time	10/1/24	11/1/24	12/1/24
DRUG NAME: Neb. Roracort; Dose: 0.5y; Route: P/o; Frequency: 1-0; Dr. Sign & Reg. No. / Seal: 183573; Start Date & Time: 10/1/24 14:00; Stop Date & Time: ; Additional Info:	8:00	→	8:00	8:55
	20:00	20:00	20:00	
DRUG NAME: Inj. deriphylline; Dose: 2cc; Route: IV; Frequency: 1-0; Dr. Sign & Reg. No. / Seal: 183573; Start Date & Time: 10/1/24 14:00; Stop Date & Time: ; Additional Info:	8:00	→	8:50	8:48 STOP
	20:00	20:10	20:00	
DRUG NAME: T. MUCINAC; Dose: 600y; Route: P/o; Frequency: 1-0-1; Dr. Sign & Reg. No. / Seal: 183573; Start Date & Time: 10/1/24 14:00; Stop Date & Time: ; Additional Info:	8:00	→	8:45	8:35
	20:00	20:10	20:00	
DRUG NAME: Neb. Duolin; Dose: 1 resp/ule; Route: P/o; Frequency: Q6h 1-1-1-1; Dr. Sign & Reg. No. / Seal: 183573; Start Date & Time: 10/1/24 14:00; Stop Date & Time: ; Additional Info:	6:00		6:30	6:00
	12:00		12:20	12:00
	18:00	18:00	18:00	
	12:00	→	00:10	
DRUG NAME: Inj. HYDROCORT; Dose: 100mg; Route: IV; Frequency: 1-0; Dr. Sign & Reg. No. / Seal: 183073; Start Date & Time: 11/1/24 20:00; Stop Date & Time: ; Additional Info:	8:00		→	8:45 STOP
	20:00	→	20:00	
Area In-charge Nurse Signature:		10/1/24	11/1/24	12/1/24

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

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 ↓

Clinical Pharmacist
Medway Heart Institute

Date →	7/1/24	8/1/24	9/1/24	10/1/24	11/1/24	12/1/21	
8:00	→	8:30	8:30	9.00	8.50	9.00	
		D1	D2	D3	D4	D5	
20:00	→	20.00	20.00	20.00	20.00		

DRUG NAME Inj. CFPOL-S.

Dose	Route	Frequency
1.5g	IV	1-0-1

Dr. Sign & Reg. No. / Seal 85851.

Start Date & Time 7/1/24 @ 16:50

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:

AS REQUIRED PRESCRIPTIONS

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

DRUG NAME
INJ. PARA

Dose	Route	Frequency
1 gm	IV	SOS

Dr. Sign & Reg. No. / Seal: K... (134779)

Start Date & Time: 12.1.24

Stop Date & Time:

Additional Info:

Clinical Pharmacist, Medanta Heart Institute

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge Nurse Signature:

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
7/1/24	13:00	NS	36ml	–	IV	Inj. Lasix	40mg	2mg/hr	[illegible]	85851	7/1/24 13:00	8-5-24 7:00	[illegible] 0208
7/1/24	20:00	NS	30cc/hr	–	IV	NS 500ml		30cc/hr	[illegible]	85851	@20:00 7/1/24	18:30	[illegible] 0208

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
7/1/24	13:00	~~[illegible]~~ (N) Diet	[illegible]	85851					
8/1/24	8:00	(N) Diet	[illegible]	85851.					
9/1/24	9:00	(N) diet	✓	128629					
10/1	9:00	(N) diet	[illegible]	183573					
11/1	8:00	Normal diet	K.B	134559					
12/1	8:00	Normal diet	K.B	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				11/1/24	Morning	parameswari	2333	W.
7/1/24	Evening	Umamageswari	0208	[illegible]		Evening			
7/1/24	Night	Sathiya	0240	[illegible]	11/1/24	Night	[illegible]	0141	A
8/1/24	Morning	S. Premalatha	0211	S	12/1/24	Morning	A. Nandhini	0170	A
8/1/24	Evening	Lavanya	0158	[illegible]		Evening			
8/1/24	Night	Ragai R	0159	R		Night			
9/1/24	Morning	S. Premalatha	0211	S		Morning			
9/1/24	Evening	A. Monisha	0141	A		Evening			
9/1/24	Night	A. Monisha	0141	A		Night			
10/1/24	Morning	M. Darsi[illegible]	0[illegible]	[illegible]		Morning			
	Evening					Evening			
10/1/24	Night	A. Monisha	0141	A		Night			

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

MHI/PHARM/2022/028

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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 2 Height (cms): + 155 Weight (kg): + 90

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

Drug Details	Description of Allergy	Doctor's Sign:
—	NOT KNOWN	Name: Dr. Sujith. R Reg. No. 183573

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

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

	Time	11/1	12/1/24						
DRUG NAME: T. MYORIL	8:00		8:30						
Dose: 8 mg / Route: P/O / Frequency: 1-0-1									
Dr. Sign & Reg. No. / Seal: 183073 / Start Date & Time: 11/1/24 19:00 / Stop Date & Time:									
Additional Info:	20:00	20:00							
DRUG NAME: ~~NANO FAST gel.~~	9.00								
Dose: / Route: Tobical / Frequency: 1-1-1	14:00		STOP						
Dr. Sign & Reg. No. / Seal: 183073 / Start Date & Time: 11/1/24 19:00 / Stop Date & Time:									
Additional Info:	21.00								
DRUG NAME: T. CISSPOL	8:00		8:35						
Dose: 1 tab / Route: p/o / Frequency: 1-0-0									
Dr. Sign & Reg. No. / Seal: 183073 / Start Date & Time: 11/1/24 19:00 / Stop Date & Time:									
Additional Info:									
DRUG NAME:									
Dose: / Route: / Frequency:									
Dr. Sign & Reg. No. / Seal: / Start Date & Time: / Stop Date & Time:									
Additional Info:									
DRUG NAME:									
Dose: / Route: / Frequency:									
Dr. Sign & Reg. No. / Seal: / Start Date & Time: / Stop Date & Time:									
Additional Info:									
Area In-charge Nurse Signature:									

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.

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	A.				Evening			
11/1/24	Night	A. Sonyha	0141	A		Night			
12/1/24	Morning	A. Nandhini	0170	A		Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

: Δ SIS :- ACUTE PULMONARY EDEMA | T2DM | SHTN

MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

A

NAME : Mrs.LAKSHMI K
81/Female/MHI202481668
SURGIC 07/01/2024/IPH2024000051
Dr.G. GNANAVELU
POSTOI

UHID NO : 202481668 AGE : 81Y SEX : F

FLUID REQUIREMENT :

9/1/24 – 5

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.		IVF 20			H.T.	H.T.	G.T.		
8.00	50	150					150	30				100	100	130	-20
9:00	100	350					250	30				100	200	360	+10
10:00	100	350					350	30				-	200	290	-60
11:00	160	510					510	30				100	300	350	-60
12:00	100	610					610	30				-	30	480	-130

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS

A 618 :- Acute pulmonary edema

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MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

A

NAME : Mrs.LAKSHMI K
81/Female/MHI202481668
SURGIC 07/01/2024/IPH2024000051
Dr.G. GNANAVELU
POSTOF

UHID NO : 202481668 AGE : 81Y SEX : F

FLUID REQUIREMENT :

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.		IVF NS			H.T.	H.T.	G.T.		
9/1/24															
00.00	110	2290					2290	30					630	1210	1080
1.00	115	2405					2405	30					630	1240	1165
2.00	100	2505					2505	30					630	1270	1235
3.00	110	2615					2615	30					630	1300	1315
4.00	115	2730					2730	30					630	1330	1400
5.00	105	2835					2835	30					630	1360	1475
6.00	100	2935					2935	30					630	1390	1545
7.00	110	3045					3045	30					630	1420	1625

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
—	—

ASP:- ACUTE PULMONARY EDEMA / T2DM / HTN

MHI/ICU/2022/064

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU
NAME

INTERMEDIATE CARE FLOWCHART

A

UHID NO : 202481668 AGE : 81Y SEX : FEMALE

SURGICAL PROCEDURE :

POSTOP DAY : D2.

FLUID REQUIREMENT :

8/1/24 → (1)

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.		IUF 30cc			H.T.	H.T.	G.T.		
8/1/24 8:00	250	250					250	30			30	50	50	80	−170
9:00	250	500					500	30			30	150	200	260	−240
10:00	150	650					650	30			30	100	300	390	−260
11:00	75	725					725	30			30	−	300	480	−305
12:00	75	800					800	30			30	−	300	450	−350
13:00	50	850					850	30			30	100	400	580	−270
14:00	50	900					900	30			30	−	400	610	−290
15:00	130	1030					1030	30			30	−	400	640	−390
16:00	130	1160					1160	30			30	100	500	770	−390
17:00	120	1280					1280	30			300		500	800	−480
18:00	110	1390					1390	30			30		500	830	−560
19:00	150	1540					1540	30			30		500	860	−680
20:00	140	1680					1680	30			30	100	600	990	−690
21:00	135	1815					1815	30	NS 100		130	30	630	1120	−695
22:00	250	2065					2065	30			30		630	1150	−915
23:00	115	2180					2180	30			30		630	1180	−1000

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS

Δ S/u, Acute pulmonary Edema HTDM

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PATIENT SAFETY & QUALITY OF CARE — NABH — ACCREDITED

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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

…RMEDIATE CARE FLOWCHART

A

NAME : **UHID NO :** 202 481668 **AGE :** 81 y **SEX :** F

SURGICAL PROCEDURE : –

POSTOP DAY : — **FLUID REQUIREMENT :** –

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	I.V. FLUIDS: Lasix Infusion	IVF NS		H.T.	ORAL/ R.T. H.T.	ORAL/ R.T. G.T.	TOTAL INTEKE	TOTAL BALANCE
8-1-24 5.00	150	1880					1880	2	30			–	400	934	-446
6.00	150	1530					1530	2	30			50	450	1016	-514
7.00	150	1680					1680	2	30			–	450	1048	-632

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
—	—

: Dis- Acute pulmonary edema / T2DM / T

MHI/ICU/2022/064

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Medway Heart Institute
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Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

NAME

ERMEDIATE CARE FLOWCHART

A

UHID NO : 202481668 AGE : 81 SEX : F

SURGICAL PROCEDURE : —

POSTOP DAY : — FLUID REQUIREMENT : —

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.		
13:00	150	150					150	2		100		~~150~~	~~150~~	102	-48
14:00	150	300					300	2				~~150~~	~~150~~	254	-46
15:00	100	400					400	2				-	150	256	-144
16:00	150	550					550	2				-	150	258	-292
17:00	150	700					700	2	100			150	300	~~510~~	-190
18:00	50	750					750	2				-	300	512	-238
19:00	60	810					810	2				-	300	514	-296
20:00	100	910					910	2			30	-	300	546	-364 ml
21:00	15	~~910~~ 925					925	2			30	100	400	678	-247
22:00	25	950					950	2			30	-	400	710	-240
23:00	50	1000					1000	2			30	-	400	742	-258
00:00	50	1050					1050	2			30	-	400	774	-276
1:00	25	~~1050~~ 1075					1075	2			30		400	806	-269
2:00	35	1110					1110	2			30		400	838	-272
3:00	20	1130					1130	2			30		400	870	-260 ml
4:00	100	1230					1230	2			30		400	902	-328

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS

1 | COPD

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MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

B

NAME : Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

BLOOD

UHID NO : 202481668 AGE : 81Y SEX : F

HEIGHT : ± 155 CMS WEIGHT : ± 90 Kg B.S.A : 2.3MD²

9/1/24 - (5)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8:00	69	Paving	98F	169/82	114	warm	++	20	Br/cl	98	Pt NPO2 2 Liters.
9:00	69	paving	98F	162/73	103	warm	++	19	Br/cl	99	"
10:00	70	Paving	98F	168/63	98	warm	++	20	Br/cl	98%	"
11:00	69	paving	98F	141/54	83	warm	+1	21	Br/cl	97%	"
12:00	69	paving	98F	154/63	93	warm	++	18	Br/cl	96%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE 1420 ML

TOTAL OUTPUT 3045 ML

BALANCE — 1625 ML

/ T2DM / HTN / COPD

MHI/ICU/2022/064

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Medway Heart Institute
Every heart beat counts

INTERMEDIATE CARE FLOWCHART

B

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH202400005
Dr.G. GNANAVELU

NAME :

BLOOD

UHID NO : 20 24 81 668 AGE : 81 Y SEX : F

HEIGHT : ± 155 cm WEIGHT : ± 90 kg B.S.A : 2.3 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
@ 20.00	69	paced	97.3	141/68	91	warm	++	21	Br/d	99	BIPAP < 12/6
1.00	69	paced	97.3	152/69	95	warm	++	20	Br/d	100	11
2.00	69	paced	97.3	151/71	100	warm	++	17	Br/d	99	11
3.00	68	paced	97.3	140/69	99	warm	++	18	Br/d	99	11
4.00	69	paced	97.3	152/70	101	warm	++	19	Br/d	99	11
5.00	69	paced	97.3	156/71	103	warm	++	20	Br/d	99	11
6.00	69	paced	97.3	153/67	96	warm	++	19	Br/d	100	11
7.00	69	paced	97.3	163/71	104	warm	++	20	Br/d	100	11

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

COPD.

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MHI/ICU/2022/064

Medway Heart Institute
Every heart beat counts

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051

RMEDIATE CARE FLOWCHART

B

NAME : Dr.G. GNANAVELU

UHID NO : 2024p81668 AGE : 81Y SEX : F

BLOOD GROUP :

HEIGHT : ± 155 WEIGHT : ± 90 kg B.S.A : 2.3m²

8/1/24 → (3)

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8/1/24 8:00	69	Sinus	98F	145/60	88	warm	++	20	Br/cl	92	Pt on NIPOP 2 litres
9:00	70	Sinus	98F	122/70	74	warm	++	21	Br/cl	93	"
10:00	69	Sinus	98F	132/51	79	warm	++	24	Br/cl	92	BiPAP 12:6 on place
11:00	68	Sinus	98F	134/55	83	warm	++	20	Br/cl	92	"
12:00	69	Sinus	98F	134/62	80	warm	++	21	Br/cl	93	"
13:00	69	Pacing	98F	157/68	96	warm	++	20	Br/cl	91	"
14:00	69	Pacing	98F	148/62	89	warm	++	22	Br/cl	91	"
15:00	69	pacing	97.3°	164/73	103	warm	++	21	Br/cl	94	"
16:00	69	pacing	97.3°	144/57	86	warm	++	21	Br/cl	95	"
17:00	65	pacing	97.4°	144/54	86	warm	++	20	Br/cl	95	"
18:00	69	Pacing	97.4	151/62	92	warm	++	21	Br/cl	94	"
19:00	69	pacing	97.3°	148/64	92	warm	++	20	Br/cl	98	"
20:00	69	pacing	97.8	141/55	86	warm	++	18	Br/cl	99	"
21:00	69	pacing	97.4	136/60	85	warm	++	19	Br/cl	100	
22:00	69	pacing	97.4	139/66	95	warm	++	20	Br/cl	100	"
23:00	69	pacing	97.4	150/68	99	warm	++	21	Br/cl	100	"

PREVIOUS DAY - HOURS

DRAINAGE –

URINE 1680 ml.

TOTAL INTAKE 1048 ml

TOTAL OUTPUT 1680 ml

BALANCE – 632 ml

HTN | COPD.

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

NABH ACCREDITED

MHI/ICU/2022/064

Medway Heart Institute
Every heart beat counts

Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH2024000051
Dr.G. GNANAVELU

RMEDIATE CARE FLOWCHART

B

NAME :

UHID NO : 2024[illegible]68 AGE : 81 y SEX : F

BLOOD GROUP :

HEIGHT : ± 155 WEIGHT : ± 90 B.S.A : 2.3 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
5:00	69	Pacing	98.6	141/63	91	Warm	++	20	BRCL	95%	//
6:00	68	Pacing	97.6	145/68	94	Warm	++	22	BS/Cl	95%	//
7:00	~~69~~	Pacing	97.4	138/70	90	Warm	++	20	BS/Cl	94%	//

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

ITN / COPD.

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MHI/ICU/2022/064

Medway Heart Institute
Every heart beat counts

ERMEDIATE CARE FLOWCHART

B

NAME: Mrs.LAKSHMI K
81/Female/MHI202481668
07/01/2024/IPH202400051
Dr.G. GNANAVELU

UHID NO : 202481668 AGE : 81 SEX : F

BLOOD GROUP : –

HEIGHT : ± 155 WEIGHT : ± 90 B.S.A : 2.3m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
13:00	69	pacing	98F	174/78	108	warm	++	28	B/L clear	99%	O2 2 litres of FM
14:00	70	pacing	98F	175/77	110	warm	++	30	B/L clear	98%	"
15:00	70	pacing	98F	168/83	92	warm	++	23	B/L clear	100%	Pt on nasal prong 2 litres of O2
16:00	70	pacing	98F	149/65	83	warm	++	25	B/L clear	100%	"
17:00	69	pacing	98F	149/54	86	warm	++	25	B/L clear	100%	"
18:00	70	pacing	98F	132/65	94	warm	++	22	B/L clear	98%	"
19:00	69	pacing	98F	145/56	86	warm	++	18	B/L clear	95%	"
20:00	70	pacemaker	98.6	153/65	94	Warm	++	16	BrCL	100%	"
21:00	70	Pacing	98.6	166/73	104	Warm	++	21	BrCL	100%	"
22:00	69	pacing	98.6	139/61	87	Warm	++	22	BrCL	98%	"
23:00	70	pacing	98.6	151/71	98	Warm	++	20	BrCL	99%	"
24:00	70	Pacing	98.6	137/62	87	Warm	++	20	BrCL	99%	"
1.00	69	pacing	98F	161/74	103	warm	++	21	B/L clear	95%	
2.00	71	pacing	98F	157/70	99	warm	++	25	B/L clear	97%	
3.00	68	pacing	98F	161/70	100	warm	++	27	B/L clear	95%	BIPAP 12/6
4.00	69	pacing	98.6	147/63	91	Warm	++	28	B/L clear	94%	

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE