

# MRD CHECKLIST

	PARTICULARS	YES	NO
-	IP Number allocated to each Patient		
_	Name, Age & Sex of Patient	1	
-	General Admission Consent	/	
-	Initial Assessment of Patient / Diagnosis	/	
-	Nutritional Assessment by Consultant	/	
-	Plan of care counter signed by the Consultant	/	
_	Treatment Orders - Date, Time, Name & Sign.	/	
	Medication Order / Drug Chart - Date, Time, Name & Sign.		
	Vital Signs Chart (TPR Chart)	/	
-	Intake Output Chart	/	
-	Drug Chart (Duly filled)	/	
_	Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist		
-	Anesthesia Assessment Sheet		
-	Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon		
-	Surgery Notes - Post Operative Plan		
-	Pain Scoring System		
-	Blood Transfusion if done		
	High Risk Procedures		
-	A copy of the Discharge Summary	/	





#### Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Every heart beat counts

# Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

# **ADMISSION SLIP**

				6 .				
Admitting Doctor: DR. Po	ulanjappan.	Speciality:	Genero	D Medici	ine			
Advised Date & Time:	30/12/23 (6:20							
Provisional Diagnosis:	FENSIL RIM CUMMINION							
	pm - and -							
	NEUMONTHS / WEDMONTHS	radinarian loni	75110					
Reason for Admission:	Medical Management	Surgical Man	agement	_	,			
'	Others (please specify details)	)						
Admission Type:	☐ Day Care ☐ ER	✓Ward						
	☐ ICN	(Specify details)						
Surgery / Procedure Name	(if planned):				,			
Blood Product Requirement	Yes (Kindly specify	details of component	s required in s	pace below)				
·				,				
Expected Duration of Stay:	3-5 Days		•					
Expected Cost of Treatment	as per Financial Counseling Form	n):	<del></del>					
Payer: Self Insurance	Others							
Instructions to Nurse (if any)	: ADMIT IN WOME ( WI)	2 BILLYANTURUS N	res .		-			
,	WONING MADE							
	·							
Any other Instructions (if any):								
Dostario Cianatura	Name	Pog. No.	•	Data	Time			
Doctdr's Signature	Dr. Anish Nelson	Reg. No. Dr. Anish Nelsor Reg. No: 88434		Date				
	Reg. No: 88434	Neg. 110; 00434	'	70/1483	16:20			

For admission desk staff of	only:		
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others	* (M. 14 · 14 · 14 · 14 · 14 · 14 · 14 · 14	•
Admission intimation	Receipt Details	Admission T	ime in HIS
Date	Time	Date	Time
Bolides	4.30 1~	30/1/20	4.70 pc
To be filled only if Blood	OPD ER Direct requirement specified by the	_	No
Front office Staff Signature	Name Sturguest	Emp. No.	Date Time
		: Op! 2:	

,

# Medway Hospitals The way to better health

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#### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/PH2023002639

Dr.T.PALANIAPPAN



Heart Institute

MHI/HOSP/2022/129

## **ADMISSION FORM**

Marital Statu	s Full Add	ress	Telephone Number					
M		59, Lakshmi Nagar, Katlerpalekan,	29944131417					
Occupation \ •\		Ch = 56.	7 199131917					
Referred from			I No. of Days					
Dog: m	Redicu Piva 30/10/20. 2.30pm 5/1/23@18:30 6d							
UNIT		311(23(-10))	7,					
UNIT Gene	ral hedicing	MLC Yes No If Yes AR No.:						
		FINAL DIAGNOSIS	ICD Code					
<u>CHR</u>	wonic Ki	DNEY DISEASE	N18.9					
Ace	ELERATE.	D HYPERTENSION, ACUTE	<u>I10</u>					
PUL	MONARY	EDEMA, TYPETI DIABETES	J81.0					
MELL	19US , V	TRAL PNEUMONITIS, BENIGN	EH. 9, N40					
PRO	STATE	HYPERTROPHY, HYPOTHYROIDISM	E03.9					
-Hyr	ERKALEM	1A, HYPOALBUMINEMIO	E87.5					
•		·	E 88.0					
DATE		OPERATION / PROCEDURES	ICPM Code					
_								
			}					
DATE		TYPE OF ANESTHESIA						
	GENERA	L SPINAL LOCAL REGIONAL	☐ EPIDURAL					
		DISCHARGE STATUS						
□ Cured		☐ Discharge at Request ☐ Ex	pired < 48 hours					
✓ Improve	pired > 48 hours							
☐ Absconded								
	<del>(Kr.) / K</del> 5	☐ Transferred to ☐ Po	Sol Operative Boatin					
8 N	1. 13 13 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M. i.m.	hazan					
Signature	of the Consu	tant Signature of Medi	cal Records Officer					

#### **AUTHORISATION FOR TREATMENT I PAYMENT**

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

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

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

I have read out and explained the contents of the above to the Signatory in his vernacular . சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி தெரிவிக்கீப்பட்டிருக்கீறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியா கையொப்பம்

தேதி

எனது/உறவினர்/காப்பாளர் கையொப்பம்

C. Peny

Signature of Admitting Nurse

Date 30/12/23

Signature of the Patient / Relative / Gurdian

உறவுமுறை

.. ..

Nature of Relationship



discharge.





#### Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





#### **GENERAL CONSENT FOR ADMISSION**

	ראסיסילי lease tick the correct option above and below) Read	_the	Patient or	r	☐ Representative of patient have
	☐ Read ☐ Been explained this consent form in English, which I t	fully u	ınderstand.		•
•	I give my full consent and authorization for admissio plan has been explained to me.	n and	d treatment at	this	s hospital. The proposed treatment
•	I consent and authorize the hospital, treating doctorelevant care and to conduct diagnostic as deemed no				
•	I also consent to use of assistants such as resident do by the hospital and treating doctor/ team.	ctors	, other doctors	s, nı	urses, and other healthcare workers
•	I consent for clinical consultation, admission, disclosured confidence), routine medical examination (physical elab and imaging investigations, general nursing care,	exam	ination, palpat	tion	, percussion, auscultation), routine
•	I have been explained about the proposed care plan cost of treatment/ hospital stay.	ר, exp	pected result(s	s), <sub> </sub>	possible outcome(s) and expected
•	I understand that the hospital will take due care of munexpected complication(s) which may necessitate leases, procedure different from those contemplated a	onge	r stay and / or	us	e of intensive care services. In such
•	I declare that, I have and will inform the doctor of my meaction(s), surgical procedure, relevant medical family shall not hold the hospital/doctor responsible for any relevant information on my part.	nily h	istory and all	oth	er facts relevant to my treatment. I
•	I declare that I have been explained about my rights	and r	esponsibilities	s.	
•	I have been made aware of the rules and regulations promise to abide by them.	s of t	he hospital ind	clud	ding those related to security and I

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	For c. Puff	Pranad -S	30/12/20	4-30/~
Surrogate/Guardian (if applicable #)	c. pup.	(Write name and relationship with patient)	30/10/23	4.20%
Reason for surrogate consent	Patient is unable to give consent	because:		
Witness	c: Pup	C-RENUGO.	30/10/2	4.30 yr
Interpreter (if applicable)				′

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







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#### DISCHARGE SUMMARY

IP No.

IPH2023002639

D.O.A

: 30/12/2023

UHID

MHI202381576

D.O.D

: 05/01/2024

Name

Mr. PRASAD SUGUMARAN

Room No. : 109

Age / Gender

42Years / MALE

Consultant

: (1)Dr. T. Palaniappan MBBS MD DNB MNAMS MRCP (UK)

Senior Consultant Internal Medicine

(2) Dr. Jaishankar. K MD., DM., FIAMS

Director and Clinical Lead

Cardiology and Electrophysiology

(3)Dr. Elakiya Mathimaran M.D. Respiratory Medicine

Pulmonologist (4)Dr. Yuvarai Consultant Urologist

(5)Dr. Aswin

Medical Gastroenterologist

#### **DIAGNOSIS:**

CHRONIC KIDNEY DISEASE

ACCELERATED HYPERTENSION

**ACUTE PULMONARY EDEMA** 

TYPE II DIABETES MELLITUS

VIRAL PNEUMONITIS

BENIGN PROSTATE HYPERTROPHY

**HYPOTHYROIDISM** 

**HYPERKALEMIA** 

HYPOALBUMINEMIA

#### PRESENT COMPLAINTS

A 42 years old male came with History of high grade fever with chills on and off for 3 days.

H/o Burning micturition, associated with lower abdominal pain on and off for 3 days.

H/o Shortness of breath on and off, associated with history of bilateral swelling of both legs for 3 days.

H/o decreased urine output for past 3 days.

Now admitted here for further management.

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

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**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

Chengalpattu

Villupuram

Kumbakonam

Kakinada

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

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



**PAST HISTORY:** 



#### Every heart beat counts

Known case of Type II Diabetes mellitus/ SHTN/ Hypothyroidism/ CKD on medication. Healthcare Pvt Ltd)

H/o had right lateral plataeau fracture 3 months before, but not treated.

DRUG ALLERGY:

Not Known Drug allergy

#### ON EXAMINATION:

Patient Conscious / Oriented / Febrile

Weight-73.3Kgs 102°F Temperature -92/min BP 110/70mmHg PR

92% in room air RR 20/min SPO2 -

bilateral wheeze (+), Bilateral crepts(+) **CVS** S1S2 (+) RS

CNS **NFND** Soft, non - tender Abdomen

**INVESTIGATIONS:** 

Enclosed

#### TREATMENT GIVEN:

INJ. LASIX 60MG IV STAT, INJ. MUCOSYS 1 AMP IV BD, NEB. LEVOLIN 1 RESP P/N Q8H, NEB. BUDAMATE 1 RESP P/N Q8H, INJ. HEPARIN 5000 S/C OD, INJ. MEROPENEM 1 GM IV BD, INJ. DYTOR 20MG IV BD, NEB, IPRAVENT 1 RESP TDS, SYP. ASCORIL – LS TDS, SYP. RESWAS 15ML HS, TAB. LYRICA 75MG BD, TAB. ZYTANIX 2.5MG OD, TAB. ZYLORIC 100MG OD, CAP. AWAYTOX TDS, TAB. ECOSPRIN 75MG HS, K BIND SACHET 15GMS BD, TAB. MINI PRESS XL 5MG BD, TAB. CARCA CR 10MG OD, TAB. TELMA 40MG OD, TAB. ELTROXIN 100MCG OD, TAB. ABPHYLLINE BD, TAB. ROSUVASTATIN 10MG HS, TAB. ARKAMIN 100MCG TDS, TAB. LINID 600MG BD, TAB. TAMBEST D HS, TAB. NEBIVIOLOL 5MG OD, TAB. UDCA 300MG TDS.

#### COURSE IN THE HOSPITAL

A 42 years old male, Mr. Prasad Sugumaran, came with History of high grade fever with chills on and off for 3 days, H/o Burning micturition, associated with lower abdominal pain on and off for 3 days. H/o Shortness of breath on and off, associated with history of bilateral swelling of both legs for 3 days. H/o decreased urine output for past 3 days. On fluid restriction 1 liter/day. Patient got admitted under Dr. T. Palaniappan. Baseline investigations showed increased total count, increased NT PRO BNP levels, deranged RFT levels, Increased serum PCT and D - Dimer. Echo done (EF - 52%), ABG done. Due to Hyperkalemia (K+ - 5.60), appropriate correction given. Due to increased blood pressure and decreased urine output Dr. Jaishankar - cardiologist opinion obtained and orders followed. Due to shortness of breath continuous cough with expectoration and increased NT PRO BNP levels. Dr. Elakiya pulmonologist opinion was obtained and she advice for sputum culture and sensitivity and sputum AFB. Sputum culture and sensitivity and sputum AFB showed negative. HRCT showed suggestive of acute pulmonary infection with normal flora grown in culture possible super added early pulmonary edema. Urine culture and sensitivity and blood culture and sensitivity showed no growth. Due to hypoalbuminemia (albumin – 2.1) 2 units of Inj. Human albumin was transfused. USG abdomen showed cholelithiasis.

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Kodambakkam .

Mogappair

Kakinada Heart Institute 044 - 4310 8959





Bilateral medical renal diseases, cystitis with significant post void residual urine volu (A Unit of United Alliance Hea ascities. Due to lower abdominal pain. Dr. ashwin medical gastrpoenterologist opinion was obtained. He was advised for Ascitic fluid tapping done. Ascitic fluid sent for analysis. Reports awaiting. Due to difficulty in micturation and increased cystitis with significant post void residual urine volume. Dr. Yuvaraj Urologist opinion obtained and orders followed. Due to Increased D - Dimer, bilateral venous doppler study done. Dr. Palaniappan - Intensivist reviewed periodically and advised followed. Dr. Jaishankar cardiologist reviewed periodically and advised followed. He advised to consider renal denervation. Patient was diagnosed to have Chronic kidney disease, Accelerated hypertension, Acute pulmonary edema, Type II diabetes mellitus, Viral pneumonitis, Benign prostate hypertrophy, Hypothyroidism, Hyperkalemia, Hypoalbuminemia. Patient was treated with IV fluids, antibiotics, antipyretics, analgesics, Antihypertensive, Anti diuretics, mobilization and other supportive measures. Glycemic levels were monitored and insulin were given accordingly. Vitals stable. Patient general condition improved and symptomatically felling better and hence being discharged with. Advice medication. Plan renal denervation therapy later.

#### CONDITION ON DISCHARGE:

GC Stable

GCS 15/15

Temp 98.6°F BP 175/110mmHg PR SPO2 98% in room air 79/min

#### ADVICE MEDICATIONS

SI.	NAME OF THE	STRENGTH	DOSAGE	FREQUENCY		ROUTE	RELATION	DURATION	
NO	DRUGS			M	Α	N		SHIP WITH	
							_	MEAL	
1.	TAB. ELTROXIN	100MCG	1 Tablet	1	0	0	Oral	Empty Stomach	To Continue
2.	TAB. ROSUVASTATIN	10MG	1 Tablet	0	0	1	Oral	After Food	To Continue
3.	TAB. ECOSPRIN	75MG	1 Tablet	0	0	1	Oral	After Food	To Continue
4.	TAB. ARKAMIN	100MCG	1 Tablet	1	1	1	Oral	After Food	To Continue
5.	TAB. AB PHYLLINE N		1 Tablet	1	0	1	Oral	After Food	Till review
6.	TAB. ZYTANIX	2.5MG	1 Tablet	1	0	0	Oral	After Food	To Continue
7.	TAB. TELMA	40MG	1 Tablet	1	0	0	Oral	After Food	To Continue
8.	TAB. DYTOR	20MG	1 Tablet	1	0	1	Oral	After Food	Till review
9.	TAB. NEBIVIOLOL	5MG	1 Tablet	1	0	0	Oral	After Food	To Continue
10.	TAB. UDCA	300MG	1 Tablet	1	1	1	Oral	After Food	Till review
11	K BIND SACHET	15 GRAMS		1	0	1	Oral	After Food	X 2 Days
12.	TAB. TAMBEST D		1 Tablet	0	0	1	Oral	After Food	Till review
13	TAB. MUCINAC	600MG	1 Tablet	1	0	1	Oral	After Food	To Continue
14.	SYP. RESWAS	15ML		0	0	1	Oral	After Food	sos
15.	TAB. LYRICA	75MG	1 Tablet	1	0	1	Oral	After Food	To Continue
16.	TAB. ZYLORIC	100MG	1 Tablet	1	0	0	Oral	After Food	To Continue
17.	MDI. FORACORT	200MCG	2 PUFF	1	0	1	Oral	After Food	To Continue
	WITH SPACER								
18.	INJ. HUMAN			12	10	8U	S/C	BEFORE	To Continue
	ACTRAPID			U	U			FOOD	

#0 1ct Main Doad	United India Colony, Kodambakkam, Chennai - 600024, Tel: 044 - 4310 8959
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**Heart Institute** 044 - 4310 8959 institute of Pulmonology 044-2473 4451

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





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(A Unit of United Alliance Healthcare Pvt Ltd)

To report: If temp > 101 'F/Difficulty in breathing/ Headache/Giddiness

Persistent vomiting / loose stools.

Persistent pain / bleeding / discharge at operated site

In case of emergency Contact: Medway Hospitals @ 2473 4455.

#### DISCHARGE ADVICE

- Low salt low fat diet
- Limb elevation
- Avoid oil and spicy food
- On fluid restriction 800ml/day
- To collect pleural fluid analysis report as OP
- Check CBG TDS watch for hypoglycemia
- Check BP once at home

#### REVIEW

To review with Dr. T. Palaniappan after 7 days with FBS, PPBS, CBC, RFT, LFT reports as OP with prior appointment in the front office.

Typed by: S. Hari

( legon : USVE)

Mhened lydron

To visit at www.medwayhospitals.com

Consultant signature (Dr. T. Palaniappan)

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#### Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





# **INPATIENT INITIAL ASSESSMENT**

Date: 20/12/23 Time of arrival in ward: 1220
Allergies (if Yes, specify details):
Drugs Yes No
Blood Transfusion
Food □ Yes □ No □
Others
Vital Signs: Temp: ♀8 ← (°F)   Pulse / HR: ♀○ (beats/min)   BP: p夕 (mmHg)         Respiration: ☑○' (breaths/min)   SpO₂: ♀2 (%)   Height:(cms)   Weight: (kgs)   BMI:
Pain: Yes No. If Yes, Score: /(D  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  A 42 ym come with close the on 8  Cho X 3 days clo burning micheration x 3 days close  Anothers of breath on 8 of X 3 days. Patint cuss apparently  Normal blood 3 days, then, she developed tenox enter prillent in  Normal blood 3 days, then she developed tenox enter prillent in  Normal blood 3 days, then she developed tenox enterprillent in  Normal blood 3 days, then she developed tenox enterprillent in  Normal blood 3 days, then she developed tenox enterprillent in  PAST MEDICAL HISTORY (with duration of illness): Yet ad Muttle For Flottly walled on  Diabetes Mellitus: Tyes No. If Yes, duration: by hypertension: Tres No. 47 Yes, duration: by hypertension: Tres No. 47 Yes, duration: by hypertension: Tres No. 47 Yes, duration: by hypertension: The pathy of  Modi (a trin hip had practure over the Internal language among
_

Prese	ent Medication (for a	Medication I	Reconcilia	tion):			1 . 1
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
		<u></u>					☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
			470				□ Yes □ No
							☐ Yes ☐ No
						·	☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
	onal / Social Histor				:	<u>.</u>	
	tyle: ☐ Sedentary, king:		Occup l: ☐ Yes ☐	٠ .	Recreationa	 I Drug Use: ☐ Yes 反	
Othe		· · · · · · · · · · · · · · · · · ·		<u> </u>	_ ;	,	
Menst	rual and Obstetric	History (to t	be filled up	o for fema	le patients):		
· ·				✓.	:		1
		2					·
Pallo	eral Physical Ex	lcte	erus: 🗌 Ye			: Clubbing: ☐ Yes	; No
⊭aem	na: Ves No	_	_	opatny:∟	]Yes □ No		
	BIC Pedal	KULLIU	<i>(</i>				
		(H	<b>'</b> ) '				

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~ ~ ~ ~ ~ ~ <u>~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ </u>	
SYSTEMIC EXAM	INATION
cvs:	
•	
Respiratory System:	Ble whouse & Ble crepts &
Gastrointestinal Syst	em:  Detalox  Non-tendox
Central Nervous Syst	tem:
Urinary / Reproductiv	ve / Locomotor System:
Skin / Opthalmic / EN	Optralamic - Diabetic Retenopatry
Suspected of contagi Isolation required:	ous disease: ☐ Yes ☐ No Immuno compromised status: ☐ Yes ☐ No Immuno compromised status: ☐ Yes ☐ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet
Psychological Evalua	
	(ESPEN Guidelines for Nutritional Screening - NRS 2002):  last 3 months? ☐ Yes ☐ No ☐ Is the patient severely ill? (e.g. in Intensive Therapy) ☐ Yes ☐
Reduced dietary intake	e in the last week? ☐ Yes ☐ Mo Is the BMI < 20.5? ☐ Yes ☐ Mo
	nswer is "YES" to any 2 questions, the patient is at nutritional risk nswer is "NO" to all questions, the patient is at Normal and not at risk
Provisional Diagnosi	5: 12Dm/ HTN/ CKD/ Hypothyroldism
Plan of Care:	Plan! Medical management
	Patrent admitted under Dr. T. Pors.
a de la companya della companya della companya de la companya della companya dell	Plan: Medical management Patient admitted under Dr. T. Pors. Monday within
•	Bo flow one chart

Investigations Advised:									
	Reports encl	wsed							
	•								
						-			
Diet Advice:									
☐ Nil per Oral	Clear liquid diet	☐ Normal liquid	d diet .	Diabetic l	iquid diet				
☐ Semisolid diet	☐ Soft solid diet	South Indian	normal diet	☐ North Ind	ian normal d	iet			
□ Neutropenic liquid	diet					<del>-</del>			
Early Discharge Planning (fill in those which are appropriate at this stage): PFE: Patient Family Education									
Special support need	led at home	☐ Yes ☐ No	If Yes, PFI	If Yes, PFE done					
Home equipment ant	icipated	□Yes□No	If Yes, PFI	E done and equ	ipment advis	ed			
Physiotherapy at hon	ne anticipated	☐ Yes ☑ No	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, PFE done and medication advised						
Special Dietary needs	S	☐ Yes ☐ No	If Yes, educated on dietary restrictions, food drug interactions and allergies						
Continuous / ongoing	g care anticipated	□Yes ☑No	If Yes, educated on various aspects of ongoing care required						
Other special educati	ion need, i.e.:	□Yes ☐No	If Yes, PF	E done					
Nature of post hospit infection control, fall I	al needs like patient safety, risk, etc, addressed	☐ Yes ☐ No	If Yes, spe	ecific education	given				
Others:	The free of the	• 1.5		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	, and	ger gartyst i	3	. (1)					
	Signature	Name :	100	Reg. No.	Date	Time			
Resident Doctor	W QQ	Dr Wham	edhydr	1 pessis	30/12	19.0			
Consultant		Dr-pala	71	25250	31/12	19100			
Patient Attendant	(Jeng)	Relationship Ren	100/y) .	( wite)	30/12/2	19-20			

wife



Patient Details (Affix Label here)

Mr.PRASAD SUGUMARAN 43/Male/MHI202381576

Date of Reg :

30/12/2023 02:35 PM





### **Emergency Department Consent Form**

Authorization for Medical Examination / Treatment & Diagnosis

in a language I / We understa voluntarily consent / Authorize	and, the need of therapeutic e to the rendering of such care sion by Emergency Physician	/ diagnostic treatment for e, including diagnostic prons, primary care-giver or	agree and give consent for the we been clearly explained, or me / my dependent. I hereby occedures, surgical and medical their authorized designees, as all or emergency care.
I/We further give consent to t treatment necessary to prese			or emergency medical care and
CU Admission	☐ Ventilator	Intubation	Central Line
Artery Line	Bladder Catheter	Ryle's Tube	Suturing
_ ICD	LP	Radiology Imagi	ing
Bedside USG	√V/IA Line ·	Lab Investigation	ı (Blood Test)
Others, if any:			

In making medical decisions on my behalf for the benefit of me / my dependent, I direct that the care-giver attempt to contact me / my attenders. However, if medical care becomes essential, I give permission to the care-giver to make decisions regarding such treatment as deemed appropriate by the Doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the care-giver on me / my behalf for my benefit / for the benefit of my dependent, I authorize the care-giver to obtain, review and inspect any and all information bearing upon me / my dependent's health.

I acknowledge that no guarantees have been made to me / my attenders as to the effect of such examinations or treatment on the condition of me / my dependent and that I / We are responsible for all reasonable charges in connection with the care and treatment rendered to me / my dependent during this period.

#### ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER

I / We understand, that if any health care worker is exposed to me / my dependent's blood or other body fluid, (as optional), can test blood for disease including hepatitis, HIV and syphilis.

#### ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I/We hereby authorize and direct my insurance provider or company to make payments to Medway Heart Institute lalso agree to settle my bills in prompt manner.

#### STATEMENT OF INTERPRETER (WHERE APPROPRIATE)

I / We have interpreted the information above to the person giving consent to the best of my ability and in a way which I / We believe they understand.

Sigņature		Name	Date	Time
Doctor	Som	Dr. Anish Nelson Reg. No: 88434	30/1/23	13:30
Interpreter (if applicable)				

The information given contains nature and purpose of care and the related risk. There is opportunity to clarify any doubts regarding scope of the consent.

I/We have read this consent and agree to its scope and contents. I/We will not hold Medway Heart Institute Chennai or its doctors/staff responsible in the event of any untoward complications.

	Signature	Name	Relation	Date	Time
Patient					
Patient Representative	C.P. AG	7. C. BARNABAS.	UNCLE	30/2/23	13:50
Witness					



Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





# **DOCTORS INITIAL ASSESSMENT - EMERGENCY**

Par	ť₽	(to be fil	led by	Nurses) Date	of Arrival: 30/12 23	_Time:	13:30	Non MLC	ML	C no.:	
Vital	Sic	ins: Temp	loi & C	°F) Pulse / :	HR: <u>II의</u> (bea	ts/min	BP: I	2012v	(mmHg	۵)	
	•									57	
		Hespir	ation:a	(breaths/mir	n) SpO <sub>2</sub> : <u>94</u>	_(%)(**	СВО:_	(mg/	ui)		
		_		GLASGOW COMA SCA	<del></del>	$\rightarrow$	1	Requires imme	ediate A	. 🕜	
		Adu		Child < 4 Years	Infant			life-saving interv	ention? Ye	<b>▶</b> ①	
	NG	Spontaneou	ıs	Spontaneous	Spontaneous	4		<b>+</b>			
	OPENING	To sound		To sound	To sound	3_2	Γ-	High risk situati	on? or	ן"	
	EOF	To Pressure None	<u> </u>	To Pressure None	To Pressure  None	1	Con	fused / lethargic / or Sever pain / d		Yes	
	EYE	NonTestable	e (NT)	NonTestable (NT)	NonTestable (NT)		<u> </u>	1		, <u>, , , , , , , , , , , , , , , , , , </u>	6
	_	Oriented	. (, 11)	Oriented	Coos, Babbles	5	<u> </u>			° (2	·
	RSPONSE	Confused		Confused	Irritable cry	4	How ma	ny different resou	rces are nee	ded?	`
	3SP(	Words		Words	Cries to Pressure	3	Моле	Оле	Many	<u>'</u>	ľ
		Sounds	•	Sounds	Moans to Pressure	2	. ↓	. ↓	. ↓	D	
	VERBAL	None	_	None	None	1	<b>(5)</b>	(4)	Danger a	one	
	^	NonTestable	e (NT)	NonTestable (NT)	NonTestable (NT)				vitals	?	j
	몽	Obeys Cor	nmands	Obeys Commands	Follows Commands	6			<3m >180	>50	
	RESPONSE	Localising		Localising	Localising	5			3m-3y > 16	Consider	
	띪	Normal flexi		Normal flexion	Normal flexion	4			3-8y >14	>30	
	МОТОВ	Abnormal fl Extension	exion	Abnormal flexion	Abnormal flexion Extension	3 2			>8y >100	<del></del>	
		None		Extension None	None	1			SaO, < 9		
	EST	NonTestable	e (NT)	NonTestable (NT)	NonTestable (NT)				Ψh	lo	
	8	11011100125		stable (NT) / Total Score					3	)	
Triad	ne i	L—— Prioritv: □			evel 3 🗌 Level 4 [	Leve	 el 5				
			Signa		Name			Emp. No.		Date	Time
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Par	t E	3 (to be fil	led by	Doctors)							
Chie	af (	Complaints									
Onn	υ · ·	•									
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			· 46	FERL - N	o palkopul muo c	nor	n OL-T	ρ.			
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Allergies:	
Pain Score:	
Pain Scale used:  ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 week) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ CPOT (ventilator / comatose)	
Past History:	
Personal / Social History:	
Airway: Assessment	Management
pasem	
<i>(p-</i> (1 ) 1 / 1 · 1	
Breathing: Assessment	Management
Spor 24-96), 140	
•	·
Circulation: Assessment	Management
from M- 120/70	
1 7 U	
Disability: Assessment	Management
Men	
Exposure: Assessment	Management
7 Rmo 101°67°	Ins prosent

GENERAL EXAMINATION  Pallor	Cyano	eie 🗆	Lymp Aden	opathy $\Box$	Dehydrat	ion
Edema: Yes \( \int \text{No}  \text{If Yes, specify deta}	<del>-</del>				<b>20</b> ,1, a. a.	
Pregnancy: Yes No LMP:			_	Breast Feeding:	] Yes [	No 🗌
Oth sum				_		
Otners:		-				
SYSTEMIC EXAMINATION						
Head, Neck & Face:						
cvs:					<del></del>	
Chest:						
One cycles + +						
ENS:		Riç	ght Pupil: Siz	e: Left	Pupil: Siz	:e:
Nomo			Reactio	n:	Reactio	n:
Abdomen:		•			-	- · <u>-</u> -
Extremities: Arms: Left:			Leg: Left	10 10 7 7 1 1 2 28 8 8 10 1 ( )		
	(N Kan)	14500 A	UF - N			
				Date & Time of	To be co	ontinued
Drug	Dosage	Route	Frequency	last Dosage	Yes	No
					_	
	-					
Communicable disease(s), if any:		0; 4-1 G. 4-1	<u> </u>	<u> </u>	<u> </u>	<u> </u>
Provisional Diagnosis:		୍ ୍ୟ		nostuff (fr. 19. nd.		
FERCE RM GI	( <i>VB</i> 241(47)~	~-		Reg. 15 571 4		

Investigation					-				
СВС		RP2			LFT		PT	/ INR	
ECG		ABG			UR		S. E	Electrolyte	
Viral Marker		Thyro	id Profile		2D ECHO		Che	est X-ray	
CT Brain		Blood	l Culture		Urine Culture	. 🗆	US	G	
Blood Group	ing & Typing 🗌	PAN-0	СТ		Creatinine		Tro	ponin-l	Ð
Others:								_	
Abnormality	& Findings (inves	tigations):							
Treatment Pla	an:	لمديركار			CBZ OUI PET CAR PET 684 ECG EUTO	1015-4 WUN P tolfc4/c	ne ausi	irrz	
Initial	Signature		Name			Reg. No.		Date	Time
Assessment Completed by	Dr. Anish Nels Reg. No: 884		Alus			Dr. Anish No Reg. No: 88	elson 8434	201723	15130
Refferal						<u>.                                    </u>			
Referred t	to Speciality		Consulta	ant Na	me	Informed	d Time	See	n at
MRSIAN		ወ <b>≮.</b> የ₊(		M 4	Minn	13:30		13:45	•
Outcome:	√ Admission  ☐ Others:		Discharge		☐ Transfer	☐ LAM	IA		
Transferred t	o: 🗌 Ward:		ICU:		□ OT:	□OP:		<u>_</u>	
	Others:								
	Signature		Name			Reg. No.		Date	Time
ER Physican	1 Anns		Dr. Al Reg.	nísh Nel No: 884	son 34	Dr. Anish I Reg. No: I		adular	مر: را
Receiving Physican	Dr. Anish Ne Reg. No: 88	Ison 434	Dr. A	∖nish Ne ı. No: 88	lson	Dr. Anish M Reg. No: 8	Jol-	301145	1320



Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Medway Heart Institute Every heart beat counts

			KGENC	יו חבו	PARII	VIEN I	- NOK	) II	IG INI	TIAL ASSESS	SIVIE	=N I	
Patier	nt Name MR	-pras	5 <del>0</del> ₽.	Age :	43	Sex	:M/F		UHID N	10.:20238157	ଧ   G	rage Level Freen (<120 Min) Fellow (<60 Min)	
			e & Time : 3 : 30		Assessm		e at : - 13 !46		Allergie	s: No	R	Prange (<10 Min) led (Immediate)	
<u> </u>	nt Comp				,-,-	-	72710		l			elatives are awa Yes   ro Reason :	are No
				<del>~ ~ ~ ~</del> —									
Emer	gency (	Contact	No.: 4	1441	13/4/ P	RIMAF	Name & R	ela EY	tionship	: C. BARNI	AB/	AS / UNICO	<u> 6 ·</u>
Asses	ss Resp	onse :[	Respo	nsive [	Unres	oonsive	Blee	dine	e E	xternal $\Box$	Int	ernal 🔲 N	0
<u>Ai</u> rwa			1	reathing			ore : 🗖 0			1		t pain Assessm	
		☐ Nois	· I—	Present		☐ 1-3 =	Mild Pair	1		☐ = Hot		Site	
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						_	-			Chest Compres			
						<u> </u>	-			Electrical Cardio			
					ļ					If Yes : Time of F			
<b></b> -						+							
		Assess	-	7 1	1					Types of Ventila		: Face Mask	(
1	l Weaki ted Sid	=	」Yes L ]Right [	No	j Unabl	e to ass	ess			☐ Bag Valve Mas	sk	☐ ET/LMA	Tube
	Veakne	_	Yes [	] 40° [	] Unable	e to ass	ess			☐ Others :			
	ted Sid		Right	Left	-					Time of First Ass	isted	Ventilation:	
Spee	ch Diffic	ulties : _			Unable	to asse						т	
-	<b>-</b>	_	AL SIGNS		0.5	655	PUP React	on t		Conscious level: A=Alert V = Ve	oice	Special Instru	ction:
Time	Temp F/C	Pulse bts/min	Res. bths/min	BP mmHg	SpO₂ %	CBG mg/dl	Lig Right	$\neg \vdash$	Left	P ≃ Pain U = Unresponse			
12:30	58°F	11044	22	120/20	81.	193		$\top$	7		U	1	!
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_	Orug Na	me	Time	Dose	Route		Pr	осе	dure (Tic	k)			
7	PPE	241	73:30	1gm	/V	_	eripheral Itor Vital sign	5		fibrilation bulization			
30			_			Blee	ding Control s Tube		☐ Su	iture inary Catheterization			
-						ET I	nsertion		□тР	4			
	<del></del>	,	<del></del>			Drain	1		عم 🖳	BG/VBG		(	
						日 Oxys	gen /BVM			nttal / Arterial Line inse	rtion		
								_					

Doctor's Order:

DATE & TIME	NURSES NOTE	R/N SIGN WITH REG.NO.
30/12/23 13:30	NURSES NOTE  PH Got PDMISSION TO ER PH is Conscious  France feel Crity-113 I footned to 07.  Daniel Sis In paren 19 IV grand  Formal Somy IV great. Covid orpid-negation  Shood Ample Collected.  I blood sample realled to leb /hasix Gony  gives.  Photology gives.  Photology feel to les.	REG.NO.

D - 1 - 4" N1	pital is not responsible for	•		pship with the patients:
Patient Outcome :	Improved  Unchanged	d ☐ Worsened ☐ Died	1	
Disposition: Ad	mission   Discharge	Transfered / Refer t	to other hospital / Time 🗌	
Handed Over Department Discharge summary Records & Reports	Handed Over by E.R.R/N.Signature	Taken over by R/N:	Attendant signature	Date & Time
		<u> </u>	·	







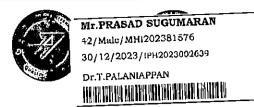


DATE	NOTES
30 12 23	S/B Dr.Tp.
15:00 hrs	Hypothyroidis mx broths.
	TZDM x 10 yrs
	HINX 6mths
	CKD x 1 year
	# POST LAT CONDY IE - 2 Months
	Chable to Walk.
	admitted in trichy knewny
	on Mefformin/Vildagliptin for TZDM/H-MIXTARD 16-0-12
	and Telma/Minipressxl/Carca CR for HTN.
	Hypothysoid on Thysonorm-100 mcg:
	Fever x 4 days. / coose stoots-today- reprisode.
	cough x 4 days.
	+ Unine output x 2 days
	Burning Micturition??
	Temp- 101°F.
	BP-140/80 PR-103 Saoz-944. RA.
	CUS- 5152
	RS-BAE/NUBS/Bil creps (Pleural effusion on USA)
	PlA- Soft. (Minimal as vites on USA)
	EF-45%. Global Hypokinesia / Trace Pericardial effussion.
	May 1 Suggest
	1. CBC/LFT/RFT/TFT
	2. Se-ca/se-P04
	3. USG abdomen - Check IVC SIZE U.98-

DATE	NOTES
	4. IVF. NS- 150ml bolus over 20 mins
	5. Unine Cfs. Blood Cfs. CRP. Se-PCT
	6. Pulmonology opimion
	7. Stop Gahus/ Dapanorm -
	8- Only Insulin TOS as per Sugars.
	9- Inj. Meropenen- 19 W bd.
	10. In mucons in 6d.
	11. Stop PAN.
	12. Im. Para 19 TV SOL.
	13. Im. lasex bong iv stat after Ms
	Chailenge and ho output.
	14. 7. Lysica 75mg 1-0-1
	15. Contine Carca CR/Minipress XL
	and Telma.
	16. 7. Zytanix 5mg 1-00 1/2 hr
	before lasix if no co-output after
	fried Challenge.
	17. 7. Zylosic 100 mg 1-00.
	18. 7. Rosyless long 0-0-1
	18. 7. Rosyless long 0-0-1  19. 7. Ecosprin 75mg 0-0-1
	20. C. Awaytox 1-0-1,
	21. Sath nebu- 8haly
-	21. Sats nebu- 8holy (Levolin)
	22. K- find 15gms bd.
	23. Viral panel - throat Swab.
	Rania Lista rapporta
	1 46530 1 46530
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	29 12 23

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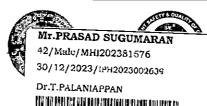


(A Olit of Olited Alitalic	115
	DOCTOR'S PROGRESS NOTES
DATE	NOTES
30 12 23	S/B DR. NDRAMIL (PULMO).
4:30PM	
	Thanks for the Keperal!
· · · ·	Go: Cough & spurum x le days.
	fever x 4 days.
	Ho: No prior ATT intake No Contact expocuses   No seasonal varietions   No deux alleigy.
	No Gasonal Variations No deux alleigy.
	Non-Smoker.
	KICO: TODMX 10 ym
	HTN × 6 MWs
<del>.</del>	CKD × lycar
	Hypo tryvidim
	HÉREF.
	0/E: Sp0,: 93%. +R-A.
	HR: 1051 min.
	RR: 20 min.
	BP!
	SIE: CVS: SIGN RS: BIL VBS+
	DI Magae +
	B/L Wheeze + B/L Clepts +
- <del></del>	The Marian
J	
	<del>-</del>

DATE	NOTES
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	CxR-PAviao.
	· · · · · · · · · · · · · · · · · · ·
<u>(2)</u>	T. ABPHYLUNE-NI-OT
3	No Marine Ochole
	Nes. BUDAMATE 912 holy.
	Neb. BUBMATE Q12 Way.
<b>(</b> 4)	RT-PCR for viral panel.
<b>®</b>	I/o monitoring.
6	Fluids as per IVC.
	C >== 0 >>
(1)	Sr. PCT, C-RP
R	Thoracoceascis if moderate effusion on Col.
	Trivaciase equiviliant on the
	4
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MHI/IP/2022/041

Medway
Heart
Institute

Every heart beat counts

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	- clo B/L hmib Smelling	HR: 726pm
	- c/o Congh & sputum	Bp: 140/80 mmry.
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	-Albumi 2.3	Temp: afthub
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· ` ` `	DW Dr. T.P	
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	- Monitor UOP.	
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	- Thuis au bichen 1-2	
	- Laux Bomg Ivsta	+ f/b Albumin infución.
<u> </u>	- Jana 60 mg IV sta - DVT Schennig tomorro	w ·
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DATE





Medway Heart nstitute

: beat counts

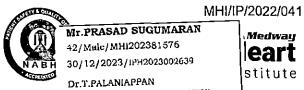
DOCTOR'S PROGRESS NOTES
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Trom HON [CND] Port LAT conducte

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	Patient revieus	
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	OB patient conscious, oriented	
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$\overline{}$	S/B DT TP	·
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	Bil pedal edema	
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		Te-10440
	Adv: Isofomic Albumin - 10me/hr	Plt-1.78
	(Hatch for dyspnea)	
<del> </del>	Sputum C/s. AFB.	_ <del></del>
	Oral Intake-Illday	







Medway eart stitute eat counts

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٠	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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	- Pulmo review
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	- After Sputam of 7. LINID Goomy 1-0-1
	- By. Reewas 0-0-15ml
	- Monitor vitals and hely
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Jopm.	01/1/24
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# MHI/IP/2022/041 Mr.PRASAD SUGUMARAN 42/Mula/Mul202281576

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

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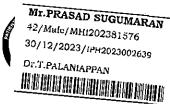
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-	DOCTOR'S PROGRESS NOTES
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2/1/24	S/B DY TP
19-30	
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	Bil-pedal edema.
	BP-180/120 PR-90 UTER-122 (133)
	Crt - 2.8 C3.37.
	Adv: Rot USG abdomen CT- Lival preuma
	150 tomic albumin over 4hrs. Pul edema.
	Confine I pravent
	Hold Inhabx
	Hiripmen XL 1-0-1
·	Concor CR 1-50
	Telma 40mg 0-1-0
	PT. Arkamine somy 1-1-1
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<del></del>	Monitor output
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	After Cardiologist opinion.  * (Check IVC Stze-during USG)
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**DOCTOR'S PROGRESS NOTES** NOTES DATE as, 530 128:18 4501 collapsitulity 9308

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D-18011001	3E. CM -6,62P
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Sputum C	monitor unals
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massande	I 1550ml - Limb cleintion
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11/100	
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	13/11/20)
-today	
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	orders by Dr. T. Palancappan.
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AFB&C/S	- to do urea, creat, electrolites, Ho, do
when do	181 - Dr. Ashwin (MgE ofinson)
1000	10- B) - Fluid restriction to 800ml.
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rugari	Mose .





#### CENT OF THE Mr.PRASAD SUGUMARAN

42/Male/MH1202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





DOCTOR'S PROGRESS NOTES , NOTES DATE Condition Telaund

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	T-Nebivobol Sing 100.
	- Stop Catalordial.
	- In Dyfor 1v . 10 -0 10
	-7- Zytamba 2-Eng 1 -0-E
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	(manual BP)
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# MHI/IP/2022/041

42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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Mr.PRASAD SUGUMARAN 42/Malc/MHi202381576 30/12/2023/iPH2023002639



MHI/IP/2022/041

Dr.T.PALANIAPPAN

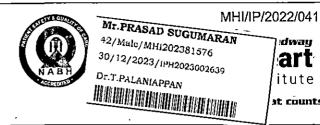
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•	DOCTOR'S PROGRESS NOTES
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tpm.	Since morning 11-30am.
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	Padent consiens
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	Afebule
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DOCTOR'S PROGRESS NOTES

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### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

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. counts **DOCTOR'S PROGRESS NOTES** DATE **NOTES** r. Mohamed 3Pm. Robert Curin - Uses guiled.

DATE **NOTES** CISIB: Dorh-Aleiten LSAP, Assitie Stable. S/R Dr Yourg - wro KICGO CRD, DM, SHT, Hypolyson hilo Story to world - 4 noutly ho h/o · boendra, calada Cr 23-Coche Production LIE Gross Releas UPUER/EL Tolad Clorns CKD, Fluid ocaload To careter UTI / Carlibro, RPHE DOO Janepul D To collabore if PUR had

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### мні/IP/2022/041 Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

:art Dr.T.PALANIAPPAN :itute 

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-	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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1.50 PM	Patrent reviewo
	cho: generalised fixedness g mild breathlessn
	OB: patient Conscious, Orientes, A Febrile.
	3/B. WS-6,6,A)
	PS - BDRP)
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		associated with follow Abdominal pain on a off x 3day,
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		filo Bilateral swelling of both logs of 3days.
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		medication in the participation of the participatio
_		palapiappan baseline investigation showed
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ma	pasad seximpi	FECTO date (FF - N2/-) ABOI done. Due to Hyperkalum
	( Kt-8.60	DAPPROPRIATE consection given. Due to increased blood
		Prossure Dr. Jaishankar (Cardiologist) opinion
		optained a orders followed. Due to shortness of
		brooth & continuous cough Dr. Elaking Julmo
		copinion obtained as no advised for sputum cle
		8 Spotiem AFB. Sputim C/s & sputum AFBShow
		hogative. HRCT should suggestive or acute rulm
	( nom	al flora grown culture) infection w
	P0883	ble buper Added Farly Pulmonary alema . wino cle 8)
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	Albunia 2	
	Usu ab	domen shouled chole litthiasis, B/c medical Renge
	diseases.	Cystitus with significant post wind Residual usine
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#### MH!/IP/2022/041

#### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

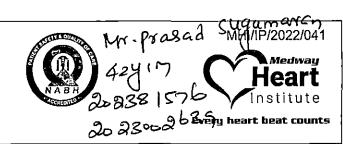


**DOCTOR'S PROGRESS NOTES** NOTES DATE WS: SS2\_ ţ

DATE	NOTES
OF 1124	Discharge Advice
0000	
1-30PM	
namo:	MR. PRASAD SUGUMARAN AGE GENDER, 424/M
consultant	Dr. T. Palaniappan . D.O.A. 30.12-2023
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Diagnosis	
	2. Accelerated Hypertuni On
	3 - Acute pulmonary Edoma.
	H. Hypor Kalemia
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	8 Hypothysoidism.
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### PRE/POST OPERATIVE ECHO

Mr.PRASAD SUGUMARAN 43/Male/MHI202381576

Date of Reg : 30/12/2023 02:35 PM



Date & Time		
30/12/23	Screening Echo Re	port
4 34 pm	3	
<del>- \                                   </del>		
	- Concentric LVH	(Ivs:11mm, pw:(2mm)
	Dilated Aortic sinus. me	asures: 38mm
	- All Chambers normal sized	
	- NO RWMA.	LYIDD :- 50 MM
	- Adequate W SYS Colic fund	LYIDS: 36 mm
	Grade I Dissolic duster	
	Normal RV Systolic funct	ton.
	IAS ITUS FORTACE	RVIDI:19 emls
	All Valves abuchwallyno	
	Thirial MR	
	Terrial TR 100 PAH	E/Aratto :- 1,2
	Ive normal in size and coor.	Collapsing medial E/E 1:21.
	- minimal permandial Effusion	Lateral ElE1270
	postuolateral to LV, bostono Ante	nor TRGE: RommHg
	to RV.	Rusp 1-30 mm Hg
	mild bilateral pleural Effus	COA-
	No clot (regetation.	
	4 R. 100 bpm	
		Lone By
		Ms. Zebidh (phy Assti Res)
<u> </u>		( phy Assti Res)





## MR. PRASAD MHI/IP/2022/065 Medway Heart Institute Mr.PRASAD SUGUMARAN 42/Male/MH1202381576 30/12/2023/1PH2023002639

Dr.T.PALANIAPPAN

# **DIABETIC CHART**

ACTUAL WE	EIGHT	73-31gs HbA,c		own mod My H-M (b	1cml v-0-120(1/4
PREVIOUS	DIABETIC I	MEDICATIONS		ar Garan Fra	m 500/16mg
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
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112/23	6-364			8 Sulv	le hours
	12.30	184 mg/dl	Try- HA 60	give al 1200	K. 80 134 1000)
	18-30	198 maldl	Inj. HD-15U	of opnion	13U109
1/1/24	6:30	184 moldl	Pri HA	given of 8.30 poly 42.0	doz 16580.
	12.30	123 majdl	IN. HA - 141	Down 1	10 AD 13 11 15 15 7
	\&3U	185 mg/di	Inj-HA 8J	(4 23)	Old 160m
2/1/24	6.30	129 mg/de	Inj. HA 6V	017 gam	a usm
	<u>9</u> ,30	[S7 mg/dc_	71.4A bu.	1300 A1300 24	Dr. T. P
	15.30	101 mald		apoint	Dr.T. Psix
-lilay	bi.30	84 mgldl		Poor	Dr.T.Par-
<del>• (</del>	1920	is mold!	R: 40 lov	med 18:30	salla-

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

TIONS FOR INSULIN INFUSIONS

Miedway Hospitals
The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

o Natise?

0x-2.810 nat\_140 1 k111

MHI/IP/2022/065

Heart
Institute

Every heart beat counts

\_ Wea-110

# DIABETIC CHART

Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

PREVIOUS DIABETIC MEDICATIONS

DATE TIME BLOOD SUGAR DIABETIC DRUG Sign. ENDORSED BY

1 24 18 30 167 mg dl

18:30 167 mg dl

18:30 934 mg/dl

Try. H.H. 180 Superior Akilan

Fill 21 6 30 172 mg/dl

Try. H.H. 100 Superior March 1. 12 mg/dl

Thy. H.H. 100 Superior March 1. 12 mg/dl

Thy. H.H. 100 Superior March 1. 12 mg/dl

Thy. H.H. 100 Superior March 1. 12 mg/dl

### **INSTRUCTIONS FOR INSULIN INFUSIONS**

*	Mix 40u short acting Insulin in 40 ml. of	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.





Every heart beat counts

Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/19H2023002639

Dr.T.PALANIAPPAN

**URINE ROUTINE ANALYSIS** 

### **MICROBIOLOGY SHEET**

ORNE ROOTINE ANA	1010		
DATE	30 12 28		
COLOUR	Pale Vellou		
REACTION	ı		
SPECIFIC GRAVITY			
APPEARANCE	Slightly tueb	A	
ALBUMIN	0 0		
SUGAR	+		
ACETONE		_	
BILE SALT		-	
BILE PIGMENT			
UROBILINOGEN			
PUS CELLS	A-6		
EPITHELIAL CELLS	1-2		
RBC	2-3		
CASTS	GRANMAR CAST		
CRYSTALS	NLIL		
OTHERS	(ICA		

### MICROBIOLOGY-CULTURE REPORTS

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



- -BLOOD GROUP -





- Every heart beat counts

Mr.PRASAD SUGUMARAN

42/Male/MHi202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



# **INVESTIGATION SHEET**

<u> </u>		. ,	<u> </u>			
Date	30/12/23	31112/28	211/24	3121	A 1 24	5/1/22
- HAEMATOLOGY		-'			,	
Hb	8-7-	_ 1,,				· • · · · · · · · · · · · · · ·
P.C.V	~~26·0~~~					
Platelets	178000	1				
TLC	10440	-				
Polymorphs	81/7	!				
Lýmphocytes	16.0	المراب المحادد الم				. <del>"</del> .
Eosinophils	6.1		7	<u> </u>		,
Mono / Basophils	3,0/0,2				·	
E.S.R		,			:	
BIO-CHEMISTRY		,		1.1 4.	1	
Urea	135	133	์ เมล.	114	110	106
Creatinine	3.70	3-36	2182.	2.87	3.20	3-01
Sodium	136	137		140		138
Potassium	5.60	A169		A 86	.5.31	5.08
Bicarbonate	- 22	ંજી		20		
Chloride		[95]		110.6		10 . ( ) 22 - 2 - 1
Magnesium -						
Calcium						,
Phosphorus						<u>-</u> .
LFT		1				
T.Bilirubin	· 017-		<u> </u>		-	
D.Bilirubin	010					
· I.Bilirubin - · · ·	りのチ	·		-,		-
S.G.O.T	63	· <b>-</b>	•			
S.G.P.T	32					
ALP ·	72					
GGT	25					
Total Protien	4,4		-			5
S.Albumin 7 77 7	2.1	•				
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK		-				<u> </u>
CK - M.B. MASS						
LDH						
Ntpro bnp			12509			

30/2/22 3/1/84 Date COAGULATION PT/INR Fibrinogen 2.11 D Dimer LIPID PROFILE **Total Cholesterol** Triglyceride H.D.L L.D.L **VLDV THYROID FUNCTION** T.S.H T.3 T.4 **SEROLORY** HIV HBsAg V.D.R.L COVID 19 RT- PCR ΙgΜ lg HBA1C FBS/PPBS RBS S.AMYLASE S.LIPASE C.R.P PROCALCITONIN DDIMER S.Osmolality <u>URINE</u> Osmolality Spot - Na

 $\sum_{i=1}^{n-1} \frac{1}{N_i^{2n}} = \frac{1}{N_i^{2n}} \frac{1}{N_i^{2n}}$ 

2 - 5

#### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576

30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

114 101 180 114 115 1140 1814 1815 41150 118 1150 11



# **VITAL INFORMATION SHEET**

MHI/IP/2022/074 Every heart counts

**BLOOD GROUP** ON ADMISSION Height in CM Weight in Kg. 73.3Kgs Hocms

Diagnosis:	A	YP	0	Tŀ	14	R	9 l	D'	(S)	M	,	[2	Di	λ)	٦	T	ا لا	Ckį	Pr	oce	dur	e:																	=	0	Ch	<i>1</i>	<u> </u>			7:	3 <i>.</i> —–	31	Kg	∕S —–
NO. OF DAYS		90 F				Αų				D+	т	-2	C	B:	٧	3		D	Αų	1	4	I	>P	ų-	-5		ا ()	ąγ	- ļ	2.								_			_									
DATE	2	D [17.	2 إد	-3	St	12	12	3			12		Ş	I'	- [	LU		3	Ιι	a)	ł.	A	<u>: [[</u>	(B)	1	1	5	1	12																					
HOUR		6 10											0 2	6	10 2	6	10	2	6 10	2	6 10	0 2	6 1	0 2	6 1	0 2	6	10	2 6	10	2	6 10	2	6 1	0 2	6	10	2 (	6 10	2	6	10	2 6	10	2	6 1	0 2	6	10	2 6
40.5	•		1	H	7	$\Box$	$\Box$	$\perp$	П	7	T	П	Ţ	П	1	Н		$\bot$	$\perp$	П	$\perp$	$\Box$	Τ.	$\perp$	П	_	$\Box$	$\Box$	<u> </u>	$\coprod$		1-	$\vdash$	4	_	$\square$	$\bot$	+	_		Н	4	- -	$\blacksquare$		$\perp$	4	Н	$\Box$	$\bot$
40	•	$\Box$		$\Box$	+	H		+	H	#	+		+	H	+	Ë		‡	+	H	#	$\exists$	‡	+	Ħ	Ŧ	Ħ		+	+	+	‡	F	Ħ	‡	+	+	#	+	F		#	Ŧ	Ħ	H	+	‡			丰
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36				Ц	Ţ	Ц	$\Box$	$\perp$	$\Box$	Ţ	$\perp$		L	Ų	$\perp$	$\square$	Ц.	Ţ	Ţ	Ų		Ц	Д		Ц	Ļ		П		Ц	$\Box$		lacksquare		$\perp$	Ш	$\mp$		$\perp$					Ц	$\Box$	$\Box$	+		Ц	$\perp$
PULSE	-		91		93		9			2.		<u>න _</u>	18	7	10	70	) {	<u> 37</u>		9	<u> </u>	+-	<u>}}_</u>		37	1	±9 20	_					╁_		+		+			,				-			+		4	
RESP	-	-	نز	0	_2	Ρ.	7	<del>)</del>	٥	<u></u>	12	4		0	4	50	na i	<u>20</u>			 14	1.8	20.	2		٠.,	20			_			╀		+		+										+		$\dashv$	
B.P.	╁			180	JED!	100	125	<u> 170</u>	18.	<u> </u>	DD C	ŲΣ	<u>" [เล</u>	7	20 601	<u> </u>	60	IIta	P	2 64	70/5 20	φ <u>18</u>	DIN:	ol <b>i</b>	ZHC.	<del>' </del> -	17/	HC.	_	-	_		L		+			-			_			_	_		_1_		$\dashv$	
SPO2 DAILY WEIGHT	+		92		4:	5%	q	6	1	<u> </u>	(	9/	9	13.	ار 22	<u>#er_</u>	+	9.	<u> </u>	_ ' '	26	44	<u>87.</u>		ĺŶν	4	4	7. 24.	<u></u>	-	_				+					-				-				<u> </u>	-+	
24 HRS INTAKE				m	1	וט	17	~\ <sup>0</sup>	1	~~		<b>.</b>					$\forall$	1	in	5M		+	<u> </u>		mil	+		<u> </u>	<del>J.</del>	+	_				$\top$		_							$\neg$					+	
24HRS OUTPUT	$\overline{}$		5 DM	. ,	<u> </u>	<u>D5</u>	<u>\</u>	~√1 1.71Å	4	<u>ئ</u>	2.€ 7.€	, <b>I</b> V	+	LD LD	רוט יוט	<u>~√</u>	+	_ <u>`</u> _	F	<u>)                                    </u>	<u>n</u>	- 1				ام			_	$\dashv$	_				$\dagger$					-				_				_	$\dagger$	
BALANCE	$\top$			M	_& _ i	$D\Delta$	שו ה	ď.	2	3	27 20	<u> </u>	), _	- A	Ω£	ml	+			2.5		┤┸	LUE LI	) <b>(</b> ) _	hi	<b>\</b>							_		$\dagger$									-1	_				$\dashv$	7
МОТІОМ	1.				<u></u>			<u>( </u>	メ				<u> </u>	4	~	<u> </u>	7	$\overline{\checkmark}$		<u></u>	V	1	<del>-~{ }</del>	٠.	<u> </u>	†;	<u> </u>			İ					†					_									7	_



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

### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Every heart beat counts

# **EARLY WARNING SCORE MONITORING CHART**

NEWS key	DATE	2202	000	119	1211	1/18	21/12	21/12/	11/2	11/2	HIM	110	7/11	211	DATE
1 2 3		251.00	210	3110	311	30	2.0	37	100	1/11	10	13/1	20.00	100	
	TIME >25	1410	22.0	6-0	10.0	chr	Col	993	6-	12:00	Idioc	18.00	22:00	6,00	>25
Respirations	21-24			-				2			Control of the last				21-24
Breath/ min	18-20	-	_	-	0	_		-	-		-	-	-	-	18-20
	15-17														15-17
	12-14														12-14
	9-11							1							9-11
	<8						1243	3	200						<8
A+B	>96	•		1	-2		_	-				1	-	-	>96
SPo2 Scale 1 Oxygen Saturation (%)	94-95		-					2							94-95 92-93
oxygen saturation (xy)	<91	100000		CHARGE STATE	<b>DESCRIPTION</b>	-	and the same	3	REAL PROPERTY.				-		<91
Spo2 scale 2 oxygen saturation ( %) use scale 2 if target range is 88-92 % eg: in hypercapid	>96 on oxygen							3							>96 on oxygen
respiratory failure only use scale 2 under the	95-96 on o2	NAME OF TAXABLE PARTY.						2							95-96 on o2
tion of qualified	93-94 on O2							1		A PORT	1				93-94 on O2
ian	>93 on air														>93 on air
	88-92														88-92
	86-87							1				1			86-87
	84-85 <83%			-				2	-	-				-	84-85 <83%
	×0370														-0376
Air or Oxygen ?	A= Air			-	1	0	-	-	-		-1	7.			- A= Air
	O2litre/ min						-	2							O2litre/ min
	Device														Device
Blood Pressure	>220							3							>220
	201-219														201-219
	181-200							2							181-200
	161-180								-		-	10			161-180
	141-160	-		~	-		-			_	-		-	-	141-160
	121-140														121-140
	111-120	8/						1							111-120
	91-100 81-90							2							91-100 81-90
	71-80			To the latest of	-	AND DESCRIPTION OF THE PERSON NAMED IN		2		Carried Street			No. of Concession, Name of Street, or other Persons, Name of Street, or ot		71-80
	61-70							3							61-70
	51-60							3							51-60
	<50				-0			3		0					<50
Diastolic BP	mmHg		80	(00)	88			80	100	88	09	82	58	80	mmHg
	>131				·			3							>131
ilse	121-130							2							121-130
eats / min	111-120	-						2							111-120
	101-110							1							101-110
	91-100			X				1	1						91-100
	81-90 71-80	-			-		_			-	- 5	100	1	-	81-90 71-80
	61-70	-													71-80 61-70
	51-60														51-60
	41-50					100		1							41-50
	31-40	THE REAL PROPERTY.					1	3	1000	ALC: NO.		10000	THE REAL PROPERTY.	NEW YORK	31-40
	<30		THE REAL PROPERTY.		1466			3		000000	STATE OF	10000		1488	<30
	Alert	0_		_	-	-	_	_		_0_	a		-	-	Alert
Consciousness	Confusion							3							Confusion
core for New onset of onfusion	V							3							V
no score if chronic )	P							3							P
no score il cinome j	>39.1 degree		-					2							U >30 1 daggas Calsius
	>39.1 degree Celsius		1000	1000		10000		-						The second	>39.1 degree Celsius
emperature	38.1-39.0							1							38.1-39.0
Degree Celsius	37.1-38.0														37.1-38.0
	36.1-37.0	0	_	-	-	-0				-	•	7-	-		36.1-37.0
	35.1-36.0							1							35.1-36.0
	< 35.0		52 Let		0			3			A COL	0		200	< 35.0
VEWS Total		0	0	2	UK	3	0	0	1	0	O		0	0	
Monitoring Frequency		fifty	NO	ALL	13	ATA	tofy ne,	No	AM	405	No	000	CITH	Uth	
scalation of Care Y/N nitials by RN		100	flew	May	an			Hary	Host	Sals	P	2	10	1	
nitials by Sr. RN		Val.	-00	real	Ne	100	/			Near	Near	Var	100	-	
		W 18	N.	10	200	1 85	A09	100	A 0.30	B 11 C	8 0 6	4 4 4	A US	. 0.5	

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





# Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



MHI/IP/2022/103 Institute

every neart beat counts

# **EARLY WARNING SCORE MONITORING CHART**

. NEWS key	DATE	4/6/3	241	211	2/2/	11.15	/Sex:	2/1/2	2110	Actitat	1110	13006.4	ult	1/1	DATE
1 2 3	TIME	OSP	1430	18:0	200	Alle	31,	P1.00	311	600	10:00		12:00	72.00	TIME
+8	>25	The same	110	(0)		0	10	3	1	A STREET	10,00	dia	(00	100	>25
espirations	21-24							2							21-24
reath/ min	18-20	>-	-	-		-	-	-	_	-	-		-0-	-3	18-20
	15-17														15-17
	12-14														12-14
	9-11							1							9-11
4.0	<8	1000000	-					3						<b>BETTER</b>	<8
A+B SPo2 Scale 1	>96 94-95			-				1			-		-		>96
Oxygen Saturation (%)	92-93							2							94-95 92-93
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<91	100000	100000	100000	100000	SEASON OF THE PERSON OF THE PE	100000	3	100000	-	Name and Address of the Owner, where the Owner, which is the Owner, where the Owner, which is the Owner, where the Owner, which is the Owner, which i			THE REAL PROPERTY.	<91
spo2 scale 2 oxygen acturation ( %) use scale 2 f target range is 88-92 % g: in hypercapnic	>96 on oxygen							3							>96 on oxygen
ale 2 under the	95-96 on o2							2							95-96 on o2
ion of qualified	93-94 on O2							1							93-94 on O2
linician	>93 on air														>93 on air
	88-92							4							88-92
	86-87							2							86-87
	84-85 <83%		200000	No. of Concession, Name of Street, or other party of the last of t		THE REAL PROPERTY.	TO STREET	3							84-85 <83%
	<8370														<83%
Air or Oxygen ?	A= Air	-	9	-5	_	~	-	-,-			-	•	70	-	A= Air
	O2litre/ min		-					2							O2litre/ min
	Device														Device
Blood Pressure	>220							3							>220
	201-219														201-219
	181-200							2							181-200
	161-180		_		1	-				-					161-180
	141-160	-	-	-				7	<b>-</b> /		-		-		141-160
	121-140														121-140
	111-120														111-120
	91-100							1							91-100
	81-90		-	-		-		2	-						81-90
	71-80 61-70							3							71-80 61-70
	51-60	1000000						3							51-60
	<50							3							<50
stolic BP	mmHg		No. of Concession, Name of Street, or other Designation, Name of Street, Original Property and Name of Street,	-	Cat	100	98	-	-	110	RI-	100	110	SYD	mmHg
	>131	100000	10000	B 20 5 0		100		3	10000		00	Op.	1	A.	>131
_ se	121-130							2				CONTRACT OF	No. of Lot		121-130
Beats / min	111-120							2							111-120
	101-110							1							101-110
	91-100							1							91-100
	81-90		-	-	-	_	1	_		1	1	•	1	-	81-90
	71-80							_	-						71-80
	61-70														61-70
	51-60							1							51-60
	41-50 31-40	-	-	No. of Concession, Name of Street, or other party of the Concession, Name of Street, or other pa				1	The same of					Name and Address of the Owner, where	41-50 31-40
	<30							3						7	<30
	Alert		~		_	*	-			-	4		25		Alert
consciousness	Confusion		The state of	Name and Address of the Owner, where	W. 100 100 100 100 100 100 100 100 100 10		THE REAL PROPERTY.	3	10000	THE REAL PROPERTY.	1000000	SERVICE STREET	Section 1	100000	Confusion
core for New onset of	V	100000						3		0				100000	V
onfusion	P	2000		S. Section			NEW BOOK	3							P
no score if chronic )	U			0259				3	HOR OF					POT NO	U
	>39.1 degree							2							>39.1 degree Celsius
	Celsius														
emperature	38.1-39.0							1							38.1-39.0
Degree Celsius	37.1-38.0			-							_				37.1-38.0
	36.1-37.0	-	5	_			,,	1		-	-	9	-0.		36.1-37.0
	35.1-36.0 < 35.0	-	No.		THE OWNER OF THE OWNER	-	-	1	No.		-				35.1-36.0
EWS Total	33.0	0	0	0	0	D	0	-0	0	A	0	10	10	10	< 35.0
Monitoring Frequency		det	tale.	Ach	ALB	ALB	Ath	won	fite	ALA	4/18	yoth	Coto	445	
scalation of Care Y/N		122	ve,	No 1	Hoy	NO	No	NO		NO	No	NO	N	N	/
nitials by RN		000	alt.	WAPY	Hoy	Deu	DS	1	No	Hay	636		1	9	
nitials by Sr. RN		1	200	har	.0	W . 3	NO	- 200	-00		.0	69	Nac	-01	-
	Note: Nurse:	Vie	100	154	100		10	V.V	124	Lis	Call	4-3M	Lall	2071	

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





#### Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



art beat counts

# EARLY WARNING SCORE MONITORING CHART

Name:			Age/Sex:	Patient Id No:	
. NEWS key	DATE	5/1/24			DATE
1 2 3					
	TIME	8-80			TIME
espirations	>25		2		>25 21-24
reath/ min	18-20	-	-		18-20
	15-17				15-17
	12-14				12-14
	9-11		1		9-11
	<8	FREE SEASON	3		<8
+B	>96				>96
Po2 Scale 1	94-95		1		94-95
xygen Saturation (%)	92-93	-	2	Control of the Contro	92-93
po2 scale 2 oxygen	<91 >96 on oxygen		3 3		>96 on oxygen
ituration (%) use scale 2 target range is 88-92 % g: in hypercapnic	250 dii daygen				
ile 2 under the	95-96 on o2		2		95-96 on o2
on of qualified	93-94 on O2		1		93-94 on O2
nician	>93 on air				>93 on air
	88-92				88-92
	86-87 84-85		2		86-87 84-85
	<83%	THE RESIDENCE OF THE PARTY OF T	3	MANUAL PROPERTY AND PERSONS ASSESSED.	<83%
					300
ir or Oxygen ?	A= Air				A= Air
	O2litre/ min		2	The second secon	O2litre/ min
	Device				Device
lood Pressure	>220		3		>220
	201-219				201-219
	181-200		2		181-200
	161-180				161-180
	141-160				141-160
	121-140				121-140
	111-120				111-120
	91-100		1		91-100
	81-90		. 2		81-90
	71-80		3		71-80
	51-60		3		61-70 51-60
	<50		3		<50
tolic BP	mmHg	110			mmHg
	>131		3	TATE OF THE PERSON NAMED IN	>131
e	121-130		2	THE RESERVE OF THE PARTY OF THE	121-130
eats / min	111-120		2		111-120
	101-110		1		101-110
	91-100		1		91-100
	81-90				81-90
	71-80 61-70	•			71-80
	51-60		<del>                                      </del>		61-70 51-60
	41-50		1		41-50
	31-40		3	DOTAL SECRET STATE OF THE PARTY	31-40
	<30	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3	THE PERSON NAMED IN COLUMN	<30
	Alert	•		71 234.2	Alert
onsciousness	Confusion	A 100 100 100 100 100 100 100 100 100 10	3		Confusion
ore for New onset of	V		3	THE RESERVE TO SERVE SERVE	V
infusion no score if chronic )	Р			AND STREET STREET STREET STREET	P
o sole il cilionic j	U >30 1 degree		2		U >39.1 degree Celsius
	>39.1 degree Celsius		-		>39.1 degree Celsius
mperature	38.1-39.0		1		38.1-39.0
egree Celsius	37.1-38.0	,			37.1-38.0
The state of the s	36.1-37.0				36.1-37.0
	35.1-36.0		1		35.1-36.0
	< 35.0		3	CONTRACTOR OF STREET	< 35.0
EWS Total		0			
Ionitoring Frequency		4th			
calation of Care Y/N		W			
itials by RN itials by Sr. RN		200	<del>                                     </del>	of 3 in any single parameter or ag	
		20-01			

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



Mr.PRASAD SUGUMARA

42/Malc/MHI2023815', 30/12/2023/IPH2023002002

Dr.T.PALANIAPPAN







From: 30[12]22 To: 3//12/23 Bed No: Date **INTAKE & OUTPUT** Ended Time: 7100 24 Hrs: Started Time: リオンタグ **CHART** NPO Started at: NPO Over at: **SHIFT** Morning Night **Restricted Fluid (RF)** Afternoon INTAKE **OUTPUT** 550 Total Intake: FOTMI. **Total Output:** Difference: 1550 M INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** tidel Time | Oral (Tefel): Others Feeding Type of Fluid **Time** Urine **Vomitus** R/N Sian Aspirate Tube **Additions Amount** by 600 18:0 200 200 18:00 600 假 50 250 150 1050 Ivg- 30ml hu 50ml Inj. Mays 75 A25 DAILS 1550 500 5:30 001 525 **ਰ**:ਅ 804 DE TO 405 de 705 Intake ssbml BULLBULT 8×5m Ballanee fay SODS 100 0021



Mr.PRASAD SUGU
42/Mulc/MHI 815/0
30/12/2023/iPHzu23002639
Dr.T.PALANIAPPAN

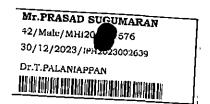




Every heart beat counts Date From: 31/12/23 To: 1 124 Bed No: Lo **INTAKE & OUTPUT** 24 Hrs : Started Time : אינים Ended Time : づ たっっ **CHART** NPO Over at: NPO Started at: SHIFT Night Restricted Fluid (RF) Morning Afternoon INTAKE 345  $\Omega$ 50 950 OUTPUT 500 From Total Output: 2050M Difference: \DAOM uno ndi Total Intake: INTAKE (ml) OUTPUT (ml) Intravenous Infusion Tube N/G Drain **Endorsed** Time | Oral Total Total Time Urine Vomitus Others R/N Sign Feeding Aspirate Tube Type of Fluid **Additions** bγ Amount 800 KO 820 Zw A.C 50 Tues 8-40 91-50 400 low 50 000 50 2:50 12-45 300 1000 340 18.00 200 12-5 12DD 12.00 440 22180 A50 650 100 16.00 prod 120 560 6:60 A00 205 b INT. ALLOMIN work 45 20,00 720 INT. MUCKS 50M 50 &0 >34 840 SINT. Medo 50M Intake - 10 0 M 1:00 lDD 000 Tota 2050m Hoy d40m anlo Naa වරන <u>∞2</u>€









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Date	Fro	ש ו   m: ו	ų To	0:2/1/24	Be	d No:						INITA	VE 9	OUT	'DUT
24 Hı	24 Hrs : Started Time : キャップ Ended Time : ギャップ									INTAKE & OUTPUT					
NPO Started at : NPO Over at :									CHART						
SHIF	Т	N	lorning		Afterr	noon			Nigh	t		Restricted Fluid (RF)			
INTA	KE	•	700	50	00 mr			3	SOML			1.2 ditoes lday			
OUTPUT 950 700 MZ									rom L	<u> </u>					
Total Intake: 1550 MC Total Output: 9300 Difference: ゴラ															
	1	1	INTAKE	<u>`                                    </u>		£			<u> </u>	OUT	PUT (	(ml)	<b>T</b>		
Time	Oral	Tube Feeding	Intraver Type of Fluid	Additions	n Amount	<b>To</b> (e)	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
\$.9	101					100	\$ · DC	450					450		
100	30					400	11.30	500					950		
11:20						700	15:30	900					1350	<u> </u>	
1380	ද්ලා					900	19:00						1650		
<b>15.00</b>	600					1000	2200	350					2000	<u> </u>	
1700	100			ļ		(100	zam	200					2300	ــــــ	
[030_	loo					H00								ļ	
M:00	50			ļ <u>.</u>		1250					ļ				
2013C	Plon			ļ		350	· _								
21.90	toe			<u> </u>		11120						_			<u> </u>
فاءدا	50		<u> </u>	<u> </u>		1500			<del>-/</del> 27	AC 1	NTA	CE - 1	550		
<u> </u>	50	,		<u> </u>		1552			707	<u>oc c</u>	UTPC	7-	9300	<u>-</u>	Nece
<u> </u>		ļ	<u></u>	-				а .			BAL	Mar-	7753		<i>J</i> .
					1						<b>I</b> .		l '	747	



Mr.PRASAD SUGUMARAN 42/Male/MHi202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN







Date	Fre	om:	1 9 11 To	0: 3,	Dic Be	ed No:	109			_					
24 Hrs : Started Time : From Ended Time : From								INTAKE & OUTPUT							
NPO	Start	ed at :				PO Over			-			CHART			
SHIF	T		lorning		After			Night				Restricted Fluid (RF)			
INTA	-		75			වට		Soomk							day
TUO			20,	<u> </u>		Ko.				onl			<del>  -  </del>	<del></del>	<u></u>
Total Intake: 10 FSM Total Output: 1500 M Difference: 425 M															
<u> </u>		<del></del>	INTAKE			<del></del>				ר <u>טס</u>	<u> </u>	(ml)	···		
Time	Oral	Tube Feeding	Intraven Type of Fluid	Additions	ion s Amount	Total.	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	letor	R/N Sign	Endorsed by
81.00 19430	275		leo ·			275	12-250	300		-	<del></del>		310	_	
	ĺ							300					650.		
Mig An	Jec	>				454	18:30	26cm					[600]		
<u> 30,90</u>	100			<u> </u>		575	22:00	300				<u> </u>	300		
<sup>న్రవ</sup> ్రాజ	100		Try. Alsun	h100		875	6,00	200				<u> </u>	1800	<u> </u>	
6.00	100		Inj. Meso	7,150		1075									
			Tay'. Newys	19,00											
									Tota	l Int	ake	-10	front		
				<u> </u>	<u> </u>				Tota	_	put		som	l i	
				<u> </u>		<u> </u>				Bal	an	- A8	m		10 ex
				<u> </u>	<del></del>	<u> </u>							1	Jay Ovor	2
	<u> </u>				<u> </u>	<u> </u>						ļ		<u> </u>	
					$\perp$										







Mi SAD SUGUMARAN

42, MHI202381576

30/12/2023/IPH2023002639

Or.T.Palaniappan



Date   From: 3   1   24   Bed No: 109										INTAKE & OUTDUT					
24 Hrs : Started Time : 7:00 Ended Time : 4:00									INTAKE & OUTPUT CHART						
NPO Started at : NPO Over at :															
SHIFT Morning				Afterr	noon	_		Nigh	t			ricted F			
INTAKE 345 ml				15	o m/			55	omb		10	2 lot	sexld	ay	
OUT	PUT	2501	nl			-			<u> २</u> -е	om!					<u> </u>
Total	ntake:	1175m	<u> </u>		Total Outpu	it:   150	r			Differen					
		<u>,                                      </u>	INTAKE			Y		1	•	OU	<b>TPUT</b>	(ml)	-7489		
Time	Oral	Tube Feeding	Intraven Type of Fluid	Additions		্য <b>ি</b> ভা	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
8-30	75					75	14.8	350					<b>1</b> 50		
8.30 30 4.30	loo		Pry Mucomplin	L 100		275	23100	350					800		
			0 (	U L		375	8:30	350					1150	_	
18/20 18/20 18/20	(150m		<u></u>			525									
20:30		<u> </u>	Inj-Mucos	V9100		tas								٠	
21,30	loo		Inj-meso	I W.		825									
2)30	150	<del></del>				975			Tota	1 Into	ake	-1175	ml		
6230	200					1175	_		Tota	el pu	put	-1150	ens		
		<u> </u>								Bal	anıe	- 25	ml		
												ļ 	<u></u>	Hey-	<u> </u>
		<u></u>	<u> </u>												
									,				<u></u>		
						_									Das
															024







ID SUGUMARAN Mr.I

42/N

HI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Date	te From: Alily To: 5 liley Bed No: 109										INTAKE & OUTDUT				
24 Hrs : Started Time : 7:00 Ended Time : 7:00								INTAKE & OUTPUT CHART							
NPO Started at : NPO Over at :															
SHIFT Morning					Af	ternoon			Nigh	t			ricted F		
INTAI	KE	35	omp		C	350ml			100 k	J		800 mllolay			
OUTF	PUT	350	ml.		č	Dogwi		1	510 m	<i>b</i> ,					
Total I	ntake	<u> </u>			Total Ó	utput:	_			Differen					
		<del></del>	INTAKE	<u> </u>			<u> </u>			OUT	PUT (	(ml)	<del></del>		
Time	Oral	Tube			ous Infusion		Time	Urine	Vomitus	N/G	Drain	Others	TACE!	R/N Sign	Endorsed
		Feeding	Type of Fluid	Addition	s Amo	unt [Offi	Tithe	Office	Volintus	Aspirate	Tube	Outers	(COT-	luit oign	by
8.30	45	-				75	8.00	350	1				850		
₹ <b>,</b> 30			Inj. Mucomykin	ploom		250							550		
11.30	leo			Ϋ́		350	1800	100					650		
230							6.00						1060		
14.00	l					220		7			_				
18.30	ľ					600									
6-00						650					_		_		
		<del> </del> -												_	
								_		<i>‡07.81_</i>	TNTA	VF. >	650		
		<u> </u>		<u> </u>		/				TOTAL	OUT	DUT -	106	<b>6</b> -	
												BALA	WE -	410	
														Harford	100



Patient Details (affix label here) Mr. Prarad Sujunaian 42/M (Dr.T. Palaniappan

### PSYCHOLOGICAL WELLBEING REPORT

Date: 04.01.24

Time: 1.00 pm

Unit: 109

Clinical diagnosis: CKD, Hypwth groidism.

Surgery/ Procedure:

Impression:

Functioning well

- calm affect, ociented, responsive - sleep I ('2m), appelite @ \_ us jongehors gical distrem repoeted.

Employee ID: MHO 2-1884

Signature of the Psychologist:







Every heart beat counts

### Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN

# 

# Department of Dietetics

### NUTRITION ASSESSMENT AND CARE PLAN FORM

P10333	M Dal	sheposthy De	time rathy	1 H(V)	1 Nephu	warde stade	om BF481,
ght:	⊃cms \	Weight H. Hgs			es, specify	do	Way Hootenie
gious Beliefs:		Vegetarian	Non Vege	tarian		☐ Eggetarian	□ Jahn Ol ()
: Prescription:	1000	(alous, b	cottal c	\at	600 70	third eigh	wited deal
BJECTIV	E GLOB	AL ASSESSMENT	(AD)ULTS)	. ,	•	0	1 -
	(A) -	Patient's related Medical Histo	η	_			· · · · · · · · · · · · · · · · · · ·
	1)	Weight Change (overall change	in past 6 months)				
			□ 2	<b>□</b> 3		□4	□ 5
		No weight change/ gain	<5%	5 - 10%		10 - 15%	>15%
2)	Dietary intakę	Duration: 10 day					<u> </u>
			77	<b>□</b> 3		<b>0</b> 4	<b>□</b> 5
	Oral	No change	Sub - optimal solid diet	Full liquid die moderate		Hypo - caloric Ilquid diet	Starvation
			<u> </u>	overall decre	35e / -		
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub-optimal	Inadequate		Typo - caloric feeds	Starvation
3)	Gastrointest	nal Symptoms Duration:	Dun'				
<del>-</del>			13.	-		□4	□s
		No symptoms	Nausea	Vomiting/ .		Diarrhoga	severe anorexia
				moderate GI symptoms			service management
4)	Functional C	apacity (Nutrition related functional impa	irment) Duration:				
		<u> </u>	□ 2	⊡ 3	•	<b>0</b> 4	□ <u>5</u>
	-	None /Improved	Difficulty with ambulation	Difficult normal		Ught activity	Bed / chair - ridden with no or little activity
5)	Co · morbidity	(Disease and its relationship to nutrition	requirements) -euu	· -(3de	Zeil \		
<del></del>		1	1 2	- Fig.	<del>- 17)</del>	Tar-	5
		Healthy	Mild co - morbidity	mor	erate co - bidity/ age years	severe co - morbidity	Very severe multiple co - morbidity
B),	Physical exa	mination	<u> </u>		-		
1)	<del></del> -		<u>.</u>				
	Decreaseu (2	t stores or loss of subcutaneous fat	<del></del>		<u>-</u>		□ 5
		1 1	2		<del></del>	<del>-   ''</del>	<del>-   -</del>
ļ	<del></del>	Hormal	Mild	Moderate	<del></del>	<u> </u>	Severe
	Sign of muscle	T	T_ · - · · ·	<del>- 1</del>			<del></del>
	<del></del> -	<u> </u>		□3		4.	□5
		Normal	MIG	Moderate			, Severe
Total Score =	Sum f above 7 com	ponents		<del></del>			· .
Nutritional St	tatus ; Based on thi						
	Well Nourished			☑(7 to 14)		\ . · · · · · · · · · · · · · · · · · ·	<del></del> -
	Moderately Ma	<del>-</del>	,1	☐(15 to 18) ,	(-13	· <u>· · · · · · · · · · · · · · · · · · </u>	
	Severely Main	purished		☐ (19 to 35)		<u> </u>	_
Nutrition Inte	ervention:		1 .	1	-		<u>-</u>
	ايبو 🗆			☐ Enteral		arenteral	
Diet counsell	<del></del>	Yes		□ No			
	re-assessment:	- Diversity	1	<u> </u>	☐ Fort - night	☐ Monthly	
			1- 1 1		Calorie count: Y		<del></del>
Enteral / Pare	enteral	□ Dailý,	.1	•			

Dietitian Signature / Name / Date / Time:

Maria Catherine John 2-01)
Senior Dictitian

30/12/M , 19:50

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
30/12/41	A gryeau sed male came & clo	•
$\alpha$ i $\beta$ 1	from ( madrate grade (or off) sind so	۳)
	provided à shortem of breakle	
	half) wer arrend to be were would	P
	ar enident by SUA.	
	Kleb-DH/HED/ Hypoteyes/dum/cu	9) <u>w</u> or mm
,	Educated ter patriot and fainly	
<u>.</u>	er too calain, on fat to rait;	
	800 rue fluid eester tid, drakster did. Enpejd on snall fut ruah E 60 gjunie certust.	(D <sub>1</sub> OV) .  1. izriz Catherine John Senior Dietitlan
-	- ml. is betw. Hotsated b	
कार्यः ११/१४५,	lost were. But lodge themse	Senior Dietikan
,	laif cation dos.	
ofilm,	geal intalu à god. Educated ten	. '
	patient and family on two calours,	
	bet, be sout, some fleid which did dut on dir charge. Emplis on through	( College
	mean els glamin ventrel. Put modifice and claim colin dos. Det chart gren	Senior Dietitian

dir day.





# Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





# **NURSING ADMISSION ASSESSMENT (ADULT)**

		(* 1					
Date of Admission: 30(12)つり	me of Arrival: <u>(そょらら</u> Mode of Admission:ロ W	alking 7%heelchair Stretcher					
Accompanied by Relative: Yes No If Yes, Name of the Relative:							
Relationship with Patient:	Contact Person's Name: Mls Richald	Relationship:Ulife					
Contact No.: 99 44 1314 1구	Primary language spoken: Tamil Englis	h Indian International					
Interpreter needed: Yes No							
	Unconscious Disoriented   Patient Vulnerab						
Menstrual History : LMP :	Menopause:	14. M. 6 tola					
Medical History : DM / HTN / Co Drugs History : Antiplatelet	- Menopause:	month. = /					
		_ <u></u>					
	Anxious Withdrawn Agitated Depressed						
Do you have any special religion of the light of the ligh	is, spiritual or cultural needs to be considered?	Y LI Yes No					
	loyed Retired Own Business Home-Make	or Athors:					
	Ise / HR: 90 (beats/min)   BP: 150 80	<u>.</u>					
B.	SpO <sub>2</sub> : 97-(%)   CBG: (mg/dl)   Height: 17						
<u> </u>	·						
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Mot known							
If Yes, specify:							
Pain: Yes No. If Yes, Score: Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years)							
Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)							
Duration:	Location:						
Pain Character: Dull Aching	Sharp Stabbing Shooting Burning	Referred / Radiant Pain					
Nutritional Screening:							
Last 3 months Appetite: Incre							
Last 3 months Weight: Incre		•					
Type of Patient:	· · · · · · · · · · · · · · · · · · ·	Normal Diet					
Dietician Informed: Yes No	. If Yes, mention the Name:	Time: 17.55					
Orient Patient if: Conscious	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	ars Nurses Call Bell Television 1	ight Controls Telephone					
Functional Assessment:							
Particular Assessm	ent Remarks	Outcome					
Visual Impairment Yes							
Hearing Impairment Yes	10						
Chewing Difficulty Yes	lo .						
Walking Difficulty ☐ Yes ☐	To Control of the Con						

Daily Activity Of Living:											
Activity		Independe	ent		\ssis	ted			Dep	ende	nt , · ·
Bathing							1				
Dressing							T I				
Eating		<u> </u>					Î				
Walking			-								
Toilet Use											-
Pressure Injury Ri	isk Asses	sment: Brad	en Scale		•	<del>1.</del>					
Sensory Percep	tion	Score	Moisture		S	core	Degre	ee of A	Activity	,	Score
No Impairment		4	Rarely Mois	t		4	Walks				-4
Slightly Limited		3	Occasionall	y Moist		3	Walks	Occa	sionall	у	3
Very Limited		2	Very Moist			2	Chair	Fast			2
Completely Limit	ed	1	Constantly I	Moist		1	Bed F	ast			1
Mobility		Score	Nutrition		S	core	Fricti	on & s	Shear		Score
No Limitation		4	Excellent			4	_	_	nt prob	lem	<b>3</b>
Slightly Limited	<u>-</u>	3	Adequate	<u> </u>		3			oblem		2
Very Limited		2	Probably In	-Adequate		2	Probl	em Pr	esent		1
Completely imme	obile	1	Very Poor			1					L,
High Risk: 12 - 10; Severe Risk: 9 - 6  Total Score: Action needed: Yes No Pressure injury present at the time of a lf yes, Location: Grade: Siz Witnessed by: Relation						Size	e:		<del></del>		
MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)											
Fall Risk Assess	sment (Mo	dified Mors	e Scale):								
Variables										Nun	neric Value
History of falling	(immediate	e or within 6	months)					-	No		<u> </u>
	<u> </u>		<u></u>						Yes		25
Secondary diagr	nosis (≥ 2	medical diag	nosis)					-	No Yes		
8 h - Vada , 8 fel									163		
Ambulatory Aid None / Bed Rest		ssist						ľ			0
Crutches / Cane		30101									<b>_13</b>
Furniture											. 30
Introvenous Ther	onu / Llone	anim Look / Tu	.b.c. locit						No		10
Intravenous Ther	ару / пера	ann Lock / It	Joes Insitu						Yes		20
Gait Normal / Bed Re	st / Wheel	Chair					-				<b>/</b> 0
Weak									10		
Impaired				<u> </u>							20
Mental Status Oriented to own	stability										<b>∕</b> 0
Overestimated o		mitations									15
Medications											
Includes PCA / o							S,	1	No		0
laxatives, hypogl	ycemics, s	sedatives, im	munosuppres	ent and psyc	notro	ppics			Yes		J5
Score Interpretation	Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk  Total Score							core			Ur

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As per the score, tick the following appropriate l	boxe	s:						
Low Risk Interventions (0 - 24)  Familiarize the patient with the immediate surrounding:  Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all times.  Keep the call bell, bedside table, water, glasses within the Remove excess equipment or furniture to make a clear Keep the patient's bed in the low position at all times extoxic treach fall-prevention techniques, such as sitting up for 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 puse use safety belts during movement in wheelchair  The patients are not ambulated by themselves. They are Medium risk interventions (25 - 44)  Apply all the low risk interventions  Tie yellow fall risk tag in the bed and Wheel chair / Stretch Make sure that proper transfer precautions are instituted 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 effection of the patient while going to bathroom Advice the patient to use grab bars near the toilet, batht Make sure the family and other visitors understand the High-risk interventions (above 45)  Apply all the low and medium risk interventions  Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurse 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)  Inappropriate, consider using protection devices: safet	bed for all he pai path cept d a mor  re to be cher uted for tor fects I ment a tub, ar restric ses' sta	tient' during ment te fal e am or he level areas areas ation	nt's easy reach ng procedure nt before rising from the bed  alls mbulated only with assistance leavy or debilitated patients in a  el of consciousness, gait and as shower ns mentioned above					
Initial Assessment to Special Needs and Vulnera	abilit	v of	 of Patient:					
	Yes	_						
Terminally ill patients			1					
Patients with intense chronic pain								
Woman in labor or experiencing termination of pregnancy			1					
Patients with emotional or psychological distress			1					
atient suspected of drug or alcohol dependency								
/ictims of abuse and neglect								
Patients whose immune system is compromised								
Patient with infections and communicable diseases	$\Box$							
Does the patient have implants	$\Box$		<b>_</b>					
Has tracheotomy been done			<u></u>					
Has colostomy been done .	+	-/	<del>                                     </del>					
Any other potential needs of the patient	†		<del>/</del>					

	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.	7.00.3 4.0		Param							es / No	Score
1	Active cancer					d within 6 months o	r palliative car	e)			yo ov
2	Bedridden red	ently >3 days o	major	surge	ry w	ithin four weeks				Yes 🔽 I	No -
3	Calf swelling (Assess for bo		d with	asym	pton	natic side, measur	ed at 10 cm b	elow tibial tubercle		Yes 🕝 I	4o .
4	Collateral (noi	nvaricose) super	ficial ve	ins pr	rese	nt (Assess for both	legs)			Yes 🔯 i	19
5	Entire leg swo	llen (Assess for I	ooth leg	js)						Yes []	10
6	Localized tend	derness along th	e deep	venou	us sy	stem (Assess for b	oth legs)			Yes 🔯 1	lo l
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)								Yes 🕝 i	lo	
8	Paralysis, pare	esis, or recent pla	aster im	mobi	lizati	ion of the lower ext	remity (Assess	for both legs)		Yes 🏳 1	10
9	Previously do	cumented DVT (	Assess	for bo	th le	egs)				Yes 1	lo
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.										
	Score Inter	pretation (Pro	babili	ty of	DV	T):			F	inal Sco	re O
HON	Action Taken						Date	Time			
Low	Risk	-2 to 0					<u> </u>				
Mod	lerate Risk	1 to 2									
Hig	h Risk	3 to 8		1							
Per	sonal Belong	jings / Valuab	les:				·				
Valua	ables	Description	n	Wit Patio		With Patient's Attendant		Signature of the tient's Attendant		Rema	rks
Dent	ures	□Upper□L □Both □N	_								
Hear	ing Aid	□Right □L □Nil	eft								i
	glasses / act lens	□Yes □N	o	_							
Jewe	ellery	☐ Yes .☐1	ō								
Othe (spec	r valuables cify)										
Rep	ort (List of X-	ray, ECG, lab	reports	reta	ined	d with the nurse)	:				
_		Sign.			Na	ime		Emp. No.		Date	Time
	ent / ent's Attend		2-10	•		RENOMO	ڼ	Relationship	30	12/2	19-3-0
Nur	se	<b>C</b>	/			Monda	Λα.	0141	I -	str122	-1920
Unit	In-Charge	No	0	1		S-Naley	ù	0024		4.123	2000

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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Date: 30(12(23) Shift: Morning Devening Night									
S	Ventilator Periphera Ryle's Tub	s: CD) / T2 EWS Score: — day: — I line day: Right: DT Le be:	ft: — (	GCS: (6) POD: Central line of VIP Score:	days: —				
В	On room		09 om est " "	Date of surg V fluids on fl	<u> </u>				
A	ASSESSMENT  Vital Signs: Temp: 9EF 9F   Pulse / HR: 2 (beats/min)   Respiration: 20 (breaths/min)  BP: \[ \int \left( \text{Sp} \right) \right( \text{mmHg} \right) \right) \right( \text{sp} \right) \right\] Height: \[ \frac{1}{10} \constant{cms} \right) \right\] Weight: \[ \frac{1}{3} \cdot 2 \cdot 2 \cdot 2 \right) \right\] BMI: \[ \frac{1}{28} \right\] Moderate FACES Pain Rating Scale \[ \text{NRS} \right) CPOT \]  Fall Risk Score: \[ \frac{1}{2} \right\] Fall Risk Protocol: \[ \right\] Low \[ \right\] Medium \[ \frac{1}{2} \right\]  Braden Score: \[ \frac{1}{2} \right\] Minimal Risk: 23-:9 \[ \right\] At Risk-Mild Risk: 18-15 \[ \right\] Moderate Risk: 14-13 \[ \right\] High Risk: 12-10 \[ \right\] Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): \[ \right\] Yes \[ \right\] No \[ \right\] At Orains: \[ \right\]								
R	Pending Pending Pending Critical va Changes	MENDATION doctors: medications: medication indent: dab reports / Investigations: alue alert and its corrections in nursing care plan: ☐ Yes follow-up orders:	.	ıre pian date	p:				
		Signature	Name	1	Emp. No.	Date	Time		
Handover g			B-WOND	ks.	orri	80/12/23	18730		
Handover ta		Hay-	Hannah Gr	rale	oros	30/12/23	19120		
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	NURSES PROGRESS NOTES									
Date & Time		Observations / Action	Sigr	ature with Emp. No.						
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(03)				•						
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(100)	-st floor.	Clo Breathry								
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(7)	to Styl	it duty starts		2012						
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<b>D</b>	Signature	Name	Emp. No.	Date Time						
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42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.palaniappan



Date: 3	Date: 30(12/13 Shift: Morning Evening Night									
S	Ventilator Periphera Ryle's Tul Urinary C	s: AHI, CKD PEWS Score: O day: Il line day: Right: Left De: Yes No Day atheter: Yes No Dáy		GCS.LS (5 POD: — Central line of VIP Score: pecify organis	days:					
В	Allergies On room	ROUND  urgery:  if any: N K-DA  air / oxygen: ON X DON  its / New Symptoms in last si	rou's	Date of surge	ery: — ow: Somlthe on floor	ν. ., Μ2				
A	ASSESSMENT  Vital Signs: Temp: 98.6(°F)   Pulse / HR: 80 (beats/min)   Respiration: 10 (breaths/min)  BP: 12080 (mmHg)   SpO <sub>2</sub> : 98 (%)   Height: 170 (cms)   Weight: 13.3 (kgs)   BMI: 28 (g/m) <sup>2</sup> Others:  Pain Score: 100 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 100 Fall Risk Protocol: 10w Medium 11gh  Braden Score: 11minmal 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): 19es No NA Wound Dressing done: 19es No NA Orains: -									
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes		_	:					
		Signature	Name		Emp. No.	Date	Time			
Handover o	jiven by	Hou	Harrah C	rall	ows	31/12/22	72130			
Handover t	aken by	8	el. X	evi la	08	3mh	FU			
Document endorsed		Nag	a. Nalini		0102U	31/2/20	200			

NURSES PROGRESS NOTES									
Date & Time	0	bservations / Action		Signature with Emp., No:					
30/12/23	Nigh	t duty notes		<del></del>					
[9] > 30°	patient in Joon Eveni In a Ihen Condition.	unding over + ng duty Stat rodynamically s	aken f lable	Hay Stor					
20.00	Vital Signs	Checked & Ree	orded	Hay Stos					
21:00	Due deugs per deug	all given a Chalt	8	Hoy					
22:00	1	1 0		Hay over					
2:00	patient Sleep no Compl	sing well, had	ρ .	Hayons					
6:00	Mebulization	Gören		Heyolos					
6)30	Politient Vita Relooded Ilo Chart	l Signs Cheeke	d &	Heyous					
7.00	patient ha	nding over given	<i>fo</i>	flory.					
	Signature	Name	Emp. No.	Date Time					
Document endorsed by.	Naa	S-Nalini	oay	31/2 Play 20p					





# Mr.PRASAD SUGUMARAN 42/Male/MHi202381576 30/12/2023/IPH2023002639 Dr.T.PALANIAPPAN



Date: 30 112 2 Shift: Morning Evening Night									
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: AF (CCD) PEWS Score: O day: ← I line day: Right: ← Lef pe: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	POD: Centra t: VIP So	al line days:— core: O(5					
В	On room		als IV fluid	of surgery:					
A	Vital Signs: Temp: 986°F)   Pulse / HR: GODIN (beats/min)   Respiration: John (breaths/min)  BP: 190   AD (mmHg)   SpO <sub>2</sub> : 98. (%)   Height: 170 (cms)   Weight: 13.3 (kgs)   BMI: 281 (glass)    Others:								
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections Changes in nursing care plan: Yes- No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any: to do viteu porch								
	-	Signature	Name	Emp. No.	Date	Time			
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	NURSES PROGRESS NOTES			,	,
Date & Time	Observations / Action		Signati	ure with Er	np. No.
21/10/12	Morning duty	_			
<u> </u>	, , , , , , , , , , , , , , , , , , ,			· · · · · · · · · · · · · · · · · · ·	•
40	-> patient hand over feller fr	0 m			<u> </u>
	wight duty start				
70	right duty staff  > patient is dobb & vital se	nge			
	-> prefiert Normal Oliver		Ø,	<u> </u>	
8 .00	- perficued Modicition given as	pus			
<u> </u>	troday steet				
	spatient Sto Band chell				
	- specifical Nebilizeation give	<b>D</b>			
10.00	-> patient & usel sloop		a	-	
	-> pertient Not complaintien		900	<u> </u>	
1030_	-> patient Normal Vituel Singl				
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	Signature Name	Emp. No.		Date	Time
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#### Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576

| 42/Malc/MHI202381576 | 30/12/2023/IPH2023002639





Date: 31/10/2> Shift: Morning Evening Night								
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: C(<) PEWS Score:	_eft: Day: Day: DDR: ∐Yes ☑No. If Yes	GCS: 1601 POD: Central line VIP Score: 6	015		- ··•	
В	Allergies On room	ROUND urgery: へ if any: タタイ (An st air / oxygen: シハ (C ats / New Symptoms in las	soom WY	Date of surg			ſ	
A	Others: Pain Sco Fall Risk Braden S	re: Pain Scale us Score: Minimal Risk: 23-19 Ulcer Scale for Healing (P	90 (%)   Height: ☐ ( ed: PIPPS / CRIES / FL/ Protocol: ☐ Low ☐ Mei g ☐ At Risk-Mild Risk: 18-1 PUSH): ☐ Yes ☐ No ☐ Ñ	2(cms)   Weight ACC / Wong-Ba dium	: <u> </u>	28 kg m² ng Scale NR : 12-10 □ Seven		
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations alue alert and its correction in nursing care plan: follow-up orders:	ns:	d care plan dat	e:	-		
Handover g	iven by	Signature	Name	) han	Emp. No.	Date S//1p/rs	Time	
Handover to	<del></del> .	1702	A. Mandhi	<u>'01'</u>	0/70	31/12/28	19.00	
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Date & Time		Observations / Action	Signa	ature with Emp. No.
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N 42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





	PATIE	NT CLINICAL H	IANDOVER RECO	ORD FOR NUI	RSES 👾
Date: 3	1/12/2	Shift: Morr	ning □Evening □Nigpt	3 × 13 × 5	
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	EWS Score: day: I line day: Right 2 Lef be: Yes 250 Day atheter: Yes 250 Day	t: — r:	line days:	•
В	On room		1 Air Williams	surgery:	
R	BP: 5 Others: Pain Sco Fall Risk Braden S Pressure Current d  RECOM Referral of Pending if Pending if Critical value Changes Pending if	re: O Pain Scale used Score: So Fall Risk Pro Core: Minimal Risk: 23-19 Ulcer Scale for Healing (PU) iet:  MENDATION Coctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections	Height: HO (cms) We PIPPS / CRIES / FLACC / Wong Cotocol: Low Medium Hig At Risk-Mild Risk: 18-15 Modera SH): Yes No ANA Woo	g-Baker FACES Pain Ration th ate Risk: 14-13 High Risk: and Dressing done: Ye Drains:	Daligim ng Scale HNRS / CPOT 12-10□Severe Risk: 9-6
		Signature	Name	Emp. No.	Date Time
Handover g	given by		A. Nandhini	0/\$	1/1/24 7.31
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NURSES PROGRESS NOTES								
Date & Time		Observations / Action		Signatu	re with E	mp. No.		
31/12/23	Make	duty Notas						
		=	_			•		
19.00	-> Patient	taken over from	7	D		•		
	11 /	duly Staff	∆lur80	山水	1			
	> patient a	and was 9 orients	d		<u> </u>			
	spatient v	1141 Signs che	lead &					
	Pelorded		<u>,</u>					
20:00	-> Medicatio	en given as po	9r -					
	drug char	<del></del>		412				
	> putient	Sleep well						
2.00	putient	philse & Sat	urati	<b>h</b>		1		
-	cheered ,	Patient is no						
	com plaints			-11				
	Mornin							
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63,	=> patient	pulso & Sabura	tion					
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7.30	-> patient	handing over to		12/20				
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# Mr.PRASAD SUGUMARAN 42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



•	PAHE	NI CLINICAL P	MANDOVER F	IECOKD	FUR NUF	ISES	•
Date:		Shift: 🔂 Mor	į̇̇̇̇̇̇̇̇̃g □Evening □N	light .		, , <u>,</u>	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: \L\D- PEWS Score: day: al line day: Right: \D <sub>2</sub> Lef	t:	GCS: (5 / 1 POD: Central line da VIP Score: ©	5	,	
B	On room	urgery: J. D.A.	<del>,                                     </del>	Date of surger	-	b	
	ASSESS			,		-	ş
		n <b>s:</b> Temp: <u>97 - 6(</u> °F)   Pulse <u> </u>	•				4. P.
	Others:	, '	<del>(76)</del>	ms)  weight. <u>4</u>	- <u>&gt;, Э</u> (v.ða)   ым. <u>- С</u>		m.
_	- · · · · - ·	re: _ <i>O</i>  _0_Pain Scale used	: PIPPS / CRIES / FLAC	C / Wong-Bake	r FACES Pain Ratin	ے Scale / NR	S / CPOT
Λ		Score: 5 Fall Risk Pro				J,	,
		Score: Minimal Risk: 23-19 [ Ulcer Scale for Healing (PUS) fiet:	SH): □Yes □ No □NA		essing done: 🗌 Yes		
	RECOM	IMENDATION					
_		medications:					
	_	medication indent: lab reports / Investigations:	need				
H	_	alue alert and its corrections	:				
	Changes	in nursing care plan: Yes	No. If Yes, modified	are plan date:			
	Pending '	follow-up orders:	~				
	Special ir	nstructions if any:					
		Signature	Name	<u> </u>	Emp. No.	Date	Time
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Date:01/}	ودو	Shift: ☐ Morn	ing				
S	Ventilator Periphera Ryle's Tul Urinary C	s: CLD PEWS Score: P5 day: I line day: Right: D5 Left be:	: VIP Score	e days: — : OG			
В	On room						
A	ASSESSMENT  Vital Signs: Temp: 98 (°F)   Pulse / HR: 186 (beats/min)   Respiration: 206 (breaths/min)  BP: 20 [0] (mmHg)   SpO <sub>2</sub> : 95 (%)   Height: 170 (cms)   Weight: 73.1 (kgs)   BMI: 28.1 cyfm2  Others:  Pain Score: 0 0 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: 4 Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6  Pressure Ulcer Scale for Healing (PUSH): Yes No No NA Wound Dressing done: Yes No NA Current diet: AD moderate Risk: 10-10 Drains:						
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:						
Handover gi		Signature	Name  M. Devila	Emp. No.	Date	Time 1930	
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



Every heart beat counts

MHI/NUR/2022/048

•	PALLE	IN CLINICAL I	MINDOVER	ILCON	D FOR NOR	SES	ì
Date: )	12,7	Shift: Morn	ing Evening 1	<b>Vight</b>			, , , , , , , , , , , , , , , , , , ,
S	Ventilator Periphera Ryle's Tut Urinary C	s: ( )  EWS Score: ( )  day:  I line day: Right: ( )  be:	,	GCS: S POD: Central line of VIP Score: of specify organis	olays:—		,
B	On room			Date of surg			
A	BP: TO Control of the Pain Sco Fall Risk Braden S	ns: Temp. 3-2 (°F)   Pulse of the Core of the Pain Scale used Score: 50 Fall Risk Proscore: 50 Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	: PIPPS / CRIES / FLAC btocol: Low Mediu	cms)   Weight: CC / Wong-Bak um	Ker FACES Pain Ratin sk: 14-13 High Risk: Oressing done: Yes	g Scale / NR:	
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan:  Yes follow-up orders:	/	care plan date	o:		
	_	Signature	Name	<del>-</del> ,	Emp. No.	Date	Time
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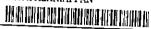






42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





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Date:	9/1/2	Shift: 100m	ing ⊡Evening ⊡Nigh	t · · ·	;			
S	NEWS / F Ventilator Periphera Ryle's Tu	s: CLD - PEWS Score: Q 4 r day: al line day: Right: D 4 Left be:	Ce Culitury VI	OS:  5  5  OD: Intral line days: P Score: 0   5		,		
B	Type of s Allergies On room	ROUND urgery: if any: ルガく Д 4_ air / oxygen: ユののいこ nts / New Symptoms in last s	air IVI	te of surgery:		¥		
	ASSESS	SMENT		•				
	Vital Sig	Vital Signs: Temp of - 6(°F)   Pulse / HR:						
		_		•		M 7		
ľ	Others:	BP: 130 80 (mmHg)   SpO₂:97-(%)   Height: 170 (cms)   Weight: 72_ (kgs)   BMI: 2 5 129   W						
_			 : PIPPS / CRIES / FLACC / '	Wong-Baker FACES Pain Rat	ing Scale / NRS	S /*CPOT		
Λ	Fall Risk	Score: 50 Fall Risk Pro	otocol: Low Medium	∃High	-			
		Ulcer Scale for Healing (PU		loderate Risk: 14-13 High Risk  Wound Dressing done: Ye  Drains:				
	RECOM	MENDATION						
	Referral	doctors:						
	Pending	medications:						
	Pending	medication indent:	( mil					
	Pending	lab reports / Investigations:	- mu					
	Critical v	alue alert and its corrections		~				
	_	in nursing care plan: Yes	No. If Yes, modified care	plan date:	_			
	_	follow-up orders:	_					
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	1 '	Signature	Name	Emp. No.	Date	Time		
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	taken by	3040220	r. Tight	0029	12/1/24	12-30		
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



Every beart beat counts

MHI/NUR/2022/048

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Date:	1/29	Shift: Morr	ning Kerping Night	Same Land		
S	Ventilator Periphera Ryle's Tu Urinary C	s: OMD PEWS Score: r day: al line day: Right: Lef be: Yes No Day Catheter: Yes No Day	/: VIP Score: 6	days:		
В	Type of s Allergies .On room	• •	Date of surg	ery:	,	
Α	Others: Pain Sco Fall Risk Braden S	ore Of to Pain Scale used Score: Minimal Risk: 23-19	/ HR: (beats/min)   Respire [	上子 (kgs)   BMI: Ser FACES Pain Rations is the FACES Pain Rations is t	ng Scale / NR:	
R	Referral of Pending Pending Pending Critical volume Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care plan date	e:		
		Signature	Name	Emp. No.	Date	Time
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





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Date: ຝົ∫ເ	124	Shift: Morr	ning Evening Might	• • •		
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: (LD) PEWS Score#) day: I line day: Right: Lef be: Yes No Day atheter: Yes No Day	/: VIP Score:	days: —		ı
В	Allergies On room	ROUND urgery: ー if any: いたDA air / oxygen: かいをのかの uts / New Symptoms in last s	1	•		
A	BP: / SC Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>914</u> (°F)   Pulse    10	/ HR:	(kgs)   BMI: ó ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	g Scale / NR	e Risk: 9-6
R	Referral of Pending Pending Pending Critical va Changes Pending	medications:  medication indent:  lab reports / Investigations:  alue alert and its corrections  in nursing care plan: Yes	Nil ENO. If Yes, modified care plan date to vs a abdomen to epho opinion,			,
		Signature	Name	Emp. No.	Date	Time
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42/Malc/MHI202381576 30/12/2023/12H2023002639

Dr.T.PALANIAPPAN





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Date: 3	24	Shift: 🔲 📆	orning Evening Night	of the state of th	्रीक 	
S PO	IEWS / Pl 'entilator 'eripheral lyle's Tub	EWS Score: O  day:  line day: Right:  Per Yes No D  atheter: Yes No D	GCS: (Second Podicing	e days:		
B	llergies if In room a	ROUND Irgery: — I any: NK DA air / oxygen: Is / New Symptoms in las	Date of su IV fluids or t shift:		- N	9 · s <u> </u> 
V B O	P: 170 Others : _ Pain Scor	s: Temp: <u>PR. (</u> (°F)   Pul (mmHg)   SpO₂: re: 0 (D Pain Scale us	se / HR: 80 (beats/min)   Resp 98 (%)   Height: 10 (cms)   Weig ed: PIPPS / CR(ES / FLACC / Wong-E	ht:	28 Kg	S/CPOT
B	Braden S Pressure	core: Minimal Risk: 23-1	Protocol: Low Medium High  9 At Risk-Mild Risk: 18-15 Moderate  PUSH): Yes No NA Wound  Dra		-	e Risk: 9-6
R	Referral d Pending r Pending r Pending la Critical va	medications: medication indent: ab reports / Investigation lue alert and its correctio		ate:	_	
1	-	ollow-up orders:				
·		Signature	Name	Emp. No.	Date	Time
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8 1 84 Q	> pt hando morning du > patient con > patient becorded, 900-9	Lorning duty Note d over taken by uty Staff scious & oriented vitals signs chec - PALANIAPPAN SIR odu  t, electrolytes, HB, D-	ked p	£ · (0		
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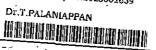






# Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576

30/12/2023/IPH2023002639





. Date: 3/0			IANDOVER RECORI	D FOR NUF	19E9	
	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	ON SEWS Score:  day: I line day: Right: De: Yes No Day atheter: Yes 100 Day	GCS: 15 POD: Central line of the control of the con	days: —		
В	On room		Date of surg  IV fluids on fi			
A	BP: 10.20 Others: Pain Sco Fall Risk Braden S Pressure	re: 5 Fall Risk Pro	/ HR: 80 (beats/min)   Respira (%)   Height: 70 (cms)   Weight: : PIPPS / CRIES / FLACC / Wong-Bal ptocol: 1 Low Medium High At Risk-Mild Risk: 18-15 Moderate Ris SH): 1 Yes No NA Wound Drain	(kgs)   BMI: Exer FACES Pain Ratings   BMI: Exer FACES Pain Ratings   BMI: Exer FACES Pain Ratings   BMI: Exer FACES   B	g Scale / NR	e Risk: 9-6
R	Pending Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	☑No. If Yes, modified care plan date	e:	, , ,	,
		Signature	Name	Emp. No.	Date	Time
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Date: 3/1/24	Shift: ☐Morn	ning Evening Night		,	,
NEWS / Ventilato Periphering	s: OFD PEWS Score: Ø r day: al line day: Right: Left be: Yes No Day Catheter: Yes 1 No Day	GCS: 15 17 POD: Central line of VIP Score:07: R:  Yes No. If Yes, specify organis	days:		•
B Type of s Allergies On room	ROUND urgery:— if any: ハレタチ air / oxygen: つれ そのがい nts / New Symptoms in last s		•		`
BP: So Others: Pain Sco Fall Risk Braden	ns: Temp: 978(°F)   Pulse  [10 (mmHg)   SpO <sub>2</sub> : 95  ore: 0 w Pain Scale used  s Score: 50 Fall Risk Pro	•	(kgs)   BMI: 0  ker FACES Pain Ratin  sk: 14-13  High Risk:  Dressing done: Yes	g Scale / NR	e Risk: 9-6
Referral Pending Pending Pending Critical v Change	medications: medication indent: lab reports / Investigations:	No. If Yes, modified care plan date			* *
	Signature	Name	Emp. No.	Date	Time
Handover given by	Hay	Hannah Grale	0181	Alilau	4:30
Handover taken by	I &/	l li Daila	OBL	11111 200	70

	NU	JRSES PROGRESS NOTES				
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2;07	Patient 3 leepir Complaints	g well, chad no	:	1	fayotas	
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





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Date: リ	1/2-21	Shift: 🖂 Morn	ing Evening Night	<u> </u>		
S	Ventilator Periphera Ryle's Tul Urinary C	s: CLD PEWS Score: G day: Left be: Yes \understand No Day atheter: Yes \understand No Day	PO Cer : <i>1</i> 76 : VIF	S: 15/15 D: — Intral line days: — Score: O(5,  fy organism: —	•	·
В		urgery: —	ain IVII	e of surgery:		-
A	Others: Pain Sco Fall Risk Braden S Pressure	<b>ns:</b> Temp: <u>948 (</u> °F)   Pulse <u> </u> (mmHg)   SpO₂: <u>9</u> (	(%)   Height: <u>/</u> 译D(cms) : PIPPS / CRIES / FLACC / V Nocol: □ Low□ Medium	Weight: <u>+</u> (kgs)   E Vong-Baker FACES Pair ∄Tigh	BMI: <u>De log f</u> m? I Rating Scale /NR I Risk: 12-10 Sever	e Risk: 9-6
R	Referral of Pending Pending Pending Critical vi 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:		
		Signature	Name	Emp. No.	Date	Time
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#### Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576 30/12/2023/IPH2023002639 Dr.T.PALANIAPPAN

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Heart Institute

Every heart beat counts

MHI/NUR/2022/048

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

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В	On room	Y	on etr i l'affuid	f surgery:		
Α	Others : Pain Sco Fall Risk Braden S	re: Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS		reight: 주오(kgs)   BMI: 5 ng-Baker FACES Pain Ratin gh	g Scale NR	∍ Risk: 9-6
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### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639



#### MHI/NUR/2022/048

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#### Mr.PRASAD SUGUMARAN <sup>42</sup>/Malc/MHI202381576 30/12/2023/1442023002639 Dr.T.PALANIAPPAN 115 AN 1811 DE LEGE MAI DE LEGE MAI DE LEGE DE LEGE DE LEGE DE LEGE DE LEGE DE LEGE DE LEGE DE LEGE DE LEGE DE



Every heart beat counts

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В	Allergies i On room	ROUND  urgery:  if any:	in Room A	tr	Date of surge	ery: ————————————————————————————————————	k · ·	
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#### Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





### PATIENT CLINICAL HANDOVER RECORD FOR NURSES

PATIENT CLINICAL HANDOVER RECORD FOR NURSES					
Date: 5 1 24 Shift: Morning Evening Night					
SITUATION Diagnosis: Cko NEWS / PEWS Score: 0 Ventilator day: Peripheral line day: Right: 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: NKDA On room air / oxygen: RA Complaints / New Symptoms in last shift: NI					
ASSESSMENT  Vital Signs: Temp: 15-9°F)   Pulse / HR: 80 (beats/min)   Respiration: 22/mf (breaths/min)  BP: 110   70 (mmHg)   SpO <sub>2</sub> : 97 (%)   Height: 70 (cms)   Weight: 72 (kgs)   BMI: 32 kg/m <sup>2</sup> Others: Pain Score: 0   Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CFall Risk Score: SD Fall Risk Protocol: Low Medium 16gh  Braden Score: Minimal Risk: 23-19   At Risk-Mild Risk: 18-15   Moderate Risk: 14-13   High Risk: 12-10   Severe Risk Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA Current diet: Soft Solid chief					
Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:					
Signature Name Emp. No. Date Tii	me				
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PALL PRASAD SUGUMARAN

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Initial Date: 30(12/2	ලියා දිර : Time: /දිර	Modified Date: Time:		
Reason for Modification:		Diagnosis:		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION  ☐ Keep NPO	Patient will have adequate nutrition with no nausea and vomiting	Provide Prescribed diet on time Encourage patient to consume the served meal	M	
Pagular Diet ☐ Others:	Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Record amount of food consumed	E pt had get	187 197
			NPt had rosmal	Hort
OXYGENATION  Room Air  Nasal Cannula / High Flow O <sub>2</sub> Mask  BiPAP / 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	coughing exercise / Spirometry exercises  Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O <sub>z</sub> saturation and pulse rate	M	
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits  Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	<ul> <li>If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>Place patient with proper body alignment for maximum breathing pattern</li> <li>Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> <li>Note for changes in level of consciousness</li> <li>Send sputum for culture and sensitivity based on physician order</li> <li>Maintain clear airway by suctioning or encouraging patient with successful coughing</li> </ul>	E 202- 824	SON
			patient was  Noon aix	flay ocos
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	М	
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 260 Chest us montor	San!
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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY  Mobile / Immobile  Walk with assistance  Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment	М	
Others:	P_tient will use safety measures to minimize potential for injury     Patient will demonstrate the use of adaptive devices to increase mobility	<ul> <li>□ Consider the need for home assistance (e.g., physical therapy, visiting nurse)</li> <li>□ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)</li> </ul>	Ept mobilised sol	Sept
			N Patient Mobilized Slightly	flay olos
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	м	
Others:	and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter     Check placement before feeding     Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E purffori &	Fan!
		Check for malena / constipation / urinary retention	N Pt had normal elimination patter	they
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		М	
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	E	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Şign & 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 ·		
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	EM yourself	10 m	
			n Patient groomed well	Henry	
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	M		
CENTRAL LINE Side rails Others:		☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient	E = D bond	Ton!	
		Follow restrain policy (if needed)	N ID bandpresent	Hay.	
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	M		
☐ Sleep Patterns ☐ Others:	behavior about pain relief and ; adequate sleep	adequate sleep	<ul> <li>☐ Monitor pain scale / sleep pattern</li> <li>☐ Provide pharmacological and non-pharmacological therapy</li> </ul>	E	
			N :		
OBSERVATION  Vital Signs GCS Blood Sugar	Datient 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		
☐ Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E offer out of Stable	Sord	
			N Pt vital Signs all Stable	Hay 0109	
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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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials				
COMMUNICATION    Patient will communicate effectively with positive feedback		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed		M								
Sigh language Others:				No negative speaking about the patient's or prognosis in the patient's presence	condition	E PT COM	mo r'cufer,	Perh!				
	, 	,				N Pt Con	munitated well	they				
SPECIAL INTE  Medication  Wound care  Isolation	RVENTIONS	☐ To manage on time		Deuble check for high alert medication     Observe and report any medication react     Provide proper measures of wound care     Follow hospital polices and protocols of its content of the protocols.		М						
☐ Ostomy Care ☐ Blood / Blood p transfusion ☐ Fluid tapping			and explain to the patient / family  Check for cross matching and typing compatibility  Practice strict asepsis while transfusir			and explain to the patient / family  ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or		and explain to the patient / family  ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or		E reads	-	
DVT Managem Others:	ent ,			blood products and fluids  Monitor DVT score and continue treatment as per doctors order	nt	N Due de	eugs all	-fay				
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Nat. ASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639





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Reason for Modification:		Diagnosis: CKD, AF)		_
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 p4 · DM Diet  E PT Lood Olef	On Con
	delivity foreign included in the delivity foreign in t		Butient had pro diet	
OXYGENATION  Room Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	<ul> <li>□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises</li> <li>□ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order</li> <li>□ Utilise pulse oximetry to check O₂ saturation and pulse rate</li> </ul>	M pt room els	d'a
☐ 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 300 g = 98 g.	and	
		<ul> <li>Note for changes in level of consciousness</li> <li>Send sputum for culture and sensitivity based on physician order</li> <li>Maintain clear airway by suctioning or encouraging patient with successful coughing</li> </ul>	N Patient 18	<del>- 1</del>
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	Ratient will have balanced fluid and effectrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output	M P4 Olcetrolype	Dor
☐ Parentéral Nutrition ☐ Others:			ESTO Churt and	Sint
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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY  Mobile / Immobile  Walk with assistance Physiotherapy Others:	<ul> <li>□ Patient will mobilize freely</li> <li>□ Patient will perform physical activity independently or within limits of disease</li> <li>□ P_tient will use safety measures to minimize potential for injury</li> <li>□ Patient will demonstrate the use of adaptive devices to increase mobility</li> </ul>	□ 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 mobilize  Preally  E pt mobilized a	Sin!
ELIMINATION	☐ Patient will have normal elimination	□ Encourage fluid intake	N Patient Mobilized well	<b>A</b>
Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	pattern  Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	Encourage fibre diet intake     Encourage early ambulation     Report any abnormalities to physician     Observe voiding accessories as foley's /		808
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hernetemesis as per doctors order and follow proper protocol	E elimentes	Sin!
		☐ Check for malena / constipation / urinary retention	N/Ormu/ Elimination	$\mathbb{A}_{j_2}$
SKIN INTEGRITY  Maintain normal skin integrity Pressure points site assessment HAPI OPI	☐ Patient will maintain normal healing status ☐ Patient will diecharge with intact skin integrity		M pr mountain D Steeles	800
GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status			E	
☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given			Mountain Mormell  Notin integrity	$\bigcirc$
☐ Others:	•		N8kin integrity	户净

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  Bed-Bath Assist-Bath Self-Care CBO Care	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	Mp+ come come	89
☐ Others:	Patient will recognize individual weakness or needs	Apply moisturizing solution	Ept 9500 rel	ranj
			Patient use groomer	<b>15</b> /4
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 ralls	Mp+IlD Bahal	842
CENTRAL LINE Side rails Others:		Provide proper invasive line care  Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	E ad band of	Point
			N JU bund (7)	
COMFORT AND SLEEP	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	M p + comfortable, sleep	800
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep.	☐ Monitor pain scale / sleep pattern     ☐ Provide pharmacological and     non-pharmacological therapy	E	
	, , , , , , , , , , , , , , , , , , ,		N	
OBSERVATION  ☐ Vital Signs ☐ GCS ☐ Blood Sugar	Patient will have normal range of vital parameters		M p+ vital series	) (4)
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E vistal vos Stuble	FIN
			Nite 18 Chellad	The state of the s
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	☐ Pray or encourage the patient to pray☐ Use inspirational words☐ Respond to spiritual needs as they arise	м	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs     Encourage verbalization of feelings / therapeutic touch     Provide empathy and reassurance	E	
			N	

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION  Verbal  Non-verbal  Sigh language  Others:		Patient will communic with positive feedback		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain-interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	condition	E A com	pel'	Syln Polh
SPECIAL INTE  Medication  Wound care Isolation Ostomy Care Blood / Blood ptransfusion Fluid tapping DVT Managem Others:	oroducts '	☐ Ær manage on time		Double check for high alert medication Doserve and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b blood products and fluids Monitor DVT score and continue treatments as per doctors order	solation ensure lood or	M p+ leelic as p	ition grun vandury Hon wen	Sur Jelhi Pelhi Pelhi
	Signature	,	Name		Emp. (D	1 UD FOI CI	Date	Time
Endorsed by	1)	a9	<u>S.</u> 1	valini	00	Zvj	31)12/23	නිපා <sup>න</sup>

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### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639





Initial Date:	1/24 Time: 7.00	Modified Date: Time:					
Reason for Modification:	, ,	Diagnosis: CKD , AF					
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	MP+ takes. ©  Let  Ep+ talon dred  NP+ hoed and	Stafer Service Of A			
OXYGENATION Roem Air Nasal Cannula / High Flow O, Siphapa / CPAP Ventilator Tracheostomy	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	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	pt is on M loom air	Jofer			
Others:	or through behavior, feeling comfortable when breathing	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 pt room euo	Str			
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	Pt noom (	0271			
FLUTB & 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	pt takes Moral fleed	Alas S			
☐ 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 pr terter porcel fluid Pet Whom I did	Day (B)			
			2000 hydrata	Sort			
			U				

Patient Specific Problems /•Needs •	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY    Mobile / Immobile    Walk with assistance   Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment	M pt mobilized cuell	Seef
☐ Others:	□ P⊥tient 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 pt Mobilituel	802
			NP+ mobilities	02
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 foley's /	M D voideig	Japo
Others:	and regular elimination patterns	silicone catheter  Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E D validhiy  pertferin	Don
		and follow proper protocol Check for malena / constipation / urinary retention	Patturn Was good	027
SKIN INTEGRITY Maintein 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 D Skie integulog	J-sel
INJURY  GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased			E Soin interputer.	Soun
Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	,		Soin intaguto.  Novintained  NON Stern	P 2
· · · · · · · · · · · · · · · · · · ·	<u> </u>		Leitersituy	

				,
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 fales  E pt Julie solf-Bath  N Pt taltes Self ( Bath	8 2 AT
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails	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	M ID Bond (D)  EDD Bound (P)	Jed Sur
Others:		☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	N Sd hand Checked	ODA!
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	E PT Sleeped cod	Jan Dan
OBSERVATION  Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly  Menitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient	M prietale M cee Cheched	89/
		☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E PT VIC I	
PSYCHOLOGICAL / SPIRITUAL SUPPORT	Patient will achieve spiritual needs Patient will be able to control his	Pray or encourage the patient to pray Use inspirational words	M Checked Graa	507
☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	feeling toward his illness Patient will maintain normal psychological pattern	<ul> <li>☐ Respond to spiritual needs as they arise</li> <li>☐ Evaluate spiritual needs</li> <li>☐ Encourage verbalization of feelings / therapeutic touch</li> <li>☐ Provide empathy and reassurance</li> </ul>	E	
			N	

Ostomy Care  Blood / Blood products transfusion Fluid tapping DVT Management    Statistics   Sta	Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions	,	Evaluation		Sign & Initials
SRECIAL INTERVENTIONS   Medication	] Verbal ] Non-verbal ] Sigh language	$\mathcal{L}$	Patient will communicate effectively with positive feedback		Encourage the use of call bell     Obtain interpreter if needed     No negative speaking about the patient's condition		E p+ welby		geofe En
Signature  and explain to the patient / family Check for cross matching and typing, to ensure compatibility Check for cross matching and typing, to ensure compatibility Check for cross matching and typing, to ensure compatibility Check for cross matching and typing, to ensure compatibility Check for cross matching and typing, to ensure compatibility Practice strict assepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment as per doctors order  Signature  Name  Emp. ID  Date  Time	CDECIAL INTE	Medication  Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping		Thuble check for high plant medication		N	J MORDOUN a	(P)	
Fluid tapping   Practice strict asepsis while transfusing blood or blood products and fluids   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continu	Medication  Wound care Isolation				<ul> <li>□ Observe and report any medication reaction</li> <li>□ Provide proper measures of wound care</li> <li>□ Follow hospital polices and protocols of isolation and explain to the patient / family</li> <li>□ Check for cross matching and typing, to ensure compatibility</li> <li>□ Practice strict asepsis while transfusing blood or</li> </ul>		to ensure E pue uselici keufwr		Jufaz.
Signature    Monitor DVT score and continue treatment as per doctors order    Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment as per doctors order   Monitor DVT score and continue treatment   ☐ Blood / Blood p transfusion ☐ Fluid tapping								80	
	DV1 Managem Others:	erk			☐ Monitor DVT score and continue treatme	nt	"given	medicator as part.	02
Endorsed by Note 3. Nationi 0024 [1] Dy Darots		Signature		Name		Emp. ID	U	Date	Time
	Endorsed by	ed by Nota 3		z. Nalini	0	024	।।।२५	Down	
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Mr.PRASAD SUGUMARAN

42/Male/MHI202351576 30/12/2023/IPH2023002639





Initial Date: 2   2	Time: 77 30	Modified Date: Time:					
Reason for Modification:		Diagnosis: ( )	Diagnosis: COD				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sìgn & Initials			
NUTRITION  ☐ Keep-NRO ☐ Hegular 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 is on regular Ept had Frest NPt had Dm diet	Jour Joy			
OXYGENATION  Room Air  Nasal Cannula / High Flow O <sub>2</sub> Mask  BiPAP / 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 O₂ saturation and pulse rate	pt is less M noom air	Self			
☐ Ventilator ☐ Tracheostorny ☐ Others:	within established limits  Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	<ul> <li>If any O₂ abnormalities detected inform immediately to the concerned physician</li> <li>Place patient with proper body alignment for maximum breathing pattern</li> <li>Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis</li> <li>Note for changes in level of consciousness</li> </ul>	E' Sport - 96 4-	COM/			
		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 Stable on soom	Hoy Des			
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 takes one	l Jufor			
☐ 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 eto Chrotinad	Phl			
			NIB Chart Maintained	olos Olos			

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 Arti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment	M p+ molsi di zed weell	Jud
Connection of the control of the con	P_tient 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, Hóman's sign, redness, localized swelling, a rise in temperature)	E pt mobilised	96/h
		' .	N Patient Mobilised Well	#24 8105
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 Doideid	Sefer
☐ Urination ☐ Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter     Check placement before feeding     Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E patien D	ah!
		and follow proper protocol Check for malena / constipation / urinary retention	N Patient had normal elimination pattern	flay,
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 Skir villerguites	Sefory
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	E	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE  Bed-Bath Assist-Bath Self-Care CBD Care (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 17+ takes Solf Balls	<b>}</b> γ
			N pt groomed well	Hey BLOS
SAFETY Check ID Hand IV care	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient  Raise side rails	M to Band @	3 ylv
CENTRAL LINE Side rails Others:	<b>.</b>	☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	E TO hand &	De la la la la la la la la la la la la la
	1 1		N ID band present	Hoy
COMFORT AND SLEEP  ☐ Pain-Gontrol ☐ Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	☐ Provide clean calm and restful environment☐ Provide privacy at all time☐ Monitor pain scale / sleep pattern	M pt Sleeped week	John
Others:	adequate sleep	Provide pharmacological and non-pharmacological therapy	E N	
OBSERVATION  ☑ Vital \$igns	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time	M St witals are	
☐ GCS ☐ Blood Sugar ☐ Others:	or vital paramotals	Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient	ilomeded.	Beek_
		Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doptors order	E UTT- Jupha	Off /
			NPt vital signs all stable	toy.
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	м	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions	<u> </u>	Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:	TION	Patient will communic with positive feedbac	cate effectively k	☐ 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	condition	E PA com	war god	Sur Aug
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood g transfusion Fluid tapping DVT Managem Others:	products	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 i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b blood products and fluids Monitor DVT score and continue treatments as per doctors order		MDree Me gi e modice given	initated well edicate ore into	Seyou For Ship
	Signature		Name	<u></u>	Emp. ID	<u> </u>	Date	Time
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Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639





Initial Date: 3/1/24	Time: 8:00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CkD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION  ☐ Keep NPO ☐ Hegular Diet	Patient will have adequate nutrition with no nausea and vomiting  Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	MP+ had om aliet	DC 5007
Others:	requirements in accordance to his activity level and metabolic needs		E for had Downer	D.
			N Patient had DM diet	Hay
OXYGENATION   Room Air   Nasal Cannula / High Flow O,   Mask   BiPAP / 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 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 O₂ saturation and pulse rate  If any O₂ abnormalities detected inform immediately to	MPt is on room	200 H
☐ 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 Pot on Room	(P)
		Send sputum for culture and sensitivity based on physician order  Maintain clear airway by suctioning or encouraging patient with successful coughing	Patient was stable N room air	Hou
ELUID & 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 I lo Chart maintained	DC 120}
☐ 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	ES10 Monites	27/1
		LI Monitor by for orthostatic changes	N I lo Motentained	flay

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Patient Specific Problems / Need's	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 Pritient 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 well mobilized  E mobilized  well	2007 (2007 (2007)
			N Patient Mobilized well	Hay OLOS
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	MPt normal.  Plimination pattern  Elinination pattern  Normal  Pattern what hormal  Climination pattern	1207. 1207.
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	
INJURY  GRADE 1 GRADE 2  GRADE 3 GRADE 4  Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis			E	
☐ Pressure injury / blisters site care given ☐ Others:			N	



Patient Specific Sign & **Nursing Interventions** Measurable Goals **Evaluation** Problems / Needs Initials Patient will stay cléan and Encourage patient to do daily bathing and oral hygiene HYGIENE ☐ Bed-Bath well-groomed Change patient's gown daily ☐ Assist-Bath Patient will demonstrate lifestyle ☐ Encourage hand hygiene Self-Care CBD Care ☐ Consider the patient's need for assistive devices changes to meet self-care needs ☐ Patient will recognize individual Apply moisturizing solution (if present) Others: weakness or needs N Patient groomed well Datient will have no life-threatening SAFETY: Check the identity with ID band before any M Pt ID Bard (1) Check ID Hand situations interaction with the patient ☐ IV care ☐ EJV ☐ Raise side rails . . . Provide proper invasive line care CENTRAL LINE ☐ Side rails ☐ Keep bed locked and low at all time Others: ☐ Educate care providers to be the patient Follow restrain policy (if needed) N IP band present COMFORT AND SLEEP Patient will have comfortable sleep Provide clean calm and restful environment ☐ Pain Control Patient will verbalize / or through Provide privacy at all time ☐ Sleep Patterns behavior about pain relief and ☐ Monitor pain scale / sleep pattern Ε ☐ Others: adequate sleep ☐ Provide pharmacological and non-pharmacological therapy Ν Patient will have normal range Monitor vital signs regularly **OBSERVATION** m pt v/s checked p 9207 0207 Vital Signs Monitor vital signs on ordered time of vital parameters Assess physically for any abnormality ☐ Blood Sugar Inform doctor if there is any abnormality ☐ Others: Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order all Suble A105 ☐ Patient will achieve spiritual needs PSYCHOLOGICAL / Pray or encourage the patient to pray М SPIRITUAL SUPPORT ☐ Patient will be able to control his Use inspirational words ☐ Sbiritual Needs feeling toward his illness Respond to spiritual needs as they arise ☐ Beliefs / Values / Customs ☐ Patient will maintain normal Evaluate spiritual needs ☐ Anxiety and Copying Pattern psychological pattern ☐ Encourage verbalization of feelings / therapeutic touch Ε ☐ Identify Stressors ☐ Provide empathy and reassurance ☐ Others: Ν

Patient Specif Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:	•	Patient will communicate effectively with positive feedback		Introduce the care giver     Encourage the use of call bell     Obtain interpreter if needed     No negative speaking about the patient's or prognosis in the patient's presence	s condition	E (000)	munically Omr	25)
	.· 					N rocket	well	Hay
Medication Wound care Isolation Ostomy Care Blood / Blood ptransfusion Fluid tapping	Wound care     Isolation     Ostomy Care     Blood / Blood products     transfusion     Fluid tapping     DVT Management			Double check for high alert medication  Observe and report any medication react  Provide proper measures of wound care  Follow hospital polices and protocols of i and explain to the patient / family  Check for cross matching and typing, to compatibility  Practice strict asepsis while transfusing b blood products and fluids  Monitor DVT score and continue treatments as per doctors order	isolation ensure blood or	M Pt due gwe E Maria N Due du giver	drugs are	
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Nea		R. Nalin:	0081	f	3/1184	18:00
7,								









Initial Date: 4/1/234	Time: 8;00	Modified Date: Time:		
Reason for Modification:	·	Diagnosis: CKD		
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	E POT MESS	Sous PM/
	,		NP+ had a 10 miet	Day
OXYGENATION  Room Air  Nasal Cannula / High Flow O,  Mask  BIPAP / 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 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 O₂ saturation and pulse rate	Mp+ room als	200
☐ Ventilator ☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ If any O₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central cyanosis	E Sport Opm	DIN)
,		□ 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 stir	Qui olao
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	MPT dectrolytes	8
☐ Parenteral Nutrition☐ Others:			E_E(0 chest und Strble	AN SPAI
	· 	,	NILO Chart maintained	Qy ordo

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Patient Specific Problems 7 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 will Mobilize Frally	der
Others.	☐ P_tient 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 pt mobilised.	Sen!
			n pi well mobilized	Cy otho
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 bewel incontinence,	□ Encourage fluid intake     □ Encourage fibre diet intake     □ Encourage early ambulation     □ Report any abnormalities to physician     □ Observe voiding accessories as foley's /	M p+ D elimination Perform	82
Ofhers:	, and regular elimination patterns	silicone catheter  Check placement before feeding  Aspirate NG tube, check colour / consistenct / volume / Hernetemesis as per doctors order and follow proper protocol	E purifier @	AN AN
		Check for malena / constipation / urinary retention	N pt (10) Elimination Pattern	Cay 5100t.
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 pr D skin integrity i	8
☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased			E	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	





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

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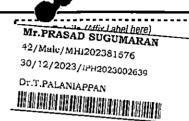
Patient Specific Problems / Ne		Measurable Goals		Nursing Interventions	·	Evaluation		Sign & Initials
COMMUNICATORY  Verbal  Non-verbal  Sigh language  Others:	rion <sub>.</sub>	Patient will communic with positive feedback		☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed☐ No negative speaking about the patie or prognosis in the patient's presence	nt's condition	M Pt will communicate  E PT co mouniste  COOL  N Pt well  Communicated		Col otar
SPECIAL INTE  Medication  Wound care Isolation  Ostomy Care Blood / Blood rtransfusion  Fluid tapping  DVT Managem  Others:	products	☐ To manage on time		Double check for high alert medication of Observe and report any medication reprovide proper measures of wound care follow hospital polices and protocols and explain to the patient / family Check for cross matching and typing, compatibility Practice strict asepsis while transfusing blood products and fluids Monitor DVT score and continue treat as per doctors order	action are of isolation to ensure g blood or	E moder	icition given a clury	Son Cay
	Signature		Name	<u> </u>	Emp. ID	•	Date	Time
Endorsed by	· · · · · · · · · · · · · · · · · · ·	Noll	۷.	Nalini	008	, <sub>r</sub> t	41124	(8:00

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Initial Date: 5 / 1 / 2 /	Time: 🕏 🔾 🔾	Modified Date: Time:		-
Reason for Modification:		Diagnosis: CKD		
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	Matatakes soft solid  E  N	path
OXYGENATION   Room Air   Nasal Cannula / High Flow O <sub>2</sub>   Mask   BiPAP / CPAP   Ventilator	☐ Patient ABG levels will return to and	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	Patrit 1's on M loom aig	Pauffra
☐ 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	
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N	
FLUID & ELECTROLYTES  Oral Intravenous Enteral Nutrition	Patient-will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output	M Takes ade junte	Podln
☐ 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	
			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY    Mobile / Immobile   Walk with assistance   Physiotherapy   Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the service consider the need for here assisted.	M Pt mobilized well	Poln
Coulers.	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	
			N	
ELIMINATION  Catheter, bedpan, urinal  Nasogastric tube  Bowel movement	Patient will have normal elimination pattern  Patient will control of urinary in-continence or urinary retention,	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician	M Self voiding	Postn
☐ Urination ☐ Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter     Check placement before feeding     Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E	_
		and follow proper protocol  Check for malena / constipation / urinary retention	N	
SKÍN INTEGRITY    Maintain normal skin integrity   Pressure points site   assessment   HAPI   OPI	Patient will maintain normal healing status Patient will discharge with intact skin integrity		Maintains normal M Skin integrily	fostn
GRADES OF PRESSURE INJURY		Lany death and weathers     Keep position changing 2 hourly and manage pain     Manage moisture, clean and dry skin     Maintain adequate nutrition and hydration     Proper application of medications and dressing	Skin integrily	40012
☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased		Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	E	
☐ PUSH Increased ☐ Intermittent Assisted ☐ 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 pt well groomed	Rojin_
			N	
SÁFETY  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 D band @	Poln
CENTRAL LINE Side rails Others:		□ Provide proper invasive line care     □ Keep bed locked and low at all time     □ Educate care providers to be the patient     □ Follow restrain policy (if needed)	E	
			N	
COMFORT AND SLEEP Pain Control Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern	м —	
Others:	adequate sleep	Provide pharmacological and non-pharmacological therapy	E	
			N	
Ø8SERVATION   ☑ Vital Signs  □ GCS □ Blood Sugar	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality	M Vital Signs Stable	Partn
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E	
			N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs	☐ Patient will achieve spiritual needs☐ Patient will be able to control his feeling toward his illness☐ Patient will maintain normal☐	<ul> <li>□ Pray or encourage the patient to pray</li> <li>□ Use inspirational words</li> <li>□ Respond to spiritual needs as they arise</li> <li>□ Evaluate spiritual needs</li> </ul>	M Provided Psychological Support	Posts
Anxiety and Copying Pattern  Identify Stressors  Others:	psychological pattern	Evaluate spiritual needs     Encourage verbalization of feelings / therapeutic touch     Provide empathy and reassurance	E	
			N	
-	•			

atient Specific Problems,/ Needs,		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION  Verbal  Non-verbal Sigh language		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	M sfec	tive verbal	Poln
Others:				or progression in the patient's presence	_	N		
SPECIAL INTERVEN Medication Wound care Isolation	TIONS	☐ To manage on time	A	□ Double check for high alert medication □ Observe and report any medication reaction □ Provide proper measures of wound care □ Follow hospital polices and protocols of isolation and explain to the patient / family □ Check for cross matching and typing, to ensure compatibility □ Practice strict asepsis while transfusing blood or blood products and fluids		M Neda	chrons given	Path
Ostomy Care Blood / Blood produc transfusion Fluid tapping DVT Management	ets		,			E		
Others:				Monitor DVT score and continue treatme as per doctors order	nt	N		
Sign	nature		Name		Emp. ID		Date	Time
Endorsed by	K	Ju D	S. L	valin'	00	æ4	5/1184	





### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Date: 20 12 3

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK	Date: 3.6		3) 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 vo commands. Has no si deficit which would ability to feel or voice discomfort	ensory d limit	I dj	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 Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, line requires changing at intervals		t	3
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or/must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room a twice a day and inside at least once every two during waking hours	e room	87	25
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 fr changes in position assistance		3-7	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	4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement	4. Excellent Eats most of every Never refuses a Usually eats a total more servings of me diary products. Occas eats between meals not require supplement	meal. of 4 or eat and sionally . Does	47	_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.	strength to lift up completely during move. N		in bed	3	3
	assistance. Spasticity, contractures or agitation leads to almost constant friction	Maintains relatively good position in chair or bed most of the time but occasionally slides down		Initial & Em	-	Ton,	the
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 & Em of Sr. Staff I	•	204	New





#### Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/iPH2023002639

Dr.T.PALANIAPPAN





Every heart beat counts

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK	Date: Time:	31 M	12 E	23
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 ve commands. Has no se deficit which would ability to feel or voice p	ensory Limit	H	H	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, line requires changing at r intervals	en only coutine	4	4	4
ACTIVITY degree of physical activity	Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room a twice a day and inside at least once every two during waking hours	room	4	4	+
MOBILITY ability to change and control body position	Completely Immobile     Does not make even slight changes in body or extremity position without assistance	2. Very Limited  Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and fre changes in position v assistance		4	4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every Never refuses a Usually eats a total of more servings of mediary products. Occas eats between meals. not require supplement	meal. of 4 or at and ionally Does	3)	**	3
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. Nor chair		ORE	3 22 9002	7	3
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp	o. No. lurse:	कुट्ट इट्ट	Nach	Jag OO





Patient Details
Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639

1 Dr.T.PALANIAPPAN





Every heart beat counts

Date:

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	M	F	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited     Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	H
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	9	4	H
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4 Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	4	4
MOBILITY ability to change and control body position	Completely Immobile     Does not make even slight changes in body or extremity position without assistance	2. Very Limited  Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		4	4
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4.Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	9.	4	#
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally	3. No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. Nor chair		3	3	3
Score	agitation leads to almost constant friction  Interpretation: Minimal Risk: 23 - 19; At Risk	slides down 	High Risk: 12 - 10; Severe Risk: 9 - 6	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	1381	380	0 38





42/Mulc/MHI202381576

30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Every heart beat counts
Date: 2 1 214

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time	: W		V
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited     Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4-No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	· (	A.	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist  Skin is usually dry, linen only requires changing at routine intervals		H	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 / ordexistent 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 leas twice a day and inside room at least once every two hours during waking hours	ı	7	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	4. No Limitation Makes major and frequent changes in position without assistance		7	4
<b>NUTRITION</b> 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		4. Excellent  Eats most of every meal  Never refuses a meal  Usually eats a total of 4 or  more servings of meat and  diary products. Occasionally  eats between meals. Does  not require supplementation	4	*	, ,
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 minimumassistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. No chair			3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		TOTAL SCORE Initial & Emp. No. of Staff Nurse:	13 mal	27	do Hou
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	NO	Nagu	Na





42/Male/MHI202381576 30/12/2023/trH2023002639

Dr.T.PALANIAPPAN





Every heart beat counts

Date:

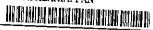
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	V DICV		3 M	E	2).  2
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited     Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited 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 vert commands. Has no sens deficit which would li ability to feel or voice pair discomfort	ory imit 🗾	4	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3.Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4 Marely Moist Skin is usually dry, linen or requires changing at rou intervals		+	4	M
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 le twice a day and inside ro at least once every two ho during waking hours	oom	et	4	.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	4 No Limitation Makes major and frequent changes in position with assistance		•	4	4
NUTRITION usual food intake pattern	Never Poor     Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered., Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Eats most of every m Never refuses a me Usually eats a total of more servings of meat diary products. Occasion eats between meals. D not require supplemental	eal. 4 or and nally loes	4	4	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,	3 No Apparent Problem  Moves in bed and in chair independentl strength to lift up completely during move. Norchair		cle ped	3	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		TOTAL SCO Initial & Emp. I of Staff Nur	No. §	2.c	$\overrightarrow{\mathcal{O}}$	20 Hay
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. I of Sr. Staff Nur	No.	رسمه	مثق <b>ل</b> منقل	روی





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Dr.T.PALANIAPPAN





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(A Unit of United All	iance Healthcare Pvt Ltd)			Lveig I		Tear co	TUILLE
	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	$\perp$	<u>                                     </u>	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	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	F	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	H	H	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	U	H	4
MOBILITY ability to change and control body position	Completely Immobile     Does not make even slight changes in body or extremity position without assistance	2. Very Limited  Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		¥	26
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	杆	4
FRICTION & SHEAR	1. Problem  Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem  Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem  Moves in bed and in chair independently strength to lift up completely during move. Nor chair	TOTAL SCORE Initial & Emp. No.	(3) (3)	23)	non
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	   Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	 	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	08 1957 24	24	NE NE





42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





Every heart beat counts

Date: 5

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time:	m	15	R
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		
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 Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Burely Moist Skin is usually dry, linen only requires changing at routine intervals	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
MOBILITY ability to change and control body position	Completely Immobile     Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4		
FRICTION	Problem     Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently			em  n chair independently and has sufficient muscle pletely during move. Maintains good position in bed			
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	23 Posts		
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:	Na		







42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



MHI/NUR/2022/052



Every heart beat counts

# **PAIN RE-ASSESSMENT & MONITORING CHART**

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
30/0/0		po pro				an (	Pag
22,00		No pain	<b>-</b>			Hay	Nagu
				Patiend	is Steeping		
81/12/20 6).00	Olw	No pain				Hay exos	Nag
10.D	010	Nopain	J			8002	Nag
14/20	elop	No pain		1	~ ·	Point	Nag 20024
	ofi	00 pin			·	Pehl	Nagory
92.00	داره	No pain	_	_	_	A 2/p	Nag
		/		patent 12	Sloeping		



÷ -	4	: 4 									
Date & Time	Pain	i (dull. a	Pain Character chy, sharp, stabbing, shooting, ning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Sta Initial & Emp. No			
6.00	0/15		No pain		-						
[0.∞	0/10		vo pair	-	-	<del>-</del>	Boh	Pagu			
14.40	Pla		NO pain	د	_		84	Nag 002			
1820	!Plw	\ \ \ \ \	Nopeùs	_	/		8 T	Nach			
					· PA	IN SCALES					
(28 wee	PIPPS eks to <u>&lt;</u>		6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to seve	de comfort me		n	_	,			
(38 w	CRIES eeks - 2					of gestation. A maximal score of 10 is possible. If the CRIES score is > esic administration is indicated for a score of 6 or higher.	4,				
	LACC So onths - 7		0: Relaxed & comfortab	le, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both					
Pai	ig-Baker in Rating ears - 12	Scale	O 2 No Hurts Hurt Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age representation of the North Moderate None Mild Moderate	7 8	9 10			
Observ	! Itical care vation To- liator / co	ol (CPOT	COMPLIANCE WITH VE	- Absence of m INTILATION (II tubated patien Relaxed, 1 - Te	novements or normal ; ntubated patlents): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	ventilator (or)				
	pharmac nterventi		Cutaneous Stimulation Thermal Theraples (no	and massage: onger than 15	: E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mental exercisers  abbing / Massage the skin  application; H - Hot application; I - Shortwave diathermy  arferntial therapy   Psycho-social therapy/counselling; K - Individual Cour		•			







42/Malc/MHI202381576 30/12/2023/iPH2023002639

Dr.T.PALANIAPPAN



MHI/NUR/2022/052



Every heart beat counts

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No:
92-00	Vic	No pair	)			827 627	Nue Dif
111/2H 2arn			_			<b>P</b> 41	Noe-
barn			-	•		O At	Nas
<b>10</b> -06	0/10	No Daet	-	_		Bezler	News
	Olso	1969	•	_ ^		(Esh)	Nas-
`	Sol 90	pa pein				Rahl	Nas
	olw	<b>^</b>	1			Hay	Naco 024
				Patient	us steeping		
डीरिय 6:00	olw	Nopain				Hay	Nue.

	,	,							
Date & Pain Nme Score	(dull, achy,	in Character sharp, stabbing, shooting, referred / radiant pain)	Duration	Location / Site		Interventions		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
6/60	N	pain	-	-				907 907	Near 024
Mos ela	N	o pain	_	-	~			alph.	Nac
العوالي بعزوم	60%	pun		-	<u>`</u>			on!	Noo
32% o(10	ln	o pain	_	_	_			Hay	Nasi
	,			PA	AIN SCALES				1
PIPPS (28 weeks to <u>&lt;</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on				
; CRIES (38 weeks - 2 mg	onths)				of gestation. A maximal sco			,	,
FLACC Scal		0: Relaxed & comfortabl	e, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe	e discomfort / pain / bo	th	<u>_</u>	_
Wong-Baker FA Pain Rating So (7 years - 12 ye	cale	O 2 No Hurt Little Bit	600 Hurts Little Moro	6 Hurts	8 10 Hurts Worst	Numerical Ra	ating Scale (age moderate	7 8	9 10
Critical care F Observation Tool (ventilator / com	(CPOT)	<b>COMPLIANCE WITH VE</b>	Absence of mattern (I NTILATION (I Subated patient Relaxed, 1 - Te	novements or normal p Intubated patlents): 0 nts): 0 - Talking on nor ense, Rigid, 2 - Very Tel	position, 1 - Protection, 2 - Res - Tolerating Ventilator or Move rmal tone or no sound, 1 - Sigh nse, Rigid	ment , 1 - Coughing but		rentilator (or)	
Non-pharmacolo Intervention		Cutaneous Stimulation a Thermal Theraples (no le	and massage onger than 15	: E - Positioning; F - Ru to 20 minutes): G - Co	- Music; D - Physical and menubbing / Massage the skin old application; H - Hot applicateristical therapy   Psycho-se	tion; I - Shortwave diath		eling; L - Family	counseling
Pharmacological in	ntervention	as per doctor's prescrip	otlon						





42/Mulc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



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.
				Patient	is Steeping		
6.00	olo	No pain	۵.			200	Nua n24
10.00	0/10	Nopatr		;		Sier	News
16/100	O (so	plo pain.	1			ON AN	Naes 0024
لتسلط	el co	No poin	· * · · · ·			@ Jan I	Nac-
2.00	olio	no pain	τ -	•		Orde	Nac
2-00	0/10.	ar paio	1			Orac Contraction	Nas
ऽगिभ , ००	20	No_12 (2)	1	,— .	`~	Cont	Naos 02/
10.00	0/0		<i>-</i> .	-		Sulm	Nae





Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions							31	enior Staff Initial & Emp. No.
, , , , , , , , , , , , , , , , , , ,								<u> </u>							
				9											
	_									_			·		
								<u> </u>							
					P/	AIN SCALES	<u></u>					,			
(28 week	PIPPS (s to <u>&lt;</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	le comfort me		on								-	
(38 we	CRIES eks - 2 m	onths)	The CRIES scale is used further pain assessment	for infants > should be u	than or = 38 week ndertaken, and anal	s of gestation. A maximal gesic administration is inc	score of 10 licated for	0 is possib a score of	ole. If the	CRIES ter.	score is	'> 4,			vë.
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	scomfort, 4-6: Mode	erate discomfort, 7-10: Se	vere disco	mfort / pai	n / both						
Paln	-Baker F/ Rating S ars - 12 y	cale	O 2  No Hurts Hurt Little Bit	4 Hurts Little Moro	6 Hurts Even More	8 10 Hurts Whole Let Worst	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1	2 3	ng Sca	5	6 <b>∱</b> ;	7 8		9 10 • • • •
Observa	cal care i ition Tool ator / com	(CPOT)	FACIAL EXPRESSION: 0 BODY MOVEMENTS: 0 - COMPLIANCE WITH VEI	- Relaxed, No Absence of m NTILATION (li ubated patier Relaxed, 1 - Te	eutral, 1 - Tense, 2 - G novements or normal ntubated patlents): ( nts): 0 - Talking on no nse, Rigid, 2 - Very Te	rimacing position, 1 - Protection, 2 - D - Tolerating Ventilator or Mormal tone or no sound, 1 - ense, Rigid	lovement,	ss / Agitatio 1 - Coughi	ng but tole	erating, ut, sobt	Moderate 2 - Fight ping			evere	
	harmacol tervention		Distraction: A - Relaxation Cutaneous Stimulation a Thermal Therapies (no lo	n-conducive e and massage: onger than 15	nvironment; B - TV; C E - Positioning; F - F to 20 minutes): G - C	C - Music; D - Physical and r lubbing / Massage the skin old application; H - Hot app terferntial therapy   Psych	olication; I -	Shortwave			vidual Co	; ounseli	ing; L - Fam	ily co	ounseling



## Medway Hospitals

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

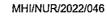


#### Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN







Where heart beat never stops.

# MODIFIED MORSE FALL RISK ASSESSMENT CHART

			•							
Variables	Date	30/12/	30/12/12	21/04	3/112/1	31/2	23/1/2	1 11	1/1/5/8	elili
variables	Time		32%			90.00		14:00	2000	8-00
History of falling	No		0	_هر	10	•	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	0	0	0	0	<b>/</b> 0
(≥ 2 medical diagnosis)	Yes	15	15	15	15	15	15	18	<del>1</del> 5	15
Intravenous Therapy /	No	0	0	0	0	0 /	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID				_						
None / Bed Rest / Nurse Assist		9	0	D	9/	0	0	0	0	8
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT	-									
Normal / Bed Rest / Wheel Chair		10	9	,0	٦	0	0	0_	8	-0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS				_				-		
Oriented to own stability		1	.9/	₩	0 /	8	6	0	8	-8
Overestimated or forgets limitations		15	15	15	15	16	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0	0	0	a	0	0	0	0	9/
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	(1)35	15	15	<b>t</b> 5	15
Total Score		60	50	50	50	چی ا	10	5)	40	50
Low Risk (0 - 24)			<u> </u>							
Medium Risk (25 - 44)										
Medium Risk (25 - 44) High Risk (45 or above)		~	. ✓			X	-		<u>,</u>	
	(	, in	The for	- - - -	o dur	<b>V</b> 3/4	·/	800 Jan	Le Constitution of the con	Bell

		17	3			<del>                                     </del>	0.2			
INTERVENTIONS	Date	20/12/	30/12/5	31/10	3/12/6.	31/12/	il lik	illh	<i>W</i>	<u>, '</u>
Tick as per the Risk Score	Time	1907 J	Dis	ميهو	\n\ <sup>2</sup>	oo.oc	800	[AO	000	, t
Low Risk Interventions (0 - 24)		(					,			_
Familiarize the patient with the immediate surround	ings		1	_	<b>/</b>	//			$ \nabla_{\mathcal{L}} $	
Remind the patient to use call bell before getting ou	t of bed									
Keep the two side rails in the raised position at all t			/	-				1		
all patients regardless of age									.•/	
Keep the call bell, bedside table, water, glasses w	ithin the							V		
patient's easy reach										1
Remove excess equipment or furniture to make	a clear					. /			1	
path				<u>۔ ب</u>				<i>-</i>		
Keep the patient's bed in the low position at all times	except			, -						
during procedure	-				<i>\\</i>					
Teach fall-prevention techniques, such as sitting	up for a		-	, <u> </u>		1				_
moment before rising from the bed				<u></u>		<i>'</i>	1/			
Bed wheels should be locked						1		/		
Encourage family participation in the patient's care								-		
Ensure that floor of the bathroom is dry and not slipp	ery				/					
Review medications for potential side effects the	nat can					. /				<del>,</del> ,
promote falls							_	·		
Use safety belts during movement in wheelchair						V				$\overline{}$
The patients are not ambulated by themselves. The	ey are to				./				1/	
be ambulated only with assistance						\ \tag{\chi}	/		<b>'</b>	
Medium risk interventions (25 - 44)		<b>—</b> —							1	
Apply all the low risk interventions										6
Tie yellow fall risk tag in the bed and Wheel chair / St	retcher			- /	V					//
Make sure that proper transfer precautions are in	stituted						-	•		
for heavy or debilitated patients in a bed or wheel	chair or						-/		\ \ \ \	
on a toilet seat				10	/	•				/
Use restraints and bed monitors as ordered by the o	doctor						1	 	1	
Allow the patient to ambulate only with assistance									r N	
Consider peak effects of the medications that effects	cts level									
of consciousness, gait and elimination when p	lanning					_				
patient's care						<b>V</b>				
Do not leave patients unattended in diagno	stic or									
treatment areas										]
Accompany the patient while going to bathroom								\		
Advice the patient to use grab bars near the toilet, t	oathtub,			1						$\overline{}$
and shower					V_	~			1	
Make sure the family and other visitors understant	and the				_		-			_ /
restrictions mentioned above	_	/								
High-risk interventions (45 or above)		<del>-</del>	-			<del></del>				
Apply all the low and medium risk interventions										′ /
Tie red fall risk tag in the bed, wheel chair and stretc	her			<u></u>		/			$\mathcal{V}$	
Locate the high-risk patients in a room close to the	nurses'				_		<u>-</u>		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	· /
station	1	/_					_ /			/
Answer these patients call bells as quickly as possit	ole					\ <u>\</u>				
Provide a commode at bedside (if appropriate)					/_	V				
Urinal/bedpan should be within easy reach (if appro					/	$\bot \checkmark$			1	
Encourage family members or other visitors to s	tay with						- 		[,]	,
them		//				~		<u> </u>		
If appropriate, consider using protection devices	: safety	′ ′			. /	,/	'			
belts		<del></del>			$\downarrow \checkmark$	Ž.	<u> </u>	_		
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# Medway Hospitals

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



# Mr.PRASAD SUGUMARAN

42/Malc/MHI202381576 30/12/2023/IPH2023002639





MHI/NUR/2022/046

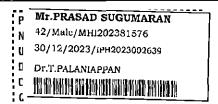
Where heart beet never stops.

# MODIFIED MORSE FALL RISK ASSESSMENT CHART

<del>_</del>	,	1 10 1	•			ı		r		
Variables	Date	2/1/24	2/1/24	3/124	3/1/24	3/1/24	HUBY	MipH	4/1/29	3/1/2
	Time	A FD	800,00	8,00	14,00	20,00	8.0	14100	30.00	8,00
History of falling	No	6	w		6	0	_0_	b	9	28
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	15	15	15	<b>15</b>	15	15	J5	15/
Intravenous Therapy /	No	0	ŏ	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20/	29/	20	20	20/	20	_28	120	29/
AMBULATORY AID										
None / Bed Rest / Nurse Assist		.0	0	سموا	( a	0/	0_	0_	0	9/
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	' مور	0,	9	18	ے	9	9/
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS			-						-	
Oriented to own stability		-0-	\0_	اسو	٥	8	0_	0	0	⁄و
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	.18	15	15	15	118	15	15	J15	15
Total Score	•	0	50	50	50	50	8	50	50	<0
Low Risk (0 - 24)		.:							-	
Medium Risk (25 - 44)			-							
High Risk (45 or above)				<b>~</b>	<u></u>		/	_	1	1
Signature & Emp. No. of RN		19 ElbH	Hosto	(a).c.   1000 }	9	48 tos	DOV	Boul	Confee	Softer
Signature & Emp. No. of Sr. RN		Nogu	120	1994	المؤولا	1923	1224	124	127	YOU
	- ;`	, Ò-	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk

			t	_	_			,	4	٠
INTERVENTIONS	Date	V Kolly	2/1/29	3/1/24	3/1/24	31/24	માાીઝ	orlipas	whiley	
Tick as per the Risk Score	Time	التركيلا	D0;00	8.00	14150	20,00	800	Min	20-00	2.6
Low Risk Interventions (0 - 24)		<del>- 1:</del>		^			,			
Familiarize the patient with the immediate surround	lings				`/					
Remind the patient to use call bell before getting ou								~		
Keep the two side rails in the raised position at all t	imes for						_			
all patients regardless of age									~	
Keep the call bell, bedside table, water, glasses w	ithin the									
patient's easy reach									ļ	
Remove excess equipment or furniture to make path	a clear			<i>_</i>		/	~	/	~	
Keep the patient's bed in the low position at all time:	s except								/	
during procedure	•						<u>~</u>		<b>/</b> _	′
Teach fall-prevention techniques, such as sitting	up for a			0			ľ	_		
moment before rising from the bed										
Bed wheels should be locked								V		
Encourage family participation in the patient's care			0	<u> </u>						
Ensure that floor of the bathroom is dry and not slip	pery			$\checkmark$	1					
Review medications for potential side effects t	hat can	- *		/		-	_	🗸		
promote falls			_						<u> </u>	
Use safety belts during movement in wheelchair									/	
The patients are not ambulated by themselves. The	ey are to		_				1 /	/		
be ambulated only with assistance			_	•	] `	^	_	•	-	
Medium risk interventions (25 - 44)			/						7	
Apply all the low risk interventions				t/				<u> </u>	<u> </u>	
Tie yellow fall risk tag in the bed and Wheel chair / S								<u> </u>	<u> </u>	
Make sure that proper transfer precautions are in				<b> </b>	/			1		/
for heavy or debilitated patients in a bed or wheel	chair or			-		_		•	•	′
on a toilet seat	4		<i>V</i>	<u> </u>				<del></del>	<b>-</b>	
Use restraints and bed monitors as ordered by the	doctor	<del>/                                    </del>		-	<u> </u>		<u> </u>	1	<del>-/-</del>	/
Allow the patient to ambulate only with assistance  Consider peak effects of the medications that effe	ata laval				<b>_</b>			<u> </u>	<u> </u>	
of consciousness, gait and elimination when p					/			/		,
patient's care	nammy			•			į		1	
Do not leave patients unattended in diagno	netic or	<del>  _</del>			<del>                                     </del>				<u> </u>	
treatment areas	Jane of		_	<b>✓</b>						/
Accompany the patient while going to bathroom					<del></del>				1	-
Advice the patient to use grab bars near the toilet, I	bathtub	-					-			
and shower	but itab,			<b>~</b>					<b>✓</b>	
Make sure the family and other visitors underst	and the								./	
restrictions mentioned above		′		<b>~</b>			1		*	
High-risk interventions (45 or above)		┡								
Apply all the low and medium risk interventions		] /	/				1	/	/	1
Tie red fall risk tag in the bed, wheel chair and streto	her			<u>~</u>	,			/	7	/
Locate the high-risk patients in a room close to the	nurses'									
station									√	
Answer these patients call bells as quickly as possil	ble			· •		/	1			
		/		<b>~</b>			//		<i>J.</i>	
Provide a commode at bedside (if appropriate)					. (	l '	1/	/	1 7	
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Provide a commode at bedside (if appropriate) Urinal/bedpan should be within easy reach (if appro Encourage family members or other visitors to s				./				/	1	
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Provide a commode at bedside (if appropriate) Urinal/bedpan should be within easy reach (if appropriate) Encourage family members or other visitors to sthem If appropriate, consider using protection devices	tay with	: /		\sqrt{\sq}\sqrt{\sq}}\sqrt{\sq}}}}}}}}}}\sqit{\sqrt{\sqrt{\sq}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}				/	4	/
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Provide a commode at bedside (if appropriate) Urinal/bedpan should be within easy reach (if appropriate) Encourage family members or other visitors to sthem If appropriate, consider using protection devices	stay with		Hayle		(Sym)	Portos	82	To lo	03%e	o.Xn







### **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		Biller	1 1 2	12/120	3124	A 11/24	15/124
	Time	لصع ع	6,00	<b>1.00</b>	7.00		6,00	6.00
S. No.	PARAMETERS				,		•	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	6	0	0	0	O	Ю
2	Bedridden recently >3 days or major surgery within four weeks	0	0	ರಿ	Ø	0	0	<b>10</b>
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	+	4)	+ /	1+	1	1	14
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	ව	0	D	Ø	Ю	0	ю
5	Entire leg swollen (Assess for both legs)	0	0	0	Ð	0	0	ь
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	Ð	Ø	6	0	O
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	ව	0.	0	0	0	0	Ø
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	Ó	0	0	0	6	ð	О
9	Previously documented DVT (Assess for both legs)	0	0	0	0	0	D	10
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.	O	0	0	6	Ô	6	0
	FINAL SCORE		+1	41_	4/1			
Low F	lisk: -2 to 0   Moderate Risk: 1 to 2   High Risk: 3 to 8	nod	red	1700	Mad	Mod	mod	mod
	DVT prophylaxis started	□ Yes □ No	□ Yes	□ Yes □ No	∐Yes □No	□ Yes □ No	☐ Yes ☑ No	☐ Yes ☑ No
	Signature & Emp. No. of RN	3/old	they !	新	\$5\B	Hay	Hay	(delace
	Signature & Emp. No. of Sr. RN	Nag	بي وي	1994	424	Mark	Mesig	M24



MHI/IP/2022/116 Medway

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Every heart beat counts

AGE / SEX:

Mr.PRASAD SUGUMARAN PATIENT NAN 42/Male/MHi202381576

30/12/2023/IPH2023002639 Dr.T.PALANIAPPAN

IP No. / UHID No

Ward / Bed No. (○ ∫

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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





#### PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f						olines. U					<u>-</u> -		1	
Barriers to	Lea	arning								Plan t	o A	ddr	es	s Factors
None		Vision	/ He	aring	g lin	nitations	;			Use	of Ir	iterp	rete	er .
Limited Reading Abilities		Physic	al b	arrie	rs					Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers					Sim	ple L	.ang	uag	<u> </u>
Congnitive Limitations - unable to		Low m	otiv	ation	/ de	esire to	learı	1		Write	ten l	nstu	ctio	ns
understand and follow directions			_								`		,	•
Completed By : Date Tim	ne	يخ كوم	70		lurs	e Signa	ture	·:_		( P)	Ve	tψ	1	•
N.														
Learning Record				_	_			_						<del></del>
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Disease														Doctor
☐ Information on														1,61
Disease / Diagnostics			א	ીં.	N	•	D	577	0		p	OD	G	W.85.
Treatment			ľ				•				Γ			134
Medications			12	OP)	u		D	07	ט		p	nΩ	ر ۲	Doctor / Nurse
☐ Information on Safe and			٧											
Effective use of medicines						_								JOHN (
Information on drug / drug and														
drug / food interactions	i		R	0	ų		P	<b>500</b>	J	1	$\mathcal{P}$	(10)	レ	
☐ Discharge Medications											,			
Surgical Instructions														Nurse
Pre - Operative Instructions														The same of the sa
Post - Operative Instructions														K 7 0C (
(Wound / Dressing Care)														
Pain Management														Nurse
Reporting of pain	Ì		P	9			P	Ø	ソ					
Pain Management			P	8			P	Ø	7					024
Safe and effective use of medical	ı													Doctor / Nurse
Equipment (if required)														
Name of Equipment														
Rehabilitation Techniques								1						

leed	Date	1	Visit	1	Date	١ ١	Visit 2		Date	١ ١	/isit	3	Signature
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Nutritionel Guidance					_								Dietician
Diet Instruction for patients at Nutritional risk		ր	~	O		-		_	-	_		~~	Varia California Seni
Diet advice for home		_	-	Ħ		2			·				- Nurse <sup>utian</sup>
Discharge Planning								П					
Self care													
Follow up													
Reporting Concerns Immunizations													
Parenting education				П								П	
Others	<del>                                     </del>		t	П				П				П	
Risk Factor Reduction			t	П				Н	_			П	
Smoking Cessation			ĺ	П				П					Doctor
Weight Control	<del>                                     </del>			П				П					
Exercise			ĺ	П				П					
			-	-		_	=						
Hypertension													
Hypertension  Other Risks  EARNER (L) - P-Patient, M - Mother  PROCESS (P)- OD - Oral Discussion,  OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	ion,	W- Wri	itter					(;	Stat	te Relationsh
Hypertension	D- Demo	ons	trati	ion,	W- Wri	itter					(\$	Stat	e Relationsh
Hypertension  Other Risks  LEARNER (L) - P-Patient, M - Mother  PROCESS (P)- OD - Oral Discussion,  OUTCOME (O) - RD - Return Demons	D- Demo	ons	trati	ion,	W- Wri	itter					({	Stat	e Relationsh
Hypertension  Other Risks  LEARNER (L) - P-Patient, M - Mother  PROCESS (P)- OD - Oral Discussion,  OUTCOME (O) - RD - Return Demons  Written Material given and explained  Reports Given :  Given Pendi	D- Demostration, (if any)	ons	Verb	on, paliz	W- Wri	itter	tanc			1	Per		
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#### PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f						plines. U					JR	עו						
Barriers to	Learn	ing								Plan t	o A	ddr	es	s Factors				
None	☐ Vi	sion	/ He	aring	j lin	nitations	i			Use	of Ir	nterp	rete	r				
Limited Reading Abilities	☐ Pi	ıysid	al ba	arrie	rs					Edu	cate	fami	ily					
Religious / Cultural Factors	La La	ngu	age	barri	ers					Sim	ple L	.ang	uag	e				
Congnitive Limitations - unable to	Lo	w m	otiva	ation	/ d	esire to	learr	ı		Written Instuctions								
understand and follow directions											À			_				
Completed By : Date Tim	ie <del>{</del>	تحدي	د	N	lurs	e Signa	ture	·:_		(a)		ley						
Learning Record										•								
Need	D	ate	\	/isit	1	Date	\ \	/isit	2	Date	\	/isit	3	Signature				
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Disease			2	ממ	,	,								Doctor				
☐ Information on			7		٦									. 00				
Disease / Diagnostics				Oh	ļ, .		<b> </b>	00	٧		P	00	ט	1.81.55				
☐ Treatment			7	100	7		De.	00	\ \		р	20	U	134				
Medications			アカ	08)	(	)	「	വ			0	00	J	Doctor Nurse				
☐ Information on Safe and		_			ĺ		Ţ							CARJELY				
Effective use of medicines																		
☐ Information on drug / drug and				ı														
drug / food interactions			رد ا	1 <b>7</b> 2	ט		*	20			D	92	U					
☐ Discharge Medications	ĺ		7				7							_				
Surgical Instructions														Nurse ,				
A Pre - Operative Instructions														A SIM				
Post - Operative Instructions														7				
(Wound / Dressing Care)						•												
Pain Management					Г									Nurse				
Reporting of pain			Ρ	ற	7		P	80	$\checkmark$					S.C.				
Pain Management			٥	00	く		P	<u>0</u>	$\bigcup$					10208				
Safe and effective use of medical	- -				Ť									Doctor / Nurse				
Equipment (if required)							L '											
Name of Equipment																		
Rehabilitation Techniques																		

	Date	١	/isit	1	Date	L١	/isit	2	Date	١ ١	/isit	3	<sup>°</sup> Signature
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Nutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk		l)	نه	p		h	ھہ	٥		᠙	à	Ź	Senior Dietition
Diet advice for home		-				_		E					Nurse
Discharge Planning													
Self care													
Follow up				Щ		_		Щ			<u> </u>	<u> </u>	
Reporting Concerns Immunizations													
Parenting education	_			Г									_
Others													
Risk Factor Reduction													
Smoking Cessation						•			. \	۲,			Doctor
Weight Control													
Exercise													
Hypertension													
Other Risks	,									L			
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Written Material given and explained (			•	_		_			_				
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Reports Given :	· -	- NA							Give	n	Per	ndir	ng NA/
Reports Given :	· -	NA NA			Advice				Give	n	Per	ndit	ng NA / ,
Reports Given :  Given Pending  Discharge Summary	· -	NA	_ [		Advice Scan Re				Give		Per	ndir	ng NA /
Reports Given :  Given Pending Discharge Summary  ECG Report	, -	NA	ر - ر	CT S		рог			Give		Per	ndir	ng NA /
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42/Male/MHI202381576 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





#### PATIENT AND FAMILY EDUCATION RECORD

Assessment To be fi		by cond									JK	را.		
Barriers to	Lea	arning	_							Plan te	<u>о А</u>	ddr	es	s Factors
None		Vision	/ He	aring	g lin	nitations	;			] Use	of In	ıterp	rete	
Limited Reading Abilities		Physic	al b	arrie	rs				卫	Edu	cate	fami	ily	
Religious / Cultural Factors		Langu	age '	barri	iers					] Sim	ple L	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	1 / de	esire to l	learr	1		Writ	ten I	nstu	ıctio	ns
understand and follow directions														
Completed By : DateTim	ie	ď	. ).	<u>N</u>	lurs	e Signa	ture	· <b>:</b>		4	201	niffu	<u> </u>	
Learning Record										•		-		
Need		Date	\ \ \	Visit	1	Date	١	/isit	2	Date	١	/isit	3	Signature
		2/1/2	L	Р	0		L	Р	0		L	Р	0	
Disease													Г	Doctor
Information on														180
Disease / Diagnostics			e l	020	J									1300
Treatment														1392
Medications			0	380	<b>V</b>						П			Doctor / Nurse
Information on Safe and											П			
Effective use of medicines			8	જી	V									Naca
☐ Information on drug / drug and														Day
drug / food interactions								_						<u>'</u>
Discharge Medications														
Surgical Instructions														Nurse
☐ Pre - Operative Instructions														_
Post - Operative Instructions														
(Wound / Dressing Care)						`								
Pain Management														Nurse
Reporting of pain			P	00										Passin
Pain Management			8	5	<b>V</b>									
Safe and effective use of medical	П			302					П				П	Doctor / Nurse
Equipment (if required)						_								
Name of Equipment														
Rehabilitation Techniques	- 1		l '		/									j

Need	Date	١	/isit	1	Date	١	/isit	2	Date	\	/isit	3	Signature
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Nutritional Guidance									_				Dietician
Diet Instruction for patients at Nutritional risk		b	م	9								Ma Si	ia Catherine
Diet advice for home		U	30	ン									Nurse,
Discharge Planning													_
☐ Self care													
Follow up													
Reporting Concerns Immunizations													•
Parenting education													
Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise									<u>-</u>				
Hypertension													
☐ Other Risks					1 2	, ;							
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Reports Given :				_									
Given Pending	g 1	IA							Giver	1	Per	ndin	g NA
Discharge Summary	- 🗸		_ [	Diet	Advice					_			
ECG Report	_Д		_ (	CT S	ican Re	port	ł			_			
Doppler Report		١	_ (	CT S	can Fil	m				_			
X-Ray Report		\_	E	ECH	O Repo	rt							
X-Ray Film		ota	נ	Jitra	sound	Rep	ort			_			
Compact Disk		$ \bot $	_ /	٩ny	Other F	Repo	ort			_			
Name of Attendant / Patient : Name of Discharge Nurse			7		<u> </u>		•		ure :		-		

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Mr.PRASAD SUGUMARAN
42/Malc/MHI202381576
30/12/2023/IPH2023002639
Dr.T.PALANIAPPAN



# Inter Disciplinary Team Rounds (IDTR) Checklist

Data - / - N	Time:	B.12	<del></del>			<u>.</u>	
50 0 7	<del> </del>	\——	r		- Constant		
Checklist	Yes	No	NA	Ac	ction / Remarks		· · · · ·
MEDICAL							
Daily Consultant Visit		ļ <u></u>					
Plan of care discussed	<del>                                     </del>	<b>/</b>	ļ				
Discharge Planning	1/						
Others if any					- <u> </u>		
NURSING	Ļ						
Safety Precautions Ensured						_	_
Care of Lines and Tubes							
Infection Control Measures					<del> </del>		
Skin Care							
Response to assistance							
Others if any					•		
DIETICIAN							
Diet Adequate		1,					
Special Request							
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living							- <del>-</del>
Others if any							
PATIENT CARE SERVICES							
Room Cleaning satisfactory							
Room Amenities Adequate							
Billing Update available							
Non-Availability of any service							
Spiritual Needs (if yes specify)	,					•	
Others if any	1				-	-	
		in	iter Dis	sciplinary Team Members			
	Signatu	re		Name	Reg. / Emp. No.	Date	Time
Doctor	RA	<u></u>		DR. Anusaya	134575	25/124	
Nursing Staff	(V	<b>X</b> Y		A-mondule.	0 (h)	20/12/2	حراها
Dietician	00	~ \ \ \	سينا	Maria Catherine John	2401	30 MM	Bw
Physiotherapist				Salifor Dietitiali	1 -		
Patient Care Service Staff			_				

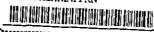
MHI/NUR/2022/188



# Mr.PRASAD SUGUMARAN

42/Male/MHI202381576 30/12/2023/IPH2023002639







#### VITAL MONITORING CHART

¢	Time	Temp (°F)	Pulse (beats/min.)	Resp. (breaths/min.)	BP (mmHg)	SpO₂ (%)	Sign. & Emp. No.
	8.00	97-67	88	<i>Qd</i>	160/100	991.	payi 12
	10.00	98°F	88	22	120/104	981.	pust 2
	12:30	97.2°F	94	ગ્ર	171/106	.1001.	Ports
	14230	986	105	22	170/100	981.	POIN
A Transfer of the State of the	16-20	es b	98	22 /	[62/100	981.	aloin
	10719	97.7	98	22	170/000	484.	opolh!
	22.00	98.4	92	20	160/1024	984-	Haj_
	2.00	92.0	90_	22	170/100	98-1	Hai
1/8	rb. 20	99.4	96	22	170 100	981.	thi
	0-00	98.2°	90	22	160/105	99-1	Joston
					/		
			·				
	Docume	Signa	ture	Name	E	mp. No.	Date
	Endorse Sr. Nurse	d by	Nue	S. Nalini	ox.	284	21,127

MHI/NUR/2022/188



#### Mr.PRASAD SUGUMARAN

| 42/Male/MHI202381576 | 30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN





#### VITAL MONITORING CHART

Į					·		
	Time	Temp (°F)	Pulse (beats/min.)	Resp. (breaths/min.)	BP (mmHg)	SpO <sub>2</sub> (%)	Sign. & Emp. No.
1	20:00	97.8	82	20	160/100	987.	Hay
	22:00	98-6	80	2b	150190	96%	they seen
C,A	2:00	98.5	85	25	160/100	95%	Hay DLES
	6:00	97.8	84	do.	1701700	9-6%	Hay stor
	8,00	78.8	88	20	180/110	97%	F. Coto
	(0.00	97.2	90	20	170 100	94./	f Cato
	18.00	98.2	90	20	140/100	98%	F-Cato
	16 200	98 6	92	20	160/600	984	Alph)
	18/30	98-6	92	. 90	100/80	984	Cop)
	22200	98.6	88	20	180luo	977	Hay olds
	11124	97.8	80	20	170100	95%	Hay
	6)30	98	82	20	180/110	96%	Hay jor
	8-30	98.86	82 b/m	20 b/m	170/100	96 1.	F-Cati
	9.30	98°F	86 b/m	20 b/m	160/90	96%	F. Cotions
					· .		
	r.	Sign	ature	Name		Emp. No.	Date
	Docume Endorse Sr. Nurs	ed by	New	g. Naliñ	,	0024	4/1124



Drug Chart:\_\_

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# Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576 30/12/2023/IPH2023002639 Dr.T.PALANIAPPAN

MHI/PHARM/2022/028



Every heart beat counts

Height (cms): 170cms Weight (kg): 73-3kg

# **MEDICATION ADMINISTRATION RECORD**

		KNOWN MEDICINE AL	LERGIF	ES (if NC	ONE is c	, write NKDA ir					
Drug De	tails		Descrip	ption of A	Allergy		. 4	Docto	Sign:	7	
	N	INDF					: :	Name	e: D1 :-{}[]	instha	
						·		Reg.	No. 1395	<u>নি</u>	
D	OCTO	R INSTRUCTIONS	<u> </u>		NU	RSING S	TAFF INSTRUC	CTIONS	•		
<ol> <li>Write in</li> <li>Sign and</li> <li>No presented</li> </ol>	n BLOCK ind enter l escription	ame when prescribing drug K LETTERS, clearly and legibly MCI registration no. or apply seal a should be altered / overwritten rmat when writing time	2. Nurse 3. For ne follow 4. Standa Q8hrly:	e in-charge ew prescrip / standard lard Timing /: 06:00hrs,	e should ver iption, follov timings gs: Q24hrly: , 14:00hrs, 2	w the timing: /: 10:00hrs, Q 22:00hrs or 0	d omissions art on daily basis s of doctor's presc 212hrly: 10:00hrs, 22 19:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	2:00hrs or 00 21:00hrs, Q6	06:00hrs, 18:00hr 6hrly: 05:00hrs,	nrs,	
	<del></del>	Stat / C	Once O	nly / P	remed	lication		, <u>;</u>	· ·	₹	
Date	Time	Drug		Dose ·	Route	Sign	Reg. No.	Sign.	Administered Emp. No.	d Time	
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Clinical Pharmacist Medway Heart Institute

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Medway Heart Institute

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Clinical Pharmacist Medway Heart Institute

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Clinical Pharmacist Medway Heart Institute

, 1	April 1			_	_						
3 			Date →	To be	filled b	Nurs	ing Sta	iff only.	Sign a	nd time	given
DRUG Dose Dr. Sign Addition Dose Dr. Sign Dose Dr. Sign Dr. Sign Dose Dr. Sign Dr. Sign Dose Dr. Sign	DRUG NAME	s only \	Time <b>♦</b>	3017	3/11/2	9.00	2/1/6 2/1/6	2 12	9,00	897 21m	
	. NEB · LEVO LIN		8.02	<b>G</b> 55X	8 or	888	pof	Bir	E	MA	
	REGULAR PRESCRIPTIONS To be filled in by Doctors only  DRUG NAME  N & L L NO L IN  Dose Route To Sign & Reg. No. / Seal Start Date & Time Stop Date & Time  Additional Info:  DRUG NAME L SIND  Dose Route Stop Date & Time  Additional Info:  DRUG NAME L SIND  Dose Route Stop Date & Time  Additional Info:  DRUG NAME L SIND  Dr. Sign & Reg. No. / Seal Start Date & Time  Additional Info:  DRUG NAME  Trequency Stop Date & Time  Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Trequency Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time	Prequency Q 8 Hry	الهرص	- :	MS	90V	115	15.15	14.0c		
l Pharmacist Heart Institute	Dr. Sign & Reg. No. / Seal	30 12/23 @20		(							
es inca	dditional Info:  RUG NAME  To Sco SPRIN  OSE  Route  Plan  Start Date & Time  20121272  Stop Date & Time  Stop Date & Time  Additional Info:  RUG NAME  K. BIND  OSE  Route  Route  Frequency  Frequency  Frequency  Frequency  Frequency  Frequency		26-00	20:30	ليمول المولا		21/00	1100	91-00 20-18	<b>1</b>	
	DRUG NAME					702	1,0				
st te	Dose Route	Frequency			<b>;</b> -		,				
	Dose Route Frequency  Dr. Sign & Reg. No. / Seal  Classian Start Date & Time  Stop Date & Time  Stop Date & Time  Stop Date & Time  Additional Info:  DRUG NAME  L SIND  Dose Route Frequency		ين,				2, 4 4				
Clinica Aredway		Stop Date & Time	25.00	3030	20%	20	97:10	alino	20 -q(		
٠ <i>١</i>	Additional Info:  DRUG NAME  L 51ND  Dose  Route  Prequency  Dr. Sign & Reg. No. / Seal  Start Date & Time		8.03	17(-)	96	9.00		H-		<del>:</del>	
acist stitute	Dose Route	Frequency		3	Doz	f post		STO	Θ.	-35(j)	
ical Pharm gay Heart In	Dr. Sign & Reg. No. / Seal	Start Date & Time	D. 2	1	24111				Ž		
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`	Additional Info:			1600	Her	<u> </u>					
	DRUG NAME: MINI PRESS XI		3.00		0 8	9.8	2.15	7.15	SHE	15 Jan 19	
art Institu		Frequency	15.15		7		. <b>.</b>			<u>;</u> -į	
rr - '-''- سعط Madway He	Dr. Sign & Reg. No. / Seal	30/12/23@20	(n)	د جاء د خرد			, ( e '.				
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linica! Pham edway Heart I	Dr. Sign & Reg. No. / Seal	26/12/23@20	a) į						\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	<u> </u>	
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Clinical Pharmacist Medway Heart Institute

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		Intravenous		Rate /		Additive Drug	_		Do	ctor	Adn	ninistratio	n
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31/12	8:00	HS. UP Diabetic diel	V.850	134559			<u> </u>			
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2/1	6:00	UR- UF Dr 800m IFR die	C-1.80	13455	7					
3/1	3:0	Bompri ycup Diabeti	POG '	(835)						
4	\$;D	LIS.4F Diabetic dieb-	20)	183873				,		

#### 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	<b>Shift</b>	Name of Nurse	Emp. No.	Initials
	Morning		·	<b>&gt;</b> .	37/18/	Morning	F. Cathrine Mary	0207	£ C
_	Evening				31124	Evening.	Ha Moriha	0141	MD-
20/12/12	Night	Hannah Grace	0105	Hay	3/1/24	Night	Hannah Grace	olos	Hay
31/2/23	Morning	Pavidha	00 Fa	Post	AL &A	Morning	E-lathrine	00907	RON
Llabor	Evening	A-Monisha.	0/41	A	11 2-4	Evening	Monisha	010(1	TOP_
31/12/2	Night	Harrah Grace	OLOS	Hay	تعليا	Night	U- Jideya	0249	Figf
1124	Morning	Pavilha	00 F2	Pass	עלוול	Morning	Paritha	00 f2	Post
1 1/21	Evening	U. Davila	Olh	Bou	, ,,,,,,,	Evening			
1123	Night	PIN BARASAL	0271	Ď.	í	Night			
2/1/23	Morning	As Mongher	2 th	A	<u></u>	Morning			
2 ld 23	Evening	Poriamerwaei	2333	P		Evening			
242	Night	Harrah avace	0603	thy		Night			





#### Mr.PRASAD SUGUMARAN 42/Malc/MHI202381576

30/12/2023/IPH2023002639

Dr.T.PALANIAPPAN



MHI/PHARM/2022/028



Every heart beat counts

177

# **MEDICATION ADMINISTRATION RECORD**

Drug Chart:	of	• • • • • • • • • • • • • • • • • • •		Weight (kg):_ ( 3 3 /3/	
	KNOWN MEDICINE A	LLERGIES (if NONE is confirmed, write	e NKDA IN I	)OX 1)	
Drug Details	• • • • • • • • • • • • • • • • • • • •	Description of Allergy	4.1	Doctofs Sign:	
	•	1		9	1
NKDA			•	Name: Dr. Mlogne	غر م
1000				Bog No 16 Tabo	[
		The section of the section of		Reg. No. 1653/07	

#### **DOCTOR INSTRUCTIONS**

- 1. Use generic name when prescribing drug
- 2. Write in BLOCK LETTERS, clearly and legibly
- 3. Sign and enter MCl registration no. or apply seal
- 4. No prescription should be altered / overwritten
- 5. Use 24-hour format when writing time

#### **NURSING STAFF INSTRUCTIONS**

- 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
- Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, '22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

#### Stat / Once Only / Premedication Drugs

Date	Time	Drug	Bess	Boule		Doctor		Administered	
Date	Time	Drug	Dose	Route	Sign.	Reg. No.	Sign.	Emp. No.	Time
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	DBUG NAME	mA		8.00			9,15	837	- 1/			   <b> </b>
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	Additional Info: Area In-charge				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	. 9/x	.4 -	.N.				
	Nurse Signature	e: 			સ્ત્રુપ	<b>*</b> */	4	200			_	

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Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning		Ì	1 1		1		1	
_	<del></del>					Morning			
	Evening					Morning Evening			
શ્રીહ્ય	Nich	Hannah Grace	0105	Hay					
21124	Nich	Hannah Crave E. Cathrine	0105	Hay E.C		Evening			
3 1/21	Night	F-lathrine				Evening Night			
2/1/24	Night Morning	F. Cathrine Monisha	0207	E'C		Evening Night Morning			
3/1/24	Night Morning Evening	F-lathrine	0207	E.C.		Evening Night Morning Evening			
3 194 1128	Night Morning Evening Night	F. Cathrine Monisha Hannah Grace	0207 0141 0105	Fig.		Night Morning Evening Night			
3 1/20 1/20 1/20 1/24	Night Morning Evening Night Morning	F-Cathrine Hannah Grace F-Cathrine Cothrine	0207	F-C		Evening Night Morning Evening Night Morning			
1120	Night Morning Evening Night Morning Evening	F-Cathrine Hannah Grace F-Cathrine Cothrine	0207 0141 0105 0207 0207	Fic Self		Evening Night Morning Evening Night Morning Evening			
3/1/20	Night Morning Evening Night Morning Evening Night	F. Cathrine Monisha Hannah avace F. Cathrine L. Sugha	0207 0141 0105 0207 0231	Fic Self		Evening Night Morning Evening Night Morning Evening Night			0)

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