

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.	7	
- 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





Mrs.LAKSHMI K

81/Female/MHl202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Every heart beat counts

Medway Hospitals® The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd) ADIVISSION SLIP	
Admitting Doctor: Dr. GNANAUELU Speciality: CARDIAL	
Advised Date & Time: 4 (1/24 @ 12.50	
Provisional Diagnosis: Acut pulm. edema. for. GRESORPJ	
fcz~-	
CHB ON BPJ	-
Reason for Admission: Medical Management Surgical Management	
Others (please specify details)	_
Admission Type: Day Care ER Ward	
CCu (Specify details)	
Surgery / Procedure Name (if planned):	
/ MM	
Blood Product Requirement: Yes (Kindly specify details of components required in space below)	
Expected Duration of Stay: $H - \Gamma d = 1$	
Expected Cost of Treatment (as per Financial Counseling Form):	ſ
Payer: Self Insurance Others:	_
	_
Instructions to Nurse (if any): ARG Almorn po MCV:	
Herry L. J.	
Any other Instructions (if any):	
Doctor's Signature Name Reg. No. Date, Time	\neg
Dr. Kuthen 3885] 7/1/24 1251	, .
	_

		***	,-I
For admission desk	staff only:		· ·
Room Category:	General Ward		
,	Single Room		
	Twin Sharing		
	Deluxe Room		
	Suite Room) (
	Others	<u> </u>	i.c
	,		
Admission intim	ation Receipt Details	Admission Ti	me 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 E	Blood requirement specified, by the	e Doctor:	_
ls Blood Reservation	n and Blood Bank clearance com	pleted as advised: 🔲 Yes	No
Front office Staff Sign	ature Name	Emp. No.	Date Time
This	I fortisha. K:	7 0192	7/1/2301.19

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Mrs.LAKSHMI K 81/Femalc/MHi202481668 07/01/2024/IPH2024000051 Dr.G. GNANAVELU

Dr.G. Gnanavelu



MHI/HOSP/2022/129

ADMISSION FORM

Marital State		dress No: 102, Marali	Sadasivam.	Stroet	Telephone Number
Occupation	<u> </u>				
Referred fro			on Date & Time of Discharg	ge Total	No. of Days
		#/1/24 01·1	pm 12/1/24	600	J'
UNIT	syd,	MLC Yes	No If Yes Al	R No. :	
		FINAL DIAGN	NOSIS		ICD Code
. ———	COD -	ACUTE BX	ALBRBATION	31p	J44,9
188	MBDTA	ONIL MODE	: VVI FOR CH	+B (7/26)	I50.0
DILV	TIPHAL	HYPONATRE	MIA - CORRE	ECTED _	-
NOR	MAL	LY FUNCTIO	oul modera	113 PAH	J50.1
८५९	TEMIC	HYPERTEN!	Stock fupe it		T27.2
DIAB	127ES 0	nellitus			110
					F11.9
DATE		OPERATION	/ PROCEDURES		ICPM Code
ĺ					
ı					
. —					
		•			
DATE		TYPE OF	ANESTHESIA		-
	☐ GENERA	L SPINAL	☐ LOCAL [REGIONAL	EPIDURAL
		DI	SCHARGE STATUS		
☐ Cured		☐ Discharge at Re		□ Ex	pired < 48 hours
Improve	ed	☐ Against Medica ☐ Absconded	I Advice	□ Ex	pired > 48 hours
☐ Unchan	ged			□ Ро	st-Operative Death
	GNAMAVI			Qui de la	
Signatur€	Striffe Consu	Itant	S	ignature of Medic	al Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical a administer such drugs as may be necessary and deemed necessary and / or advisable in the dia who is my(Relations	d to perform such operation gnosis and treatment of m	on under anaesthesia or other wise as may be
I hereby under take to settle all the bills for hosp basis. In any case, I shall pay all the dues before	-	to me/the patient named overleaf on a periodic the hospital.
However, in case I fail to pay the charges due to me/the patient to any other hospital/institution for		
I also acknowledge having been informed if the and valuables belonging to the patient or theis a next of kin and I absolve the hospital of any resp	attendants have been remo	•
I have read out and explained the contents of th	e above to the Signatory in	n his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய <i>அ</i>	·	
		கள் எனக்கு /நோயாளி . 🛵 🏿 🖒 🌣 🏗 🎉
மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூ	· •	ழங்குகீறேன். நான் / இதீல் குறித்துள்ள நோயாளின்
• •		கட்டத் தவறினால் என்னை நோயாளியை வேறொரு o எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம்
மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி ஒ	தரிவிக்கீப்பட்டிருக்கீறேன்.	
•		ம் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நாயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட	. பிறகுதான் கையொப்பமிட்டே	டன்.
17/2°		6hr
செவிலியர் கையொட்பம்	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date 07-1-24	Signature of the Patient / Relative / Gurdian

500,

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Nature of Relationship



81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





GENERAL CONSENT FOR ADMISSION

1,
☐ 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		LAKSHANI K	7/1/24	1:01
Surrogate/Guardian (if applicable #)	Cent		7/1/24	1:01
Reason for surrogate consent	Patient is unable to give consent	oecause;		
Witness	lain	Kani Mon.	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



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



ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

	ADMISSION CRITERIA FOR INTENSIVE CARE UNIT		
S. No.	PARAMETERS	MARK - APPROP	
	Hemodynamic instability defined as		
	Pulse less than 40 or more than 150 beats/minute	i	
1	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		
	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		
2	Propertensive 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		
	Miscellaneous Conditions		
3 -	Septicshock with hemodynamic instability	1	
٦ [Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
	Post procedure elective admission		
	Post Coronary Angioplasty		
	Post Cardio-vascular Surgery		
; }	Following angiographic procedure		1
	Complication resulting from the angiographic procedure including any significant change in pulse in the		ł
	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-	1	J
- (procedure		
	Significant findings on diagnostic anglography warranting further therapy that would necessitate inpatient admission is also a reasonable indication for admission		
<u></u>	Admission at the time of the study is encouraged if problems are suspected or arise		
	Pulmonary System	-	
			1
_	Acute respiratory fallure requiring ventilatory support (Invasive / Non-Invasive)		
	Pulmonary embofi with hemodynamic instability Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory		
۰	deterioration		
_	Need for nursing / respiratory care not available in such intermediate care units		
	Massive hemoptysis		
	Respiratory failure needing imminent intubation		
	Renal fallure		ļ
,]	Oliguria or anuria for more than 12 hours		
7 -	Metabolic acidosis (pH < 7.1)		[
-	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline	ı	,

S. No.		PARAMETERS							
	Diabeti insuffici	iency, or severe acidosis	ed by hemodynamic instability, alte	red mental status, respi	ratory	•			
8	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								
	Hypo or mental:	status	dium less than 110 mEq/L or more than 1		Itered				
	Hypo or muscula		modynamic compromise or dysrhythmi ssium less than 2.0 mEq/L or more than weakness		ias or				
		Signature	Name	Reg. No.	Date	Tij			
Do	ctor	4 7	······			7			
 1 -		M	Dr.Kenthons	(B) (S)	<u> </u>	24 18: 1			
S. No.		CHARGE CRIT	ERIA FOR INTENSIV	,		MARK - AS PPROPRIATE			
No.	DISC	CHARGE CRIT	ERIA FOR INTENSIV	,					
No.	DIS(nemodynamic parameters espiratory status (Pt. extubat	ERIA FOR INTENSIVE PARAMETERS	/E CARE UNIT					
1 2 3	DISC Stable in Stable re Minimal	nemodynamic parameters espiratory status (Pt. extubat oxygen requirement (not me	PARAMETERS ted with stable arterial blood gases) & air ore than 3 L by nasal prongs)	/E CARE UNIT					
No. 1 2 3 4 5	Stable h Stable re Minimal Intraven Cardiac	nemodynamic parameters espiratory status (Pt. extubat coxygen requirement (not motor) nous/Inotropic/Vasopresso dysrhythmias are controlled	PARAMETERS ted with stable arterial blood gases) & air ore than 3 L by nasal prongs) or support and vasodilators are no longer	/E CARE UNIT					
No. 1 2 3 4 5 6	Stable h Stable re Minimal Intraven Cardiac Presence	nemodynamic parameters espiratory status (Pt. extubat exygen requirement (not me nous/Inotropic/Vasopresso dysrhythmias are controlled	PARAMETERS ted with stable arterial blood gases) & air ore than 3 L by nasal prongs) or support and vasodilators are no longer	/E CARE UNIT					
No. 1 2 3 4 5 6 7	Stable h Stable re Minimal Intraven Cardiac Presenc No signs	nemodynamic parameters espiratory status (Pt. extubat coxygen requirement (not motor) nous/Inotropic/Vasopresso dysrhythmias are controlled	PARAMETERS ted with stable arterial blood gases) & air ore than 3 L by nasal prongs) or support and vasodilators are no longer	/E CARE UNIT					
No. 1 2 3 4 5 6 7	Stable h Stable re Minimal Intraven Cardiac Presenc No signs	nemodynamic parameters espiratory status (Pt. extubat oxygen requirement (not motors) nous / Inotropic / Vasopresso dysrhythmias are controlled the of distal pulses s of bleeding and hematoma	PARAMETERS ted with stable arterial blood gases) & air ore than 3 L by nasal prongs) or support and vasodilators are no longer	/E CARE UNIT					
No. 1 2 3 4 5 6 7 8	Stable h Stable re Minimal Intraven Cardiac Presenc No signs	nemodynamic parameters espiratory status (Pt. extubat coxygen requirement (not me nous/Inotropic/Vasopresso dysrhythmias are controlled the of distal pulses s of bleeding and hematomate care pathway chosen	PARAMETERS ted with stable arterial blood gases) & air ore than 3 L by nasal prongs) or support and vasodilators are no longer at puncture site Name Name	/E CARE UNIT	A	PPROPRIATE			







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: 07/01/2024

: 12/01/2024

D.O.A

D.O.D

DISCHARGE SUMMARY

IP No.

: IPH2024000051

UHID

: MHI202481668

Name

: Mrs. LAKSHMI.K

Age / Gender

: 81 Years / FEMALE

Consultant

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

Chief Cardiologist

Room No. : 114

8

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, 81 years 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

SPO₂: 99% on room air

CVS : S1S2 (+)

RS : BAE(+), B/L crepts(+)

Mogappair

Abd : Soft CNS : NFND

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

Villupuram

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Kodambakkam

(O) @medwayhospitals

Chengalpattu

medway-hospitals

Kumbakonam

medwayhospitals

Kakinada



Medway Group of Hospitals

Heart Institute In

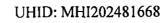
Institute of Pulmonology 044-2473 4451

044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 | E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

044 - 4310 8959 044-2473 445

Medway Centre of Excellence (Chennai)

MHI/HOSP/2022/118







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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.

<u>DEVICE INTERROGATION:</u> 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, 81 years 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.

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

♠ @MedwayHospitals

Mogappair

Kodambakkam

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Kumbakonam

Kakinada

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

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



UHID: MHI202481668



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ADVICE MEDICATIONS:

NAME OF THE DRUGS WITH	DOSAGE	FREC	UENCY	7	ROUTE	RELATION	DURATION
GENERIC NAME		M	A	N		SHIP WITH FOOD	
TAB, CLOPITAB CV	75/10 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
TAB. LASIX	40MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
TAB. ALDACTONE	25 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
TAB. ACTON OR	1000MG	1	0	1	ORAL	AFTER FOOD	X 5 DAYS
NEB. FORACORT	400MCG	1	ō	1 PUFF	P/N	AFTER FOOD	X 10 DAYS
NEB. GLUCOHALE	25 MCG	0	1	Ō	P/N	AFTER FOOD	X 10 DAYS
NEB. LEVOLIN	0.63MG	1.	1	1	P/N	AFTER FOOD	X 10 DAYS
TAB. AB PHYLLINE N	1 TAB	1	0	I	ORAL	AFTER FOOD	X 10 DAYS
TAB. MONDESLOR	1 TAB	0	0	1	ORAL	AFTER FOOD	X 10 DAYS
TAB. PREDNISOLONE	40MG	1	0	0	ORAL	AFTER FOOD	X 5 DAYS
TAB. PREDNISOLONE	20МС	1	0	Ö	ORAL	AFTER FOOD	X NEXT 5 DAYS
SYP. BROZEDEX	5ML	1	ī	1	ORAL	AFTER FOOD	X 10 DAYS
NEB. DUOLIN	1 RESP	1	1 1	1	P/N	6 HOURLY	
TAB. MYORIL	8 MG	1	0	1	ORAL	AFTER FOOD	X 1 WEEK
TAB. CISSOL	1 TAB	1 -	0	Ō	ORAL	AFTER FOOD	X 1 WEEK
TAB. PAN	40MG	I	0	1	ORAL	BEFORE FOOD	TO CONTINUE
	TAB. CLOPITAB CV TAB. LASIX TAB. ALDACTONE TAB. ACTON OR NEB. FORACORT NEB. GLUCOHALE NEB. LEVOLIN TAB. AB PHYLLINE N TAB. MONDESLOR TAB. PREDNISOLONE TAB. PREDNISOLONE SYP. BROZEDEX NEB. DUOLIN TAB. MYORIL TAB. CISSOL	TAB. CLOPITAB CV 75/10 MG TAB. LASIX 40MG TAB. ALDACTONE 25 MG TAB. ACTON OR 1000MG NEB. FORACORT 400MCG NEB. GLUCOHALE 25 MCG NEB. LEVOLIN 0.63MG TAB. AB PHYLLINE N 1 TAB TAB. MONDESLOR 1 TAB TAB. PREDNISOLONE 40MG TAB. PREDNISOLONE 20MG SYP. BROZEDEX 5ML NEB. DUOLIN 1 RESP TAB. MYORIL 8 MG TAB. CISSOL 1 TAB	GENERIC NAME M TAB. CLOPITAB CV 75/10 MG 0 TAB. LASIX 40MG 1 TAB. ALDACTONE 25 MG 0 TAB. ACTON OR 1000MG 1 NEB. FORACORT 400MCG 1 NEB. GLUCOHALE 25 MCG 0 NEB. LEVOLIN 0.63MG 1 TAB. AB PHYLLINE N 1 TAB 1 TAB. MONDESLOR 1 TAB 0 TAB. PREDNISOLONE 40MG 1 TAB. PREDNISOLONE 20MG 1 SYP. BROZEDEX 5ML 1 NEB. DUOLIN 1 RESP 1 TAB. MYORIL 8 MG 1 TAB. CISSOL 1 TAB 1	TAB. CLOPITAB CV 75/10 MG 0 0 TAB. LASIX 40MG 1 0 TAB. ALDACTONE 25 MG 0 1 TAB. ACTON OR 1000MG 1 0 NEB. FORACORT 400MCG 1 0 NEB. GLUCOHALE 25 MCG 0 1 NEB. LEVOLIN 0.63MG 1 1 TAB. AB PHYLLINE N 1 TAB 1 0 TAB. MONDESLOR 1 TAB 0 0 TAB. PREDNISOLONE 40MG 1 0 TAB. PREDNISOLONE 20MG 1 0 SYP. BROZEDEX 5ML 1 1 NEB. DUOLIN 1 RESP 1 1 1 TAB. MYORIL 8 MG 1 0 TAB. CISSOL 1 TAB 1 0	GENERIC NAME M A N TAB. CLOPITAB CV 75/10 MG 0 0 1 TAB. LASIX 40MG 1 0 0 TAB. ALDACTONE 25 MG 0 1 0 TAB. ACTON OR 1000MG 1 0 1 NEB. FORACORT 400MCG 1 0 1 NEB. GLUCOHALE 25 MCG 0 1 0 NEB. LEVOLIN 0.63MG 1 1 1 TAB. AB PHYLLINE N 1 TAB 1 0 1 TAB. MONDESLOR 1 TAB 0 0 1 TAB. PREDNISOLONE 40MG 1 0 0 TAB. PREDNISOLONE 20MG 1 0 0 SYP. BROZEDEX 5ML 1 1 1 NEB. DUOLIN 1 RESP 1 1 1 TAB. MYORIL 8 MG 1 0 0	GENERIC NAME M A N TAB. CLOPITAB CV 75/10 MG 0 0 1 ORAL TAB. LASIX 40MG 1 0 0 ORAL TAB. ALDACTONE 25 MG 0 1 0 ORAL TAB. ACTON OR 1000MG 1 0 1 ORAL NEB. FORACORT 400MCG 1 0 1 P/N NEB. GLUCOHALE 25 MCG 0 1 0 P/N NEB. LEVOLIN 0.63MG 1 1 1 P/N TAB. AB PHYLLINE N 1 TAB 1 0 1 ORAL TAB. MONDESLOR 1 TAB 0 0 1 ORAL TAB. PREDNISOLONE 20MG 1 0 ORAL SYP. BROZEDEX 5ML 1 1 1 P/N TAB. MYORIL 8 MG 1 0 0 ORAL TAB. CISSOL 1 TAB 1 0 0	M

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

Villupuram

★ @MedwayHospitals

Mogappair

Kodambakkam

(C) @medwayhospitals

Chengalpattu

n @medway-hospitals

Kumbakonam

medwayhospitals

Kakinada



Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

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

044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 | E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665



UHID: MHI202481668



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

DIABETIC MEDICATIONS:

Sl.	NAME OF THE DRUGS WITH	DOSAGE	FREQ	UENCY		ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N		SHIP WITH FOOD	
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

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

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94557 94557 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

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

Chengalpattu

Villupuram

Kumbakonam

Kakinada

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





Pai Mrs.LAKSHMI K

Na 81/Female/MH1202481668

UH 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





INPATIENT INITIAL ASSESSMENT

Date: 7/1/24 Time of arrival in ward: 1:01pm
Allergies (if Yes, specify details):
Drugs Yes No
Blood Transfusion
Food
Others
Vital Signs: Temp: 974(°F) Pulse / HR: 69 (beats/min) BP: 179 (89 (mmHg) Respiration: 29 (breaths/min) SpO ₂ : 99 (%) Height: ±155 (cms) Weight: ±90 (kgs) BMI: 37.5kg/w
Pain: Yes No. If Yes, Score: 45 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 (O Bosenthlessness some 2 days progress of aggrang not resserted with medicultions Alo bull 2 days Lake notable welk & machinered to pain in @ hip.
PAST MEDICAL HISTORY (with duration of illness):
Diabetes Mellitus: ☐ No. If Yes, duration: ➤ \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Others: COPD. LD7 MIN. CHB-O-PDT.
Past Surgical History: ppg - mplumbed for CHB2016.

Pre	Present Medication (for Medication Reconciliation):						
\$. Vo.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued durin	
,	T. Beplex force	1	Ø 15	0-07.	06/1/24020	Yes □ No	
ľ	7. Between 5 7. Colocar 1	82	plo	1-47	07/124@830		
չ '	1. Cilocar 1	leg	plo	0-1-0	06/124@14:00		
ı ʻ	1. Colycomet Cop	1/850		1-07	07/1/24 08:20	. ☑ Yes □ No	
5.	COMEZ	roy	Nb	1-54	07/1/24 @8:3	☐ Yes ☐ No	
,	1. Sporla PS.	r	Plu	1-00	07/1/24 @ 8:30	☑ Yes □ No	
ľ	Titricenod	10/2.5	Plo	1-00	07/1/24 @ 820	. ☑Yes ☐ No	
						☐ Yes ☐ No	
		-		,		☐ Yes ☐ No	
	•			-		☐ Yes ☐ No	
·am	ily History:	1	1	<u>l</u>	·.		
	ily History:	hever is a	oplicable)		·.		
Per Lif	rsonal / Social History (<i>Tick which</i> estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoho		ation:		al Drug Use: ☐ Yes ☐ I		
Per Life Sm Ot	rsonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoho hers:	Occup	oation: □,No	Recreations			
Per Life Sm Ot	rsonal / Social History (<i>Tick which</i> estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoholhers:	Occup	oation: □,No	Recreations			
Per Life Sm Ot	rsonal / Social History (Tick whice estyle: ☐ Sedentary ☐ Active noking: ☐ Yes ☐ Mo Alcoho hers:	Occup	oation: □,No	Recreations			
Per Lif Ot Ot	estyle: Sedentary Active noking: Yes No Alcoho hers: estrual and Obstetric History (to be	Occup I: Yes [be filled up Company of the compa	nation: ⊒No o for fema	Recreations	al Drug Use: ☐ Yes ☐ I	No	
Per Life Ot Ge	estyle: Sedentary Active noking: Yes No Alcoho hers: estrual and Obstetric History (to be eneral Physical Examination lior: Yes No Ict	Occup I: Yes be filled up Company The	es 🗹 No	Recreations		No	

SYSTEMIC EXAMINATION	ON
cvs: S, S of	Q-
Respiratory System:	
	ns.
יים	scocryps O.
Gastrointestinal System:	
8-	2C.
Central Nervous System:	sprd.
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· · · · · · · · · · · · · · · · · · ·	
orinary / Reproductive / Loco	_ ·
	Prep. 20m restricted.
Skin / Opthalmic / ENT	n4f)
	81ms.
Suspected of contagious diseased isolation required:	ase: ☐ Yes ☐ No Immuno compromised status: ☐ Yes ☐ No ☐ Yes ☐ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet
Psychological Evaluation:	
☑ Normal ☐ Anxious ☐ Der	pressed Others:
Nutritional Screening (ESPE	N Guidelines for Nutritional Screening - NRS 2002):
Weight loss within the last 3 mo	onths? Yes No Is the patient severely ill? (e.g. in Intensive Therapy) Yes No
Reduced dietary intake in the la	ast week? ☐ Yes ☐ No Is the BMI < 20.5? ☐ Yes ☐ No
	'ES" to any 2 questions, the patient is at nutritional risk O" to all questions, the patient is at Normal and not at risk
Provisional Diagnosis:	2# H.P.D.
	Actre phi-edena
	Ett M.P.D. Actre phi-edeuer Tigm, MIZ, COPD
Plan of Care:	rometris. No v + s &
7	metris.
	N1 V 4 3 85
	malisores with the
- 1	xm-flp & chest.

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Investigations Ac						à	
CAR relys Xing the for hips.							
CRR inches							
Xm ten for kills.							
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Diet Advice:							
☐ Nil per Oral	Clear liquid diet	□ Normal liquio	d diet	Diabetic [iquid diet		
☐ Semisolid diet	☐ Soft solid diet	South Indian	normal diet	☐ North Ind	ian normal d	liet	
☐ Neutropenic liquid	diet Others:					_ [
Early Discharge Plan	ning (fill in those which are a	appropriate at thi	s stage):	PFE: Pa	tient Family l	Educatioi	
Special support need	led at home	☐ Yes ☑ No	If Yes, PF	done :			
Home equipment ant	icipated	☐ Yes ☑ No	If Yes, PF	E done and equ	ipment advis	sed	
Physiotherapy at hom	ne anticipated	☐ Yes ☐ No	If Yes, edu	If Yes, educated on physical limitations, if any			
Wound care needs a	nticipated at home	☑ Yes □ No	If Yes, educated on signs on infection				
Pain Management		☐ Yes ☐ No	If Yes, PF	E done and med	dication advi	sed	
Special Dietary needs	S	☐Yes ☐ No		acated on dietar actions and alle		s, food	
Continuous / ongoing	g care anticipated	☑ Yes □ No	If Yes, edu	ıcated on variou ired	us aspects of	fongoing	
Other special educati	ion need, i.e.;	∰Yes □ No	If Yes, PF	E done		3	
Nature of post hospit infection control, fall	al needs like patient safety, risk, etc, addressed	✓ Yes □ No	If Yes, spe	ecific education	given		
Others:							
						ľ	
						ł	
, ,	Signature	Name		Reg. No.	Date	Time	
Resident Doctor	hr	Dr. huth	1	-	F11/24	13:20	
Consultant	Dr.G. GNANAVEL Reg. No: 39469	y wear	ravelu	39469	F/1/24	13:20	
Patient Attendant	France E	Relationship			7/11/24	13:20	



(A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.LAKSHMI K

81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





CONSENT FORM FOR CRITICAL CARE (ICU)

1, MAS. LAKSHMI.IC	the Ratient or Representative of patient have (please tick the correct option
above and below):	
Read	
Thave been explained in detail by the patient's illness and I am aware of the all th	e treating doctor and I understand about the condition of me / and my patient or my ne possible outcomes.
Been explained this consent form in En provided about ICU Treatment	glish/ Tamil , which I fully understand and understood the information
needed to improve the patient's condition. I her	scuss with the doctor about the condition of myself or my patient, treatment options, procedures reby give consent to treat the illness of myself or my patient and to do emergency procedures like ods of securing airway, mechanical ventilation, central venous access, arterial lines and further

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.

methods of monitoring which are needed to improve or treat my condition.

- 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 patie	nt)	
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:	



உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

		ត សា ក្រ	பெயர் கொ	ாண்∟ ⊐ நே	ரயாளியா	ான அல்	லது 🗆	் நோயாளியின்	பிரதிநிதி	யான		
	நூன்,	இந்த	ஒத்திசைவு	படிவத்தை	(மேலே	மழ்றும்	கழே	உள்ளவற்றில்	சரியான	விருப்பத்தேர்வை	தயவுசெய் து	முக்
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 பீற 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 பேரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்பற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:

மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

- ஒரு சிறிய நாளத்தைவிட, ஒரு பேரிய 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 வாசோபிரேசர்ஸ் ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அமுத்தத்தை 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), சருமத்திவிருந்து பாக்ஙியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதீட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉ றைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுனைரயீரல் 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 சுறப்பட்டிருக்கின்றன:

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவாணை:

முச்சுப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவீழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை முச்சுப்பாதையை பராமரிக்க வகை செய்யிறது 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 குமுரமைய சுற்றி வீரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய்,

கள்ளப்பற்றகான இந்த குழாயின் அள்ளு தோய்ளாயின் வியுது மற்றும் தொகைட் அள்ளுத்துப்பட்ட குற்கு பொருத்துமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பீறத் குழாவை சுற்றி வீரிவடைகின்ற காற்றின் ஒரு சிறீய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். முச்சுக்குழாய், குறல்லலைக்கு சற்றுகீழே தொடங்குகிறது. மற்றும் மற்பு எலும்பீற்கு பீன்னே வரை அது நீள்கிறது. அதன்பீறகு மூச்சுக்குமாறு இந்த மூச்சு சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுறையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பீரிகின்றன. மூச்சுக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திக ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திகக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் வீரிவானதாக ஆகிறது. மூச்சுப் வெளியே வீடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புசிறது. மூச்சுப்பாதையில் எந்தவொரு இடமும் தேதலையற் இத்தகைய தருதைத்தில் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்குடும். இந்த செயல்முறை உங்களது முச்சு / காற்றுப்பாதையை அடைப்பீன்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிலுன் தடைபின்றி, தார்வமைக்கிறது. இங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிலுன் தடையின்றி, தாராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கூடும்;

- உணர்விழப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக முச்சுப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது /உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது சுவாசிக்க உதவ:
- கவாசிப்பதை 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 முச்சுக்குழாயில் 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 வழியீல்லை.

மேற்குறிப்பீடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தனொரு மருத்துவ செயல்முறையில் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் அறிந்திருக்கிறேன், தெரிவித்துக்கொள்கிறேன், பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோரு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துல செயல்முறையீலும் ஏற்பட சாத்தியமுள்ள ஆருத்துக்கிறேன். எந்தகொரு மருத்துல செயல்முறையீலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமேல்லை 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 தோயாளி 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 ஓப்பகல், அளிக்கிறேன் என்று இகன் சுலம் நான் மேலம் உறுகிமொழிபளிக்கினேன்

-	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
நோயாளி				
பதிலாள் / பாதுகாவலர் (பொருந்துமானால் [#])	James &	ட்டு இநாயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)	J/1/24	13:30
பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்வை	- 0 11 0	. 1	
சாட்சி மெழிபெயர்ப்பாளர் (போருந்துமானால்)	· dece	Sently Kumas (Son	7/1/10	1 3:30

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

கழே, 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	Quuij	பதிவு எண்.	தேதி	<u>நேரம்</u>
மருத்துவர்	m	Dr. Lulture	4565	1/1/24	13:30
					





81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)	<u> </u>	Every heart beat counts
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Doctor's Name: . madduke		<u> </u>
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Respiratory system Oxygen supplementation – Saturation / PaO2- Ventilator : Spontaneous / Controlled Last C x R - Drains -	GIT P/A Bowels Y/N Loose stools Drains NG tube: Y/N Day USG CT	s / Melena NGA-
Nutrition & Fluids Oral feeds / NG feeds TPN – formula used Supplements Calories / Proteins achieved: IV fluids - 24 hour Urine output Fluid balance Creatinine clearance Acidosis Lactate RRT – SLED / IHD / CRRT	Microbiology Invasive lines 1. Foley's Yes No ET Tube / Tracheostomy tube Culture reports Antimicrobials with days 1. 2. 3.	
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Signature Name Reg. No.	Date	Time





81/Female/MH1202481668 U07/01/2024/IPH2024000051

Dr.G. GNANAVELU





ICU PROGRESS NOTES

Date: 8/1/24 Time: 8 50

Doctor's Name:

ICU SCORES

(as Appropriate)

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day

Background

7 Ret. pl. Ederra. -) Hyponatrenon.

> Co19. 1-8m

Issues last 24 hours

- Hypondoema.

Central nervous system

Conscious / oriented / sedated with

Sedation score GCS - E V M S(LS · Pupils Pain score

Cardiovascular system

HR-69. Rhythm -

Cardiac Output -

BP-169/70 CVP-Cardiac Medications:

Respiratory system

Oxygen supplementation - BARS (5)

Saturation / PaO2-

Ventilator: Spontaneous / Controlled Last C x R -

Drains -

GIT 300

Bowels - (Y)/N Loose stools / Melena

Drains

NG tube: Y/N

Microbiology

Invasive lines

Day NGA-

USG CT

Nutrition & Fluids

Oral feeds / NG feeds

onlycedy .

TPN - formula used

Supplements

Calories / Proteins achieved :

IV fluids -

Folev's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Antimicrobials with days

1. CEFOL-J.

2.

3.

Labs

TC /0,900 Platelets 3,35,000 ٠ ص- ١٥ Hb

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 KND

Alpha bed Y / (1)

Plan for	•				
	the day				
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Doctor	Signature	Name	Reg. No. 95851	Date 9 1 24	Time





81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



DOCTOR'S PROGRESS NOTES				
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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





Date: 8 1 2024

ICU PROGRESS NOTES

Time: 2 110pm

Doctor's Name :

ICU SCORES

(as Appropriate) SOFA score: MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day / Background

Issues last 24 hours

Central nervous system

Conscious / oriented / sedated with

Sedation'score

GCS - E V M Pain score

MU Pupils BIL

Drains

Cardiovascular system (

HR - 🚜 🕽 Rhythm -Cardiac Output -

BP - NOTO CVP -

Cardiac Medications:

Respiratory system

Oxygen_supplementation -

927. 82 202 Saturation / PaO2-

Ventilator: Spontaneous / Controlled

Last C x R -

Drains -

GIT

P/A CM

Bowels - Y+N Loose stools / Melena

Drains

NG tube: Y/N

Day NGA-

2.

USG

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

CT

Microbiology Invasive lines \

1. person p

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

2.

3.

Labs

0- 0/ dH

TC 191010

355000 Platelets -

Creatinine Urea 12

Na 112

K 3.75

AST

ALT

DVT prophylaxis Y/N

Drugs:

Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis -Y/N

Drugs

Pressure sore Y / N

Alpha bed Y / N

INR

Bilirubin

Others





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(A Unit of United Alliance Healthcare Pvi Ltd)





Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





ICU PROGRESS NOTES

Date: 8/1/2 y

Doctor's Name: BALAJ)

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate) so

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

Cardiac Output -

ICU Day Background

AEWPD, 1.E

Issues last 24 hours

better I SOB.

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS-E V M

Pupils

Pain score Drains

Cardiovascular system

HR - 28 Rhythm -

BP - 130/90 CVP -

Cardiac Medications:

Respiratory system

Oxygen supplementation - 10-7. Z2L02.

Saturation / PaO2-

Ventilator: Spontaneous / Controlled

Last C x R -Drains - GIT P/A

Bowels - Y / N Loose stools / Melena

Drains

USG CT

NG tube: Y/N

Day !

NGA-

Mechanical - TEDS / SCD

Nutrition & Fluids

Øral 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

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

DVT prophylaxis - Y/N

1.

2.

3.

Labs

Hb 10

TC 1/282

Platelets

Urea 🤈 👂

Creatinine ? . 5

Na 1/8

K 3.7

Bilirubin

AST

ALT

Stress Ulcer Prophylaxis - Y/N

Drugs

Drugs:

Pressure sore Y / N

Alpha bed Y / N

INR ·

Others

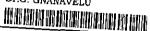






81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Date: 9 1 24.

ICU PROGRESS NOTES

Time: 8:00

Doctor's Name: Daleji

The way to better health

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate)

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

Cardiac Output -

ICU Day Background

ACS, Y.E, ACTOPD

Issues last 24 hours

Cardiovascular system

BP-130/80 CVP-

Cardiac Medications:

aunight BYBP.

Central nervous system

Conscious / oriented / sedated with

Sedation'score

GCS-EVM

Pupils

Pain score

Drains

P/A 1-1/

HR - 72

Oxygen supplementation - 100 /- 2 L 0

Saturation / PaO2-

Respiratory system

Ventilator: Spontaneous / Controlled Last C x R -

Drains -

Bowels - Y / N Loose stools / Melena

Rhythm -

Drains

NG tube: Y/N

Day NGA-

USG CT

Nutrition & Fluids

Øral 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

Preighand.

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

Bilirubin

AST

ALT

INR

Others 5

DVT prophylaxis - Y/N

Drugs:

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N/

Drugs

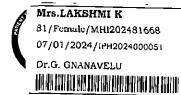
Pressure sore Y / N

Alpha bed Y / N

Plan for	r the day					, .
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Doctor	Signature	Name	T T	Reg. No.	Date	Time
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DOCTOR'S PROGRESS NOTES

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DATE	·	NOTES	
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DATE	NOTES	
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81/Female/MH1202481668





MHI/IP/2022/041 Medway



Every heart beat counts

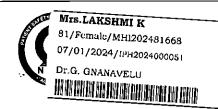
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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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DATE	NOTES
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2.00	patient revielled.
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MHI/IP/2022/041

Medway

Heart
Institute

art beat counts

	DOCTOR'S PROG	RESS NOTES
DATE	NOTES	
10/1/24	. < 9/8	pr-Gnanavelu team.
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Mrs.LAKSHMI K 81/Female/MHI202481668 07/01/2024/IPH2024000051 Dr.G. GNANAVELU

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MHI/IP/2022/041

Medway

Heart

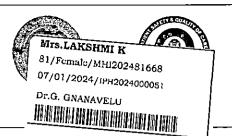
Institute

Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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10/01/24	
31.	- 81/F
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	7, mu enachoomy Plo 89
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	3) Dru h. Foreturz 0.5mg BD. Owh Duous 19up BGH. Mg. Deer 2ee 1 BD. T. Mr crosscowg Plo BD. A) plan Pt / For punon to De. 6) 10mm Dayme intenstul / oungest Estap < 2 Tother.
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DATE	NOTES	
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28.00	Pationt reviewed.	-
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	ots' patient conscious, voiented,	
-	SIE US-5152 (P)	
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	CNS - NIFRID	
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ni Johlana	183. X.1	
(0) -	BP-120/80mmHg	
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290071	SP02 - 93 -95 / RA	
	- Advico	
	- monitor vitals	
	- continue the days as perchant 8 he	bulisatu
	- Check CROH tolk	
4.00	- continue overnight BiPAP	8)
(34h)	Day time intermittent	^
	- to change Inj. hydrocost 100mg IVI	DS
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MHI/IP/2022/041

Medway

Heart

Institute

Every heart beat counts

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DATE	NOTES
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DATE	NOTES	1 7 1
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11/11/11		
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Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



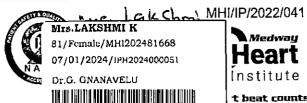


DOCTOR'S PROGRESS NOTES		
DATE	NOTES	
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10:15	Am	
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DATE	NOTES	* * .
12/1/24	- 3/B Dr. Fransing	
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23.50	Patient devieus	
	clo; short ness or breath reduced how.	
	0/6: patient conscious, oxiented,	
•	SET CUS-6162P)	
	AS-BAED.	
	21.5	
UHalsstable	- monitor vitals	
	- Continue the dayge as perchant	
Thi hudxoox	t - Check CBC1 tds	
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Inj. Conol-S	time ûntermittent BIPAP	0
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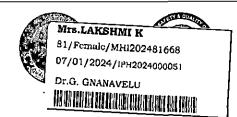


Medway Heart Ínstitute t beat counts

	THE HILL PROTECTION WHICH COMPANY AND ADDRESS OF THE PROPERTY
_	DOCTOR'S PROGRESS NOTES
DATE	NOTES
12/04:45	ADDI Clalup
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	3) may stop daytine BirAP continu orwent BirAP y) For prior to D/C.
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DATE	NOTES	
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10/1/24	app on Dr. Hear Kenson.	
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DOCTOR'S PROGRESS NOTES

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Q.	Dr ELAKIYA MATHI'' ARAN MRBS.,N	
·	(Respirator, "Audicine) Consultant Pulmonologist	
¥.	Reg No : 108445 MEDWAY INSTITUTE OF PULMONDLOR	

DATE 	NOTES
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	Dr ELAKIYA MATHIMARAN MEES MD
	(Respiratory Medicine) Consultant Pulmonologist
	Reg No : 108445 MEDWAY INSTITUTE OF PULMONOLOGY
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PRE/POST OPERATIVE ECHO

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

Dr.G. GNANAVELU

Screening Fehr

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Date & Time	SIP PPI (VVI)
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(D)	· Concentrie un
avo	· Signoid septem
	c No Puma
	· Normal en systetic question
	· Grade il digetolie depopuration-
	· Normal RV Systolie durelion
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-	· Normal ev systetie function · Grade îi digstolie dysquestion · Normal RV systetie function · Artie value sclorosed & mildly capifued · Mild As/ mild Az,
	. Other value are normal
	· IAS/ INC Intact
	· mid HR
	· mind TR. moderate PAH (RVSP: 45 mm Hg)
·	· mild right, minimal left pleural effection
	· ive normal in size & collapsing · No clot vegetation / pericardial offunos
	. No dot vegetation perseardial effusion
	· RV lead in E, ty
	HR: 69 bpm
	IVS: 13 mm TAPSE: 19 mm
	pw: 11mm pul·Ace lini: 74ms
	WIDD: EIA: 1.21
	WIDS: Med ElE! 28.61
	EF: Lat E/E': 16.6
	EDV: 71M AR PHT: 570M3 ESV: 25Ml AV max: 2.27mls
	ESV: 35 ml AV onax: 2.27ac/s EF i 50% Peak Ps: 20 marts
	Et i 50%. Peak Ps: 20 marts mean P4: 10 marts
	Done by: Which (PA) Re)
	M+11 6053(AD
	*バヤリー しもひろ つくがり

1941 18052 (AD





Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

MICROBIOLOGY SHEET URINE ROUTINE ANALYSIS

DATE	7/1/24		
COLOUR	DATE COETTON		<u></u>
REACTION	J		
SPECIFIC GRAVITY			
APPEARANCE	CLICHTLY TURBID	_	
ALBUMIN			_
SUGAR			
ACETONE			
3ILE SALT			
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	10-12		
EPITHELIAL CELLS	2 - 4		
RBC	6-8		
CASTS	NIL		
CRYSTALS	NIL		
OTHERS	NIL.		
			

MICROBIOLOGY-CULTURE REPORTS

	'T-		
DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY
oliler Ori	URINE el3		



PREVIOUS DIABETIC MEDICATIONS





Every heart beat counts

DIABETIC CHART

	Mrs.	LA	KSHMI	К
--	------	----	-------	---

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

100 MW 1000 1000 MW 10

ACTUAL WEIGHT	+ 90 Kg	j .	HbA.c	_
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DATE TIME BLOOD SUGAR DIABETIC DRUG Sign. ENDORSED BY

1/11/24 13:20 89 mg/dl

Tig. 25 D Dextree Down DR. Kauthick

Tilly 19:00 bonngldl

Tig. 25 D Dextree Drug Dr. Marthick

Stilly \$:40 86 mg/dl

Stilly \$:40 86 mg/dl

Stilly \$:40 86 mg/dl

Stilly \$:40 80 mg/dl

Stilly \$:40 80 mg/dl

Tig. HA buints

Stilly \$:50 \$0 92 mg/dl

Tig. HA buints

Stilly \$:50 \$0 \$02 mg/dl

Tig. HA buints

Stilly \$:50 \$00 \$02 mg/dl

Tig. HA buints

Tig. HA buints

Stilly \$:50 \$00 \$00 mg/dl

Tig. HA buints

Tig. HA

INSTRUCTIONS FOR INSULIN INFUSIONS

MOX

58 Mg

- 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.).

12-20

18:00

- 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.

buntos

etindrals A.H







Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

į	ט -	1919 ACM COMMENSAGE AND ACCOUNT OF THE PROPERTY OF THE PROPERT
i	U	Dr.G. GNANAVELU
-		07/01/2024/IPH2024000051
-	•	81/Female/MHI202451005

DIABETIC CHART

ACTUAL WE	IGHT	# 90-/cg HbA,c			
PREVIOUS	DIABETIC I	MEDICATIONS	<i></i>		
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
1 A. 4 A.	6.30	205 mg/d1	Bry Hm 100	given to de	P K 9347500
	12:30	252 mg-fall	Inj. HA 8U.	given at	Doee usso
	8:30	165 mg/dl	Boud tout (60).	18 20:30	programa Relation
11.1.24	6.30	318 mg/d/	In. HA-120 .	238 70 ED	134659
	1240	243 mg/d	Di. H. Achapid. But	Sold Sold Sold Sold Sold Sold Sold Sold	12 (18259) DV.Ja
	18.30	ziomaldi.	3. If Adribit & wh	My at 80	Br. soloi
12.1.24	br.30	208 mg/d/.	IN . HA - 60	Soll	K-0034000
•	18130	168 mg ldL.		Solhl	K. Moura
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INSTRUCTIONS FOR INSULIN INFUSIONS

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	normal Saline (IU - 1 ml.) Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
		251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.



-- BLOOD GROUP





Every heart beat counts

Mis.Lakshmi K

81/Female/MHJ202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



	STIGATION SHEET			Dr.G. GNANAVELU		
_Date .	711/24	801/24	क्षा २4	9/1/24	111184	i sibre ji
HAEMATOLOGY				(,,)		
Hb '	10.2	10.0	<u></u>			
P.C.V	35.7	20.4.	· • • • • • • • • • • • • • • • • • • •	- :	\$ ·	<u> </u>
Platelets	392000	355000		1.		
TLC	109-90-	10080			- :	200
Polymorphs	904	P. 48			<u> </u>	
Lymphocytes	5.0	8.0.	-			13. 3.
Eosinophils	0.7	1.3				
Mono / Basophils	3-8/01	5.5103				
E.S.R	<u>.</u>	1				<u></u>
BIO-CHEMISTRY	,	1				
Urea	19	210	·	·		5.77
Creatinine	B.52	0.59.	;			,
Sodium	115	418		132	132	
Potassium	3.90	3.75		3.52	3.91	1000
Bicarbonate	25	23				
Chloride	75.5-	76.1	<u></u>			
Magnesium	<u> </u>					
Calcium	8-6	· P-F	·			
Phosphorus -	2.5	- 3.5	<u> </u>		-	
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-T.Bilirubin			<u> </u>	- 		-
D:Bilirubin	, , , ,	1 9 -				
I.Bilirubin	. 1		- 100			
S.G.O.T	<u> </u>					
S.G.P.T	_ 1	·	-			
ALP						ļ
GGT ···					_	
Total Protien	-					
S.Albumin						
CARDIAC ENZYMES						}
Troponin I	12.7					
CKNAC - CPK	1					
CK - M.B. MASS						
LDH		_				
Ntpro bnp						

						1
Date						<u> </u>
COAGULATION						†
PT / INR						1
Fibrinogen						
D Dimer			_			-
LIPID PROFILE						-
Total Cholesterol						
Triglyceride						<u> </u>
H.D.L						<u> </u>
L.D.L		<u> </u>		<u>.</u>		
VLDV					<u> </u>	
THYROID FUNCTION						<u> </u>
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lg						<u> </u>
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Dm, HTW

Medway Hospitals The way to better health (A Unit of United Allies----

(A Unit of United Alliance Healthcare Pvt Ltd)

Mis.Lakshmi k

81/Female/MH1202481668 07/01/2024/1PH2024000051

Dr.G. GNANAVELU

NA KATABATAN BARTAN BANTAN BANTAN BANTAN BANTAN







Every heart beat counts ,

BLOOD GROUP

ON ADI	MISSION
Height in CM	Weight in Kg.
+ 155Cm	±90 Kg

VITAL INFORMATION SHEET

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Every heart beat counts

EARLY WARNING (

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frequency	3 .	Every 2 nd Hourly
	2	Every 4th Hourly







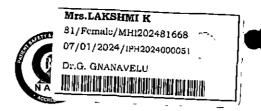
Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

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		1022		NDW		├	 	 	1	-		 	-	!	
tiels by Sr. RN		190	000												

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







From: 9/1/24 To:10/, 124 Bed No: 1/2 . Date **INTAKE & OUTPUT** 24 Hrs : Started Time : The Started Ended Time: 3,000 **CHART** NPO Started at: NPO Over at: SHIFT Morning Night Restricted Fluid (RF) Afternoon INTAKE **OUTPUT** Total Intake: Total Output: 10 Difference: INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain Endorsed Oral Time **Time** Urine **Vomitus** R/N Sign Feeding Aspirate Tube by Type of Fluid Additions **Amount** Onto T intak d M ask LataT Dutout **(** bin my 12-do UP TOBARO 2501 19,40 -150 780 1210 A2.00 300 Acres Don b 230 18,00 **රීර්**න 193.30 200 20മ ГоM 1220 m 1810 m La



Mrs.LAKSHMI K 81/Female/MHl202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

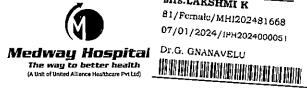








Date	Fr	om: ر	pli	24 To	o: 씨/	1/20	(Be	d No:۱۲	3 _					INITA			יים דו
24 H	rs : S	tarted 1	ime	: 7/00			Ended T	ime :	A :30)				INTA			PUI
NPO	Start	ted at :					NP	O Over a	at:						CHA	KKI	
SHIF	T		N	lorning			Afterr	noon			Nigh	t		Rest	ricted F	luid (R	F)
INTA	KE			275			18				300 ru	<u>l </u>					
OUT		_		150				<u>comb</u>		<u></u>	100 4	il					
Total	Intake): 				To	otal Outpu	ıt:				Differen					
				INTAKE					<u> </u>			רטס	PUT	<u>, , , , , , , , , , , , , , , , , , , </u>	(in the second		
Time	Oral	Tul		Intraver	nous li	nfusio	n	ीनिगि	Time	Urine	Vomitus	N/G	Drain	Others	Total	R/N Sign	Endorsed
	ļ	1 000	my	Type of Fluid	Addı	tions	n Amount				-	Aspirate	lube				by
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9-70	187	>						التعاد	17:30	600					750		
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Mrs.LAKSHMI K 81/Fernale/MHI202481668 07/01/2024/IPH2024000051









Date	Fro	m: W1/0	ک _{دی} Tu	0:12/1/2	_p Be	ed No: 21						INITAI	VE 9	OUT	DUT
24 Hr	's : Sta	arted Time	: 7 Low-		Ended T	Time : न	1200					INTA			FUI
	Starte	d at:			NF	O Over a	at:						CHA		
SHIF			lorning		Afterr				Night	t		Resti	ricted F	luid (R	F)
INTAI			lieo		<u> 58</u> 0	omL				50ml					
OUTF			weo		<u>600</u>	mL-		<u> </u>	(100						
Total l	Intake:	_ (pj@pr	/meralm		Total Outpu	ut: 2 72	ァ. ローーー			Difference					
			INTAKE	• •		Territoria de la constanta de	ļ,				rput (}			
Time	Oral	Tube Feeding	Intraver Type of Fluid	Additions	Amount	Ticital	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	चित्र	R/N Sign	Endorsed by
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9-20	-680					350	12 0	600					lboo		
[140	B						6:00						2700r		
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(Jac)						450									<u> </u>
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6%	<u>(DQ)</u>					1020Ml.	-		-		<u> </u>				pa,
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Every heart beat counts

Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

sis: Ac	ute	pulmone	vey edema	Yes/NorTryes, specify	TN/60'PD/PI	PT /2016/16
+ 155	cms \	Weight: Kgs			£1-E	50.7
us Beliefs:		Vegetarian	Non Vegeta			Jain
rescription:	hoo o	a losi es	lou s Fat	Low salt C	maketic dist	- income
JECTIVE	GLOBA	L ASSESSMEN	Γ (ADULTS)	COVER SOURCE		grest oi (ti
			Car to Car		· 5 · 2 · *	765(101 (31)
	(A) -	Patient's related Medical His	tory	i		
	1]	Weight Change (overall change	ge in past 6 months)		:	
		101	102	□ 3	□4	_ 5
		No weight change/ gain	<5% ·	5-10%	10-15%	>15%
2)	Dietary Intake	Duration				
		<u> </u>	. 🗆 2	□3 , ₁ ,	- 4 ·	5
	Drail	No change	Sub - optimal solid diet	Full liquid diet/ , , , , moderate	Hypo - caloric Ilquid diet	Starvation
	<u> </u>		• ,	overali decrease '- ,		
	Enteral / Parenteral	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric i feeds	Starvation
	Nutrition		.,			
3)	Gastrointestin	al Symptogns Duration:			· · · · ·	
-		Z 1	□ 2	□ ;	4	□ 5
	,	No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea /	severe arioretta
4)	Functional Ca	pacity (Nutrition related functional in	pairment) Duration:		, ,	
		101 .	□ 2	□ 3 '	□4	□ s
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair- ridden with no or liftle activity
5)	Co - morbidity (Disease and its relationship to nutriti	on requirements)		1	
	1	□ 1 · · ·	2	12/13	.04	□ 5 ·
		Healthy	Mild to - morbidity	Moderate co- morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
B)	Physical exam	Norton		_ 		<u> </u>
	A 14 A DAME CARDIN		·			
13	Decreased fat	stores or loss of submitaneous fat	· ·		•	· · · · · · · · · · · · · · · · · · ·
1)	Decreased fat	stores or loss of subcutaneous fat	· [] 2		ΤΠ4	П.
1)	Decreased fat	47	□ Z	I Almarate	4	G 5
		Normal	Mild Mild	☐ 3 Moderate	_ 4	Severe
2)	Decreased fat Sign of muscle w	Normal rasting	Mild	Moderate		Severe
		Normal	-	- 	D4	
2)		Normal Pasting I	Mild	Moderate .	□4	Severe
Z) Total Score = St	Sign of muscle w	Normal rasting I Normal nonents	Mild	Moderate .	D4	Severe
Z) Total Score = St	Sign of muscle w	Normal Normal Normal onents	Mild	Moderate .	D4	Severe
Z) Total Score = St	Sign of muscle w um f above 7 comp	Normal rasting I Normal Normal onents	Mild	Moderate .	D4	Severe
Z) Total Score = St	Sign of muscle w um f above 7 comp tus: Based on this Well Nourished	Normal rasting 1 Normal Normal nonents patient is	Mild	Moderate	D4	Severe
Z) Total Score = St	Sign of muscle w um f above 7 comp tus: Based on this Well Nourished Moderately Mal	Normal rasting 1 Normal Normal nonents patient is	Mild	Moderate	D4	Severe
Z) Total Score = St	Sign of muscle w um f above 7 comp tus: Based on this Well Nourished Moderately Malhou	Normal rasting 1 Normal Normal nonents patient is	Mild	Moderate	D4	Severe
2) Total Score = St Nutritional State Nutrition Interv	Sign of muscle w um f above 7 comp tus: Based on this Well Nourished Moderately Malhou	Normal rasting 1 Normal Normal nonents patient is	Mild 2 2 Mild	Moderate		Severe
2) Total Score = St Nutritional State Nutrition Interv	Sign of muscle w um f above 7 comp tus: Based on this Well Nourished Moderately Mallo Severely Malno vendon:	Normal rasting 1 Normal Normal nonents patient is	Mild 2 2 Mild	Moderate Moderate Moderate Moderate 177 to 14) 1(15 to 18) 1(19 to 35)		Severe
Total Score = Si Nutritional State Nutrition Interv	Sign of muscle w um f above 7 comp tus: Based on this Well Nourished Moderately Malho. Severely Malho. vendon: Oral g provided:	Normal rasting 1 Normal nonents patient is nourished	Mild 2 2 Mild	Moderate Moderate		Severe
Total Score = St Nutritional State Nutrition Interview C Diet counselling	Sign of muscle w sign of muscle w um f above 7 comp tus: Based on this Well Nourished Moderately Maino Severely Maino Oral g provided: e-assessment:	Normal rasting 1 Normal nonents patient is nourished orthed	Mild 2 2 Mild	Moderate	□4	Severe

Dietitian Signature / Name / Date / Time:

10280-14:00 7/1/24

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
7/1/24	N 81 years old Female Came T C/O B greathlessness (2 days) was assessed to be Well- nounished as evident by, SGA.	8286 74
	le10/0- T20m/HTW. Educated no potient & familyon bloo calvoies, ww. Fat, lowealt, piabatic diet. Emphanized on shall prequent meals & low queenic control.	
8/1/24 10:00	osal intake is better. Reemphasized on diet restriction patient succeived and.	Q-10286
13'-00	Reemphasized on diet restriction oral wall i good. Educated Ve notifiet and James on 1000 caloring	
- -	production of the place of the control of the contr	mb . C 10 .

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Mis.Lakshmi k

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

PSYCHOLOGICAL WELLBEING REPORT

Date: 09/01/24

Time: 3.15 pm.

Unit: [13

Clinical diagnosis: Acute julinmany edema, LOPDIDM, HTN

Surgery/ Procedure:

Impression:

- calm affect, sciented, responsive l'(early ingraisment)
- sleep & appetite (1). - couldn't énterent prettue due le ceasing difficulty.

Employee ID: MH10275/954

Signature of the Psychologist:





CONSENT FOR HIV TESTING

Pa Mrs.LAKSHM 81/Female/MH		Ag	e:8		: M/F
Cc 07/01/2024/IF	PH202400 005 1		·	UHID	20248166
Dr.G. GNANAV	<u> </u>				
• Iinformation	for HIV antibody te		nave been give	en verbal and writt	en educational
imormation	TIOI FITV antibody tes	suird.			
	n informed that a sai I have been informe test done				
 I hereby ad testing. 	cknowledge that I ha	ve read or have ha	d read to me this	information regardi	ng HIV antibody
 I have bee satisfaction 	n given the opportun ı.	ity to ask question	s and all the ques	tions have been an	swered to my
	dge that I have giver explained to me in $\underline{\mathcal{T}}$				V antibodies. Th
	Signature		Name	Date	Time
Patient		p LAKS t	-1M)],	811/24	9.00.
Doctor / Nurse / Counsellor) a	100 De-(-100].	18/1/2ml	9.00
Interpreter					
ONSENT OF PA	TIENT REPRESE		ROGATE		
na nationt is unable	e to consent because	a			
id I,	e to consent because	·	(name / re	ationship to the pat	ient), therefore,
-	tient I acknowledge or or doctor's design			•	ocedure, as sta
					
Patient Represent with relationship	Signati	ire .	Name	Date	Time
Doctor / Nurse / Counsellor					-
Interpreter					

CONSENT OF PATIENT REPRESENTATIVE L SURROGATE										
The patient is una	able to consent because									
and I, (name / relationship to the patient), therefore,										
consent for the patient I acknowledge that 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		\								
		•								

'n

SAFETI FIRST





MIS.LAKSHMI K

81/Female/MHI202481668 07/01/2024/(PH202400005)

Dr.G. GNANAVELU





NURSING ADMISSION ASSESSMENT (ADULT)									
Date of Admission: # 1 24 Time of Arrival: 3' 0 Mode of Admission: Walking Wheelchair Stretcher Accompanied by Relative: Yes No If Yes, Name of the Relative: MR WANT RAJAN. Relationship with Patient: Son Contact Person's Name: 9962405666 Relationship: Son Contact No.: 9962405666 Primary language spoken: Imail English Indian International Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No Menstrual History: LMP: Menopause: Yes If yes specify Drugs History: Antiplatelet Specify)									
Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty Do you have any special religious, spiritual or cultural needs to be considered? Yes No If Yes, specify details:									
Socio Economic Status: Employed Retired Own Business Home-Maker Others:									
Vital Signs: Temp: 48 户 (°F) Pulse / HR: 169 (beats/min) BP: 149 / (mmHg) Respiration: 28 (breaths/min) SpO ₂ : 160 (%) CBG: 图 (mg/dl) Height: 1755 (cms) Weight: 190 (kgs)									
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known If Yes, specify:									
Pain: Yes No. If Yes, Score: b/o Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years) Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location: 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: Loes Salt diet Dietician Informed: Yes No. If Yes, mention the Name: Mgs. Commercial 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 ☐ Ño									
Hearing Impairment Yes No									
Chewing Difficulty Yes No									
Walking Difficulty Ves No									

					·-· ·	A1 2 4		- :			
Daily Activity Of L	iving:				-			<u> </u>		,	
Activity		A	ed	Dep	ende	nt '					
Bathing	<u> </u>				-						
Dressing			一一	-							
Eating					一一		<u> </u>				
Walking		一声			〒				౼		
Toilet Use					一一						
Pressure Injury Risk Assessment: Braden Scale									<u> </u>		
	Sensory Perception Score Moisture				Sc	ore	Degree o	of Activity	, 1	Score	
No Impairment		(4	Rarely Moist	t		4	-Walks Fre			4	
Slightly Limited		3	Occasionall			3)		casionall	v	3	
Very Limited		2	Very Moist			2	Chair Fas			_2	
Completely Limit	ed	1	Constantly N	Moist		1	Bed Fast			(1)	
Mobility		Score	Nutrition		Sc	ore	Friction	& Shear		Score	
No Limitation		4	Excellent			4	No appa	rent probl	em	3)	
Slightly Limited		3	Adequate			3		Problem		2	
Very Limited	_	2	Probably In-	-Adequate		2	Problem	Present		1	
Completely immo	obile	1~	Very Poor			1			l	//	
Total Score:	Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: Action needed: Yes No Pressure injury present at the time of admission: Yes No If yes, Location: Grade: Size:										
_		-		-							
Witnessed by:			Signature:				Helatio	nship:			
Fall Risk Assess			E FALL ASSES	SSMENT SC	ALE ((Age al	bove 16 ye	ears)			
Variables								1 .,	Num	neric Value	
History of falling	(immediat	e or within 6	months)					No Yes	25		
			 					No		0	
Secondary diagn	iosis (≥ 2	medical diag	nosis)					Yes	1	15	
Ambulatory Aid None / Bed Rest		ssist				_			· · ·		
Crutches / Cane	/ Walker	-								15	
Furniture										30 '	
Intravenous Ther	apy / Hepa	arin Lock / Tu	ıbes Insitu					No Yes	20		
Gait Normal / Bed Rest / Wheel Chair Weak Impaired										0 10 20	
Mental Status Oriented to own stability											
		nitations						1 1	•	15	
	Overestimated or forgets limitations Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics									(15)	
Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk Total Score							Yes		<u> </u>		

Low Risk Interventions (0-24) Familiarize the patient with the immediate surroundings Remind the patient to use call bell before getting out of bed \bigcirc Keep the two side rails in the raised position at all times for all patients regardless of age / Reep 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 \square 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 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) **占**、Encourage family members or other visitors to stay with them If appropriate, consider using protection devices: safety belts

As per the score, tick the following appropriate boxes:

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		1						
Has colostomy been done		/,						
Any other potential needs of the patient		1						

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.											_	Yes / No		Score
1	Active cancer	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)											1 0	Ø
2	Bedridden recently >3 days or major surgery within four weeks										一	Yes []	No	<u>'</u>
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)											Yes 1	No	p
4	4 Collateral (nonvaricose) superficial veins present (Assess for both legs)										Yes V	νo	0	
5	Entire leg swo	llen (As	ssess for b	oth le	gs)						Ø	⁷ Yes 🔲 I	No	Ī
6	Localized tend	dernes	s along the	e deep	vend	ous s	ystem (As	sess for b	ooth legs)			Yes 🗾	Vo	ρ
7	Pitting edema	, greate	er in the sy	mptor	natic	leg (/	Assess fo	r both leg	ıs)	^	Ø	⁷ Yes ∐ I	No	t
8	Paralysis, par	esis, or	recent pla	asterin	nmot	oilizat	tion of the	lower ext	tremity (Asses	ss for both legs)		Yes 1	40	Q
9	Previously do	cumen	ted DVT (A	Assess	forb	oth le	egs)					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.										- -			
	k Score Inter the score ob			babil	ity o	f DV	T):					Final Sco	re	2_
	Action Taken							Date		Time				
Low	Low Risk -2 to 0													
Мос	derate Risk	1	to 2	_2	_						3/12/2	3 3	205	
Hig!	h Risk	3	to 8							-			<u> </u>	
Per	sonal Belong	jings /	/ Valuab	les:									•	
Valua	ables	De	escriptio —	n		ith ient		atient's ndant		Signature of the atient's Attendant		Rema	rks	
Dent	ures	•	per□Lo oth ☑Ni											
Hear	ing Aid		ght 🗆 Le	eft								_		
	glasses / act lens	□Ye	s JW	0	 				I					
Jewe	ellery													
Othe (spec	r valuables cify)													
Rep	oort (List of X-	ray, E0	CG, lab r	eport	s reta	aine	d with th	e nurse)	;					
			Sign.			Na	ıme			Emp. No.		Date	Tir	me
	ent / ent's Attend	ant å	ecce	- &		2	Bento	ul Ku	mar	Relationship (SOP)	11	12/231	13%	3 5
Nur	se		W/			1	MRY	vahes	huonei .	©25%	7	12/24	135	15
Unii	it In-Charge Total TAUAMSA COSS					· `.	12/22	17 .	15					

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Document endorsed





Mis.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051





	nited Alliance Healt		Covernment of the second of th		ry heart bear	t-counts				
PATIENT CLINICAL HANDOVER RECORD FOR NURSES										
Date:	î î		ning Evening Night		•	, 				
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	S: HULL PULL OF CANAGE AND CANAGE	t: Brankal POD: Central line	days: -	.:	,				
В	BACKG Type of s Allergies On room Complain	urgery:	Date of surg Lit on FM IV fluids on t							
A	BP: <u>/ 子に</u> Others : Pain Sco Fall Risk Braden S	ns: Temp:	/ HR: 69 (beats/min) Respir 2 (%) Height: ≯ 1 57(cms) Weight : PIPPS / CRIES / FLACC / Wong-Ba : PIPPS / CRIES / FLACC / Wong-	: <u>190</u> (kgs) BMI:_ ker FACES Pain Ratin isk: 14-13 □ High Risk: Dressing done: □ Yes	37 5 g Scale / NR: 12-10 Severe	S/CPOT				
R	Pending Pending Pending Critical v Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	: No. If Yes, modified care plan date Other whice Youhui sepo							
Handover g	siven hv	Signature	Name	Emp. No.	Date	Time				
-		OS R	SUMA MAMOSWAEL	0708	7/1/24	15,30				
Handover taken by		I VACI	I MINHE	100 N 44	17 lilan					

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
1/27:	of pt got Admillion to ccupt is	
1	Conscions & oriented pt Bp- 174/78	
19.05	MR-69 SP02-9911' RR-284Juit	0203.
	of In LASIX offsted, pot on Facement	<u>s</u>
·	o) - 2 littles, pto on pp I precent.	-
13:30	of caresization done pt under the	() L
-	mohitoring	nor
17,00	=> P+ Ilo chest maintained phhad	
_	DYAL Rice Kanchi II PORD 19m IV grains of Pt was skyle that's the mornistoring	02
15:00	2) Pt was skyle whiles the mornitoring	ows
16.300	=> pt Ilo chest sing meinteined, polvis x-xy done	
17:00	13ce 500 mg plo gren ordere by	0201
	Azce 500 mg No gren Order og	010.
1850	Dos. Korsteick.	<u> </u>
	of pt Aftender seen su pt.	2
(۲۰۵۵	=> Unine routine remoled to les Advised	024.
	pt handed over to the pt Might duty	_
19:36	siff.	-
_		
		<u> </u>
Document	Signature Name Emp. No	F F- N
endorsed by	Jay JAYADENS OOR	2/1/29 20 rd







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

Dr.G. GNANAVELU



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

- 1		ITI OLINIOAL I	ANDOVERN		<i>.</i>						
Date: 7	1/24	Shift: Morn	ing ☐Evening ☐₩i	ght			_				
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	s: P D EWS Score: day: I line day: Right: De: Yes No Day atheter: Yes No Day		GCS: (5) POD: — Central line of VIP Score: (ecify organis	lays:		,				
В	On room		19 on them 1	Date of surge	,						
A	ASSESSMENT Vital Signs: Temp: 98-6°F) Pulse / HR:										
R	Pending Pending Pending Pending Pending Variation Variation Pending Pe	IMENDATION doctors: medications: medication indent: lab reports / Intestigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:		are plan date	:						
		Signature	Name		Emp. No.	Date	Time				
Handover g		S	Nathiya		0240	8/1/24	7 136				
Handover ta	ken by	Dest.	F. Trongague	<u> </u>	0211:	8/1124	7:80				
Document e	endorsed	Jay	JAYAPRI	ارية	0000	8/1/20	3-70				

	NURSES PROGRESS NOTES	· -
Date & Time	Observations / Action	Signature with Émp. No.
71124	Might duty Notes	
@ 19130		
	=> Pt taken oney from	0 2 4 12
	Evening duty stapp, pt conció	i i
	& ovilented, of vitals are etab	
	= pt Np-21st on plou	
	=> p+ hool am diet.	
2 0100	mediune genen al por	5240
	drug clart.	
21:00	1 -> pt Ing. LosePx 2 mg/hr	
	on flow, Pt TVF NC	0 DH+
	South on glow	
23:00	>> pt Concious O ouented.	00-
	VICE Observed the Note, as	0240
	Compline of patient, continue	
	the seeme	RI.
7 '00	patient Concious obviented 1416	Doselo
	view roled the Notes, Do. madhuko	
	advice to Bipap 12:6 Started.	
	10 Compline of patient continue	200
	the come	
4:30	Patient Concider Oduentes verces	00
<u> </u>	elleworded the Notes, morning Investiges	0240
	flon votes, cuent, net, kt done	
	Reports due.	5240
5:20	patient Concions Occurred vich	
	decurded the Notes FCE, ORG don	A A
	NO complince of pretinit	624
7:3	patient concious Oviented veccy	
	recorded pt Hand over to mining du	ly sloth.
Document	Signature Name Emp. No	
endorsed by	Jaguer Jagapans Joan	- 18/1/24 10·a







81/Female/MHJ202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES									
Date: 8 (124	Shift: Mor	ning Evening E	Night					
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: ALUTE YULKWONDULF PEWS Score: - 'day: al line day: Right: Le be:	Odlama (8471) off: Buadrial ay: D2 DR: □Yes □No. If Yes	POD: — Central line of VIP Score: (days: _				
В	On room		802 2 littoss shift:	Date of surge		•	•		
A	BP: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	SMENT ns: Temp: Q8 F(°F) Pulse \(\bar{D} \) (mmHg) SpO ₂ : Q ore: \(\bar{D} \) (D Pain Scale use Score: \(\bar{D} \) Fall Risk Poscore: \(\bar{D} \) Minimal Risk: 23-19 Ulcer Scale for Healing (Pulse) diet: \(\bar{D} \) (Alt \(\bar{D} \))	d: PIPPS / CRIES / FLA rotocol: □ Low□ Med At Risk-Mild Risk: 18-1 JSH): □ Yes □ No □ Med	(cms) Weight: CC / Wong-Bak dium High 5 Moderate Ris Wound D	ter FACES Pain Rationsk: 14-13 High Risk:	ng Scale / NR	STCPOT e Risk: 9-6		
R	Pending Pending Pending Critical vi Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: nstructions if any:	S:	d care plan date					
Handover g	liven hv	Signature	Name	-	Emp. No.	Date	Time		
Handover to		9 - Je litra .	Store or out of		0911	81124	13.4°C		
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	NL	JRSES PROGRESS NOTES	_					
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A:40		golmt o R-Boblat o			- X			
,	Be-145/60 mmHg	•		:				
7:50		: 12:6 Outlow .						
8:00		t no other complaints			90			
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9:45	3 Du G. Granavel	u sin soon the P+ h	dd.		&			
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19:00	> Pt CBC	souces & surring	. k		A			
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13:00:	=> P+ No		γ——		- (N)			
	duty staff	- {)			~		
<u>.</u>				_				
	Signature ₂	Name	Emp. No.	•	Date	Time		
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81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES
Date: 8 t 24 Shift: Morning Evening Night
SITUATION Diagnosis: A tute pumpraty colorna GCS: IS IS NEWS / PEWS Score: - Central line days: Ventilator day: Central line days: Peripheral line day: Right: Left: Nu-faracyal Ryle's Tube: Yes No Day: Urinary Catheter: Yes No Day: Barrier nursing: Yes No MDR: Yes No If Yes, specify organism:
BACKGROUND Type of surgery: Allergies if any: On room air / oxygent: Complaints / New Symptoms in last shift: Date of surgery: Date of surgery: Complaints / New Symptoms in last shift:
ASSESSMENT Vital Signs: Temp
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 Check Na+ 8th holy.
Signature Name Emp. No. Date Time
Handover given by All Quanta. DISB 8/1/24 19.50 Handover taken by All Dall Color Col
Document endorsed Jay Jayrip V

		NURSES PROGRESS NOTES		
Date & Time		Observations / Action		Signature with Emp. No.
8/1/24	NIG	HI DURY NOTES		
@19.30				
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6-30	2 pt on	Fiby, CBCy don	$\frac{2}{6}$	·
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7,00	J.J. P.	an yong IV gara	nas	
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7.30	Signature Signature	Name 2	Emp. No.	Date Time
Document	Joel	401mnon or	0001	9/1/24/200
endorsed by	1 O V ,	I AM HDF/11. 2	1 000	111-4





81/Female/MHl202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





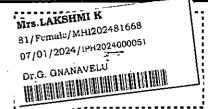
Every heart beat counts

	PAHE	NI CLINICAL I	TANDOVEN N	IECUM	D FOR NOT	1969	
Date: 0	124	Shift: Mor	ning Evening	ight	* "	, 	
S	NEWS / F Ventilator Periphera Ryle's Tul	s: Acuto Pulm Houy - C PEWS Score: day: al line day: Right: Le be: Yes No Da atheter Yes No Da	n: Nota caryol.	GCS: (5)(POD: Central line of VIP Score: Cecify organis	days: -		r
В	BACKG Type of si Allergies On room Complain	urgery:		Date of surge	ow: IVF 30 cc/W	λ, ,	
A	BP: L4 Others: Pain Sco Fall Risk Braden S	ns; Temp: Qg (°F) Pulse b 60 (mmHg) SpO ₂ : Le ore: D DPain Scale used Score: Fall Risk.Pr Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PU	t: PIPPS / CRIES / FLAC otocol: ☐ Low ☐ Mediu ☐ At Risk-Mild Risk: 18-15	ms) Weight: C / Wong-Bak m ☐ High ☐ Moderate Ris	何D (kgs) BMi:_ ker FACES Pain Ratir sk: 14-13 □ High Risk: bressing done: □ Yes	ths/min) 24 15 ng Scale NR 12-10 Sever	re Risk: 9-6
R	Referral of Pending Pending Critical via Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:		- 1	roet di	le.,	
Handover g	iven by	Signature	Name Door to a Lond G		Emp. No.	Date	Time
Handover t	-	1 by	Poomalouts Hennah Gra		02(1 810t	9 [1 2ec	18'.00
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	NL	JRSES PROGRESS NOTES				
Date & Time	(Observations / Action		Signat	ure with E	mp. Ņo.
9/1/24	=> Patient	took over fro				
@ #-30	night duty	_ataff portient	nbe			
	1 cheamody n	amically stable.	<u> </u>	A	<u> </u>	
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		re was consido	us &			
	Derentod			•		
	AVE C	ce 30 cc/hr or	How.	8		
<u>8.30</u>	=> Patient	= had broak	: faut	76	211	
	un alabetic	c diet.				
9:00	=> Pue	medication give	<u>n</u>			
	as for	hast.		_		
	-> Noh.	publin + Budo	colt		<u> </u>	
	administered		24E.	7	0211	
10:40	38800	r. Ginanavelu 28				
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·	given c	xs por y chart	A A	<u>`</u>	10241.	
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•	Signature	Name	Emp. No.		Date	Time
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Every heart beat counts

Date: 9[t	lay.	Shift: / Morr	ning Evening Nigh	t	- '	
S	Ventilator Periphera Ryle's Tul Urinary C	EWS Score: Pulry day: Il line day: Right: Lef be: Yes No Day atheter: Yes 20th Day	tr. Cel	ntral line days: —	\	
В	Ou toom		1 lite PO2: " IVA	te of surgery: luids on flow:		. •
Α	Others: Pain Sco Fall Risk Braden S	ns: Temp:9 (°F) Pulse 10	Height: 156 (cms) PIPPS / CRIES / FLACC / Notocol: Low Medium	Respiration: D (brea Weight: 90 (kgs) BMI:	37-5 kg/l ng Scale / NR	
R	Referral of Pending Pending Pending Critical vo Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:		plan date:		
Handover g	iiven by	Signature	Name	Emp. No.	Date	Time
Handover t		Hay	Hannah and		9/1/24	19:30
Document		Nug	Com Ma	0>84 0024	9/1/24	_14:00°

	NL	JRSES PROGRESS NOTES	-			·-
Date & Time	(Observations / Action		Signat	ure with E	np. No.
@ 1 lay	Reco	eiving notes				
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13:00	patient Re	ceived from cu	<i>)</i>			
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		ally Stable Co	adition	.	eler	
	<u> </u>).		
14:00	Patient on	N-cath, Skin Tr	Hait		fa.t	
	Ir line 8 10	nNp 1 lite Dz		-+	र्गे राज	
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14:30	Vital Sig	ns checked or Re	ewided		Hay	<u> </u>
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16:00	Nebulization	i was given	,	•	they_	
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1700	patient to	as Stable,	had	,		
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18:00	patient vi	tal Signs cheel	ced.	٠.		
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Document	Signature	Name C. Na Din	Emp. No.		Date	Time
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MIS.LAKSHMI K 81/Female/MHI202481668 07/01/2024/IPH2024000051 Dr.G. GNANAVELU



Every heart beat counts

Date:	9/1	<i></i>	ning Evening 🗖	(viight		_		
S	Ventilator Periphera Ryle's Tul Urinary C	al line day: Right: Left be: Yes No Day atheter: Yes No Day	t:	GCS: \\[\sum_{POD:} \\ \text{Central line of the core:} \] VIP Score: \[\text{specify organise} \]	days:	·		
B	BACKG Type of si Allergies On room Complair	urgery:	12 1 httg.	Date of surg	-		ţ	
V	ASSESSMENT Vital Signs: Tempro 15°F) Pulse / HR: 80 (beats/min) Respiration: 2 (breaths/min) BP: 120180 (mmHg) SpO ₂ : 81 (%) Height: 55 (cms) Weight: 90 (kgs) BMi: 3 1 1 1 9) M Others: Pain Score: 1 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 No NA Wound Dressing done: Yes No No NA Current diet: On No NA Drains:							
The state of the s	Referral of Pending Pending Pending Critical vo Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: nstructions if any:	<i>)</i>	care plan date	:			
		Signature	Name		Emp. No.	Date	Time	
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	NURSES PROGRESS NO	OTES	
Date & Time	Observations / Action		Signature with Emp. No.
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@ 19.A5	perom evening du	-4	
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81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





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Date: 1	0/1/24	Shift: TMorn	ing □Evening □	Night		.020	
S Date:	SITUATI Diagnosis NEWS / P Ventilator Periphera Ryle's Tut	ON S: Path pulmena9 PEWS Score: day: Il line day: Right: Left	y edema	GCS: POD: Central line o	•		
		arrieter. Ves No MD	R: ☐Yes ☐Mo. If Yes,	specify organis	sm: (, e		
B		urgery:	02 i het es	Date of surg	-		
A	BP: 120 Othèrs : 1 Pain Sco Fall Risk Braden S Pressure	SMENT Ins: Temp: 47 (°F) Pulse Ins: Temp: 47 (°F) Pu	(%) Height: <u>/- </u> (: PIPPS / CRIES / FLAC otocol: □ Low □ Medi ☐ At Risk-Mild Risk: 18-15	cms) Weight: CC / Wong-Bak um	(kgs) BMI:_ ker FACES Pain Ratir sk: 14-13 ∐High Risk: Dressing done: ∐Yes	3 7 Skg ng Scale kNR 12-10⊟Sever	S) CPOT
R	Referral of Pending Pending Pending Critical va Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	_ /	care plan date	e:		
		Signature	Name		Emp. No.	Date	Time
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81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





1	INI CEINICAL I		•			
Date: Policy	Shift: Morn	ing Evening Night	<u> </u>	·.		
NEWS / Nentilaton Periphera Ryle's Tu Urinary C	s: AP PEWS Score: day: day: line day: Right: be: Second Person Day satheter: Ves No Day	v: VIP Score:	days:-		<i>,,,,</i>	
On room		Date of surg	gery:	; , ,	• •	
ASSESSMENT Vital Signs: Temp: 98 (°F) [Pulse / HR: 80 (beats/min)] Respiration: 80 (breaths/min) BP: 10 40 (mmHg) SpO298 (%) Height: 15 (cms) Weight: 90 (kgs) BMI: 275 (spin) Others: Pain Score: 20 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						
Referral of Pending Pending Pending Critical via Changes Pending	medications: - ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	No. If Yes, modified care plan dat	e:	*, * <u>*</u> p	; ·	
	Signature	Name	Emp. No.	Date	Time	
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Handover taken by	Sein	Law mye	0284.	to hou	19:30	
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	NL	JRSES PROGRESS NOTES		_		1 1
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12:30	patient hand Mosning du hemodynamice	ling over taken ty Staff in a	from	<u>.</u>	by eier	
19:00	Vital Signs	Chuked & Recon	ded	++	eles	
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15:39	ABG taken	, Pulmo Enform	وم]			
17:00	SlB Dr. Elak	iya. Drugs acc		4	fay	
17:30	Chair Mobil on 02 2 lits	lized, Pt Stat	ole_	. +	Hay	-
18:00	Patient Vifa and Revosde Ile Chaet	l Signs are chu d Maintainld	ecked		Hory	
[9:00	patient ha night duti	noling over giver	to		900T	
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(A Unit of United Alliance Healthcare Pvt Ltd)





Mrs.LAKSHMI K 81/Female/MHl202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





SITUATION Diagnosis: PFF NEWS / PEWS Score: © POD:	Date: O	11/227	Shift: Morn	ing Evening 1	Night :			
Date of surgery: Allergies if any: NED A On room air / oxygen: BN	S	Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: PPF PEWS Score: O day: — . Il line day: Right: Left be:	: :	POD: Central line of	days: -	-	٠
Vital Signs: Temp: 98 (°F) Pulse / HR:	В	Type of st Allergies On room	urgery: — if any: NKDA air / oxygen: BN 2001		•		<u>-</u>	{ - ·
Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations:	A	Vital Sign BP: 110 Others : Pain Sco Fall Risk Braden S Pressure	re: Ollo Pain Scale used Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PU)	O (%) Height: No (: PIPPS / CRIES / FLAC otocol: □ Low □ Medi ☐ At Risk-Mild Risk: 18-15	cms) Weight: CC / Wong-Bal um ☑High □ Moderate Ri Wound [公 か (kgs) BMI: ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	27 - 5 ng Scale / NR 12-10⊡ Seven	S/CPOT
Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:	R	Referral of Pending Pending Pending Critical va Changes Pending	doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	J	care plan date	a:		
Signature Name Emp. No. Date Time			Signature	Name		Emp. No.	Date	Time
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Mrs.LAKSHMI K 81/Female/MHI202481668 07/01/2024/1PH2024000051 Dr.G. GNANAVELU



Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd) PATIENT CLINICAL HANDOVER RECORD FOR NURSES Shift: Morning Evening Night Date: Diagnosis: FCU POD: NEWS / PEWS Score: > Ventilator day: - . 1 Central line days: Peripheral line day: Right: Left: Ryle's Tube: Yes No-Urinary Catheter: Yes No-VIP Score: 2/C Day: Day: Barrier nursing: Yes Mo MDR: Yes No. If Yes, specify organism: **BACKGROUND** Type of surgery:__ Date of surgery: -Allergies if any: 1 On room air Toxygen: on 1000M IV fluids on flow: Complaints / New Symptoms in last shift: **ASSESSMENT** _&__(beats/min) | Respiration Vital Signs: Temp: (47) (Pulse / HR: 5 (breaths/min) 考(%) | Height:/ぐく (cmś) | Weight: Others: Pain Score: O// Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NBS+/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 No NA7 Wound Dressing done: Yes No ☑NA Current diet: Drains: ---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 Wolff Yes, modified care plan date: Pending follow-up orders: inlemmen BIPAB, Alight Morning Special instructions if any: Emp. No. Signature Name Date Time Handover given by Handover taken by Nua Document endorsed 6024

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81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





	Date: [1 (124	Shift: Morn	ing Evening Night		; ;	
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	В	On room			•		
	A	BP: 20 Others: Pain Sco Fall Risk Braden S	re: OLOPain Scale used Score: Alinimal Risk: 23-19 Ulcer Scale for Healing (PUS)	/ HR:	it: <u>(0</u> (kgs) BMI: daker FACES Pain Ratin Risk: 14-13 High Risk: Dressing done: Yes	3 A - 5 From 12-10 □ Sever	S / CPOT
	R	Referral of Pending Pending Pending Critical value Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan da	ite:	· · · · · · · · · · · · · · · · · · ·	
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81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Date: 🎼	1/20	Shift: Morn	ing ☐Evening ☐	vight		-	
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В	On room	•		Date of surge	_	,	
A	BP: 10 0 Others : _ Pain Sco Fall Risk Braden S Pressure	SMENT ns: Temp 97-1(°F) Pulse / 180 (mmHg) Sp0 ₂ :97 re: 010 Pain Scale used: Score: 25 Fall Risk Pro Score: 24 Minimal Risk: 23-19 [Ulcer Scale for Healing (PUStiet: 0M D LET	P (%) Height: (c) : PIPPS / CRIES / FLAC ntocol:	cms) Weight: C / Wong-Bak um-⊟High □ Moderate Ris	er FACES Pain Ratin sk: 14-13 High Risk: dressing done: Yes	rf _5 kg/m ig Scale / NR®	б∕срот
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MTS.LAKSHMI K 81/Female/MHI202481668 07/01/2024/IPH2024000051 Dr.G. GNANAVELU



Date:	12/1	Shift: Morn	ing Evening Night	,	
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81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Date: 12	Ulatt	Shift: Morn	ning Evening Ni	ight .	· 1		
S	Ventilator Periphera Ryle's Tul Urinary C	s: OVY PEWS Score: O r day: al line day: Rìght: Left ibe: Yes No Day Catheter: Yes No Đấy:	it: y:	GCS: POD: Central line of the control of the control organism of the control of			1
В	On room	_	iair	Date of surge		. , 6	,
A	BP: 730 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>98 (</u> °F) Pulse / <u>୭ (</u> go_(mmHg) SpO₂: <u></u> 9⊃	/ (%) Height: Cn (%) Height: S (cn Cn (cn Cn	ms) Weight:_ C / Wong-Bak ım ☑High ⊒ Moderate Ris	90 (kgs) BMI: 20 ker FACES Pain Rating sk: 14-13 ∐High Risk: 1 Dressing done: ∐Yes	g Scale'/ NRS	S / CPOT re Risk: 9-6
R	Referral of Pending of Pending of Pending of Critical va Changes Pending of	doctors: medications: medication indent: lab reports / Investigations: ralue alert and its corrections: in nursing care plan: Yes follow-up orders: nstructions if any:		are plan date	n:		
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	NURSES PROGRESS NOTES	
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12:30	patient chanding over taken	
	From Blooming duty stay in	1124
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13:00	Vital Signs cheeked & Recorded	Hay,
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A:00	U-cath Lemoved	
18:00	Discharge notes	
	<u> </u>	
	Patient Stable and Conscious	Len
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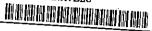
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The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



MHI/ICN/2022/102



Every heart beat counts

HAI BUNDLE

Date	& Time of Intubation	Dat	te of	ext	uba	tion:		Dat	te of	Rei	intut	atio	n:	То	tal D	ays
	DATE	H			Γ.											
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	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			<u> </u> _												
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															
	Stress ulcer prophylaxis															
11_	DVT prophylaxis	$oxedsymbol{oxedsymbol{oxedsymbol{eta}}}$		<u> </u>									$oxed{oxed}$			
Date	& Time of Insertion	Date	e of	Ren	nova	al:		Dat	e of	Reit	ıser	tion	:	Tot	al da	ıys:
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S.no	CLABSI Bundle	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N_
1	Perform hand hygiene			<u> </u>			L_	 	Ш				<u> </u>			
2	Dressing intact and labelled properly			<u> </u>												
	Site inspected			<u> </u>		Ļ	Ļ						<u> </u>			
	Catheter stabilized/no tension on line	ļ		<u> </u>		ـــــ	ldash						$ldsymbol{ldsymbol{ldsymbol{eta}}}$			
5	Dormant lumens clamped															
÷	Caps changed-administering blood & if there is visual		l													
6	observation of blood in the caps			<u> </u>												
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															
	All tubing changed every 24 hours															
	& Time of Insertion	Date	e of	Ren	nova	ıl:		Dat	e of	Reir	nser	tion	:	Tot	al da	ivs:
า	1/24 @ 13:30	12	Let	่อน	(a)	14!	८०	١.								-
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S.no	CAUTI Bundle	M	E	N	М	È	\rightarrow			N		E	N	N	Ε	N
1	Maintain sterlity of closed urinary drainage		/		,,,	./	1		∇	V		/	7	V		\nearrow
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3	Maintain unobstructed urinary flow & specimens from		/	_	0		7		V			\subsection \cdot	/ /			
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Patient Details (Affix Label here) Name:

UHID:

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Sex:

DOA: Consultant: MHI/ICN/2022/102



Every heart beat counts

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81/Female/MHI202481668 07/01/2024/1PH2024000051



MHI/ICN/2022/102



Every heart beat counts

S.no VAE Bundle S.no CLABSI Bundle		U	עוי		ע				_								
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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 vertilator circuit before repositioning of patients 7 Check and maintain appropriate ETT cuff pressure 25 - 30 cmt/20 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 12 DVT prophylaxis 13 DVT prophylaxis 14 DVT prophylaxis 15 DATE S.no CLABSI Bundte 1 Perform hand hygiene 2 Drassing intext and labelled property 3 Sito 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 santized with alcohol before & after each use. "scrub the hub". 8 Lumens flushed with minimum volume 10cc every 12 hours 10 All tubing changed every 24 hours 11 DATE S.no CAUTI Bundte 12 Maintain stellity 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 Tiefsecure catheter to patient tubing to bed					_											_	
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Patient Details (Affix Label here)

Name:

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ADULT NURSING CARE PLAN





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	Initial Date: 7/1/24	Time: 13:01 pm	Modified Date: Time:		
	Reason for Modification:		Diagnosis: Acute pulmenary e	Clema,	
	Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
O	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/t on a such N pt on Dm diet	80000 1824 U
	OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on	Pt on 02 Spo_2-99%	020
	FLUID & ELECTROLYTES ,	Patient will have balanced fluid and electrolytes balance	physician order Maintain clear airway by suctioning or encouraging patient with successful coughing Enhance fluid intake unless restricted Check IV sites and assess if there is any complication	N 100>.	D24 b
	☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:		 □ 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 	Emourage oraf Emourage oraf Note IVI= Nb - 3004	00 HD



1	Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
•	MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures 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)	pt moburged in E bed freely	Gra
				N Pt mabolise on	B Ory e
	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	M Ef as elimination Epattern	Orns.
			and follow proper protocol Check for malena / constipation / urinary retention	N Pt @ Elimination Pattorn	024 v
ļ	SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	M '	
	INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased			pt med D E Shin integrity.	Bror
	☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			pt had (1) N Skin Integrity	0240



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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 Stay clean & Well groomed. N Pt Stay Close Well groomed	1 \ <i>V</i> \$2
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 EP+ In hand (+) (N P+ ID band	O) HOWS O2
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 Eft had compute Shep N P+ had comport Pleap	Em
OBSÉRVATION 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 Fily VIS thereof E recorded N Lowels VII monifor - ed	Em bru
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 Prychological Support quen N psychological cupport to the A	8 5000 6240

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions	;	Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:		Patient will communic with positive feedback	ate effectively	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	s condition	N 10+ Ve	ey unicated bal ominicates	OWA ONA
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood p transfusion Fluid tapping DVT Manageme	products	☐ To manage on time		Double check for high alert medication Observe and report any medication read Provide proper measures of wound care Follow hospital polices and protocols of and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing the blood products and fluids Monitor DVT score and continue treatme as per doctors order	isolation ensure plood or	M	ed medwath	
	Signature		Name		Emp. ID		Date	Time
Endorsed by	Jay		JAY	AP SY'-)	00	90~	8/1/24	معرما
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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K

81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





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Initial Date: 8 [1 2 4	Time: & 100	Modified Date: Time:		
Reason for Modification:		Diagnosis: A cute Pulmone	vy Slone	
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 gregular dut E p+ Hand a prier	2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
			N& Pton PM object	Doy
OXYGENATION Froom Air Nasal Cannula / High Flow O, Mask BIARP / CPAP	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains	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	M Pt WPO2 aliteds	Se July
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ If any O₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	E pt NP02 Blitus	230
		□ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	N Spton BC12 onflow	Dovi
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output	M Pt 14 30 cc / hay	80.14
☐ Parenteral Nutrition ☐ Others:		Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	E PT TVF NS 30m11 dar going to Flow	2800
		- Total State Stat	N Spron NF. NS Domlihrs onflow	Dow





Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	m Pt on bod mobilized.	2027	
□ Others.	Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ 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)	E Pton Bod Mobilisation	730	
			N Apteon bed rest	Rog	
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence.	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as folog's	m Pt CBD Powsord Day-2	<u> </u>	
Others:	and regular elimination patterns	and regular elimination patterns silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E pt on CBO®	77.6
	·	and follow proper protocol Check for malena / constipation / urinary retention	N Apton CBD D - DD	Rog	
SKIN-INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY	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	Postavina Postavina	D.	
☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased	. ·	Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	E Skin Entregoing	275-	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N Phon been	Lon	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign'& Initials	
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene	m Pt cloon sq wall ground.	AUN.	
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	E Pr Clean & fygiere	230	
			Ny Toton cleans	Soul	
SAFETY Check ID Hand IV care EJV	Patient, will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails	M R+ ID band funent	200 N	
CENTRAL LINE Side rails Others:	,	Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient	E Pt ID Borrel present	232	
		Follow restrain policy (if needed)	N Sptende	Dom.	
COMFORT AND SLEEP ~	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern	M Pt Provide comportable	20	
Others:	adequate sleep	adequate sleep	adequate sleep Provide pharmacological and non-pharmacological therapy	E 17 Conformite position	2200
	1 1,1	, ,	N / TOV CONFROME	Dan	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality	M Pt Ulschaused Ex	S W	
Others:			E Pt vitals peusdit	2.5	
			N - FFENY 18 Cherolds Vacorded	Dov	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	M Pt Prance Phylodical	No. W	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E pt Good psychological	Mr.	
			N & PAON psychological		

Paţient Specif Problems / Ne		Measurable Goals	Nursing Interventions		Evaluation		Sign & Initials
COMMUNICA Verbal Non-verbal Sigh language Others:		A Patient will communicate e with positive feedback	Infroduce the care giver		M A Communication of the Commu	nication woll exper nunication 9000 d Question	loy
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood r transfusion Fluid tapping DVT Managem Others:	products	√ To manage on time	Double check for high alert medic. Observe and report any medicatio. Provide proper measures of woun Follow hospital polices and protoc and explain to the patient / family Check for cross matching and typi compatibility Practice strict asepsis while transfe blood products and fluids Monitor DVT score and continue to as per doctors order	n reaction d care cols of isolation ling, to ensure using blood or	M Pt Nedicat	tion given as daug chart and the ion as per and chart after on	232 232
	Signature	Na	me	Emp. ID		Date	Time ·
Endorsed by	Jo	ep	JAMPAGNI)	000	~	8/1/24	

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K

81/Female/MHJ202481668 07/01/2024/JPH2024000051

Dr.G. GNANAVELU





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Initial Date: 9/1/2	4_ Time: 8 . 00	Modified Date: Time:		
Reason for Modification:		Diagnosis: Acute Pulmonary Jebma/12DM/8HTW)		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M patient breakfast E Pt had Dm diet	AL DUST
	activity level and metabolic needs		n P+ had pydiet	02AH
OXYGENATION Adom Air Nasal Cannula / High Flow O2 BiPAP / CPAP Ventilator	☐ Patient will have normal O₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O ₂ saturation and pulse rate If any O ₂ abnormalities detected inform immediately to	M on of Support	yl
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness	E On 02 1 diffres Nasal pronze	Hay-
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	NP+en httly	02HH
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	□ Entiance 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 NO 30 CC/h r. onflow E Ilo chaet Mountained NP+Plo was	1015 1005 02117

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 P_tient 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 pad mobblished E patient on b ed	- Potes
			n p+ an bed mabilized	@ 2HA
ELIMMATION atheter, bedpan, urinal Nasogastric tube Bowel movement Urination	☐ Patient will have normal elimination ☐ pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's /	m patient elimination	10158
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E pthad normal elimination patteen	Hay Suso
		and follow proper protocol Check for malena / constipation / urinary retention	N 94 DOTA VOYABA	Q2HH
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	M Maintained Okin integrity 1	Dis
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	Patient had	Hory olas
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			Integrity Pt maintain Q N Shin integrity	D ODH H

				<u> </u>
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sigń & Initials
HYGIÉNE Bed-Bath Assist-Bath	Deatent will stay clean and well-groomed Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene	M Patient stay	This
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	E plantomed well	Hay
			N I F clean would	Q 02 MA
SAFETY CHeck ID Hand, IV care EJV	Pattent will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	m patient In bound	Abis8
CENTRAL LINE Side rails Others:		☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient	E Do band present	Herit .
	. •	Follow restrain policy (if needed)	N Pt & D band (1)	244.
COMPORT AND SLEEP Pain Control Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	Provide clean calm and restful environment Provide privacy at all time Manitor pair scale / clean pattern	Mprovided privag	-Mise
☐ Others:	adequate sleep	 ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy 	E'	
	, ,	,	N P+ combetable	02 H /4
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar	Patient will have normal range of vital parameters		m vitale stable.	0028
Others:		☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E Pt vital signs all stable	Hout
			N Pt VIS all charled	Ф <u>Р</u> НУ
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise	м	
☐ Beliefs / Values / Customs☐ Anxiety and Copying Pattern☐ Identify Stressors☐ Others:	Patient will maintain normal psychological pattern	☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	E	
			N	

Patient Specif Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATE Verbal , Non-verbal	TION	Patient will communic with positive feedback		Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		M Nath Lati	rad graphy	flesse
☐ Sigh language ☐ Others:	. •	, ,		No negative speaking about the patient's or prognosis in the patient's presence	condition	E Pt com	municated well	1 Hay
		i e		_		N P+ well	1 communication	()
SPECIAL INTE Medication Wound care Isolation	ERVENTIONS	☐ To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of its		m patient of	medications	Police
Ostomy Care Blood / Blood r transfusion Fluid tapping DVT Managem		,		and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing be blood products and fluids		// .	ougs are ivon	Host
Others:	, ·			Monitor DVT score and continue treatme as per doctors order	nt	N Pfmedica	tien gi en	D OLHH
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Verg	9	2 nalis	002	4	09/424	[8,69]

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ADULT NURSING CARE PLAN

Mis.Lakshmi K

81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



Initial Date: (a) / (/2	Time: 7200	Modified Date: Time:			
Reason for Modification:	'	Diagnosis: ← ₽ €			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
NUTRITION	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 did. E Pt had DM diet N pt had stadiet	Postna Houts Jan	
OXYGENATION Floom Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP	Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O ₂ saturation and pulse rate	pt on room	Posn	
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	Patient was Estable on some or NP glittes	Hort	
		□ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	N PT ON ROOM	Jan ODEN	
FLUID & ELECTROLYTES Defal 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	pt oral fulid taker. E Ito Chaet Maintained	folin Hay	
			N D (o chaut	، معلل	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment		88m
□ Outers:	Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ 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)	E patient mobilised	Hay-
			N pt Mobilized	Son.
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	pt elimination. M www pattern	Bodon
Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E pt shad normal elimination parteer	HBPO
·		and follow proper protocol Check for malena / constipation / urinary retention	N Pt had nonal	Joe .
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY	□ Patient will maintain normal healing status □ Patient will discharge with intact skin integrity ι		pt normal. M 3 kir interheig	pdn
☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted		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	patient had E normal Skin Integrity	OLD
Dermatitis Pressure injury / blisters site care given Others:			N Shin integits	Sex John

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 well N Pt groomed well	polin Hay Ser.
SAFETY Check ID Hand IV care	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails 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 besent N ID bound present	Alm House
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	 □ Provide clean calm and restful environment □ Provide privacy at all time □ Monitor pain scale / sleep pattern □ Provide pharmacological and non-pharmacological therapy 	M - E	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range 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 Checkod E pt vital signs all stable N Pt Vls cheeled	July Ju
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	• 0	Sign of Initial
COMMUNICATION Verbal Non-verbal Sigh language Others:	Patient will communic with positive feedbac	Encourage the use of Courage the	call bell eded about the patient's condition	E PE Cor	nnunicated well nnunicated	181
SPECIAL INTERVENTIO Medication Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping DVT Management Others:	NS To manage on time	and explain to the pating Check for cross match compatibility Practice strict asepsisg blood products and flue Monitor DVT score and	y medication reaction res of wound care res and protocols of isolation ent / family ing and typing, to ensure while transfusing blood or ids	E Due o	lication zi ven. lougs clee Given	How see
Signatu	ire	as per doctors order	Emp. ID	N Due a	dugs are given	Time
Endorsed by	120	e-nalin		 244	(6)11 24	18

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K

l 81/Female/MH1202481668 l 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Initial Date: [1] / 1 20	Time: 8:00	Modified Date: Time:		
Reason for Modification:		Diagnosis: 80B 8/PAG		
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	EPt had DM diet N Pt had DM Diet	Mil
OXYGENATION Recom Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others:	□ Patient will have normal O₂ saturation □ Patient ABG levels will return to and remain within normal limits □ No other respiratory abnormalities □ Patient respiratory rate will remains within established limits □ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	 □ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing 	patient is on Poom Air Patient is on room air N Pt is on Room air	A. My
FLUID & ELECTROLYTES Staf 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 JO Charl Monitoral E Ilo Charl monitora N Ilo Charl Monitora	AJ Holy Sug.

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease 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 blobifise treely EPt 4000 mobilized	Br. York
		•	N Pt vrood lized	Jen.
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention,	□ Encourage fluid intake □ Encourage fibre diet intake □ Encourage early ambulation □ Report any abnormalities to physician	M ρ+ will D eliminetrop	80
☐ Urination ☐ Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter	E Patton	rely.
		Check for malena / constipation / urinary retention	N Normal elimination	Jen.
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity		M p+ D Skin in tregnity	
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Increased Distribution Assisted		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	Maintain normal	LA COTA
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:		•	n Maintouin nomal skin intorguly.	Sar.

Patient Specific				Sign &
Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Initials
HyGIENE	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care 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	M p + self ceue	
(if present)	Patient will recognize individual weakness'or needs	Apply moisturizing solution	N Pol Otocal	Sex.
SAFETY Check ID Hand IV care EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M ps Flo bend	Em
CENTRAL LINE Side rails Others:	(□ Provide proper invasive line care □ Keep bed locked and low at all time □ Educate care providers to be the patient □ Follow restrain policy (if needed)	EID Bound Prosons	MD
	,		N Do band present.	Sey.
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	Mp+ will comfortable	Da
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep		E Provide Comboilable	Makas
			N Phovide contestable	Dung.
OBSERVATION Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters		M pt vital sings	8
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E Vital Signs Chackage	MAR
	v		N Vital signs checked	Jan.
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	M	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N -	

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ds	Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
		•	☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		m p+ will	conneable	(B)
				condition	endition E Pt Upon		My
					N pt veor	in municontion	Jaz.
SPECIAL INTERVENTIONS Medication Wound care Isolation			Provide proper measures of wound care		M p+ Moels	citish film	de
oducts			compatibility		-		MD
☐ Fluid tapping ☐ DVT Management ☐ Others:			blood products and fluids	ŀ		,	Jez-
Signature		Name		Emp. ID	as be a	Date	Time
	Nus	Ş	2. Nalis	0	ر م	11/1/24	16:00
	DAN ENTIONS	DN Patient will communic with positive feedback EVENTIONS	Patient will communicate effectively with positive feedback VENTIONS	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 or prognosis in the patient's presence	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 Provide proper measures of wound care Provide proper measures of wound care Prollow 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 Emp. ID	Introduce the care giver Introduce the care giver Introduce the use of call bell Obtain interpreter if needed No negative speaking about the patient's condition or prognosis in the patient's presence Pt Uoka Committee Pt Uoka Committee Interpreter of the patient's presence Pt Uoka Committee Interpreter of the patient's presence Pt Uoka Committee Interpreter of the patient's presence Interpreter of the patient of the	Patient will communicate effectively with positive feedback Introduce the care giver Encourage the use of call bell Obtain interpreter if needed Obtain interpreter if needed

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ADULT NURSING CARE PLAN

Mrs.LAKSHMI K

81/Female/MHi202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





			<u> </u>	
Initial Date: 12/1/9	Time: PJDO	Modified Date: Time:	· · · · · · · · · · · · · · · · · · ·	-
Reason for Modification:	,	· Diagnosis: Acote pulmoroum	y eclone	
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	patient had som diet	- Bif43
<u></u>			N ·	
OXYGENATION Room Air Nasal Cannula / High Flow O₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	 □ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing 	patient 18 on Poom fir E	Poigs
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 T/o Charf moniforce E	-

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury	□ 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)	M DX mobilize =	231)
	Patient will demonstrate the use of adaptive devices to increase mobility	 □ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) 	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 U/Corth prosent	P.
			N	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI DPI GRADES OF PRESSURE	Patient will maintain normal healing status Patient will discharge with intact skin integrity		M	
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		□ Maintain adequate nutrition and hydration □ Proper application of medications and dressing □ Follow doctors and TVN order properly □ Monitor the healing status	E	
☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

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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 (25%)
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 To bound D Dy
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 P C C C C C C C C C C C C C C C C C C
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 ves is stable 2
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Bellefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	 □ Pray or encourage the patient to pray □ Use inspirational words □ Respond to spiritual needs as they arise □ Evaluate spiritual needs □ Encourage verbalization of feelings / therapeutic touch □ Provide empathy and reassurance 	M E

Patient Specific Problems / Ne		Measurable Goals	•	Nursing Interventions	_	Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal	TION	Patient will communi with positive feedbac		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed	☐ Encourage the use of call bell		cadia	: 2)3
Sigh language Others:				☐ No negative speaking about the	No negative speaking about the patient's condition or prognosis in the patient's presence			
· .						N		
SPECIAL INTERVENTIONS Medication Wound care Isolation			Double check for high alert medication Dobserve and report any medication reaction Provide proper measures of wound care Follow hospital polices and protocols of isolation		m medi	giver	253	
☐ Ostomy Care ☐ Blood / Blood p transfusion ☐ Fluid tapping ☐ DVT Managem				and explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or		E	·	
Others:	GIIL			blood products and fluids Monitor DVT score and contin as per doctors order	ue treatment	N .		
	Signature	<u> </u>	Name		Emp. 1D		Date	Time
Endorsed by		Nous	٤.	valini	000	δt	12/1184	146





81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Every heart beat counts Date: Et 1 2A

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK	Date: Time:		=	24
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some	4. No Impairme Responds t commands. Has deficit which ability to feel or y discomfort	to verbal snosensory would limit		4	7
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually d requires changi intervals	dry, linen only		3	Μ
ACTIVITY degree of physical activity	1. Sedfast 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 Freque Walks outside r twice a day and at least once eve during waking h	room at least d inside room ery two hours		1	1
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently		4. No Limitation Makes major a changes in pos assistance	and frequent		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	a meal, but will usually take a supplement	4. Excellent Eats most of Never refuse Usually eats a more servings diary products. eats between a not require supp	es a meal. total of 4 or of meat and Occasionally meals. Does		3	3
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets.					3	ح ا
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		тот	TAL SCORE	<u> </u>	16	16
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			& Emp. No. Staff Nurse:		38	024
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	I	& Emp. No. Staff Nurse:		2	To a





81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Tim	72) <u>F</u>	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 verba commands. Has no sensor deficit which would lim ability to feel or voice pain of discomfort	y it 1	4	9
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 on requires changing at routir intervals		. 4	4
ACTIVITY degree of physical activity	1.) Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at lea twice a day and inside roo at least once every two hou during waking hours	m ,		
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	(2.) Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and freque changes in position witho 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. dequate 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 mea Never refuses a mea Usually eats a total of 4 more servings of meat ar diary products. Occasiona eats between meals. Do not require supplementation	or or or or or or or or or or or or or o	3	3
FRICTION & SHEAR	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices.	(3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	Maintains good position in be	<u>ا</u> 3		3
	frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	Maintains relatively good position in chair or bed most of the time but occasionally slides down	<u> </u>	Initial & Emp. No). ao	1/29	a
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No of Sr. Staff Nurse		1/1/2	WY





81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

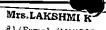




(A Unit of United Al	Iliance Healthcare Pvt Ltd)		THE REAL PROPERTY AND ADDRESS TO SERVE THE PROPERTY OF THE PRO	l:	•	_	201 L IJI		шисэ
	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISI	C Da	ate: me:	, ,	†	2y
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	command deficit w	ds to verb s. Has no senso nich would lir eel orvoice pain	ory nit	7	4	A
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day		Moist ually dry, linen o hanging at rout		3	3	3
ACTIVITY degree of physical activity	21 Bedfast Confined to bed	Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	Walks out twice a da	requently side room at le y and inside roo ce every two ho king hours	om	1	3	3
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3 Slight Limited Makes frequent through slight changes in body or extremity position independently		ajor and frequi n position with		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	Never re Usually ea more serviced diary products between	nt t of every me efuses a me ats a total of 4 /ings of meat a lucts. Occasiona /een meals. Do esupplementati	al. or and ally oes	<u>a</u>	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	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	3 Mo Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. No or chair			ed	B]#	3	13 20
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			nitial & Emp. N of Staff Nurs	se:	M	they	02
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	ligh Risk: 12 - 10; Severe Risk: 9 - 6		nitial & Emp. N f Sr. Staff Nurs		24	معم	عهم







81/Female/MHl202481668 07/01/2024/PH2024000051

Dr.G. GNANAVELU





Every heart beat counts

Date: 11 2-4

_	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK	Time:	<u> </u>	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 commands. Has no deficit which woo ability to leef or voic discomfort	sensory uld limit	H	4	A
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, requires changing intervals	linen only at routine	Ж	2+	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		ر ا	24	H
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and changes in positio assistance	frequent n without	4	24	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 even Never refuses Usually eats a tota more servings of a diary products. Occur eats between mean not require supplement	a meal. al of 4 or meat and casionally als. Does	4	4	4
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	Moves feebly or requires minimum Moves in bed and in chair independently and has su strength to lift up completely during move. Maintains good			3	3	· &
SHEAR slide	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL	SCORE	28	23	يو ا
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & E of Stat	mp. No. ff Nurse:		14	130
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & E of Sr. Sta		100	100	10 2





81/Female/MHi202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	V DICV	ime:	<u>, </u>		7
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No impairment Besponds to verb commands. Has no sens deficit which would li ability to feel or voice pair discomfort	ory 🕰 mit	۲. ۲	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 or requires changing at rou intervals		†	8	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. Warks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at le twice a day and inside ro at least once every two ho during waking hours	oom 🔟	١	\ \ \	্র
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. Mo Limitation Makes major and frequent changes in position with assistance		4	4	<i>A</i>
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 ornutritional needs	4. Excellent Eats most of every m Never refuses a me Usually eats a total of more servings of meat diary products. Occasior eats between meals. D not require supplementa	eal. 4 4 or and hally loes	4	on	_3
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. It or chair		scle C	3	م	٩
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCO	RE 2	S.	ე _ი	20
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. of Staff Nur	se: X		tey Yes	J.
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. of Sr. Staff Nur	No. La	م ا ب ب	19-	2





81/Female/MH1202481668 07/01/2024/iPH2024000051

Dr.G. GNANAVELU





(A Unit of United Ali	llance Healthcare Pvt Ltd)			Lveig ii		-	T No.
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:	48	13	3
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	ef	
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	7		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	A. 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	Completely Immobile Does not make even slight changes in body or extremity position without assistance	Wery 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	8		
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	Z. 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 independent strength to lift up completely during move. No or chair		2		
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	100		



PAIN RE-ASSESSMENT & MONITORING CHART





81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



MHI/NUR/2022/052



Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
13.00;	5/10	Dull	Ihr	HIP	Pharmagological action	oros.	Joe Joe
J3:30	3/10	Dull	30min	HIP	Phromicological action	ow.	Julson
14:00	1/10	Dull	Zomiń	H 1P	Physma cological achon	0100	Julion
14:30	oho	No prin	-	-		Ofros	Jaefoor
15,00	0/10	No psin	<u>-</u>	-		0/06	hijos
6.00	0/10	No Psin	-	·		87 -	Julos
7:00	0/10	No poin	_	<u></u>		Of s	Dufon
(B.:00	0/10	No Psin	_			oros (July and
12,00	0/10	No poin	_			Ovor !	Jayoon



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Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7/1/21 20100	n. kl	٨	lo porto	-	L		0240	(Du boer
d1:00	0 0	0.0) > ⇒ oun'	-			(B) (2) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C	Jan 2015
<u></u>	o ho	N	o Devo	<u> </u>			024	Supor
23.980	ollo	. N	pain	<u></u>			80040	of con
	•		•		PA	AIN SCALES		`.
(28 week	PIPPS (s to < 38	waaka)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid		asures			
		weeks)	>12 = Moderate to sever			on		
(38 we	CRIES eks - 2 mc	-	>12 = Moderate to sever	e pain - Pham for infants >	nocological intervention than or = 38 weeks	on sof gestation. A maximal score of 10 is possible. If the CRIES score is gester administration is indicated for a score of 6 or higher.		₹
FL	CRIES	onths)	>12 = Moderate to sever The CRIES scale is used further pain assessment	e pain - Pham d for infants > t should be u	nocological intervention than or = 38 weeks indertaken, and analg	of gestation. A maximal score of 10 is possible. If the CRIES score is	· · · · · · · · · · · · · · · · · · ·	
FL (2 mo Wong Paln	CRIES eks - 2 mo	onths) le ears) ACES cale	>12 = Moderate to sever The CRIES scale is used further pain assessment	e pain - Pham d for infants > t should be u	nocological intervention than or = 38 weeks indertaken, and analogiscomfort, 4-6: Mode	of gestation. A maximal score of 10 is possible. If the CRIES score is jest administration is indicated for a score of 6 or higher.	e more than 12	9 10
Vong Paln (7 year	CRIES eks - 2 mc ACC Scal nths - 7 yc	onths) le ears) aCES cale cars)	>12 = Moderate to sever The CRIES scale is used further pain assessment 0: Relaxed & comfortable 0: Relaxed & comfortable 2 No Hurts Little Bit FACIAL EXPRESSION: 0 BODY MOVEMENTS: 0-COMPLIANCE WITH VE	e pain - Pharm d for infants > t should be un e, 1-3: Mild d Hurts Little More O - Relaxed, Ne Absence of m NTILATION (in ubated patier Relaxed, 1 - Te	than or = 38 weeks adertaken, and analgoriscomfort, 4-6: Mode accommendation of the second of the se	sof gestation. A maximal score of 10 is possible. If the CRIES score is geste administration is indicated for a score of 6 or higher. Prate discomfort, 7-10: Severe discomfort / pain / both Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste administration is indicated for a score of 6 or higher. Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste a score of 6 or higher. Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste a score of 6 or higher. Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste a score of 6 or higher.	e more than 12	9 10
Wong Paln (7 year	CRIES eks - 2 mo ACC Scal onths - 7 yo -Baker FA Rating Sc ars - 12 ye cal care P	conths) le ears) le cars)	The CRIES scale is used further pain assessment O: Relaxed & comfortable O: Relaxed & comforta	e pain - Pharm d for infants > t should be un e, 1-3: Mild d Hurts Little More O - Relaxed, Ne Absence of m NTILATION (in ubated patier Relaxed, 1 - Te O Pain; 3 - 4: M n-conducive e and massage: onger than 15	than or = 38 weeks adertaken, and analgorise iscomfort, 4-6: Mode iscomf	sof gestation. A maximal score of 10 is possible. If the CRIES score is geste administration is indicated for a score of 6 or higher. Prate discomfort, 7-10: Severe discomfort / pain / both Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste administration is indicated for a score of 6 or higher. Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste a score of 6 or higher. Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste a score of 6 or higher. Numerical Rating Scale (age of 10 is possible. If the CRIES score is geste a score of 6 or higher.	e more than 12 6 7 8: Sev	9 10 ere



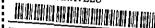






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Dr.G. GNANAVELU



MHI/NUR/2022/052



P	PAII	N RI	E-ASSESSMENT	& МС	NITORING	CHART	Every heart beat counts
T		Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.
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{ t	[2]	1	ţ .		-		De Jack
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3	100	Olio	No pais	_			orgo Jagan
4	. DP	Ollo	No pour	-			One Jalfoon
5	; _Ф Р	0/10	No Pour	,			Ongo Jack
6	' oo	Olto	No Pain		1		one de son
				/			Orno algaer
&,		olo	No Pain	1	~	<u></u>	or Jack





Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
क्षा क्रम क्षा क्रम	Oljo		lo Pain	1	`		88 <u>240</u>	Not
/o'/00	plo	, , , , , , , , , , , , , , , , , , ,	lo Prûn	_		~	St.	Noch
OC!	0/10		No Paus	_			R 4	10 cel
12:0	Olio		No Peun	,			80 0 Li	N've
	,			ı	P	PAIN SCALES	J	
(28 week	PIPPS s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to seve	de comfort me		ition		
(38 we	CRIES eks - 2 m	onths)				ks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, algesic administration is indicated for a score of 6 or higher.		
	ACC Sca nths - 7 y		0: Relaxed & comfortab	le, 1-3: Mild di	 iscomfort, 4-6: Mod	derate discomfort, 7-10: Severe discomfort / pain / both		
Pain	-Baker F <i>I</i> Rating So ars - 12 ye	cale	O 2 No Hurts Hurt Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age model) 8 10 Hurts Whole Lot None Numerical Rating Scale (age model) 0 1 2 3 4 5 6 Moderate	7 8	9 10
Observa	cal care F ition Tool itor / com	(CPOT)	COMPLIANCE WITH VE	- Absence of m NTILATION (li tubated patier Relaxed, 1 - Te	novements or norma ntubated patlents): nts): 0 - Talking on r nse, Rigid, 2 - Very	al position, 1 - Protection, 2 - Restlessness / Agitation : 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting v normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing Tense, Rigid	entilator (or)	
	harmacolo tervention		Cutaneous Stimulation Thermal Therapies (no l	and massage: onger than 15	E - Positioning; F - to 20 minutes): G -	C - Music; D - Physical and mental exercisers Rubbing / Massage the skin Cold application; H - Hot application; I - Shortwave diathermy Interferntial therapy Psycho-social therapy/counselling: K - Individual Counse	eling; L - Family	counseling
Pharmac	ological l	nterventior	s as per doctor's prescri	otion				



No poon

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Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



MHI/NUR/2022/052



PAI	N RI	E-ASSESSMENT	& MC	NITORING	CHART	Fvery heart	beat counts
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff initial & Emp. No.	Senior Staff Initial & Emp. No.
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[Z:00	al/O	No pain	-			Poloce	Non
16.00	opo	No pain				PL	New
l뒤·00	Olo	No pain	_			70158	1000 24
₹·00	°/w	No pain		:	-	POISE	Doe
19:00	Ww	No town		~		TRUSP 15P	Nes





Date & Time	Pain Score	(dull, achy	Pain Character y, sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	1.	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
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1 3.00	Jo		NO poon		<u> </u>			Pa	10 cre
0, 0, 0, 0)(po	. po	o pôn					Sory:	10 ce
, o	D/bo	* * * *	No pain					800	10 200
 					PA	AIN SCALES			
(28 week	PIPPS s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	le comfort me		חס		,	, , , ,
(38 wee	CRIES eks - 2 mo	onths)					re of 10 is possible. If the CRIES score is > ted for a score of 6 or higher.	4,	1 7 . 17.
1	ACC Scal		0: Relaxed & comfortable	e, 1-3: Mild d	iscomfort, 4-6: Mode	erate discomfort, 7-10: Severe	e discomfort / pain / both	-	
Pain	-Baker FA Rating So Irs - 12 ye	cale	O 2 No Hurts Little Bit	4 Hurts Little	6 Hurts Even More	8 10 Hurts Whole Let Worst	Numerical Rating Scale (age n 0 1 2 3 4 5 6 None Mild Moderate	7 8	years) 9 10
Observa	cal care F tion Tool tor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (II ubated patier Relaxed, 1 - Te	novements or normal ntubated patlents): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Res - Tolerating Ventilator or Move rmal tone or no sound, 1 - Siglanse, Rigid	tlessness / Agitation ement , 1 - Coughing but tolerating, 2 - Fighting hing, Moaning, 2 - Crying out, sobbing	ventilator (or)	and the second
	narmacolo ervention		Cutaneous Stimulation a Thermal Therapies (no lo	ind massage: onger than 15	E - Positioning; F - R to 20 minutes); G - Co	- Music; D - Physical and men ubbing / Massage the skin old application; H - Hot applica erferntial therapy Psycho-s	•	seling; L - Famíly	/ counseling
Pharmace	ological li	nterventio	ns as per doctor's prescrip	tion					

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Mis.Lakshmi k

81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

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PAII	N RI	E-ASSESSMENT	& MC	NITORING	CHART		Every heart I	seat counts
	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	iij .	Staff Initial & Emp. No.	Senior Staff Initial & ' Emp. No.
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Date & Time	Pain Score	(dull, achy,	sharp	Character o, stabbing, red / radian	shooting,	Duration	Location / Site		Interventi	ons			_		Staff Ini & Emp.		lni	or Staff tial & p. No.
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12:00	0/10		No	Pain		<i></i>	V								R	21	es: Uk	25_
16po	ola	·	No	pain		-	_		-		_				Hay	ر ا	7	24
Jo. 60	0/0	' N6	o S	Pain	}	_		_							@ 02H	H -	28	24
					*	٠,	P.	AIN SCALES			,				•			
(28 week	PIPPS s to < 38	weeks)	7 - 1		ain - Provid	de comfort me	easures nocological intervent	ion										
(38 we	CRIES eks - 2 mo	onths)	The furth	CRIES sca her pain as	le is usec sessment	for infants >	than or = 38 week ndertaken, and anal	s of gestation. A maximal sco gesic administration is indica	ore of 10 is po ited for a sco	ossible. ore of 6 o	f the C r highe	RIES : r.	score i	s > 4,				
	ACC Scal		0: R	elaxed & c	omfortabl	e, 1-3: Mild d	iscomfort, 4-6: Mod	erate discomfort, 7-10: Severe	e discomfort	/ pain / i	ooth			- -	-			
Pain	-Baker FA Rating Sc ars'- 12 ye	cale (O No Hurt	2 Hurts Little Bik	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Num 0 1	erical I	Rating 3	Sca - - -	le (ag	6	re than	12 <u>1</u>	9	i) 10
Observa	cal care P tion Tool (tor / coma	(CPOT)	CON VOC MUS	DY MOVEM MPLIANCE CALIZATION SCLE TENS	ENTS: 0 - WITH VEI N (non-Int SION: 0 - F	Absence of m NTILATION (in the state of the	ntubated patients):	position, 1 - Protection, 2 - Res 0 - Tolerating Ventilator or Move ormal tone or no sound, 1 - Sigl ense, Rigid	ement , 1 - Co	ughing b	ut toler	ating, , sobb	2 - Figh bing	nting ve	ntilator (d	or)		÷
	narmacolo ervention		Cuta The	aneous Stir rmal Thera	nulation a pies (no lo	and massage onger than 15	: E - Positioning; F - I to 20 minutes); G - 0	C - Music; D - Physical and men Rubbing / Massage the skin Cold application; H - Hot applica nterferntial therapy Psycho-s	ation; I - Short	wave dia	thermy	. Indi	vidual C	Counsel	ing; L - F	amily	couns	seling:
Pharmace	ological Ir	ntervention	sasp	per doctor's	prescrip	tion												<u></u>





81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr G. GNANAVELU

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MHI/NUR/2022/052



Date &	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.
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Hipo	l •	100 pin				SA CAR	Nua
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2200	0/10	no fain	-		_	Jen Jen	NUO-
6.00	0/6	no fair	l			Jon	Nag- 024
1000	0/0	ropain	_			Qu/	Noo
1400	ી છ	NO Pain	-			MD 0225	Nao-

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)		Duration	Location / S	Site		•		Inter	venti	ions	ı						aff Ini Emp. I	tiai	In	or Staff itial & p. No.		
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<i>3</i> 000	olw	No Pain			_					_									0	en		37	24 24	
600	olio	NO Pain				-				-									5	on	. •	1	24	
10,00	0/10	7	3	Pai	. ^	_				~											93.		10	24
PAIN SCALES																								
				2 = Mild p	ain - Provi	de comfort m	easures mocological inter	vention				-					,			,			•	. (
							> than or = 38 w Indertaken, and a											score	is >	4,				
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)				O No Nort	2 Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	Hu	B surts lie Lot	1 Hu	ソ	0	2	 1 <u> </u>	al Ra	ating 3	Sca 4 1	ale (a		more 6 }	than	12 y 8 Seve	9	s) 10
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																								
Pharmaco	ological i	ntervention	s as p	er doctor	's prescrip	otion																		_





81/Female/MH1202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





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	41/20	RIIDA	chip	NIP.	(0)(2)	12/192	12/1		
ĺ		13:10		pipo			bra			
S. No.	PARAMETERS									
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	Q	6	$^{\circ}$	D O	P			
2	Bedridden recently >3 days or major surgery within four weeks	P	O	0	Ø	6	P			
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	ð	Q	0	0	0	0			
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	Ø	O	9			
5	Entire leg swollen (Assess for both legs)	İ	1		C	1	_ 1			
6	Localized tenderness along the deep venous system (Assess for both legs)	O	D	Ð	0	0	Ø			
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	1	1	0	0	0	Ø			
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	Ð	0	0	Q	0	B			
9	Previously documented DVT (Assess for both legs)	0		0	0	0	Q			
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	O O	0	O	0	0			
	FINAL SCORE	0	0	+0	H_	+1	41			
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	9	2	uod.	كبوم	mod	mod			
	DVT prophylaxis started	☐ Yes ☐ No	⊠Yes □ No	□Yes ☑No	□ Yes □ No	□ Yes ☑ No	□ Yes □ No	☐ Yes ☐ No		
	Signature & Emp. No. of RN	P208	Down	NIE	A)	J& -	Jy.			
	Signature & Emp. No. of Sr. RN	1		100	Nac	199	سعفا			
000 24 24 25										



Medway Hospitals

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



Mrs.LAKSHMI K 1 81/Female/MHi202481668 1 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



MHI/NUR/2022/046

here heart best never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

											١.
Variables	Date	\$11/24	46/2A	8/1/8	8/1/24	81/104	9/1/24	d1124	9/1/24	rolle	}
variables .	Time		20'.00	g>x0	14,00	2000	8.00	l		8-00	
History of falling	No	(8)	0	0	0	(a)	0	0	0	0	
(immediate or within 6 months)	Yes	(25)	(25)	. (25)	(25)	(25)	(25)	\25	(25)	25	
Secondary diagnosis	No ·	0	0	0	0	<u></u>	Ō	0	0	. 0	
(≥ 2 medical diagnosis)	Yes	(15)	(15)	(15)	(15)	(5)	(15)	15/	(15)	15	
Intravenous Therapy /	No	0	0	0	0	0	ō	0	0	0	
Heparin Lock / Tubes Insitu	Yes	(20)	(20)	(žo)	(20)	20	(20)	20	(20)	28	
AMBULATORY AID								_			l
None / Bed Rest / Nurse Assist		(0)	(0)	(0)	(O)	(A)	(0)	10	(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			_ '	•							l
Normal / Bed Rest / Wheel Chair	_	0	(10)	0	0		(10)	0	0	0	L
Weak		(10)		16)	(19)	20		J10	(10)	10	l
Impaired		20	20	20	20	20	20	20	20	20	l
MENTAL STATUS		 									
Oriented to own stability	· -	6	(b)	(b)	0	0	(g)	0	(6)	0	r
Overestimated or forgets limitations		15	15	15	15	1s	15	15	15	15	
MEDICATIONS Includes PCA / opiates, diuretics,											
laxatives, hypnotics, sedatives,	No	0	0	0	0	0	0	0	0	0	l
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics	Yes	(15)	(15)	(15)	(15)	(15)	(75)	16	(15)	15	L
and psychotropics								•			
Total Score		85	85	85	AS	RS	85	85	85	85	-
Low Risk (0 - 24)			,			0/				_	
Medium Risk (25 - 44)			-6. 1								
High Risk (45 or above)		-	Vs.,	/		1		V			
Signature & Emp. No. of RN		Myor	Gar.	Agu	12 30 30 A	Day	Sain	Hart	Q _X X,	godn	1
Signature & Emp. No. of Sr. RN	7	1	2	1	رون ا	المؤلم	122	1254	سولا	Na	
	9	OV 6-	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk \	Ì
	_						· · · · · · · · · · · · · · · · · · ·		-		,

INTERVENTIONS	Date	41124	2/2/2	2/1/03	12/1/22	8/1/0×	0/1/25	9/1/29	(101)	
Tick as per the Risk Score	Time	13,00	80,00	6 8 B	140	00.CO	8,00	[A:06	8-00	
Low Risk Interventions (0 - 24)		•	J		_	7				-
Familiarize the patient with the immediate surround	lings		/			$ \wedge $	5/		ا ا	1
Remind the patient to use call bell before getting ou	t of bed		7	. /	/ /		1/			
Keep the two side rails in the raised position at all t	imes for					n				
all patients regardless of age					_	'/'			•	
Keep the call bell, bedside table, water, glasses w	ithin the		·							
patient's easy reach	_)		\		2		(
Remove excess equipment or furniture to make	a clear		.)			//	7			
path	x	℃ .				<u> </u>				
Keep the patient's bed in the low position at all time	s except		/				. /			
during procedure				2/		/ /	<i>\(\begin{array}{c}\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>		(
Teach fall-prevention techniques, such as sitting	up for a		√ .	·			,			
moment before rising from the bed									•	
Bed wheels should be locked		1	V/			_ج_ا	~			
Encourage family participation in the patient's care										
Ensure that floor of the bathroom is dry and not slip						_م_ا				
Review medications for potential side effects t	hat can	,		'						ì
promote falls			_//		_		1			
Use safety belts during movement in wheelchair		1/			_	لصـــٰ	1			
The patients are not ambulated by themselves. The	ey are to		. /							
be ambulated only with assistance		/					1/			
Medium risk interventions (25 - 44)			,		-					
Apply all the low risk interventions					-					
Tie yellow fall risk tag in the bed and Wheel chair / S	tretcher)		\) •	\		
Make sure that proper transfer precautions are in	nstituted									
for heavy or debilitated patients in a bed or wheel	chair or	ر ا				1 /	./	_		
on a toilet seat										
Use restraints and bed monitors as ordered by the	doctor	\vee	✓				<i></i>			
Allow the patient to ambulate only with assistance			~					,		
Consider peak effects of the medications that effe		,								
of consciousness, gait and elimination when p	olanning	 	/				ارى			
patient's care						/				
Do not leave patients unattended in diagno	ostic or	Ι,					ا ہ . ا			
treatment areas										
Accompany the patient while going to bathroom		_/	→							
Advice the patient to use grab bars near the toilet,	bathtub,		./			/	[] [
and shower		V					~		Í	
Make sure the family and other visitors underst	and the	۔ ا				 ′	_			
restrictions mentioned above					/					
High-risk interventions (45 or abovc)			. /							
Apply all the low and medium risk interventions		<u></u>				ļ	2			
Tie red fall risk tag in the bed, wheel chair and stretc							<u></u>			
Locate the high-risk patients in a room close to the	nurses' ့	_	` ,	l		ĺ ,	レレ		 	
station			V,							
Answer these patients call bells as quickly as possi	ble		-	/						
Provide a commode at bedside (if appropriate)						/	/ <u>/</u>	ļ		
Urinal/bedpan should be within easy reach (if appro		NA	EZR.			/				
Encourage family members or other visitors to s	tay with		./	46	25	43/84				
them		WA	~ /	ļ <u>~</u>	<u></u>	<u> </u>	NA	<u> </u>		
If appropriate, consider using protection devices	s: safety	l 🏏	🍕	⁄ٺ ا		$ \wedge $	1. /		/	
belts		1,,,,,,	<u> </u>			 		[
Signature & Emp. No.	of RN ,	KV68	(2)	1.486%	W. 24	RE	1 St. 18	11931	Poss	
Signature & Emp. No. of	Sr. RN	11/	70	1.0	مور	للحوة كم ا	Too a	ميوه مه	سوار	
		<u> </u>		100	1 Co	100	' '-		- 6 c	<u> </u>



(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs.LAKSHMI K 81/Female/MHI202481668 07/01/2024/PH2024000051

Dr.G. GNANAVELU



MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	0/1/21			11/124	भाग्र	12/12/			_
	Time	18:00	20.00	8.00	1400	30,00	800			
History of falling	No	0	0	0	0	0	0	0	0	0
(immediate or within 6 months)	Yes	25	25/	25	35	25^	25	25	25	25
Secondary diagnosis	No	0	0	<u></u> 0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	18	,15	15	-15	15	15	15	15
Intravenous Therapy /	No	0 /	0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	\20	.20	28	20	,20	20	20	20	20
AMBULATORY AID	,							,		
None / Bed Rest / Nurse Assist	-	9	ی ا	0	0	9	70	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			1				ĺ			
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	, 0	0	0
Weak	ļ	10	+0	10	10	187	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS	 	/								
Oriented to own stability		-8/	10	ے ا		.87	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,	No	0	0	0	0	0	0	, 0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15/	15	15	ার্চ	15	15	15	15	15
Total Score		85	85	85	82	85	85			
Low Risk (0 - 24)										I
Medium Risk (25 - 44)								• •		
High Risk (45 or above)		V	1		~					
Signature & Emp. No. of RN		18:34	Son	Bliv	MAL	Jen	855)		
Signature & Emp. No. of Sr. RN	. ,	Ner	بيقيها	NO	Nac	Non	Nea			
, .	· .	0 -	24: Low	Risk; 2	5 - 44: N	/ledium	Risk; 45	or abo	ve: High	Risk

	Date	21/2	libe	. \08	11.	3.1	1/12	\		, , , "	7
INTERVENTIONS	Date	10,	1611,	111129	11112	1/1/24	ν'		<u>'</u>	<u> </u>	4
Tick as per the Risk Score	Time	1200	80.00	80	140	20-00	&60			-	
Low Risk Interventions (0 - 24)			1				9 /				1
Familiarize the patient with the immediate surround	lings	/		-						1	Ì
Remind the patient to use call bell before getting ou										 	1
Keep the two side rails in the raised position at all t								_			7
all patients regardless of age											
Keep the call bell, bedside table, water, glasses w	ithin the		1	/							1
patient's easy reach								_			
Remove excess equipment or furniture to make	a clear										
path					ļ —					 	
Keep the patient's bed in the low position at all times	s except	/									
during procedure				•	<u> </u>			<u> </u>			4
Teach fall-prevention techniques, such as sitting moment before rising from the bed	up ior a			1/	\ /						ı
Bed wheels should be locked			1							 	\dashv
Encourage family participation in the patient's care	_								 	ļ	-
Ensure that floor of the bathroom is dry and not slip		<u> </u>			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		-				1
Review medications for potential side effects t		/		0			- /			<u> </u>	
promote falls		/		•					1		
Use safety belts during movement in wheelchair					t /		1		•		٦
The patients are not ambulated by themselves. The	ey.are to			1		_	7	_			1
be ambulated only with assistance	_										ı
Medium risk interventions (25 - 44)		-									┨
Apply all the low risk interventions		Ĺ			<u> </u>		/				
Tie yellow fall risk tag in the bed and Wheel chair / Si											
Make sure that proper transfer precautions are in		/				•					
for heavy or debilitated patients in a bed or wheel	chair or			/	\ /	_					ı
on a toilet seat											4
Use restraints and bed monitors as ordered by the	doctor	V		<u>``</u>						<u> </u>	4
Allow the patient to ambulate only with assistance	eta (aval	 							-		\dashv
Consider peak effects of the medications that effects of consciousness, gait and elimination when perfect the consciousness.					_						
patient's care	nammy	ر ا	_	/			`				
Do not leave patients unattended in diagno	ostic or	1/							-		┪
treatment areas		"		/							
Accompany the patient while going to bathroom									Ì		
Advice the patient to use grab bars near the toilet, I	oathtub,						7				٦
and shower											
Make sure the family and other visitors underst	and the	1/									
restrictions mentioned above				_	- 🗸		'				
High-risk interventions (45 or above)	_								 		٦
Apply all the low and medium risk interventions	l		1						-	<u> </u>	_
Tie red fall risk tag in the bed, wheel chair and stretc		V			\sim					<u> </u>	4
Locate the high-risk patients in a room close to the	nurses	🗸	/	· /	/						
Answer these patients call bells as quickly as possil	ble	<u> </u>					/-		 		+
Provide a commode at bedside (if appropriate)		1./	. /		K /		1				\dashv
Urinal/bedpan should be within easy reach (if appro	opriate)	1	· ·	-		<u> </u>	1		<u> </u>	<u> </u>	1
Encourage family members or other visitors to s		1					/				1
If appropriate, consider using protection devices belts	s: safety	10	1				/				
Signature & Emp. No.	of RN	1007 to 5	371.	8	Holati	8%.	(V)				
Signature & Emp. No. of	Sr. RN	10 TO	109	109	1000		-67/			<u> </u>	7
Orginatale & Emp. Horor		ا لمايح		3×	1 7) [2	160	102 2/8		ı		L
		y	· / `			V	~ \				





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Pa	81/Female/MHl202481668	ı
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DI.	114 AD 1911 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD 1818 AD	1
Cor	nsultant:	



PATIENT Assessment To be						DUC, plines. U					OR	RD		
Barriers to	Lea	arning								Plan t	o A	ddr	es	s Factors
None		Vision	/ He	aring	g lin	nitations				Use	of I	nterp	rete	er
Limited Reading Abilities		Physic	al b	arrie	rs					Edu	cate	fami	ily	
Religious / Cultural Factors		Langu	age	barri	ers				Ш] Sim	pie l	ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	ı / d	esire to	earr	,		Writ	ten	Instu	ctio	ons
understand and follow directions		_												
Completed By : Date FIDM Tin	ne	3.0	Ī	N	lurs	e Signa	ture	:_	Ŵ	200	?			
Learning Record								•					_	
Need		Date	١	/isit	1	Date	l	/isit	2	Date	١	Visit	3	Signature
		1/24	L	Р	0	8/1/2	Ţ	Р	o	0/1/2	۱Ľ	Р	O	سغسيع
Disease														Doctor
Information on			<u>ر</u>		, ,		_					25		17
Disease / Diagnostics			P	00	ט		₽	Øð,	U		8	00	V	
Treatment			17	72	U		P	00	v_			QQ	W	25951
Medications			1				-							Doctor / Nurse
Information on Safe and			0	מכ	U		7	<i>"</i> "				•		Q
Effective use of medicines			1				~	OD,	>		P	0P		0208
Information on drug / drug and			,	17	()						D	6 0	ri)
drug / food interactions		V		<i>''</i>			R	Ø	\supset		٢	VF-	3	
☐ Discharge Medications														
Surgical Instructions								-						Nurse
Pre - Operative Instructions														
Post - Operative Instructions									ı					
(Wound / Dressing Care)			<u> </u>		Щ									
Pain Management					Щ					_		Ш		Nurse
Reporting of pain					Щ							Ш		•
Pain Management					Ц							Ш		
Safe and effective use of medica	ıl													Doctor / Nurse
Equipment (if required)					Щ				_				L	
Name of Equipment														
Rehabilitation Techniques														

		l '	√isit	1	Date	\	/isit	2	Date	١ ١	/isit	3	Signature
		L	Р	0		L.	Р	0		L	Р	0	
lutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk		6	a -	ور		6	ھ	2		0	o.	M:	ria Cathal Catohan
Diet advice for home		_	F	П	•	_		F	7		_	Ħ	Nurse
Discharge Planning													
Self care													
Follow up													
Reporting Concerns Immunizations													
Parenting education				Ħ									
Others						<u> </u>		Г			一		
lisk Factor Reduction	Î					Γ_		┪				T	
☐ Smoking Cessation						•			, . , .	,-			Doctor
Weight Control													
Exercise													
Hypertension													
Other Risks					, .	,							
EARNER (L) -P-Patient, M - Mother, PROCESS (P) - OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Dem tration,	ons	trati	ion,	W- Wr	itter					(-	te Relationship
PROCESS (P) = OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Dem tration,	ons	trati	ion,	W- Wr	itter						Sta	
PROCESS (P)=0D - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained	D- Dem tration,	ons	trati	ion,	W- Wr	itter						Sta	
PROCESS (P)=0D - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained	D- Dem tration,	ons	trati	ion,	W- Wr	itter							
PROCESS (P) = OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained	D- Dem tration, (if any)	ons	trati	ion,	W- Wr	itter				n		ndii	
PROCESS (P) - OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained	D- Dem tration, (if any)	ons	Verk	on,	W- Wr	itter			9	n			
PROCESS (P) - OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained Reports Given : Given Pendin	D- Dem tration, (if any)	ons	Verb	on,	W- Wr	itter	tano		9	n			
PROCESS (P) = OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained Reports Given : Given Pendin	D- Dem tration, (if any)	ons	trati	on, valiz	W- Wr	ders	tano		9	n			
PROCESS (P) - OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained Reports Given : Given Pendin Discharge Summary ECG Report	D- Dem tration, (if any)	ons	Verk	Diet	W- Wr zed Und Advice Scan Re	eport	tano		9	n			
PROCESS (P) - OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained Reports Given : Given Pendin Discharge Summary ECG Report Doppler Report	D- Dem tration, (if any)	ons	Verk	Diet	W- Wr zed Und Advice Scan Re Scan Fil	eport m	tano		9				
PROCESS (P)= OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained Reports Given : Given Pendin Discharge Summary ECG Report Doppler Report X-Ray Report	D- Dem tration, (if any)	ons	Verb	Diet CT S	Advice Scan Re Scan Fil	eport m Rep	t		9	n			

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| Mrs.LAKSHMI K | 81/Female/MHl202481668 | 07/01/2024/IPH2024000051 | Dr.G. GNANAVELU



PATIENT AND FAMILY EDUCATION RECORD

Assessment To be to	filled	by cond	ern	ed di	iscip	olines. U	se k	ey b	elov	v			4	
Barriers to	Lea	arning								Plan to	οА	ddr	ess	s Factors
None		Vision	/ He	aring	g lin	nitations	,			Use	of Ir	nterp	rete	F
Limited Reading Abilities	П	Physic	al b	arrie	rs				Į	Edu	cate	fam	ily	
Religious / Cultural Factors	\Box	Langu	age	barri	ers					Sim	ple 1	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	ı / de	esire to	learı	n] Writ	ten l	nstu	ctio	ns
understand and follow directions														_
Completed By : Date John Tin	ne	8.	δ>		lurs	e Signa	ture	·:_	4	auth	رعا			<u></u>
Learning Record														·
Need		Date	\ \	/isit	1	Date		Visit	2	Date	\ \	/isit	3	Signature
		رزازا برز	L	Р	О	11))~-	L	Р	0	12/11/21	7L	Р	0	
Disease		7/12				VIII.				V2 1.			Г	Doctor
Information on														1.00
Disease / Diagnostics			b	ಎ	L		ק	ආ	0		Ø	99	$ \checkmark $	(0)
Treatment			1								1			1345
Medications	·		p	മ	J		D	ÖÞ	U		а	σ9	\mathcal{L}	Doctor / Nurse
☐ Information on Safe and							ľ				ľ			Q.
Effective use of medicines			p	മ	U		P	DΩ	O		Ω	σÇ	\sim	Ser
☐ Information on drug / drug and											ţ			
drug / food interactions								L						
☐ Discharge Medications														
Surgical Instructions								L				L		Nurse
☐ Pre - Operative Instructions														
Post - Operative Instructions														
(Wound / Dressing Care)													Ш	
Pain Management														Nurse
Reporting of pain			P	8 0	v		D	Op.	0		P	ØΩ		poln
Pain Management			P	80 80	1/		8	DP_	اسا		۵	đО	М	
Safe and effective use of medica	1										١ ١			Doctor / Nurse
Equipment (if required)														
Name of Equipment														
Rehabilitation Techniques									1					

Need	Date	\	/isit	1	Date	\ 	/isit	2	Date	\ 	/isit	3	Signature
		L	Р	0		L	Р	0		L	Р	0	
Nutritional Guidance	1												Dietician
Diet Instruction for patients at Nutritional risk		6	φ,	2		m	مد	S		0	S.	5	Sementine (1997)
☐ Diet advice for home						_				Ţ,	-		Nurse
Discharge Planning													
☐ Self care													
Follow up	<u> </u>	<u> </u>		L		_						Щ	
Reporting Concerns Immunizations					,								
Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation					,	L.,			•	•			Doctor
☐ Weight Control													
☐ Exercise													
Hypertension									_				
Other Risks		<u> </u>			<u> </u>								_
PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained	stration,		Verb										
Reports Given :	$\overline{}$									_			
Given Pendi	ng l	NA							Give	n	Pe	ndiı	ng NA
Discharge Summary	- \		1	Diet	Advice)			, - -		=-	_	
ECG Report		\setminus			Scan Re		t						
		$\overline{}$			Scan Fil	•	-						— —— <u> </u>
Doppler Report			$\overline{}$		iO Repo								
<u> </u>			_		asound								— <u>,</u> — —
X-Ray Film			_ 1	١.		_	/			_			<u> </u>
Compact Disk			_ '	ny	Other I	Kepo	TIC			_	_		
Name of Attendant / Patient :			L	_					-				
Name of Discharge Nurse							Sigi	nati	ure :				

* ₁ '4

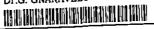




Mis.Lakshmi K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 7 1 24	Time: †	3:0	15	· · · · · · · · · · · · · · · · · · ·			
Checklist	Yes	No	NA	A	ction / 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					<u> </u>		
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			-				
·		ln	ter Di	sciplinary Team Members			
	Signatur	е		Name	Reg. / Emp. No.	Date	Time
Doctor	K		_	by thather	35881.	7/1/24	13:05
Nursing Staff	- Joe	15		JAYAP91')	00x	7/1/2	13.05
Dietician	-G	FILL	<u> </u>	Senior Dietition	D491	17 Mu	14100
Physiotherapist					, v	 	
Patient Care Service Staff							



Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU





IN-HOUSE TRANSFER FORM

			_	_				
	Pari	Ă (to be filled by Ņu	rses)				<u>—</u>	
	Date	e of Transfer: 9 12	Time: 12	<u>.00</u> Tra	ansferred	from:	<u> </u>	(103)1ª floor
Ì	Dia	gnosis:	<u>· </u>		Λ	<u> </u>	}	
ļ		Aute	4	/4		_	uthe ma	
	Vita	Śigns: Temp: · Co (°F) Pulse / HR:	Pd.	(beats/m	nin) BP: <u>(151</u> 4	(mmHg) Respi	iration: <u>&</u> (breaths/min)
	Part	B (to be filled by Ph	ysicians)	Any Critic	al Investig	ations:		
ŀ		Check for				sferring Docto		Receiving Doctor
		oiratory (Breath sounds)	Clear	Crepitat			thers:	Yes No
I		omen	Soft	Tender			thers:	Yes No
ſ		t Sound	Normal	Feeble				Yes No
ŀ	CNS For S	Surgical Patients	Consciou		iented		re:	
		plicable)	Surgical Site;	-			thers:	Yes No
ļ			Prese	nt Medic	ation (for	Medication R	econciliation)	
	S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	1	T. Clopitals	ω	11/10	Plo	0-0-1	8/1/24@20:00	☐ Yes ☐ No
	2	7. Tricin		12/125	₹ t	1-0-0	9/1/24@stop	☐ Yes ☐ No
J	3	Nes T Auch			PIN	1-1-1	9/1/24@200	Yes □ No
	4	Nus = pole	<u> </u>		PIN	1-0-1	9/1/2408.30	☐ ¥es ☐ No
ľ	5	Sy. Devi		200_	PV	1-0-0	9/1/24/08/3	Xes □No
١	b	T. Natur		15	Plo	1-0-0	9/1/2408,38	∠ Yes □ No
ļ	7	Jy. Ly dutin	<u> </u>	100_	IN	1-1-1	9/1/24 @2.30	t —
	8	Dy. Linx		20	IV	1-0-0	91112408.3	
ŀ	٩	T. Al danton		25	PD	1-0-0	9/1/24 66-5	
	α١	anj. Paning		(9	JA	TOJ_	9/1/2011/15	<u> </u>
	11	T- Aph		41	olg	131.	-	☐ Yes ☐ No
							<u> </u>	☐ Yes ☐ No
								☐ Yes ☐ No
				<u> </u>				· 🔲 Yes 🗆 No
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Additional De	tails (if any):				-		
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Patient Condi	tion: Stabl	e Sick-need urge	nt care 🔲 Oth	ers:			
	Sign.	Name		Reg. No.	Date	<u> </u>	Time
Transferring Doctor	a	13ALAJ!	e Herekan	(2361).	· a/1	124	12.00
Receiving Doctor	O CO	Drash	medlydom	1 /1500	9)1	124	13,00
Part C (to be t	filled by Nurse:	s)	O		- <u>-</u>	•	
Check for			nsferring Nurse		_	Receivi	ng Nurse
Drains	Ches	t Abdominal Oth	ers:			Yes	No No
Respiratory		Type: Patent Trach Therapy: No Yes vi	eostomy Other ia: Notal PY		 _li/min	Yes	No 🗌 No
NG Tube / Oral	Yes [No For Feeding	Gastric Suction	Fluid Restriction		Yes	No No
Foley's Catheter	Yes [No	•			Yes	No 🗌 No
Intravenous Acc	ess Periph	neral Line Central Vend	ous Line Others	:		Yes	No 🗌 No
Pressure Injury	Yes [No If Yes, give details:				Yes	i 🗌 No
Score		<u> </u>	NEWS / PEWS:			Ves	No No
Patient Belongin	ngs Yes [Mo If Yes, give details:				Yes	No No
Handover Detail	2	on Administration Record e agnostic Reports handed o	•	_		Yes	i 🗌 No
Patient Attendar Informed	ntes [No If No, give details:	•			Yes	i ☐ No
Additional De	tails (if any):		*				
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	Sign.	Name		Emp. No.	Date		Time
Transferring Nurse		Poemalo	xtha.	041	91	1124	00°.ce
Receiving Nurse	Hay	Hannal	· Cirace	ows	9/4	[22]	2130

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FAMILY COUNSELLING FORM

CONSU	LTANT-DPIO	rnanavelu	DIAGNOSIS- Acute pulmonary colling,										
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS		FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN	•						
7/1/24	Doctos—	gon).	MEDICAL UPDATE At Condition Explemed to furty members		Service Control of the 95951	<u>-</u> (.							
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aliba.	DOYOR.	BoN	P+ Condition englained to attenders	<i></i>	J. 1	727675							





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

Dr.G. GNANAVELU





PHONE / VERBAL ORDER FORM / CRITICAL VALUE REPORTING FORM ☐ Telephone order ☐ Verbal order ☐ Critical value reporting form Additional information if any Name of the Drug N/A Dose Route Informed to Dr.: Kallful Lab / Radiology Critical result reporting (if any): SODIUM - 115 Non Medication Order (if any): - N/A Order Recipient Response: Please Tick Write Down Yes 7/No Read Back Yes No Confirm Yes No Received by Ordering Physician / Informing Staff Signature: O----Signature: Name: SUMA MAHESWARI Date: 7/1/24 Name: Indhumsthi ses Of Critical Value): Time: 15:35 Albitroral hyportering Emp. No.: 0204 Action Taken (only in Cases Of Critical Value): NAME **SIGNATURE** REG. NO. DATE TIME Dr. Karkhou A5851 **Doctor**







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

Mis.Lakshmi K

81/Female/MH1202481668

07/01/2024/IPH2024000051

AGE / SEX: Dr.G. GNANAVELU IP No. / UHID No

202481668

Ward / Bed No. CCU

D BE MONITORED IN EVERY SHIFT

	DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.
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	·	14.00	grachia	6/5	patens	Fluggo	peollowed	word
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		p.00	ap hatic	210	Patient	blucke	followed.	65HH
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	10/1/24		cephalic	015	Partent	Hushed		Hoyour
		30.00	sophalic	06	Patent	flushed		Ser-
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Where heart best never stops..

REQUISITION FOR MEDICINE

(A Unit of United Alliance Healthcare Pvt Ltd)

Name of Patient : NW Lax Slinw

Age / Sex : & / F

IP No. : 2024CDOOH
DOA : 本山

UHID No. :202481668

Consultant Name: Dr. Granallolu. Room No.: acu

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<u>9.</u>	Date	Medicine Name	Qty.
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The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)





REQUISITION FOR MEDICINE

Mrs.LAKSHMI K

81/Female/MHI202481668 Name of Patient 07/01/2024/IPH2024000051

Age / Sex Dr.G. GNANAVELU

. A COLOR DE COLOR CENTRALISMO DE COLOR Consultant Name :

IP No.

DOA

UHID No.:

Room No.: Cou

	itant Name		
S No.	Date	Medicine Name	Qty.
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The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)

REQUISITION FOR MEDICINE

: NPF 10 KB

IP No. DOA

UHID No.:

Consultant Name

Name of Patient

Age / Sex

Room No.: ((U

Consu	Itant Name	: Room No. : C 🤻	<u>_</u> 1
lo.	Date	Medicine Name	Qty.
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Where heart beat never stops...

REQUISITION FOR MEDICINE

(A Unit of United Alliance Healthcare Pvt Ltd)

IP No.

Name of Patient

DOA

Age / Sex

UHID No.:

Consultant Name:

Room No.: ()

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Date	Medicine Name						
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	2-	Matrico (15 ng					

Nurse Name

Pharm Bill & Name







(A Unit of United Alliance Healthcare Pvt Ltd)

REQUISITION FOR MEDICINE

IP No.

. MUB. LAK SHMILE. Name of Patient

DOA

Age / Sex

UHID No. :

Consultant Name :

Boom No · (14)

Jonsultant Name :		HOOM NO.: YY							
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The way to better health (A Unit of United Alliance Healthcare Pvt Ltd)







Where heart beat never stops...

REQUISITION FOR MEDICINE

Name of Patient

Age / Sex Consultant Name: IP No.

DOA

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Room No.: C_CU

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Medway Hospitals

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





IP No.

DOA



Where heart best never stops...

REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex : UHID No. :

Consultant Name: Room No.: CUU.

e No.	Date	Medicine Name	Qty.
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12	11	20 m syrige	3
13	11	10 ml syringe	ව
14	11	5 ml chiênae	A
15) 1	2 mi cyringle	, i

Nurse Name

Pharm Bill & Name











Where heart best never stops...

REQUISITION FOR MEDICINE

IP No.

2024000051

Name of Patient

Age / Sex

mæ. Lakshini

DOA

Consultant Name

31 1 1 -

F. UHID No.: 202181668

L No. Date Medicine Name Qty. 11 suconae 1 1 Catheler И Mictory 11 100 11 17 Giova B h a 11 Ð 11 ١١ 11 Ħ)_





Mis.Lakshmi k

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



MHI/PHARM/2022/028



(A U	nit of United All	ance Healthcare Pvi Ltd)	TEO.	<u> </u>			<u> </u> -:	Every	/ heart beat (counts
		MEDICATIO	N AD		IIȘTI	RATIO	Ņ REC	ORD		
Drug	Chart:	:of	-		Heig	ht (cms):	1155	Weigh	t (kg): <u>+9</u>	okg
	_	KNOWN MEDICINE A				onfirmed	, write NKDA i			
Drug De	etails		Descri	ption of	Allergy			Doct	or's Sign: 🛭	2
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	осто	R INSTRUCTIONS	4.051				TAFF INSTRU	CTIONS		
2. Write in 3. Sign an 4. No pre	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, 22:00hrs, Q6:00hrs, 10:00hrs, 10:00hrs, 12:00hrs, 12:0									
		Stat / 0	Once O	nly / F	Premed	lication	Drugs			
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h #						Sign.	Reg. No.	Sign.	Emp. No.	Time
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Date -To be filled by Nursing Staff only. Sign and time given **REGULAR PRESCRIPTIONS** Time ↓ To be filled in by Doctors only DRUG NAME Nab. 8,00 Route f(N Frequency Dose 1-7-7. wesp. 16,00 Start Date & Time Dr. Sign & Reg. No. / Seal 00:00 1/ms 851. 10/1/24@1800 Additional Info: DRUG NAME NOG. BUDGLERT. 8,00 Frequency Dose 1-07. Dr. Sign & Reg. No. / Seal Start Date & Time 20.00 Stop Date & Time 10/18/10 MR:00 Additional Info: DRUG NAME F. CLOPITAB- CV. Dose, Route Frequency 0-07. Start Date & Time Dr. Sign & Reg. No. / Seal 20,00 0040 Mas-851. Stop Date & Time Additional Info: **DRUG NAME** 1. TRICINOD 8,00 Frequency 1000 Start Date & Time Dr. Sign & Reg. No. / Seal 7 1/ 94@ 14 00 Stop Date & Time MAS811. 8/11240 1000 Additional Info: 834 1020 **DRUG NAME** 8.30 In Deriphrium 8,00 Frequency Dose Route 1-00 24 Start Date & Time Dr. Sign & Reg. No. / Seal #11 DAG 1400 Stop Date & Time Additional Info: Area In-charge Nurse Signature:

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist Medway Heart Institute



	REGUL	AR PRESCRIP	TIONS I	Date →	To be	filled b	y Nurs	ind Sta	ff only.	Sign a	nd time	given	٠ ،
		filled in by Doctor		Time ↓	9/1	امرارا	11/11	Olife				~	
+: 8:	DRUG NAME	UP		& 00	%	Ω.6 ⁴⁶						:	
Clinical Pharmacist Medway Heart Institute	Dose	Route ~	Frequency	14.00	[(3 /	Han Wa	حہر	2					: -
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Clinical Pharmacist Medway Heart institute

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Clinical Pharmacist Medway Heart Institute

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	- :	Intravenous	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Rate /		Additive Drug		·	Do	ctor	Adn	ninistration	n
Date	Time	Fluid	Volume	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time		
1/24	13:00	NL.	36ml		IV	Inj. Jask	40 mg	2mg/fro					<u>u</u>
11/29	20:00	Ns	30 cc/h		IV	Nr 200mt		30ce)h	Hr.	85851.	@ 20:00 -1/1/24	18130	SE
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PARENTERAL MFUSION PRESCRIPTION AND ADMISSTRATION RECORD **Additive Drug** Doctor Administration Rate / Intravenous Date Time Volume Route Duration Fluid Start Time | End Time | Sign. Name Dose Range Sign. Reg. No.

		DII	ET ORDERS	(to be pre	scribe	d by Do	ctors only)		
Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
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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
1	Morning				4/1/24	Ban-i	pangmeguei	2333	₩.
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8/1/26	Evening	Lavanja.	0118	PL		Evening	(11 / (10)		
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19 le 12e	Night	A- Mondler Ji	Med	Ð		Night		*	







Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug) Chart	: <u> </u>			Heig	ht (cms):	155	Weigh	it (kg): <u> </u>	0
		KNOWN MEDICINE AL	LERGIE	S (if NO	ONE is c	onfirmed	, write NKDA i	n box 1)		
Drug De	etails	· · ·	Descri	ption of	Allergy			Doct	or's Sign:	
			ŀ	•				8	James	
		7		. 1. 1	NOT	rkn	ص	Nam	e: ۵۲.34	46. B
				•					No. 1838	_
						_		нед.	NO. 1831	57}
	ОСТО	R INSTRUCTIONS		_			TAFF INSTRU	CTIONS		
1. Use ge	eneric na	me when prescribing drug	1. Check	entries in	every sec	tion to avoid	d omissions art on daily basis			
		LETTERS, clearly and legibly	3. For ne	w prescri	ption, follo		s of doctor's presc	ription on	Day 1 only, and	then
_		MCI registration no. or apply seal		standard		r: 10:00hre (212hrly: 10:00hrs, 22	2:00hre or (16:00bre 18:00b	re
	-	should be altered / overwritten mat when writing time	Q8hrly	: 06:00hrs,	14:00hrs,	22:00hrs or 0	9:00hrs, 14:00hrs, 2	21:00hrs, Q	6hrly: 05:00hrs,	
	7 110 41 101						00hrs, 06:00hrs, 10:	:00hrs, 14:0	00hrs, 18:00hrs,	22:00hrs
		Stat / C	Once O	nly / P	remed	ication	Drugs ————————			
Date	Time	Drug		Dose	Route		Doctor	,	Administered	i
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Clinical Pharmacist Medway Hearl Instituto

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PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD **Additive Drug Doctor** Administration Rate / Intravenous Time Volume Date Duration Fluid Route Name Dose Sign. Reg. No. Start Time | End Time | Sign. Range Acres

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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
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-	Morning					Morning	<u> </u>		
-	Evening				-	Evening			<i>p</i>
	Night					Night		<u> </u>	

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INTERMEDIATE CARE FLOWCHART

NAME: Mrs.LAKSHMI K

81/Female/MH1202481668

SURGIC 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

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UHID NO :202481668 AGE: 814

SEX: F

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UHID NO : 20248/668 AGE: 814









SEX : F

INTERMEDIATE CARE FLOWCHART

NAME: Mrs.LAKSHMI K

81/Female/MHi202481668

SURGIC 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

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Mis.Lakshmi k 81/Female/MH1202481668

07/01/2024/IPH2024000051

ERMEDIATE CARE FLOWCHART

Dr.G. GNANAVELU NAME WANTED TO THE STATE OF THE

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SEX: PEPULPER

SURGICAL PROCEDURE:

POSTOP DAY : $\mathcal{D} \mathcal{Q}$.

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Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

NAME:

Dr.G. GNANAVELU

SURGICAL PROCEDURE:

RMEDIATE CARE FLOWCHART

Α

UHID NO: 202 4886 & AGE: 8-1 4

SEX: F

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: Dis-: Acute palmonary edema 1 72 pm /





Mrs.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

ERMEDIATE CARE FLOWCHART

UHID NO: 20218168 AGE: 81

SEX: 🔑

SURGICAL PROCEDURE: -

POSTOP DAY:

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SPEC	iFIC O	BSERVA	TIONS	REMAR	KS			MEDI	CATI	ON	I / DRUC	SS				
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SEX: F

INTERMEDIATE CARE FLOWCHART

В

Mrs.LAKSHMI K

81/Female/MHI202481668

NAME: 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

HEIGHT: 土 155 CM

WEIGHT: #90 kg

B.S.A: 2.510

UHID NO: 200401668 AGE: 814

9/1/211-6 **HAEMODYNAMICS RESP. PARAMETERS INVESTIGATIONS / OTHER DATA** TEMP H.R. RHY. ST. B.P. R.A.P. PERI. P.P. RR BREATH | SPO2 Boronell dige P+ NPO2 2 liters. Brlel 98 114 g8.00 man/ 103 Brld Bound 989 $\rho\rho$ Q DD magn ++ 989 89 do Brich Grind doit of 10001 to menu (1 Pacing 986 Bylch 0a: ||21 nuum +1 U priva 151 989 1au00/69 as wount Qb. 18 Byld 11)

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE 1420 MOL TOTAL OUTPUT 3045 MOL

BALANCE







SEX: F

INTERMEDIATE CARE FLOWCHART

UHID NO :20 246/668 AGE :8/ Y

Mrs.LAKSHMI K

81/Female/MH1202481668

NAME: 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

BLOOD HELDER BLOOD

HEIGHT: ±155 Um

WEIGHT: ±90 bg

B.S.A: 2.3100

TOTAL OUTPUT

BALANCE

		НА	EMOD	YNAM	ics	•		RES	P. PARAMET	TERS	INVESTIGATIONS /
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1,00	b9	poids	93.3	151/15	95	cuen	孙	20	ødd	100	1/
2.00	199	paking	97-3	料	ioo	wan	4+	17	Brld	99	1
<u> 3</u> 00	B	padry	97-3	140	9	uan	++	10	Brly	99	11
d.00	69	porang		152	'	uom	++	19	Brly	019	11
5.00	69	porally	94-3	156	108	Mesm	#	20	Brlu	99	1
J. or OC	V (wery	973	53	96	ceran	//- _	19	Brla	100	//
4.0C	69	powhs	97.9	110	104	allm)	44	20	BHU	100	10
<u>.</u>			_								·
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				,	DR	AINAG		Р	REVIOUS DAY		LINTAKE

URINE /







Mis.LAKSHMI K

81/Female/MHI202481668 07/01/2024/IPH2024000051

NAME: Dr.G. GNANAVELU

RMEDIATE CARE FLOWCHART

UHID NO: 202481668AGE: 814

SEX: F

BLOOD CINOUR .

WEIGHT: \$ 90 kg

B.S.A: Q.Sm2.

HEIGHT: 4 155					WEIG	3HT : 🤦	£90	kg		B.S.A: Q.3m ²			
						_	- ₍	J			8/1/24 - 12		
		HA	EMOD	YNAM	IICS	,		RES	P. PARAMET	rers	INVESTIGATIONS /		
TEMP		RHY.	S-7.	В.Р.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA		
8.00 8/1/31	1 .	કં ત પાણ	98F	90 1712	88.	www	++	do	By (c)	92.	P+ on NPO2 alitous.		
d:00.	40	Sims	06,ℓ	۱		NOON	#	21	Buld	93	(1		
-1010	69	Sinns	goif	132	त्रन्	(LOUM	1+1	24	BYLLI	92.	BIPAP 12:10 on How		
//×00	68	7 ang	981	<u> </u>	83	waun	++	g o	Brlcl	Q21	11		
b_>00	-69	Strus	986	35/35/5	80	man	J 4.	21	Brlu	93.1	<u></u>		
13/100	<u>b</u>	Run	986	3	Qb,	10 Octor	++	D 10	Br(cl	વાન	ŧ		
14.00	ta	Buig	98 Ì	43/62	2 9 (gm	4	22	Bld.	917	¢		
reior	69	phuny	वृत्र वृत्र	当我	103	Wan	44	21	BIG	947	1,		
Lbiox		paury	0	亚	86	Main	44	<u>D</u> 1	Brct	95J ·	. 1		
[] 400	,	aury	944 144	पिष		Won		20	BICL	951	· u		
18:00	69	Dey	474	151	92	Hear	1	21	BLCC	94%	1)		
19:00	169	pawy	943	100	92	Wan	44	, 20	BLU	981.	10		
20.00	69,	aling	93 3			woom	4-1	8	Buld	99	<u>//</u>		
2100	69	polòv	9स 4	0	85	Clom	/ -	19	erld	100	t '		
22.00	691	Oreit	1944	0/0	95)		+4	20	PX/4	r00	//		
	ر ا	poèrg	9F-9	19/88	.99	luan	11	2	Brld	100	4		

PREVIOUS DAY - HOURS

DRAINAGE '

URINE 1680m1.

TOTAL INTAKE (OH8m)

TOTAL OUTPUT 1680 MM

BALANCE

63a m1







Mis.Lakshmi k

81/Female/MHl202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU NAME:

RMEDIATE CARE FLOWCHART

В

UHID NO: 2004 CH 6 BAGE: ET 4 SEX: F

BLOOD GROUP:

HEIGHT: ± 155

WEIGHT: + 90

B.S.A: Q. 3 m 2

TOTAL OUTPUT

BALANCE

<u> </u>	_	НА	EMOD	YNAM	ics	•		RES	P. PARAME	TERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
£;00	69	Paurg	98.p	147	91	hlarm	1+	Дo	BRCL	95%	<i>'</i>
6.00	8	laving	17.6 -	1419	94	wam	44	дa	Bolcl	9 sy.	4
7 °60	to	Paing	99.4	138	90	Warn	++	20	Bolci	94%	را
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	J	<u> </u>				LLLAGE		þ	REVIOUS DA		S INTAKE /

URINE







Every heart beat counts

Mis.Lakshmi k

81/Femule/MHI202481668 07/01/2024/IPH2024000051

Dr.G. GNANAVELU

ERMEDIATE CARE FLOWCHART

NAME

UHID NO: 2024 PIGGE: 8/

 $\mathbf{SEX}: \mathcal{F}$

BLOOD GROUP:

неі**с**нт: ±155

WEIGHT: ± 90

B.S.A:

		НА	EMOD	YNAM	ics			RES	P. PARAMET	ERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
13200	£9	garly)	98F	174	10-8	Wes ~	<u>-</u> 44	216	gold	39-1.	D22 libes of FM
14:00	70	pain		34	110	blak-	71	30	Bolel	98 [.])	α
15,00	go	pacm)	968	168	92	WY	11	27	Bolef	100 1.	pton Masel porony of liber
16:00	70_	prat	ł		83	w	} t	25	Bold	100.1.	l,
17:00	69	ercity	९६ ६	142	Хþ	Wes-~	14 0	25	pold	[60.].	
18,60	Fo	Pagig	78 F	132	94	ws~	74	22	Bolch	4g -J.	1/
19:00	6 9	pay		75/0%	نــــــــــــــــــــــــــــــــــــــ	Wohan	74-	18	BOLN	76 ¹ ·	n
00،00	70	pactrot	Qe b	153	94	hlarm	++	16	Brch	160%	//
21:00	70	Pauly	92.b	165	401	Horr	<u> </u>	21	Brcl	100%	′,
22 :bo		Pacity			ļ	kloum	+-	22	BrcL	q.&>	<i>(</i>)
23; ₆₀	70	pacin	98-6	151	98	hlagi) + +	26	BrcL	99%	′/
3 4100	70-1	كودندم	qe.6	137	87	hlven	, 1 —-1-	20	BRCL	99%	٠,
۱, ا				161	10%	victory	KF.	21	Br(ce	95-1	
a-00	*		asir	157	99	۸ی ا	17	95	Belcc	971	; •
3.00	108	Q ACI (18)	OBIV-	. 1 2	100	Carolaly	48	27	Be (Cc	95.1	BIBBP < 6
4.00			98.b	147	91	Mon	7+	'3\$	Beer	94	

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE