

MRD CHECKLIST

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





Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

Patient Details (Affix Label here) N MIS.RAJAMMAL C

73/Female/MHM66291

30/12/2023/грн2023002638

[Dr.K.JAISHANKAR





ery heart beat counts

ADMISSION SLIP

Admitting Doctor: $\int_{\mathcal{O}}$.	Jaishankar.	Speciality:	cology
Advised Date & Time: 30 -	12-23 @ 12.05		71
Provisional Diagnosis:			
CAD ACS	- Homm L+LWMI (WORZ	DANK / THEN / SCA	?ý
	•		
Reason for Admission:	Medical Management	Surgical Management	
	Others (please specify details	CAGEPCI.	·
Admission Type:	Day Care ER		
j		(Specify details)	
Surgery / Procedure Name ((if planned):		
Blood Product Requirement	: No Yes (Kindly specify	details of components required in	space below)
	T \$ 5110		
Expected Duration of Stay:		· 	
Expected Cost of Treatment	(as per Financial Counseling Forn	n):	
Payer: Self Insurance	e 🗌 Others:		
<u>. </u>		·	
Instructions to Nurse (if any)):	•	
,	ADMIT INICUI		
			•
Amu akhan laga-saki (ff			
Any other Instructions (if an	y);		
			•
Doctor's Signature	Name	Reg. No.	Date Time
All John	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	20/12/29 2.05
VI VIM			18011- 11.

For admission desk staff o	nly:		
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		•
Admission intimation	Receipt Details	Admission Ti	me in HIS
Date	Time	Date	Time
20/12/23	12:5	30/12/23	12:5
To be filled only if Blood	OPD ER Direct requirement specified by the	e Doctor: pleted as advised:	No
Front office Staff Signature	Name Partlibarta	Emp. No.	Date Time 12:5



(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



MHI/HOSP/2022/129

ADMISSION FORM

Marital Statu		ress.	Parkainer	an Nagar,		Telephone Number
Occupation CA	Periya	akuladi R	oad, Thiru	ivenkadu, Chennai		9688865785
Referred from	Mr Jaislan	Date of Time	ofAdmission	Date & Time of Discha	arge Tota	al No. of Days
Medway.	West racgoppain.	7 30/12	12:05	211124	4	days
TINIT	xolog1	MLC	☐ Yes	No If Yes	AR No. :	_
		FIN	IAL DIAGNO	SIS		ICD Code
CAD	- Acs-	(WM)				725.2
THEO	MBOLY SE	D WIT	H TNK	- Cloam, 30.12	.2023)	T45.6
				-451., SYST		<u> </u>
<u> </u>	ERTENSIC	N, ? W	PD, P	ESOLVING HA	EMATOMA	I10
OVER	FOREHE	ADR	LEFT 1	EYEBROW.		S00.8
DATE		0	PERATION /	PROCEDURES		ICPM Code
2/124	CORO	NARY 1	4NG10G1	RAM		88 <i>-</i> 50
DATE			TYPE OF AI	NESTHESIA		
2/1/24	☐ GENERA	L/: □	SPINAL		REGIONAL	☐ EPIDURAL
			DISC	CHARGE STATUS		
Cured	_	☐ Disc	harge at Requ	uest	 D E	expired < 48 hours
☐ Improve	d	☐ Agai ☐ Abso	nst Medical A	Advice		xpired > 48 hours
☐ Unchan	ged	_			. 🗆 Р	ost-Operative Death
dun	1				IN ISS	D _G
Signature	of the Consul	tant			Signature of Med	ical Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

AUTHORISATION FOR TREATMENT I PATMENT
I hereby authorise the Administration, Medical and Nursing and Paramedical, Staff of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient
I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.
However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.
I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.
I have read out and explained the contents of the above to the Signatory in his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்
இதன் மூலமாக நான் நீர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி . இது இது இது இதன் மருந்துகள் கொடுத்து 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 சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.
மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.
நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.
18M
செவிலியர் கையொப்பம் தேதி எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse Date 30/12/2023. Signature of the Patient / Relative / Gurdian

உறவுமுறை : Gjandson.

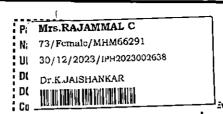
Nature of Relationship



discharge.









GENERAL CONSENT FOR ADMISSION

١, ـ	Rajammalthe Patient or Representative of patient have
••_	please tick the correct option above and below) ☐ Read
	Been explained this consent form in English, which I fully understand.
•	I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
•	I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor/team.
•	l also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor/ team.
•	I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
•	I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
•	I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
•	I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
•	I declare that I have been explained about my rights and responsibilities.
•	I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
•	I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.

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

- 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		Rajammal Chinnasamy	30/12/2023	12:76
Surrogate/Guardian (if applicable #)	Halley.	Ramasamy Nuvugan (Write name and relationship with patient)	30 12 2023	12:075
Reason for surrogate consent	Patient is unable to give consent	because:		
Witness	1949:	Dri Ramadwiai Nuvugan.	30/12/2023	12:05
Interpreter (if applicable)				

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



Mrs.RAJAMMAL C
73/Fcmalc/MHM66291
30/12/2023/IPH2023002638
Dr.K.JAISHANKAR



ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

<u> </u>	ADMISSION CRITERIA FOR INTENSIVE CARE UNIT		
S. No.	PARAMEYERS	MARK APPROP	
Ì	Hemod_n incinstability defined as	Ì	
	Pulse less than 40 or more than 150 beats/minute		
	Systom arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure		
1	Mean arterial pressure less than 60 mm Hg	ĺ	
	Diastolic arterial pressure more than 120 mm Hg		
f i	Respiratory rate more than 35 breaths/minute	<u> </u>	
	Cardio-vascular System		
	Acute myel andial infarction in	. V :	
lt 	Cardiog in shock		
.	Complex air rythmias requiring close monitoring and intervention		
ŀ	Acute congestive neart failure with respiratory failure and / or requiring hemodynamic support		
2	Hypertansive emergencies		
F	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain	1	
1	Post cardiau arrest		
ļ	Carolac lamponade or constriction with hemodynamic instability		
	Dissecting Fortic aneurysms		
) !	Complete fort block	·	
			
	Miscellansous Conditions		
3	Septic sheek with hemodynamic instability		
3	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care	,	
<u></u>	Post procedure elective admission		
4	Post Colon by Angioplasty		
, T	Post Ceral Jascular Surgery	-	
<u> </u>			
	Following anglographic procedure		
	Complication resulting from the angiographic procedure including any significant change in pulse in the	i .	
	, affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-	•	
5	procedure	 .	
ļ	Significant Indings on diagnostic angiography warranting further therapy that would necessitate inpatient	!	
1	acmission is also a reasonable indication for admission		
	Admission of the time of the study is encouraged if problems are suspected or arise		
	Pulmonary System	,	
	Figure 1997 (Invasive / Non-Invasive)		
1	Pulmonary emboli with hemodynamic instability		
	Postents in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory		
6	determination	,	
ļ.	Moed for hersing / respiratory care not available in such intermediate care units		
<u> </u>	hasea romemaphysis		
	Respiratory falure needing imminent intubation		
			
	Ronal (adors	ı	
7	Oligur and mafor more than 12 hours	·	
	Metaltolic audicais (pH < 7.1)		
	Patterns requiring hemodialysis can be performed in ICU when the blood pressure is borderline	<u>.</u>	

S. No.		· •	RK ✓ AS ROPRIATE			
8	Endocrine System and Metabolism related Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis Thyroid storm or myxedema coma with hemodynamic instability Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl Other endocrine problems such as adrenal crises with hemodynamic instability Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring hemodynamic monitoring Hype or hypernatromia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered manual status					
****	Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias Hypo or hyperkallemia (Serum Potassium less than 2.0 mEq/L or more than 6.0 mEq/L) with dysrhythmias or inuscular weakness Hypophosphatemia with muscular weakness					
Do	ctor	Signature	Name Dr. Anish Nelson Reg. No: 88434	Reg. No. Dr. Anish Nelson Reg. No: 88434	Date 20/12/23	11me

DISCHARGE CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK ✓ AS APPROPRIATE
1	Stable hemodynamic parameters	
2	Stable respiratory status (Pt. extubated with stable arterial blood gases) & airway patent	ļ.
3	Minimal oxygen requirement (not more than 3 L by nasal prongs)	
4	Intravenous / Inotropic / Vasopressor support and vasodilators are no longer necessary	
5	C: rdiac dysrhythmias are controlled	
6	Presence of distal pulses	
7	No signs of blooding and hematoma at puricture site	
. 8	End of life care pathway chosen	

	Signature	Name	Reg. No.	D₃te	Time
Doctor	(W	Or. 4. Ahilan	94200	3.1.42)	17:00







DISCHARGE SUMMARY

IP No.

IPH2023002638

D.O.A

: 30/12/2023

UHID

MHM66291

D.O.P

: 02/01/2024

Name

Mrs. RAJAMMAL, C

Room No. : 209

Age / Gender

73 Years / FEMALE

Consultant

: Dr.JAISHANKAR.K MD., DM., FIAMS

D.O.D

: 02/01/2024

Director and Clinical Lead

Cardiology and Electrophysiology

DIAGNOSIS:

CAD – ACS – IWMI

THROMBOLYSED WITH TNK (10 AM, 30.12.2023)

MILD LV DYSFUNCTION. EF – 45%

SYSTEMIC HYPERTENSION

? COPD

RESOLVING HAEMATOMA OVER FOREHEAD & LEFT EYEBROW

PROCEDURE:

CORONARY ANGIOGRAM DONE ON 02.01.2024 – TRIPLE VESSEL DISEASE.

BRIEF HISTORY:

Mrs. Rajammal. C 73 years / Female, presented with the complaints of chest pain radiating to jaw & left shoulder – 30.12.2023 morning for 2 hour. She initially went to medway hospital (Mogappair) received in ER, ECG showed ST elevation in V5-V6 leads & suggestive of IWMI and thrombolysed with Inj. TNK 40mg IV. She was stabilized and conservatively managed. Then she was shifted to medway heart institute on 30.12.2023 for further evaluation and management.

H/o fall with injury to forehead

No H/O cough, vomiting, diarrhea.

Known case of systemic hypertension on medication.

N/K/C/O Type II Diabetes Mellitus, bronchial asthma, dyslipidemia and Seizure disorder

ON EXAMINATION:

Patient Conscious, Oriented, Febrile

HR

59bpm

BP

170/91 mmHg

SPO₂

99%

SIS2 (+)

#931st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959

AbdelinenHospitals **CNS**

Of the Byayhospitals

[@medway-hospitals

@medwayhospitals

94557 94557 1800 572 3003

Medway Centre of Excellence (Chennai)

Kodambakkam

Mogappair

Chengalpattu

Villunuram

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

Kakinada

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

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

Medway Group of Hospitals



UHID: MHM66291



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

INVESTIGATIONS: BLOOD (30.12.2023):

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	12.4	Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
UREA	39	14 - 40	mg/dl
CREATININE	0.80	Male: 0.7 - 1.2	mg/dI
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
SODIUM	139	135 - 150	Meq/l
POTASSIUM	4.98	3.5 - 5.0	Meq/l

139	133 - 130	Meq/1
4.98	3.5 - 5.0	Meq/l
10970	4000 - 10000	Cells/ Cumm
161000	Male - 1.5 - 3.5	Lakhs/Cumm
	Female $-1.5 - 3.7$	
95.0	<25	U/L
425	Male: 20-200	U/L
	Female: 20-180	
0.8	0.9 – 1.3	Secs
958.8	< 19 negative	Ng/l
	4.98 10970 161000 95.0 425	4.98 3.5 - 5.0 10970 4000 - 10000 161000 Male - 1.5 - 3.5 Female - 1.5 - 3.7 95.0 <25

ECG: sinus rhythm @ 69 bpm, T inversion in V4-V6 leads.

CXR: No cardiomegaly, BVM (+).

SCREENING ECHO (30.12.2023): Hypokinesia of basal & mid. Anterior wall / inferior lateral. Inferior wall & apical sateral. Mild LV systolic dysfunction. EF – 45%. Grade I LV diastolic dysfunction. Mild MR. AV sclerosis, Mid AR. Mild TR / PAH. No PE / clot. Normal RV function.

CT brain (30.12.2023): Age related cerebral atrophy with small vessel ischemic changes. No evidence of acute intra / extra – axial hemorrhage at pressent study. Extracalvarial soft tissue hematoma in left pre frontal, periodical region. Small hypodense lesion with peripheral calcific rim in right cerebellar hemisphere - likely calcifc granuloma.

COURSE IN THE HOSPITAL:

Mogappair

Mrs. Rajammal. C, 73 years / Female, admitted with above mentioned complaints. Basic investigation were done. Cardiac enzymes were elevated. She was diagnosed as ACS- CAD - IWMI and advised for coronary angiogram. After obtaining consent, she underwent Coronary Angiogram on 29.11.2023 by right radial artery approach which revealed CAD - TRIPLE VESSEL DISEASE and advised for CABG vs Multi vessel PCI. Her medications are optimized and she is being discharged in a stable clinical condition.

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

Villupuram

■ @MedwayHospitals

Kodambakkam

(O) @medwayhospitals

Chengalpattu

In @medway-hospitals

Kumbakonam

medwayhospitals

Kakinada

0884-2333367



Medway Centre of Excellence (Chennai)

Medway Group of Hospitals

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

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

MHI/HOSP/2022/118



UHID: MHM66291



Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS

15/15

Temp PR

98.6°F

BP

134/88mmHg

80/min

SPO₂

95% in room air

ADVICE MEDICATIONS:

SI.	NAME OF THE DRUGS WITH	DOSAGE	FREQUENCY		ROUTE	RELATION	DURATION	
NO	GENERIC NAME		M	A	N		SHIP WITH MEAL	
1.	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. CLOPILET (CLOPIDOGREL)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. ATORVA (ATORVASTATIN)	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	I	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. AMLONG (AMLODIPINE)	2.5 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. LASIX (FUROSEMIDE)	40 MG	1/2	0	0	ORAL	AFTER FOOD	TO CONTINUE
.8.	TAB. ALDACTONE (SPIRONOLACTONE)	25 MG	1	0	0	ORAL,	AFTER FOOD	TO CONTINUE
9.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	0	ORAL	BEFORE FOO	TO CONTINUE
10.	TAB. ALPRAX (ALPRAZOLAM)	0.25 MG	0	0	1	ORAL	AFTER FOOD	X 2 WEEKS
11.	SYP. CREMAFFIN	15 ML	0	0	1	ORAL	AFTER FOOD	X 1 WEEK

DISCHARGE AL	OVICE: COLD COMPRESS FOR LEFT EYEBROW HEMATOMA
DIET	LOW FAT & SALT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES
REVIEW	REVIEW WITH DR. JAISHANKAR.K AFTER 2 WEEKS.

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

Mogappair

"I understood the Content of the K. JAISHANKAR discharge summary."

Reg. No: 49448

CONSULTANT SIGNATURE

Medway Centre of Excellence (Chennai)

Dr. Jaishankar. K MD., DM., FIAMS

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 431013959 - and indinical

f @MedwayHospitals
Typed by: Ezhilarasi

Kodambakkam

044-2473 4455

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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



INPATIENT INITIAL ASSESSMENT

Date: 30/12/23	Time of arrival in ward: Cou @ (2.01							
Allergies (if Yes, specify d	etails):							
Drugs □ Yes	s 🖵 No							
Blood Transfusion	s 🖵 No							
Food ☐ Yes	s 🗖 No							
Others								
	(°F) Pulse / HR: <u>59</u> (beats/min) BP: 「中(句) s/min) SpO₂: <u>句句 (</u> %) Height: <u>147 (</u> cms) Weight: <u>59기</u> (kgs) BMI: <u>29・3</u> を かっ							
Pain: Yes No. If Yes, Score: O 10 Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location:								
Pain Character: Dull	Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain							
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS								
Cuns a	FOR FINE MOMINING (212MB) - SJO LWMI - USURO E MI IN MIROURS MOCKROMR							
<u> </u>								
PAST MEDICAL HISTOR	Y (with duration of illness):							
Diabetes Mellitus: ☐ Yes↓	1							
Others:								
G.15.5.								
·								
5 10 11 11 11 11								
Past Surgical History:								
	<u> </u>							

Investigations Ac	lvised:				-			
EUN- E	TF -45'1.					1		
Crant Pa	ril							
. Comoi	TZ CWYZMIUS							
US	to - Brinn							
	, 							
Diet Advice:			-	-				
☐ Nil per Oral	Clear liquid diet	Normal liquid	d diet	☐ Diabetic I	iquid diet	į		
Semisolid diet	Soft solid diet	South Indian	normal diet	☐ North Ind	ian normal d	iet		
Neutropenic liquid diet Others:								
Early Discharge Planning (fill in those which are appropriate at this stage): PFE: Patient Family Education								
Special support need	☐ Yes ☑ Ño	If Yes, PFE	E done					
Home equipment ant	☐ Yes ☐ No	If Yes, PFE	If Yes, PFE done and equipment advised					
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 need	S	Yes □ No	If Yes, educated on dietary restrictions, food drug interactions and allergies					
Continuous / ongoino	g care anticipated	☑ Yes □ No		If Yes, educated on various aspects of ongoing care required				
Other special educat	ion need, i.e.:	Ŭ Yes □ No	If Yes, PFE	If Yes, PFE done				
Nature of post hospit infection control, fall	al needs like patient safety, risk, etc, addressed	Yes 🗆 No	If Yes, specific education given					
Others:	- 13 & (s							
	NPO G 6:200	n pomour	N					
	Signature	Name		Reg. No.	Date	Time		
Resident Doctor	Aus	Anish Melson 99. No: 88434		Dr. Anish Nelso Reg. No: 88434	30/02/27	12-10		
Consultant	& Aurs	DIL OTTIMON	m	49446	30/2/77	12/10		
Patient Attendant	**************************************	Relationship			30 1617	12-10		

Ramadurai Neurugan.



Mis.RAJAMMAL C
73/Fcmalc/MHM66291
30/12/2023/IPH2023002638
Dr.K.JAISHANKAR



CONSENT FORM FOR CRITICAL CARE (ICU)

I, MRS PATANNAL . C the Patient or Representative of patient have (please tick the correct option above and below):
Read
I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my patient's illness and I am aware of the all the possible outcomes.
Been explained this consent form in English / Thill, which I fully understand and understood the information provided about ICU Treatment
I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures
needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like
Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

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

Intended benefits:

Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:

Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.

The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windcipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:

The procedure might be needed for you/your patient for any of the following reasons:

- to open airways so that patient can receive anaesthesia, medication, or oxygen
- · to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
- · when patient needs help to breathe
- · when patient has a head injury and cannot breathe on his/her own
- when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:

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

Possible alternatives:

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	Rajammal.	lagamon AL	3017)3	15.15
Surrogate/Guardian (if applicable #)	Mag.	Runneduria Musivyan Gnandson. (Write name and relationship with patient)	30/12/22	19-15
Reason for surrogate consent	Patient is unable to give consent because:		•	
Witness	Nac	e-Nalini	30/12123	12:15
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time
Doctor	And	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	20/12/20	12.15



	Patient Details	(Affix Label here)
	Name:	
	UHID:	
1	DOB:	Sex:
į	DOA:	
	Consultant:	•



உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

		என்ற	பெயர் செ	என்ட	🗆 நோ	ாயாளியா	ன அல்	லது 🕻	் நோயாளியின்	பிரதிநிதி	யான		
	நான்,	இந்த	ஒத்திசை	பு பழவ	த்தை	(மேலே	மற்றும்	£Сф	உள்ளவற்றில்	சரியான	விருப்பத்தேர்வை	தயவுசெய்து	ழக்
செய்க)	•							_	• • •	•	- , .		

🗆 வாசித்திருக்கிறேன்

🗆 சிகிச்சையவிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்மாக்கிரேன்.

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

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

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

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

அடைய திட்டமிடப்படும் பலன்கள்:

மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: பறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

முச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

முக்கப் பெருங்குழ்லுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக கவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை மூச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் மூச்சுத்தின்றல் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவ, உங்களது / உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழுருப் என்றும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழுருப் என்றும் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய், குரல்வலைக்கு சற்றுகிறு தொடங்குதிறது மற்றும் மார்பு ஒலும்பிறது பின்னே வரை அது நீள்கிறது. அதன்பிறகு மூச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பீரதான மூக்கு மிறகு நடிய காற்றும் பாதைகளாக தொடர்ந்து பிரிகின்றன. மூச்சுக்குழாய் என்பது, கடின்மான தருத்ததல்பபு, தரை மற்றும் இணைக்குப்பட்டிருக்கிறது. இந்த மூச்சு சிறுகுழாய், அதன்பிறக உருவானது. இதன் அகவிறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நிக்கள் / உங்களது நோயானி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீனமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சுப்பாறையில் விடும்போது அதன் முந்தைய தனர்வான நிலைக்கு அது திருப்புகிறது. மூச்சுப்பாறையில் வந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடைபட்டிருக்குமானால் உங்களால் களாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் காற்றப்பாதையை அடைட்டிரனித்த தொக்கதிறது. நீங்கள் சுவரிக்கும்போது உங்களது நுறையில் தைக்கிறது. நீங்கள் சுவரியமாக இருக்கக்கும். இந்த செயல்முறை உங்களது முங்க தடிக்குறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கடும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

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

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பீற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயானி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிபட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதும் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் அனைத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் சிக்கல்கள் மற்றும் சிக்கல்கள் மற்றும் சிக்கல்கள் மற்றும் தன்மைகள் மற்றும் சாத்தியமுள்ள

இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான / நோயாளியின் பீரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிற மறந்து கூறிப்படுக்கிற அச்சம், அச்சுறுத்தல் அல்லது தவநான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு

	கையொப்பம் / கட்டைவிரல் ரேகை*	Gt.ru.if	தேதி	நேரம்
நோபாளி				
பதிலாள் / பாதுகாவலர்				
(பொருந்துமானால் [#])		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை]
		என்பதை எழுதவும்)		1
	நோபாளியால் ஒப்புதல் வழங்க இயலவில்கை	හ; ඉ ශ ශශ්ණ:		
பதிலாள் ஓப்புதல்				
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(பொருந்துமானால்)		J	1	- }

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

கழே, கையொப்பமிட்டுள்ள மருத்துவராகிய நான். திட்டமிடப்பட்ட ஆபரேஷன் / நடைமுறை குறித்த தன்மை, ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள், கிடைக்கும்என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பீன் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அவர், இந்த ஆவணத்தில் விளரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுகியாக நம்புகிளேன்.

	கையொப்பம்	Quuij	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					



Medway Hospitals

The way to better health

HISTORY & PHYSICAL EXAMINATION FORM Patient's Nam 73/Female/MHM66291 I.P. No. 30/12/2023/1PH2023002638 Ward: Tw Age Room No. : Dr.K.JAISHANKAR Consultant Dr. (Gen Phy) D.O.PR : 30/12/2023 Temp: 98-2- F Pulse: 696pm Resp: 21/min B/P: 1601100 Height: Weight > Current Medications : 10 7241F, WILLO S. HTN - Not on any Rx now complaints History of Present illness Co Mild breating difficulty & Past history of relevance for further evo Clinical Examination OL: GCS EUVS M6 15(13 Hydrotton - Fair

	51E;
	RS_BILAGO
	PA SOFT BS @
	CN2 - No FND
Investigation required	CBC MATILET HEARL TropT&I)
	CUMB / NT. PSO BNP
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Diagnosis	A J AWTE LATERAL WALL ME
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	2 Lyse using Inj Tenerteplase
Plan of Care	3 Ingo as per chart
	4 Monter Lutals O may
	5 Hw Sos
	6 Cordiologest opinion
	· · · · · · · · · · · · · · · · · · ·
	Signature Signature
Date: 3011212023	· · · · · · · · · · · · · · · · · · ·

Medway Hospitals The way to better health

(R) Mrs. Rajammal 1341/4291 20202638

DOCTOR'S PROGRESS NOTES NOTES DATE ECB & Sinus Brodycardio CIDIN DR SALA SUDAN (CARDIOLOGY) SWAMMAR CAG

Shift to MEDWAY HEART

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	MEDWAY HEART RUSDING.
	Partent Attendant Dr. MANIBATHWANT N.G
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Jale -	³ 20/12/2023.
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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





30/12/2022 Date:

8.30Pm Time:

ICU PROGRESS NOTES

Doctor's Name: Dr. Abishek

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate) SOFA score: MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day (D) and CAb | ACS | Background Enferolateral ware MI | SIP TNK LUMS (today) | SHTN COPD

Issues last 24 hours Throughout i

Central nervous system

Conscious / oriented / sedated with

Sedation score

My Pupils Bh PERL GCS - E,V,M

Drains Pain score

Cardiovaşcular system

HR - 70/mm Rhythm - Now Cardiac Output -

BP - 133 Hany CVP -Cardiac Medications:

Respiratory system

Oxygen supplementation - 967. on PA

Saturation / PaO2-

Ventilator : Spontaneous / Controlled

GIT P/A

Bowels - Y/N Loose stools / Melena

Drains

NG tube: Y/N

Day NGA-

USG

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

Last C x R - Au - B/L NV Bs Drains -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Others

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1. Perimulin

2.

Folev's Xes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

30112123 Labs

Hb-12.4 TC -107go Platelets - 1. 61 Lakh.

Urea - 39 Creatinine - 0.80

Na → 13a K -> 4.98

Bilirubin

INR + 10.4/0.8

DVT prophylaxis - Y/N

Drugs:

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis – Y/N

Drugs

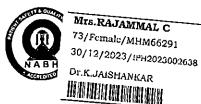
Pressure sore Y / N

Alpha bed Y / N

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Plan fo	the day				
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	to colur Chust) to do ABG Q12H	onung			
5) to	for fore	nem Swelling La Drone Cas.			
			3		
Doctor	Signature	Name Dr. Abishek	Reg. No.	Date 30 12 Vs	Time &-30pm







MHI/IP/2022/041 Medway eart stitute

(A Unit of United Alliance Healthcare Pvt Ltd)			eat counts
	DOCTOR'S PROG	GRESS NOTES	
DATE		NOTES	
	Mrs. Rayammal.		
30/12/22	-72/F	rr-Jaishankar team.	
12900	· 		
	CAP/ACS/	Inferolateral wall MI Tysed T	IVK (10 Am rodow)
	MOD SATI	1 ? COPD .	
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ELL (1=40 km).		O/E: Comeion, ensembled	
a Vh		afemil.	
-17NP-P	_	PR-60/m, BP-160/	96.
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of Parala	γάQ 	CM: 5,4, (4)	
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ALLE Oxical carbon	D	no cripti	
Evila W	35mm	Forehead Evelly 1	
Ct is pum, Mil) S - Lower Paragraph (S)	Minor gum blad (7)	Adv
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-No peldot	(2) Par facen	Brow -T. Alproso (7
	- 80	- Syp. Chemathin	
	100 from 7AM	man _T-Ambing 2-8	ing 100
- P1	on CAC formanow .	-Trepack for e	welly







Medway Heart nstitute

MHI/IP/2022/041

Dr.K.JAISHANKAR

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	DOCTOR'S PROGRESS NUIES
DATE	NOTES
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MIS.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638 Dr.K.JAISHANKAR



Date: 3/12/23

Time: 9.00 **ICU PROGRESS NOTES**

Doctor's Name: D2 KARH HICK 217.

ICU SCORES (as Appropriate) CLIF ACLF / AD score:

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day Background CAPLACS/ THOM.

cysed TTNK.

Issues last 24 hours

Herrobone (2) eyelgh.

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS-E V M Pain score

ソ/ሪ Pupils

Cardiovascular system

HR - 79

Rhythm : Cardiac Output -

BP - 130(40 CVP -Cardiac Medications:

Respiratory system

Oxygen supplementation -

Saturation / PaO2-

Ventilator: Spontaneous / Controlled

Last C x R -

Drains -

GIT

P/A

Bowels (N) Loose stools / Melena

Drains

NG tube: Y/N

NGA-Day

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

24 hour Urine output

Creatinine clearance

Supplements

Fluid balance

Calories / Proteins achieved

BARD

Spr: 98%.

Microbiology

Invasive lines

pepplaeral bis.

1.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

Acidosis

IV fluids -

Lactate

RRT - SLED / IHD / CRRT

Labs

Hb

TC

Platelets

ALT

DVT prophylaxis -/(y)N Drugs:

Mechanical - TEDS / SCD

Urea

Creatinine

Na

Bilirubin

AST

Stress Ulcer Prophylaxis - N

Drugs

Pressure sore \

Alpha bed Y /

INR

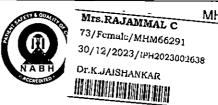
Others

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Doctor	Signature	Name Dr Murthm	Reg. No. 9417	Date	Time

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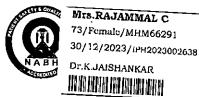
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DATE	NOTES	Ĭ ,
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11/29	S/B Dr. Moliamed Hydron	
108m	Plan: CAG Pomorrow	
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MHI/IP/2022/041 Medway eart stitute

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ieat counts

DOCTOR'S PROGRESS NOTES DATE NOTES 2/B. Dr. Sijith. B. (DND) D-2800 A. reviewed CAG (CAG NO. 2510) 2/1/24 - Pt radial aceus - 6F Sheath - SF TIA -> CAG done LMCA - (P). Boluncates into LAD & LES LAD - Type 3 versel. From LAD has 90% tubular stemperte Mid cop has haid ingularities. Distal cap how so-60% tubulum stenerst. Come 3 diagonals & many septale. Dis major versal, as troposational 90%. LCX - Non dominant. Prox. LCA 93 estatic à lumal imagalarites. LCx often on, has 90% tubular stenon's followed by 70% hibularstante Gue 5 om's. OM32 one are major versels. Omz proximal pent choice total occlurion. Ome growinal pent slows 50% hiberton stengte. RCA - Donnamt. Prox . 2 and RCA have limed thregular Mes. Destal Rep has 50 to 60% discrete steveric . PDA moxtmal pout has 70% tubulers Pu distrol point how diffuse discourse Bup - Rt dominant Triple versel disease Adv: CABG Ve Multiversel PCI

d/c today - Persero afra 2 weeks





Mrs.RAJAMMAL C

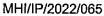
73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR **MICROBIOLOGY SHEET URINE ROUTINE ANALYSIS**

DATE	30/12/23	
COLOUR	VELLOVE	
REACTION	-	
SPECIFIC GRAVITY	1.010	
APPEARANCE	SLIGHTLY TURBED	
ALBUMIN	, , ,	
SUGAR	_	
ACETONE	+	
BILE SALT	-	
BILE PIGMENT		
UROBILINOGEN	NORMAL	_
PUS CELLS	6-8	
EPITHELIAL CELLS	2-4	
RBC	4-6	
CASTS	W/L	
CRYSTALS	· NIL	
OTHERS	NIL	
		 ,

MICROBIOLOGY-CULTURE REPORTS

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









Every heart beat counts

Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/PH2023002638

Dr.K.JAISHANKAR

DIABETIC CHART

ACTUAL WEIGH	T.	59·1	HbA₁c	<u> </u>		
PREVIOUS DIAE	BETIC MEDIC	ATIONS		_		
DATE T	IME	BLOOD	SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
20/12/23 12:	.5	10 m	glob		Dov	DR. ANIEBHI
20/12/23 12:	30 lo	12 mgb	()	_	Dong Row	DR. ANIEBHI
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			<u> </u>		<u> </u>	
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		INOTE	NICTIONS F	OD INCILI IN INCIL	NONE	

INSTRUCTIONS FOR INSULIN INFUSIONS

*	Mix 40u short acting Insulin in 40 ml. of	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	normal Saline (IU - 1 ml.) Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
	according to the lone wing agentum.	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

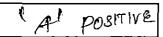
MIS.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



BLOOD GROUP



INVESTIGATION SHEET

		٠.				
Date	30/12/25	010124				
HAEMATOLOGY		7				
Hb	12.4					
P.C.V	/				. —	
Platelets	161000	_	_			
TLC	10970					
Polymorphs	84.4					
Lymphocytes	11. 4			-		
Eosinophils	0.6					
Mono / Basophils	3.3 0.3				-	
E.S.R						
BIO-CHEMISTRY						
Urea	39	31				
Creatinine	0.80	6.90		 		
Sodium	139	137			-	
Potassium	1.98	3. Ro.				
Bicarbonate	24	26		-		
Chloride	1.98 24 99.5	96.0				
Magnesium		100				
Calcium						
Phosphorus	•	-		† - -		
LFT						
T.Bilirubin						
D.Bilirubin		-				
I.Bilirubin						· · · ·
S.G.O.T		-		1		
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I	958.8.					
CKNAC - CPK	425					
CK - M.B. MASS	95.0	_				
LDH	-					
Ntpro bnp						<u>-</u>
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Date	90 (262 PAS- 10.4 INC-0.3					1
COAGULATION	- 10·4					- ,
PT / INR	TNP 12.1					,
Fibrinogen	17.0-0-0	 				
D Dimer		 				
LIPID PROFILE				-		
			_			-
Total Cholesterol	-		-	-		
Triglyceride						
H.D.L		<u> </u>				
L.D.L						
VLDV						
THYROID FUNCTION						
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SEROLORY HV	2			-		
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S.Osmolality						-
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Medway Hospitals®
The way to better health

MIS.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



VITAL INFORMATION SHEET

Every heart beat counts

BLOOD GROUP ON ADMISSION Height in CM Weight in Kg. 59.1 147

Diagnosis:	Cı	A:D	, 1		A (<u> </u>	<u>.</u> 3 /	Λ,	1/	1/	ク	1	/		2 j	15	ßĖ	= <u>f</u> _	>	ح	: 7	- W	Pro	gcı	edı	ure	:																				1	4	ſ							5	9	•	1			
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73/Female/MHM66291 30/12/2023/IPH2023002638



Every heart beat counts

G CHART

EARLY WARNING! Dr.K.JAISHANKAR

Patient Id No: Name: Dally plan NEW5 key DATE DATE 0 1 2. 3 02.00 6.00 TIME TIME >25 >25 Respirations 21-24 21-24 Breath/ min 18-20 18-20 15-17 15-17 12-14 12-14 9-11 9-11 <8 <8 A+B >95 SPo2 Scale 1 94-95 94-95 Oxygen Saturation (%) 97-93 92-93 <91 <91 Spo2 scale 2 oxygen >96 on oxygen >96 on axvæen saturation (%) use scale 2 If target range is 88-92 % eg: in hypercapnic respiratory failure only 95-96 on o2 95-95 on o2 use scale 2 under the 93-94 on O2 93-94 on O2 direction of qualified >93 on air >93 on air clinician 88-92 88-92 86-87 85-87 84-85 84-85 <83% <83% Air or Oxygen ? A= Air -6-A= Air 184 O2ktre/ mln O2litre/mln Device Device >220 >270 Blood Pressure 201-219 201-219 181-200 181-200 161-180 161-180 141-160 141-160 121-140 121-140 111-120 111-120 91-100 91-100 81-90 81-90 71-80 71-80 61-70 61-70 51-60 51-60 <50 <50 10 64 HA 10 190 90 70 30 86 Diastolic BP mmHg mmHg >131 >131 Pulse 121-130 121-130 Beats / min 111-120 111-120 101-110 101-110 91-100 91-100 1 81-90 81-90 71-80 71-80 61-70 61-70 51-60 51-60 41-50 41-50 31-40 31-40 <30 Alert Alert Consciousness Confusion Confusion Score for New onset of confusion | P P (no score if chronic) v U >39.1 degree Celsius >39.1 degree Celsius 38.1-39.0 Temperature 38.1-39.0 37.1-38.0 Degree Celsius 37.1-38.0 35,1-37,0 35.1-37.0 35.1-36.0 35.1-36.0 < 35.0 < 35.0 Note: Nurses are resined to Call Code 39 (100) when they get score of 3 in any single parameter or aggregate score of > 5 NEWS Total Monitoring Frequency Escalation of Care Y/N Initials by RN 1 Initials by Sr. RN

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



MIS.RAJAMMAL C 73/Fernale/MHM66291 30/12/2023/IPH2023002638 Dr.K.JAISHANKAR





Date	Fron	n: <u>す</u>	1 12 2 2 T	<u>o: 1 1 1 </u>	على В	ed No:	205-	<u>`B/</u>				INTA	VE 9		CDLIT
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OUTS						m).			MSOW	<u>C. </u>					
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Time		Tube Feeding	Type of Fluid	Additions	s Amount	ැල්ට	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.Jaishankar







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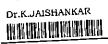






Mrs.RAJAMMAL C 73/Female/MHM66291

73/Female/MHM00251 30/12/2023/IPH2023002638





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INTA	KE	[00m								_					
OUTI	PUT	250 M	J.												
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Oral

1 Yes

- WEEKIY

☐ Dally

Diet counselling provided:

Enteral / Parenteral

Frequency of re-assessment:



Department of Dietetics



Every heart beat counts

Patient Details (Affix Label here) Name: FLR3 - PAJAWWAC MANUES GOSTING

DOBALLE SEX: PENDLE DOA: 30(12/12) NUTRITION ASSESSMENT AND CARE PLAN FORM Consultant: OR . JOE SHAMMAR NL Diagnosis: CAD - AU - MOHL ER-451, 1 HOW ! NOPDI RESOURCE Henrito na Oven Rom Food allergies: Yes/ North yes, specify..... Weight:.....Kgs t esser. (b) ey elmous Religious Beliefs: Vegetarian Non Vegetarian Eggetarian ☐ Jain Diet Prescription:. حجار ستولل fact 160 jauts SUBJECTIVE GLOBAL ASSESSMENT (ADULTS) Patient's related Medical History 1) Weight Change (overall change in past 6 months) D2 **□**3 **D**4 5 - 10% 10 - 15% >15% No weight change/ gain 2) **3** ď □ 5 No change Sub - optimal Full Equid diet/ Hypo - caloric Starvation solid diet moderate liquid diet overall decrease Enteral/ Sub - optimal Adequate / Inadequate Typo - calorio Starvation Parenteral Excessive feeds Gastrointestinal Symptoms Duration: 3) 乙, **—**4 \Box 5 \Box No symptoms Nausea Vomiting / severe anorexia moderate Gi symptoms Functional Capacity (Nutrition related functional impairment) Duration: Z. **D** 2 **3** 0.2 None /improved Difficulty with Difficulty with Light activity Bed / chair or little activity Co - morbidity (Disease and its relationship to nutrition requirements) □ 1 □ 5 □ 2 morbidity morbidity/age morbidity multiple co morbidity Physical examination 1) Decreased fat stores or loss of subcutaneous fat □ 2 □ 3 □ 4 □ 5 Mild Severe Moderate Normal 2) Sign of muscle wasting **□** 5 **□** 2 **□** 3 Normal Mild Moderate Total Score = Sum f above 7 components Nutritional Status : Based on this patient is ☐(7 to 14) Well Nourished Moderately Mainourished ☐ (15 to 18) Severely Malnourished □ (19 to 35) Nutrition intervention:

30/12/2 14:00 Dietitian Signature / Name / Date / Time: Maria Catherine John Senior Dietitian

☐ Fort - night

☐ Parenteral

ı □ Yes

☐ Monthly

C Enteral

□ No

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
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W100	ouret @ ided churt pain = mild beath	Try
	difficulty was arrused to be well	
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Every heart beat counts

Mrs.RAJAMMAL C

73/Female/MHM66291 **Department of Dietetics** 30/12/2023/IPH2023002638 Dr.K.JAISHANKAR NUTRITION ASSESSMENT AND CARE PLAN FORM Diagnosis: ACS-L+LWM Weight:.....Kgs Height:.... Food allergles: Yes/ Norif yes, specify...... Nøn Vegetarian Religious Beliefs: Vegetarian ☐ Eggetarian ☐ Jain Diet Prescription; 600 calones, SUBJECTIVE GLOBAL ASSESSMENT (ADULTS) Patient's related Medical History (A) 1) Weight Change (overall change in past 6 months) **4 D**2 <5% 5 - 10% 10 - 15% No weight change/ >15% gain Ouration: 2) Dietary Intake **□** 5 □ 3 No change Full liquid diet/ Hypo - caloric solid diet moderate liquid diet overall decrease Sub - optimal Enteral/ Adequate / Inadequate Typo - caloric Starvation Pacenteral Excessive Gastrointestinal Symptoms Duration: Z i **112** Па П Nausea Vomiting/ Diarrhoea severe anorexia moderate Gi symptoms Functional Capacity (Nutrition related functional impairment) Duration: O 5 1/2/1/ □ 2 **□** 3 8ed / chair Difficulty with Difficulty with Light activity ambulation normal activity ridden with no or little activity Co - morbidity (Oisease and its relationship to nutrition requirements) 51 $\overline{}$ $\overline{}$ Very severe Healthy Miki co. Moderate co -Severe comorbidity/age multiple coa75 vears morbidity 8) Physical examination Decreased fat stores or loss of subcutaneous fat 1) 10 1 **4** □ 2 □ 3 □ 5 Normal Mild Moderate Severe 2) Sign of muscle wasting 石.1 **□** 3 □4 □ 5 Müd Normal Moderate Severe Total Score = Sum f above 7 components Nutritional Status: Based on this patient is (7 (J 14) Well Nourished Moderately Mainourished ☐ (15 to 18) Severely Malnourished (19 to 35) Nutrition Intervention: D 6) ☐ Enteral ☐ Parenteral

Dietitian Signature / Name / Date / Time: Port 86
30/12/23/2500

☐ Fort - night

Calorie count:

ı 🔲 Yes

■ Monthly

en.

□ No

ı

Diet counselling provided:

Enteral / Parenteral

Frequency of re-assessment:

Deekly

☐ Daily

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
30/12/23	7 73 years old Fenale come To Go wast pain was assessed to well-nowwished as evident by SGiA. KICLO-SHTN	30/12/23
-	Patient received to CCU. Rept on NBM.	
-		
-		•
•		-



Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis:	ACS, IWMT	A	llergies	if any: <u>Ø</u>	AG NKDA		
From (Area)	To (Area) Date	Time	Reason	for Transfer / Nar	ne of Pro	cedure
Ind floor		7 (2.1		•	Gı		
Method of Tran	sfer: 🗌 On Bed 🖵 Of	Wheelchair 🗌 On S	Stretche	r			
ASSESSMENT General condit	OF PATIENT: lon of Patient: Con	scious 🗆 Semi-cons	scious [☐ Un-consci	ous		
Language Barr	ier: ☐ Yes ☑ No ☐ If	Yes, specify:					
Fall Risk Categ	ory: 🗌 Low Risk 🔲 Me	dium Risk 🎵 Hīgh P	isk				
Vital Signs (to be	e documented at the tim	e of shifting):	_				
Temp (°F)	RR (breaths/min)	Pulse (beats/mir	1)	SpO ₂ (%)	BP (mmHg)	Pain	Score
98.2°F	20 1/m	80 J/m		76./,	130/80 mm H	0 0	9
☐ FLACC Scale ☐ Numerical Ra	i: PIPPS (28 weeks t (2 months - 7 years) [ting Scale (>12 years)[☐ Wong-Baker FACE ☐ CPOT (ventilator /	S Pain F	Rating Scale	•	, ,	
	tion given:	-					
_	rmation:					 _	
Any specific red	commendation:						
	Signature	Name	0.		Emp. No.	Date	Time
Handover by Handed over to	May Mo	M. Pov	-17	_ , ,		2/1/24	9.00
Handed over to	I De	(Java	16 a	ny I	0176	211124	9.00
After Procedure Procedure comp	: leted: Yes Yes	Any critical informat	ion:	Nil			
Vital Signs (to be	e documented at the tim	ne of shifting):					
Temp (°F)	RR (breaths/min)	Pulse (beats/mi	ו)	SpO ₂ (%)	BP (mmHg)	1	Score /
98-E	22 PR/WY	74 both	MH	98-1.	132/570	1 0	150
☐ FLACC Scale	i: ☐ PIPPS (28 weeks t (2 months - 7 years) 〔 ting Scale (>12 years)〕	☐Wong-Baker FACE	S Pain F	Rating Scale	•		
	Signature	Name			Emp. No.	Date	Time
Handover by	Old	(R) avet	zan	બું	DIFE	2/1/24	9.50
Handed over to	118	monich a			ouy 2	11/24	1000





Zyrs.RAJAMMAL C 73/Fcmalc/MHM66291 30/12/2023/iPH2023002638 Dr.K.JAISHANKAR

Age: 7

Sex: M/F

Ward & Bed No:

UHID

OR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

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

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

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i)The nature of coronary artery disease (ii)The pumping status of the heart (iii) Your age and general health These are some of the more serious risks that can happen, but are not the only risks:

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

PATIENT CONSENT:

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

I REQUEST TO HAVE THE PROCEDURE

E (A)	Signature	Name	Date	Time
Patient/Guardian with relationship		Rajamma	11/24	14 30
witness	Bot.	Ramadwrai Murugan (Goardson).	iliby.	17 - 30
Doctor	m20721	Dr-Salai Sudhan	211/24	
Interpreter			1 ,	



way to better health of United Alliance Healthcare Pools கிருத்ய ஆன்றியோசிராம் பரிசோதனைக்கான ஒப்பம்



நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்	
மருத்துவ ஆனோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்குடி (UHID) :	•

நீலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் தருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜனா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு மோக்கல் அனஸ்தீப்புக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கதீப்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும், இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளன கான்புராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை.) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக செலுத்தப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அமையில் (இடதுயக்க இருதய கீழறை) இந்த கான்புராஸ்ட் மீடியம் உட்செலுத்தப்படமாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகீட்சையை மேற்கொள்ள முடியும். இவை பை-பாள் அறுவை சிகீட்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜயோபிளான்டி (பனுன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகைப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சின நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கீச்சையல்முறையிலுள்ள கீடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜீயோகீராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை — (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை — (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள கில தீவிர கிடர்பாடுகள் பின்வருமாறு. ஆனால் கிலைகள் மட்டுமே முழுமையான கிடர்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகீதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகீதம்)	 (b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆன்துமா, அதீர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்ஐயோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதீப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகீதம்)	 (1) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படு. (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரியாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகீதம்)	(m) குத்தப்பட்ட இடத்தீல் பெரிய அளவிலான சிராப்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கீறேன்

	கைபெழுத்து	பையர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி		Ţ		
மருத்துவர்				
மொழிபெயர்ப்பாளர் .	. T. 18 184		W 22 12	







Every heart beat counts

CORONARY ANGIOGRAM REPORT of United Alliance Healthcare Pvt Ltd)

PATIENT NAME: MRS.RAJAMMAL.C

UHID IP NO

: IPH2023002638

: MHM66291

AGE/GENDER CONSULTANT

: Dr. Jaishankar. K MD., DM., FIAMS

D.O.A : 30.12.2023

Director and Clinical Lead

: 73 YEARS / FEMALE

D.O.P : 02.01.2024

Cardiology and Electrophysiology

CATH DATE	02.01.2024	DONE BY	DR. JAISHANKAR
CATH NO	3510	ASSISTED BY	SN. SATHYA
CATH DURATION	5 MINS	TECHNICIAN	MR. TAMIL
HEIGHT WEIGHT	147CMS 59KGS	PHYSICIAN ASSISTANT	MS. SHALINI

CLINICAL DIAGNOSIS: CAD - ACS - IWMI , THROMBOLYSED WITH TNK (10 AM , 30.12.2023), MILD LV DYSFUNCTION. EF - 45%, SYSTEMIC HYPERTENSION, ? COPD, RESOLVING HAEMATOMA OVER FOREHEAD & LEFT EYEBROW.

CATHETERIZATION PROCEDURE: AFTER OBTAINING INFORMED CONSENT, PATIENT WAS BROUGHT TO THE CATH LAB. UNDER SAP, PROCEDURE DONE BY USING 2% XYLOCAINE AS LOCAL ANAESTHESIA AND SELDINGER TECHNIQUE.

APPROACH

: RIGHT RADIAL ARTERY

SHEATH

: 6FR

CATHETER

: 5FR TIG

CONTRAST MATERIAL: NON-IONIC, CONTRAPAQUE

MEDICATIONS

: Inj. Heparin 2500 IU

COMMENTS:

LMCA - NORMAL. BIFURCATES INTO LAD AND LCX.

LAD - TYPE III VESSEL AND GIVES RISE TO 3 DIAGONALS AND MANY SEPTALS. PROXIMAL LAD HAS 90% TUBULAR STENOSIS. MID LAD HAS LUMINAL IRREGULARITIES. DISTAL LAD HAS 50-60% TUBULAR STENOSIS. DI IS MAJOR VESSEL HAS OSTIO PROXIMAL 90% STENOSIS.

LCX - NON-DOMINANT AND GIVES RISE TO 5 OMS. PROXIMAL LCX IS ECTATIC WITH LUMINAL IRREGULARITIES. LCX AFTER OM3 HAS 90% TUBULAR STENOSIS FOLLOWED BY 70% TUBULAR STENOSIS. OM 3 & OM 5 ARE MAJOR VESSELS. OM 3 PROXIMAL PART SHOWS TOTAL OCCLUSION. OM5 PROXIMAL PART SHOWS 50% TUBULAR STENOSIS.

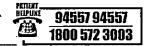
#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

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Medway Centre of Excellence (Chennai)

044-2473 4455

Mogappair

Chengalpattu

Villupuram

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

Kakinada

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





Every heart beat counts

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RCA - DOMINANT AND GIVES RISE TO PDA AND PLV BRANCHES. PROXIMAL & MID RCA HAVE LUMINAL IRREGULARITIES, DISTAL RCA HAS 50-60% DISCRETE STENOSIS. PDA PROXIMAL PART HAS 70% TUBULAR STENOSIS. PLV DISTAL PART HAS DIFFUSE DISEASE.

IMPRESSION:

TRIPLE VESSEL DISEASE MILD LV DYSFUNCTION RIGHT DOMINANT SYSTEM

ADVICE:

- 1. MULTI VESSEL PCI
- 2. CABG

Mai show **CONSULTANT SIGNATURE**

Dr. Jaishankar. K MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology

To visit at www.medwayhospitals.comAISHANKAR Reg. No: 49448

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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR

_	N 1804 PR 1811 100 100 PROFEST NO.	URSES PROGRESS NOTES		
Date & Time		Observations / Action		Signature with Emp. No.
2/1/24		Cath cab		
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9.05		Stable TV line		() Topo
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		anaesthesia		Mist
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SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

Mes. Rajammal

Jas yrs F

Man Harressbose

MHI/OT/2022/086 Medway Institute

MHM 6629) Every heart beat counts
Dr-Jeushahkal Mis.RAJAMMALC

Name of the Procedure :	CAG	Location:Cgth Lab.	Date & Time :	2/1/24 73/Female/MHM66291 30/12/2023/19H2023002638
Does the Procedure involve	e Procedural Sedation :	<i>-</i>		Dr.K.JAISHANKAR
SIGN IN 0 - [O] Before Induction of Procedural S	edation	TME OUT 'C' QO After procedural Sedation and before procedure		SIGN OUT 9-40 IIIIII IIII IIII IIII IIII IIII IIII
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural	(Anaesthetist or Qualified Physician	performing the Proced	Sedation + Nurse + Technician + Doctor
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	Yes	Identity by two identifiers	Yes	Name of the Procedure done written down
Procedure	✓ Yes —	Procedures CA-Q	1☐Yes	Name and site of all specimens / investigations Yes NA
Side	ØRt □Lt □NĀ	Side Ft RedPal action of approal	RE LI LINA	confirms labeling and sent to lab
'		Expected Blood loss NA		/
Consent	Yes	Position Supine,	☐Yes	Any recovery concerns : Yes None
Known Allergy	☐ Yes ☑ No	Consent	ØY98	If Yes, Pls. specify :
	If yes, plaese specify	Required equipment and implants available	Yes NA	
Difficult airway / aspiration risk	No ☐ Yes, equipment	Essential Imaging displayed	☑Yes □NA	
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	☐Yes ☐JXA	
Possibility of hypothermia	No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☑ NA	addressed : ☐ Yes ☐ None ☐ If Yes, Pis. specify :
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	□Yes	11 105(116.6B501).
□Sp02 □NJBP □Othe	rs pls. specify <u>ECQ</u>	Anticipated blood loss briefed	□Yes □NA	
Pre OP medication taken	☐ Yes ☐ No	Adequate fluids and blood available	Yes □NA	
		Team briefed on any critical or unexpected steps	Yes	Corrective action :
Required equipment for	☐ Yes ☐ NA	For procedural sedation cases		
procedure available		Any patient specific concerns : Intra procedure glycemic control	☐ Yes ☐ None	6
		Any concerns about sterility	Yes NA	_
Anaesthetist / Doctor giving Procedura/ Sedation	Doctor performing to Procedure :		echnician : M & · F	Others Please Specify:
- 1	1- 1.	1 2 2016		
Date:	Date : 21124	17/12:	ate: 3/1/20	Date:
Time:	Time : 4:50	Time: 9.50	ime: 9.50	Time:





Procedure Monitoring Sheet (Cath Lab)

Every heart beat counts

Patient Name 73/Fcmalc/MHM66291

Mrs.RAJAMMAL C

30/12/2023/IPH2023002638

UHID / IP:

Dr.K.JAISHANKAR

Consultant:

Age/Sex: 73 yr

Ward Unit: Ind flow

Diagnosis: ACS, IWMI

Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse)

PARAMETERS	YES	NO	NA
Vital signs: BP194 Temp: 1.1 Pulse: Sp. 77 RR: Lel. SPO2: 937.			
Urine voided	7		
Bowel preparation	5		
Pre-procedure medication administered	5		
Procedure site marked			2_
Skin preparation done	1		
NPO \$.00			
Loose Tooth removed			1
Contact lenses / Eye glasses removed	1		
Prosthesis present			
Jewellery/Nail polish removed	1	1	. /
Checked for Allergies (Drug / food)			
IV line/In-situ	1		
Consent taken	7		
Investigation reports / Documents received	5		
Signature of Nurse: QuioTuo	Date & Time :	2/01/23	Q 9,00

Intra - Procedural Record (To be filled by the Cath Lab Nurse)

1.	Time	HR / min	RR / min	BP mmHg	SpO ₂ %	Medication / Remarks	Sign. of Nurse
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	9.20	#261m		120/70 (20)	96 %		Dotte
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Contract Section (Contract)	Post Procedure	Follow Up D	ata (to	be fille	d by the d	octor)	F.	
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BP: 132/57(82	∑mmHg, HR: <u></u>	1h+ m+	_, RR :	Q 8 1	a 6/m/Sp02	:- 9	847	
Distal Pulse:	felf , Pu	incture Site: _	ho	6020	y 2.1	remats	me	N ream Z
Advise:		·						
· Shift To: Ward / IC	(I)	gsiCi 					۰۰۰۰۰ مــــــــــــــــــــــــــــــــ	
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Patient shift-to-	Recovery Room	Patient F	goom	-🗀-ccı	ا۔۔۔۔اُ <mark>ل</mark> -Oth	er	1 u	/U/
Name & Signature of th	e Nurse :		i	D	ate & Time	: 1		: :
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Doctor / Nurse /

Counsellor

Interpreter

MHI/HOSP/2022/109

Heart
Institute

(A Unit of United Alliance Healthcare Pvt Ltd) Every heart beat counts MIS.RAJAMMAL C DR HIV TESTING 73/Female/MHM66291 30/12/2023/IPH2023002638 Patient Name Sex:M/F Age: Dr.K.JAISHANKAR Consultant UHID: have been given verbal and written educational information for HIV antibody testing. I have been informed that a sample of my blood will be drawn and tested and tested to detect HIV antibodies I have been informed of the purpose, potential uses of the test and the consequences of not having the test done . I hereby acknowledge that I have read or have had read to me this information regarding HIV antibody testing. I have been given the opportunity to ask questions and all the questions have been answered to my . I acknowledge that I have given consent for performance of this blood test to detect HIV antibodies. This has been explained to me in ______ language. which I can understand. Date Time Signature Name Patient Doctor / Nurse / Counsellor Interpreter CONSENT OF PATIENT REPRESENTATIVE / SURROGATE The patient is unable to consent because ___ and I, Ur. Pancdurai __ (name / relationship to the patient), therefore, consent for the patient I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with the doctor or doctor's designee, and hereby consent to this procedure. Signature Name Date Kamadurai Navagan 30/12/23 Patient Representative with relationship

> Dr. Anish Nelson Reg. No: 88434

		ITATIVE / SURROGATE		
The patient is una	ole to consent becaus			•
		(name / rel		therefore,
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above, with the do	ctor or doctor's design	nee, and hereby consent to this proce	edure.	
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	Signature	Name	Date	Time
Patient Representative				
Witness	·			
Doctor				
Interpreter				ļ

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NURSING ASSESSMENT FORM

EMERGENCY DEPARTMENT
Patient Name: Mm: Ray am mou Age: 70 yrs Sex: M(F)
Doctor Name: Dr. Jaishankar OP/IPNo: 202300021038 : 30/14/Jime: 9 2/39
Vital Signs :
Temp: N Pulse: 69 Bpm. BP: 160 (woo months poz: 9xy-la
Ht.: 145 CM Wt.: 59 kg CBG: 80 mgfell.
Allergies if any: (Yes / No), if yes, specify:
Pain Assessment Scale :
0 1 2 3 4 5 6 7 8 9 10 No Just Mid Uncomfortable Acroying Moderate Just Strong Sovero Homble Worst Pain noticeable Pain Pain Pain Pain Pain Pain Pain Pain
Pain: Score (0-10) Location:
Character: Dull Pricking / Aching / Other:
Chief Complaints: Complaint's of Sudden. onset @ Side
Ches Pals, radiating to D Jaw 1 D Shoulder.
Since Today morning. Past Medical History!
Klelo 8 HTN - not on any Inextment
Systemic Examination:
pt vitals are cheeked and
recorted.

Nursing Diagnosis:

Plan of Care:

the patient.

> 10 monitoring vitals

-1 To follow doctor advice.

-1 To gree proper ventilation.

Staff Nurse Name

: 30/12/23 @ 9. d5 Am Date & Time



NURSES PROGRESS CHART

Name: Mrs: Pajammad

Age/Sex: Foyes [F ID No.:

NOT KNOWN Allergic To:

UHIDNO.:6891

Bed No.:

Allergic	10. 14 of (1214 Oct Unituho.: 15 oct (1) Bed No.: 12	,
Date	Nursing Care	Staff Sign & Employee No.
00/12/2	* Patient Gloceived to Ex @ 9.25Am.	
	pt Complaintle of Chest : pain: Since:	
		. 4 .
	-> Vitals Checked & vecorded	
	it Potient l's Convious & Oviended.	:
	-9 pt Condition informed to Dr.	· ·
	Manisathrom Son adviced to be give	•
	a loading dose	
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	Atorvas 80 mg - 1	Bren.
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Date	30.12.22 Nursing Care	Staff Sign & Employee No.
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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638 Dr.K.JAISHANKAR



NURSING ADMISSION ASSESSMENT (ADULT)							
Date of Admission: 30 10128 Time of Arrival: 12 . 0.5 Mode of Admission: Walking Wheelchair Stretcher							
Accompanied by Relative: Yes No If Yes, Name of the Relative: NE: PANARURDI NORUGIAN							
Relationship with Patient: FON Contact Person's Name LD PAMADORAL Relationship: MANK							
Contact No.: 958865785 Primary language spoken: Tarnil English Indian International							
Interpreter needed: Yes No							
Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No							
Menstrual History: LMP: Menopause: Medical History: DM / H7N / Co - Morbility: Yes If yes specify							
Drugs History : Antiplatelet (Specify)							
Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty							
Do you have any special religious, spiritual or cultural needs to be considered? Yes No							
If Yes, specify details:							
Socio Economic Status: Employed Retired Own Business Home-Maker Others:							
Vital Signs: Temp: 97-1 (°F) Pulse / HR: 2 (beats/min) BP: 100 40 (mmHg)							
Respiration: 2 (breaths/min) SpO ₂ : 99 (%) CBG: 112 (mg/di) Height: 47 (cms) Weight: 59 1 (kgs)							
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not 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: Increased Decreased No Change							
Last 3 months Weight: Increased Decreased No Change							
Type of Patient: Diabetic Non Diabetic Type of Diet: NOR NOA-L DIE+							
Dietician Informed: Pes No. If Yes, mention the Name: Nps. CAHERINE, Time: 10.10							
Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented							
Room Side Rails Toile Bell Patient Information Board Bathroom Bed Controls							
Use of Footstool Grab Bars Wurses Call Bell Television Light Controls Telephone							
Functional Assessment:							
Particular Assessment Remarks Outcome							
Visual Impairment Yes No							
Hearing Impairment Yes 10 Yes							
Chewing Difficulty Yes No							
Walking Difficulty Yes No							

Daily Activity Of Li	iving:			= · .:						
Activity		Independe	ent	Α	ssisted			Dependent .		
Bathing		<u> 27</u>	-			ľ				
Dressing		<u> </u>								
Eating		1)				-			
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Toilet Use		- 7 /								
Pressure Injury Risk Assessment: Braden Scale						-				
Sensory Percep		Score	Moisture		Score	Degre	ee of Act	ivity	I	Score
No Impairment		(4)	Rarely Mois	t	(A)		Frequen			An
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Completely Limit	ed	1	Constantly I	Moist	1	Bed F	ast		1	. 1
Mobility		Score	Nutrition		Score	Fricti	on & She	ear		Scere
No Limitation		4	Excellent	_		No apparent proble			em	(3) √
Slightly Limited		(3)	Adequate		(3)	Poter	tial Probl	em		2
Very Limited		2	Probably In-	Adequate	2	Probl	em Prese	ent		1
Completely immo	bile	_ 1	Very Poor		1					
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: Action needed: Yes No Pressure injury present at the time of admission: Yes No If yes, Location: Grade: Size: Witnessed by: Signature: Relationship:										
	MODIF	FIED MORSI	E FALL ASSES	SSMENT SC	ALE (Age a	bove 16	years)		<u>-</u>	_
Fall Risk Assess	ment (Mo	dified Mors	e Scale):							
Variables									Num	eric Value
History of falling ((immediate	e or within 6	months)				N			(O)
	<u> </u>						Ye			25
Secondary diagn	osis (≥ 2 ı	medical diag	nosis)				N Ye		_	(15)
Ambulatory Aid				-		•				<u> </u>
None / Bed Rest Crutches / Cane		ssist	_					\dashv		<u>(6)</u> 15
Furniture	vvaikei			· -	_		- -			30
Intravenous Thera	apv / Hepa	arin Lock / Tu	ıbes İnsitu	<u>.</u>			N			Ą
Gait						-	Ye	s	(20)
Normal / Bed Res Weak	st / Wheel	Chair								(0) 10
Impaired						<u>-</u>	 	_	<u>-</u>	20
Mental Status							+	\dashv	<u>-</u> .	
Oriented to own s		mitations						_		(2)
Overestimated or	ioideis ill	manuns ————						 		15
Medications Includes PCA / or						s,	N			(P)
laxatives, hypogly		<u>-</u>			<u>.</u>	_	Ye	s		15
Score Interpretation	: 0-24: Low	-risk; 25-44: N	ledium Risk; Ab	Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk Total Score						

As per the score, tick the following appropriate	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 Remove excess equipment or furniture to make a clear Reep the patient's bed in the low position at all times ex Teach 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 slipper Review medications for potential side effects that can publicate that the patients are not ambulated by themselves. They a Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stret Make sure that proper transfer precautions are instituted by the patient to ambulate only with assistance Consider peak effects of the medications that effective the patient to ambulate only with assistance Consider peak effects of the medications that effective the patient to use grab bars near the toilet, bath 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) Incourage family members or other visitors to stay with If appropriate, consider using protection devices: safe	bed for all the pat r path ccept d r a more y cre to be ccher uted fo ctor fects l ment a tub, ar restric r ses' sta riate) h them	ient' urinq nent te fal e am r he evel reas id sh	Is easy reach g procedure t before rising from the bed Ils Ibulated only with assistance avy or debilitated patients in a of consciousness, gait and s nower s mentioned above					
Initial Assessment to Special Needs and Vulnera	7 T	_	, · · · · · · · · · · · · · · · · · · ·					
	Yes	No	Remarks (please sp	pecify)				
Terminally ill patients		4						
Patients with intense chronic pain	1 - 1	2						
Woman in labor or experiencing termination of pregnancy	-	4						
Patients with emotional or psychological distress								
Patient suspected of drug or alcohol dependency								
Victims of abuse and neglect								
Patients whose immune system is compromised								
Patient with infections and communicable diseases								
Does the patient have implants		1						
Has tracheotomy been done	† †	1						
Has colostomy been done	+ +	$\overline{/}$						
Any other potential needs of the patient	+	1						
Any other potential needs of the patient		/	1					

DVT RISK ASSESSMENT Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10														
S. No.	Assign a s	core	01 1 11 (10	Parar			1105. 1	וט פ, מווט			_	Yes / No	<u>".</u>	Score
3. No.	Active cancer	(on-a	oing treatn		-		d within	6 months	or palliative ca	 re)			No	<u> </u>
2	Bedridden red								<u> </u>	· · · -	片	<u>=</u>	No	10
3		>3 cı	m compare					-	red at 10 cm	below tibial tubercle		Yes 🔃	No	Ð
4	Collateral (no	nvario	cose) supe	rficial v	eins į	orese	nt (Asse	ess for bot	h legs)			Yes 🗂	No	Ø
5	Entire leg swo	llen (a	Assess for I	both le	gs)	_						Yes J	No	,O
6	Localized tend	derne	ess along th	e deep	vend	ous sy	/stem (/	Assess for	both legs)	-		Yes 🔯	No	D
7	Pitting edema	, grea	ater in the s	ymptor	natic	leg (/	Assess	for both le	gs)			Yes 🔟	No	P
8	Paralysis, par	esis, o	or recent pl	aster ir	nmol	oilizat	ion of th	ne lower ex	tremity (Asses	ss for both legs)		Yes 🔲 I	No	10
9	Previously do	cume	ented DVT (Assess	s for b	oth le	egs)	_				Yes 🗐 1	No	•
10	Renal diseas oedema, Lym	e, Re phati	nal failure, cobstructio	CCF on. Sep	Cellu otic ar	ılitis (rthritis	commo s, Cirrho	only mista osis, Neph	ken as DVT), rotic syndrome	morbidity like ESLD / Dependent (stasis) e, Calf muscle tear or tendon, Fracture.		Yes 🗹 l	No	0
Risk Score Interpretation (Probability of DVT):								Ī	inal Sco	re	_			
Tick	the score ob	taine	ed (√)	√	^ [-	Action Take	en		Date	T	Time
Low	Risk	_	2 to 0	~	オ				人			20/12/2	8	12.10
Мос	lerate Risk	_	1 to 2											•
Hig	h Risk	-	3 to 8											
Pers	sonal Belong	jings	s / Valuab	les:						<u>-</u>	-	<u>. </u>		_
Valua	ables		Descriptio	on		ith ient		Patient's endant		Signature of the atient's Attendant		Rema	rks	
Dent	ures		Jpper□L Both -⊡N											
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Jewe	llery		es DN	67										
Othe (spec	r valuables eify)			,- 										
Rep	ort (List of X-	ray, l	ECG, lab ı	report	s reta	ainec	d with t	he nurse):					<u> </u>
Dati	ent /	\neg	Sign.			Na	me			Emp. No.		Date	7	ime
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Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



	PATIE	NT CLINICAL I	HANDOVER	RECOR	D FOR NUF	RSES				
Date: 30/1	मुध्द	Shift: Mor	ning Kevening 🗹	Night						
S	Ventilator Periphera Ryle's Tul Urinary C	s: (ADIACS I WIN I LYSED PEWS Score: day: al line day: Right: Le be: Yes Mo Day atheter: Yes No Day	ft:	Central line	015 · ·					
В	Allergies On room	ROUND urgery: if any: NKOR . air / oxygen: Room A/P. uts / New Symptoms in last s		Date of surg		,				
A	Others: Pain Sco Fall Risk Braden S Pressure	SMENT ns: Temp: 98 (°F) Pulse 19(99) (mmHg) SpO ₂ : 9 ore: 010 Pain Scale used Score: 35 Fail Risk Pr Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PU diet: Nourol Sut	9. (%) Height: 1147 d: PIPPS / CRIES / FLAC rotocol: □ Low Medi □ At Risk-Mild Risk: 18-15	cms) Weight: CC / Wong-Bal um	<u>FQ դ</u> (kgs) BMI:- c ker FACES Pain Rati	ng Scale / NR:	S / CPOT e Risk: 9-6			
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:									
		Signature	Name		Emp. No.	Date	Time			
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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 30	12/2	9 Shift: ☐ Morr	ing ☑Evening ☑Nigh	nt		OLO .	
S	NEWS / F Ventilator Periphera Ryle's Tul	al line day: Right: Left be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	:Netacapal Ce	DD: entral line o	days: ← <i>© </i> ≤		
В	On room		9 % . IV1	ate of surg	•		
A	ASSESSMENT Vital Signs: Temp: 4+1 (°F) Pulse / HR: 8 (beats/min) Respiration: 00 (breaths/min) BP. UO (00 (mmHg) SpO ₂ : 99 (%) Height: 10 (cms) Weight: 10 (kgs) BMI: 10						
R	Referral of Pending Pending Pending Critical vo Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yese	DNo. If Yes, modified care	e plan date د المال	::		
11	E-	Signature	Name		Emp. No.	Date	Time
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Mis.Rajammal C

73/Female/MHM66291 30/12/2023/IPH2023002638

dt.K.Jaishankar





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 31	12/23	Shift: Mor	ning Evening N	light			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	al line day: Right:	ft: — y:	POD: — Central line of	days:-		
В	On room			Date of surge	•		
A	BP: /2 // Others: _ Pain Sco Fall Risk Braden S Pressure Current of Lingary RECOM Referral of Pending Pending Pending	ms: Temp: 78 '4 (°F) Pulse The content of the	Height: 447(c	ms) Weight: C / Wong-Bak m	er FACES Pain Ratin	2-7 - 3 <i>b</i> 3 ∫r g Scale / NR 12-10∐Severe	5/cpot
n	Changes Pending	alue alert and its corrections in nursing care plan: Yes follow-up orders:		care plan date	:	***	· · · · · · · · · · · · · · · · · · ·
		Signature	Name	- -	Emp. No.	Date	Time
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Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 81	112/2	ß. Shift: ☐Morn	ing Evening \ N	light			
S	NEWS / P Ventilator Periphera Ryle's Tub Urinary C	s: CAY) ACS / 1.W day: day: Left De: Yes No Day atheter: Yes No Day	· · ·	GCS: , 15/ POD: Central line of VIP Score:	days:	,	<i>;</i>
В		urgery:		Date of surge	ery:		
A	BP: \$0 Others: Pain Sco Fall Risk Braden S	reg 10 Pain Scale used: Score: Fall Risk Pro	(%) Height: Unicolumn Leight: Unicolumn Low Mediu At Risk-Mild Risk: 18-15 SH): Yes No NA	ms) Weight: C / Wong-Bak m ☑ High	er FACES Pain Ratin sk: 14-13 High Risk:	g Scale / NR®	
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:		eare plan date	:		
•		Signature	Name	,	Emp. No.	Date	Time
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Handover ta	ken by		A-Nord-Ri	10.	0170	81 222	19.00
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:	21	Shift:	☐ Morning ☐ E	vening Night		* 36 * 4 4	t	
S	NEWS / F Ventilator Periphera Ryle's Tul	EWS Score: day: line day: Right: pe: Yes atheter: Yes	No Day:	POI Cen	tral line days:			*
В	On room	irgery:- f any: \KDA	OOM AIN s in last shift:	Date	of surgery:	7. 811.	• •	<u>.</u>
A	Others: Pain Sco Fall Risk Braden S	re: 0 OPain So Score: Score: Fall Score: Minimal Ris	SpO ₂ : 43 (%) F sale used: PIPPS / I Risk Protocol: 5 sk: 23-79 At Risk-N aling (PUSH): Ye	eight: <u>† </u> Ct] ems) CRIES / FLACC / W Low	Weight 9. /ong-Baker F/ High derate Risk: 14	_(kgs). BMI ACES Pain Ratino -13 □ High,Risk: 1	97-3kg g Scale / NRs - 2-10∐Severe	I S∕TCPOT
R	Referral of Pending Pending Pending Critical vo Changes Pending	follow-up orders:	prrections:	(es, modified care)	1	* ,	•	. •
	Special ii	nstructions if any:	<u> </u>	Plan =	<u> </u>	CAG ± P	-	·
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Mis.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

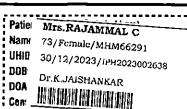
Date:	1	Shift: Morr	ning Evening Night					
S	SITUATION Diagnosis: FCS TWMI NEWS / PEWS Score: POD: NEWS / PEWS Score: POD: Ventilator day: Peripheral line day: Right: Left: Ryle's Tube: Yes No Day: Urinary Catheter: Yes No Day: Barrier nursing: Yes No MDR: Yes No. If Yes, specify organism:							
В	Allergies On room	round urgery: — if any: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	; Note that the second	f surgery: s on flow:	- -	• • •		
A	BP: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ns: Temp: 98.2 (°F) Pulse 80 (mmHg) SpO ₂ : 9 ore: 0 10 Pain Scale used Score: 35 Fall Risk Pro Score: 10 Minimal Risk: 23-19 [Ulcer Scale for Healing (PU	/ HR: J8 (beats/min) R 5 (%) Height: 147(cms) W : PIPPS / CRIES / FLACC / Wor otocol:	(eight: 57-4 (kgs) BMI:	2 16 .6 Kg ing Scale / NR: 12-10 □ Severe			
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: Towarow Plan CAG								
		Signature	Name	Emp. No.	Date	Time		
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

		IN OLIMOAL I	IANDOTENTI	1LOOI (IJLJ	j
Date:	1/41	ع Shift: ☐ Morn	ing Evening N	light			
3	Ventilator Periphera Ryle's Tul Urinary C	S: AU AWOM PEWS Score: day: Left ll line day: Right: Left be: ☐ Yes ☑ No Day atheter: ☐ Yes ☑ No Day	;	GCS: POD: Central line of VIP Score: pecify organis	daye:		
В		urgery:		Date of surg			
1	ASSESSMENT Vital Signs: Temp: Pulse / HR:						
R	Referral of Pending Pending Pending Critical vo Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections; in nursing care plan:	·				
		Signature	Name		Emp. No.	Date	Time
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Handover t	aken by	Cont	Branis	,	0195	Plog	19-30
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	NURSES PROGRESS NOTES							
Date & Time		Observations / Action		Signat	ure with Er	np. Ņo.		
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19.00	norque du	by Johnson		-				
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	Signature	Name	Emp. No.		Date	Time		
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Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: O\	01/23	Shift: Morn	ing □Evening ☑N	ght			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: ACJ -NSTEM) PEWS Score: +0 day: - Il line day; Right: - Left be: Yes No Day atheter: Yes No Day	:: Đ _J	GCS:15/15 POD: — Central line of VIP Score: Decify organis	days: —		
В	On room			Date of surge			
A	BP: \(\(\circ\) Others : Pain Sco Fall Risk Braden S	ns: Temp: 97.4°F) Pulse	. (%) Height) & ᆍ (ci : PIPPS / CRIES / FLACO otocol: □ Low□ Mediu] At Risk-Mild Risk: 18-15 [SH): □Yes □ No □ NA	ns) Weight§ C / Wong-Bak m ∐High] Moderate Ris	ter FACES Pain Ratinsk: 14-13 High Risk:	g Scale / NR:) S / CPOT
R	Referral of Pending Pending Pending Critical vo Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: follow-up orders: mstructions if any: ↑	☐No. If Yes, modified o				·
		Signature	Name		Emp. No.	Date	Time
Handover g		(84)	B-100m38	^	0198	2 11221	790
Handover t		MXX4	M. Rova	the	8228	<u> وداراد</u>	7.30
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	NURSES PROGRESS NOTES							
Date & Time		Observations / Action		Signat	ture with E	np. No.		
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01/01/23								
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	pluty Statt.		0	<u> </u>	ur 			
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	What are	hadred & Record	عول ا					
20-30	=> pt had	a Rood						
21.00		dication was	wen_					
	as per doctor	- order		Chil	<u> </u>			
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	Slowly mob			•				
22.00	Spt ba	he well Rest		_				
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	compretable	position.		2/0	<u> </u>			
2-00		dition etable. no	o					
	any other com	plants						
\$-00	=> NDO	Startoel.						
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	to mmg du	ty staff		-5\U				
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Pal Mrs.RAJAMMAL C
Na 73/Female/MHM66291
UH 30/12/2023/IPH2023002638
DC Dr.K.JAISHANKAR



Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Co.

Date: Da	11018	9A Shift: ☑Mor	ning Evening Night		·:	
S	NEWS / F Ventilator Periphera Ryle's Tut	s: CAD - ACS NS PEWS Score: O day: day: Le line day: Right: Le be: □ Yes □ No Da catheter: □ Yes □ No Da	ft: VIP Score:	days: -	*	
В	Allergies On rodm	ROUND urgery: — if any: N K D P air / oxygen: its / New Symptoms in last s	Date of surg			. + \$
A	BP: 136 Others: Pain Sco Fall Risk Braden S	ns: Temp: 91 & F) Pulse 90 (mmHg) SpO ₂ : 9 90 (mmHg) SpO ₂	(beats/min) Respin Kespin Respin Kespin Kespin	:: <u>5 </u>	23-4 kg ng Scale / NR 12-10 □ Sever	
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	s: No. If Yes, modified care plan dat	re:		
		Signature	Name	Emp. No.	Date	Time
Handover	-	E-Cati	F-Cathrine	0207	102001/24	11.00
Handover t		9	Discharged -	-	0) 6	10: -
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NURSES PROGRESS NOTES									
Date & Time		Observations / Action	_	Signatu	e with E	np. No.			
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	patient 1	vitals signs check	edf						
<u> </u>	peroled			· •					
 	=> CPG de	me CAD-TVD,	plan						
	CABO, Toda	zy Plan disch	arge						
12.30	a) pt had	VIS Checked P	record	70					
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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



	•	NT CLINICAL H	IANDOVER RECORI	D FOR NUR	ISES			
Date: 2	1/29/	Shift: Morn	ing Evening Night		· .			
S	NEWS / F Ventilator Periphera Ryle's Tut Urinary C	S: ACS NSTEM PEWS Score: day: I line day: Right: De: Yes No Day atheter: Yes No Day	: VIP(Score:	days:				
В	On room		Date of surgo IV fluids on fl nift: _	^	_			
A	ASSESSMENT Vital Signs: Temp: 9714°F) Pulse / HR:							
R	RECOM Referral of Pending Pending Pending Critical value Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	NUI No. Tr Yes, modified care plan date					
		Signature	Name	Emp. No.	Date	Time		
Handover (given by	Milly	Revelly	0228	2/1/24	9.0		
Handover t	aken by	LOD	- (Blavethany	0176	2/1/24	9.00		
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Date & Time		Observations / Action		Signatu	re with E	np. No.
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Mrs.RAJAMMAL C
73/Female/MHM66291
30/12/2023/IPH2023002638
Dr.K.JAISHANKAR



Initial Date: 30 / 12/2	3 Time: 12.10	Modified Date: Time:	,	
Reason for Modification:		Diagnosis: eAD- ACS/M1/ Ly	ISED THE CLOAM	+oolay
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	м	
☐ Regular Diet ☐ Others:	Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Record amount of food consumed	E & pton saltet	Pots
			N P+ On Soft dut	110
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O₂ ☐ Mask ☐ BiPAP / CPAP	Room Air Nasal Cannula / High Flow O₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others: Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing Patient ABG levels will return to and remain within normal limits Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O₂ saturation and pulse rate life any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order	M		
☐ Tracheostomy ☐ Others:		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 THEW OD FM) 4 LOT ON HOW	Dy
		☐ Send sputum for culture and sensitivity based on	N PT ON ROOM AIR)
			8609-46.1.	1400
FLUID & ELECTROLYTES Oral Intravenous	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	
☐ Enteral Nutrition☐ Parenteral Nutrition☐ Others:		Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss	E & Pton I to Charle made nto and	Pan
		Monitor BP for orthostatic changes	N PA ON I TO Crant maintain	ad 82

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of	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	M E Sprow bed Vest	and
	adaptive devices to increase mobility	(e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	N	700
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,	☐ Enecurage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Change validing personnelities as felouis /	M	
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 	> pton CBD (D)	20 M
		and follow proper protocol Check for malena / constipation / urinary retention	N	
SKIN-INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	M	
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	. ,	Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	= Prtagooty	Sor
☐ 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 E Toton Story Clean quelly worn	elfor
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M E PHON Challed N	Buy
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 PHEN CONJUNTABLE SLEEP	Bu
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M E Spten 1 3 Checked greend	Porg
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Bellefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal psychological pattern	 □ Pray or encourage the patient to pray □ Use inspirational words □ Respond to spiritual needs as they arise □ Evaluate spiritual needs □ Encourage verbalization of feelings / therapeutic touch □ Provide empathy and reassurance 	M E	

Patient Specif Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATE Verbal Non-verbal	TION	Patient will communic with positive feedbac	cate effectively k	☐ Introduce the care giver☐ Encourage the use of call bell☐ Obtain interpreter if needed☐		м		
Sigh language				No negative speaking about the patient's or prognosis in the patient's presence	condition	E APONO	propol nuvertion.	201
						N		
SPECIAL INTE	ERVENTIONS	☐ To manage on time		Double-check for high alert medication Observe and report any medication react Provide proper measures of wound care	ion	M		
☐ Isolation ☐ Ostomy Care ☐ Blood / Blood	products			Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to		es Medica	ution givo	
transfusion Fluid tapping DVT Managem				compatibility Practice strict asepsis while transfusing be blood products and fluids		E as por e	lowe	20m
Others:	on.			Monitor DVT score and continue treatment as per doctors order	nt	N		
	Signature	<u> </u>	Name		Emp. iD		Date	Time
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MIS.RAJAMMAL C

73/Female/MHM66291 30/1/2/2023/IPH2023002638

Dr.K.JAISHANKAR



Every heart beat counts

Initial Date: 3//12/ &3	Time: \$700	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD ACS NUM LYSED W	UTH TNK.	
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	Mpt on Mpo E pit heal (A) Siet	Ry Sel.
OXYGENATION Hoom Air Nasal Cannula / High Flow O, Mask BIPAP / CPAP	No other respiratory abnormalities Patient,respiratory rate will remains	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate	M Putient on Room	by
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	 Utilise pulse oximetry to check O₂ saturation and pulse rate If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis 	E pot Sporagy.	Del.
	- i	□ 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	Partient 18 On Room dir	Ph
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	M Pt 20 Chart Maintained M Maintained N Oli M 1	Per Sq.,
	,		To hard Monitored	

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	MP Bed Mobilised will	
Others:	□ Patient will use safety measures to minimize potential for injury □ Patient will demonstrate the use of adaptive devices to increase mobility	Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E Pt Mobilited	(Jul)
<u></u>		,	Patient Mobilized well	P
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Umnation	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 /	Mpt cBd Present	Pg
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol	E Pt God Pryent	Par
	, i	Check for malena / constipation / urinary retention	n Normal Elimination	4
SKIN INTEGRITY Maintain normal skin integrity Pressure points site ' assessment HAPI OPI	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain	Pattent Maintain, M M Skin integrity	
GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury			pt Murtun	
☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis	,	skin care	D. Stri Erstagnity	0011
☐ Pressure injury / blisters site care given ☐ Others:	4		Maintain Mormal	
)	1.		18kin integrity	

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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 will Fromed E Pt Will groomed	ASSET OF THE PROPERTY OF THE P
			Patient well groomed	Life.
SAFETY I⊒-Check ID Hand □ IV care □ EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M Pt 20 Band Rosen	- Pa
CENTRAL LINE Side rails Others:	;	□ Provide proper invasive line care □ Keep bed locked and low at all time □ Educate care providers to be the patient □ Follow restrain policy (if needed)	E Pt 2D Doine) Drugent	Sar.
		- Town residuit pointy (if needed)	To kind Present	Pal 1
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 comfortable Kolikon	A
☐ Sleep Patterns · ☐ Others:	behavior about pain relief and adequate sleep	☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	E -	
			Comportable position -	13/1
OBSERVATION Vital Signs GCS Blood Sugar Others:	☐ Patient will have normal range of vital parameters		ph vitals Cheked M cincl rewided E PH V/s Cherekeol	A.
			NVital Signs Cherod & Perorded	100 ii
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs	M Psychological support given	B
Anxiety and Copying Pattern Identify Stressors Others:	psychological pattern	Evaluate spiritual rieeds Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			Asychological Support to the pt	- Pap

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Patient Specific Problems / Nec		Measurable Goals		Nursing Interventions		Evalua	ition		Sign & Initials
COMMUNICAT COMMUNICAT COMMUNICAT COMMUNICAT COMMUNICAT COMMUNICAT COMMUNICAT COMMUNICAT COMMUNICAT	TION	Patient will communic with positive feedbac		☐ 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	M E N Olfor	8017 v	entroctiognes Montalal	
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood p transfusion Fluid tapping DVT Managems 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 is 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 treatment as per doctors order	solation ensure lood or	E N	Per O	chart en drugs ofine	Sex Series
	Signature	y	Name		Emp. ID	1002		Date	Time
Endorsed by		Nac.	ይ.	Nalini	00 8	24		31/12/23	[8,50
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Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





		<u>, </u>				
Initial Date:	Time:	Modified Date: Time:				
Reason for Modification:	. , ,	Diagnosis: CAJO / ACS / I WM /				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
NUTRITION ☐ Keep NPO	Patient will have adequate nutrition with no nausea and vomiting	Provide Prescribed diet on time Encourage patient to consume the served meal	M.Pt had Normal diet	L0890+		
☐ Regular Diet ☐ Others:	Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Record amount of food consumed	ED harman dies	Tub		
			NPI brack Mobel	004		
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP Ventilator	Patient will have normal O₂ saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate ☐ If any O₂ abnormalities detected inform immediately to	patient is on Moom air	D C B OT		
☐ 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 USA DE ON LOW	Zuo		
		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	Cont		
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	Moentained	≥ 004		
☐ 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 Moutoned	Bus		
		I Indiana. I in orthodiana ariangae	N Dlo chart	(By		

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Patient Specific . Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease P-tient will use safety measures	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance	M pt normal well mobilized	Q.C 0807
	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	e pr coer.	Peus .
			n Pt well mobilized	Qui
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 Patient normal elemenation pattern	2007
Others:	and regular elimination patterns	silicone catheter	Eft Molaling	Ly y
		Check for malena / constipation / urinary retention	NPA Self voided.	0100
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity		M	
GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury			E	
☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis				
☐ Pressure injury / blisters site care given☐ Others:			N	
	<u> </u>	<u> </u>	<u> </u>	

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	Mpt well groomed E pl wer Roomed N Pt well groomed	Rogot Cly otas
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	MPTID Band (1) E Cled (2) Board N Pt 1D Band Checked	15.C 15.007 15.00 15.00 15.00
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	 □ Provide clean calm and restful environment □ Provide privacy at all time □ Monitor pain scale / sleep pattern □ Provide pharmacological and non-pharmacological therapy 	M E N	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	MPt VIS Checked & recorded E Monitored Les Crost N Delo vitals monitoring	Disox Course
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal psychological pattern	 □ Pray or encourage the patient to pray □ Use inspirational words □ Respond to spiritual needs as they arise □ Evaluate spiritual needs □ Encourage verbalization of feelings / therapeutic touch □ Provide empathy and reassurance 	M E psychological Support N provided N psychogical Jupport	De Carl





MIS.RAJAMMAL C

73/Female/MHM66291 30/12/2023/1PH2023002638

Dr.K.JAISHANKAR





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	Initial Date: 9 124	Time: ♂-00	Modified Date: Time:		
	Reason for Modification:		Diagnosis: AU NSTEM!		
	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 fomiting 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 PE NPO from GAL	I North
	OXYGENATION Room Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP Ventilator Tracheostomy Others:	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 the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	M PEDS ON YOUND ONE N	A Ser
O	FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	M ITO Charf storage E N	of the second

Patient Specific Sign & Nursing Interventions Maagurahla Gnals Evaluation Problems / Needs Initials Patient will mobilize freely M PE YOUR MOBILIZOR MOBILITY The Encourage regular ambulation ROM exercise Mobile / Immobile Patient will perform physical ☐ Apply Anti-Embolic stocking / SCD Walk with assistance activity independently or within Evaluate the need for assistive devices Physiotherapy limits of disease Assess the safety of the environment ☐ Others: Putient will use safety measures Consider the need for home assistance to minimize potential for injury (e.g., physical therapy, visiting nurse) ☐ Patient will demonstrate the use of Note for progressing thrombophlebitis E (e.g., calf pain, Homan's sign, redness. adaptive devices to increase mobility localized swelling, a rise in temperature) N Patient will have normal elimination Encourage fluid intake FLIMINATION M Normal Elimination ☐ Encourage fibre diet intake ☐ Encourage early ambulation Gatheter, bedpan, urinal Nasogastric tube ☐ Patient will control of urinary ☐ Rowel movement in-continence or urinary retention. Report any abnormalities to physician Lirination control of bowel incontinence. ☐ Observe voiding accessories as foley's / Others: and regular elimination patterns silicone catheter ☐ Check placement before feeding
☐ Aspirate NG tube, check colour / consistenct Ε / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constinuation / urinary retention Ν SKIN INTEGRITY Patient will maintain normal Minimize / Eliminate friction and shear Maintain normal Minimize pressure (off-loading) with special beds Maintain normal skin integrity healing status Make sure wrinkles free bed / comfort surfaces Pressure points site Patient will discharge with intact and devices assessment skin integrity ☐ HAPI ☐ OPI ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin

Maintain adequate nutrition and hydration

Proper application of medications and dressing **GRADES OF PRESSURE** INJURY ☐ GRADE 1 ☐ GRADE 2 GRADE 3 GRADE 4 Follow doctors and TVN order properly ☐ Unstageable Monitor the healing status E ☐ Deep Tissue Injury Educate patient and family members about further ☐ Healing Status skin care PUSH Decreased PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis Pressure injury / blisters site care given Ν Others:

	Patient Specific 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	MPE 4000 hygrau	My
	SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	MID Band present E N	
	COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	M E N	
•	OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M vital signs checkodigs econd E	Copy
	PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M - E	

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	Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
अन्	COMMUNICAT Verbal Non-verbal	TION	Patient will communic with positive feedback	ate effectively \	Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		MPE 4000	munication	Harata
	☐ Sigh languaġe ☐ Others:			No negative speaking about the patient's condition or prognosis in the patient's presence		E			
							N		
•	SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood p transfusion Fluid tapping DVT Manageme				Double check for high alert medication Observe and report any medication reacti Provide proper measures of wound care Follow hospital polices and protocols of is and explain to the patient / family Check for cross matching and typing, to a compatibility Practice strict asepsis while transfusing b blood products and fluids	n Modiali as por as	ion given Jung Chart	New	
	Others:	STR.			☐ Monitor DVT score and continue treatment as per doctors order		N		
		Signature		Name		Emp. ID		Date	Time
	Endorsed by No.		ralix.	0024		2/1/24	16:00		
	The second of th	f 9 g				•		r'	-





MIS.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



Date: 20 12 23

	BRADEN S	CALE FOR PREDICTION	<u>NG PRESSURE INJUR</u>	Y RISK Time:	90	E-	10					
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	A-No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	¥					
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 Molst Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		3	3					
ACTIVITY degree of physical activity	1. Bediast Confined to bed	2. Chairfast Ability to walk severely timited 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	١					
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in bodycor extremity position but unable to make frequent or significant changes independently	3. Stight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		3	3					
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		3	3					
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible, Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	No Apparent Problem Moves in bed and in chair independently strength to lift up completely during move. No or chair			3	3					
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE		M	17-					
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:		2059	0211					
Score	Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 Initial & Emp. No. of Sr. Staff Nurse:											





Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





Pate: 31 10 2-3

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR'	Y RISK Time:	w 51	12	101				
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 discorptort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities			14	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. Occastonally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		3	3				
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		1	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		3	3				
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	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	3. Adequate Eate 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	3	3	_3					
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices.	3 No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	13 13	3	2 2					
Score	Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 Initial & Emp. No. of Sr. Staff Nurse:										





MIS.RAJAMMAL C

73/Female/MHM66291 30/12/2023/1PH2023002638

Dr.K.JAISHANKAR





Date:

_	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RIS	SK Time:	1/1	j-	Fi_
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	erbal commands, but Respo communicate discomfort deficit value on twhich limits ability to ability to affort in 1 or 2 extremities			G	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	y Moist usually dry, linen only s changing at routine s		ij	2	
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	s Frequently outside room at least day and inside room once every two hours vaking hours		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	Slight Limited Makes frequent through slight changes in body or extremity position independently	mitation major and frequent s in position without nce	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	4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement	lient refuses a meal. refuses a meal. eats a total of 4 or ervings of meat and oducts. Occasionally stween meals. Does uire supplementation	4	4	4	
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,				3	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:	23	29	23 Out
Score	Interpretation: Minimal Risk: 23 - 19; At Risk ;	1 Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6		Initial & Emp. No. of Sr. Staff Nurse:	24	110	100





Mrs.Rajammal C

73/Female/MHM66291

30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



MHI/NUR/2022/045*
Heart
Institute

Every heart beat counts

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time	: <u>2</u> : m		2 3,				
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited	ort commands. Has no sensory me deficit which would limit to ability to feel or voice pain or		-	N				
MOISTURE degree to which skin is exposed to moisture	1. Constantly Molst Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	A-Flarely Moist Skin is usually dry, linen only requires changing at routine intervals							
ACTIVITY degree of physical activity	Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours							
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 Simitation Makes major and frequent changes in position without assistance			•				
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	products) per day. Occasionally will refuse	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 & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair			3						
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse: Initial & Emp. No.	1 ~	-					
Score	Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 of Sr. Staff Nurse:										







Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



MHI/NUR/2022/052



PAII	N R	E-ASSESSMENT	& MO	NITORING	CHART	Every heart l	beat counts
ایا	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
2:05	0/10	No page	_	1	(O MA	NOO- 024
13:05	0/10	No pair		<u> </u>	· · · · · · · · · · · · · · · · · · ·	0159	Na2-
(4, 5	O/W	2.5	<u></u>			Log Por	Nac
15.5	or	no poin				Ay.	Nas
16:5	Op	NO provy	-			7	Nac
(J.5	40	No porty				Ly.	Nac 824
18.5	Or Go	No poin				#	Nac
(9.5	ho	No poin				A	Nae 027
do. 05	0(w	No Jain	<i>A</i>	-		021	20 5

Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.			
d1:05	ollo	١	no bany			,			A SOLI	Mosy			
તૈધ:05	0/10		No Pain	_			<i>ــ</i>		(FC)	Day			
\$3:05	8	No Pour		J	. (-			100 M	Nagy.			
31/d/23 00:05	: , D(Lo		No fanz	~		,		,	A SA	. Pag			
PAIN SCALES													
; (28 week	PIPPS cs to <u><</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 for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.										
	ACC Sca		0: Relaxed & comfortable	laxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both									
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)		cale	O 2 No Hurts Hurt Little Bit	(©) 4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating Sc 0 1 2 3 4 None Mild	ale (age mo	7 8	9 10			
Observa	ical care I ation Tool ator / com	(CPOT)	COMPLIANCE WITH VEI	Absence of m NTILATION (in Ubated patien Relaxed, 1 - Te	novements or normal intubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Ta	position, 1 - Protection, 2 - Rest D - Tolerating Ventilator or Mover ormal tone or no sound, 1 - Sighi ense, Rigid	lessness / Agitation nent , 1 - Coughing but tolerating ing, Moaning, 2 - Crying out, sob		entilator (or)				
	harmacol tervention		Cutaneous Stimulation a Thermal Theraples (no lo	i <mark>nd massage:</mark> inger than 15	E - Positioning; F - R to 20 mlnutes): G - C	c - Music; D - Physical and ment tubbing / Massage the skin old application; H - Hot applicat terferntial therapy Psycho- so		lividual Counse	eling; L - Family	counseling			
Pharmac	ological i	nterventio	ns as per doctor's prescrip	tlon				<u> </u>					





PAIN RE-ASSESSMENT & MONITORING CHART

No Pour

No

8.5 0/10

al 10



Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



MHI/NUR/2022/052

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Every heart beat counts

Senior Staff **Pain Character** Pain Staff Initial Date & Initial & (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain) Location / Site Duration Interventions & Emp. No., Time Score Emp. No. 31/12/22 0]0 No lan 01:05 عارون Olo 02:05 No Pour Ort. 00 No Run 03 : os 0/0 Nace 04:05 No Pain عاسعت OTH Nao No Pain 0/0 05:05 024 Nea No Pain 0b:05 0/10 024 0/10 Nac 07:05

₩ * V		. '		•	•	_	•	_						
Date & Time	, Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, referred / radiant pain)	Duration	Location / Site		Interventions				Staff Ini & Emp.		init	or Staff tial & p. No.
<u>. 2 9 0</u>	Olio	No	pain	-	_		~				3)	1) c	- P
1/1/24 200	0/10	No	V Pain	_			-						85 No	ve vet
6.00	ماه		Dais	-							A) 	No	م اسما
[0·00	olio	No	pain	_	_	-					20 020	7	65 Ne	9
	PAIN SCALES													
(28 wee	- PIPPS ks to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		on							•	
(38 we	CRIES eks - 2 m	onths)				s of gestation. A maximal so				re is > 4,				
	LACC Sca		0: Relaxed & comfortable	e, 1-3: Mild d	lscomfort, 4-6: Mod	erate discomfort, 7-10: Seve	re discomfort / pain /	/ both	-			•		
Pair	(2 months - 7 years) Wong-Baker FACES Pain Rating Scale (7 years - 12 years)		O 2 No Hurts Little Bit	66 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical 0 1 2 None Mil	2 3 	4	(age mo		12 y 	9)
Observa	ical care l ation Tool ator / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (I subated patler Relaxed, 1 - Te	novements or normal ntubated patients): nts): 0 - Talking on no ense, Rigid, 2 - Very T	position, 1 - Protection, 2 - Re 0 - Tolerating Ventilator or Mov ormal tone or no sound, 1 - Si ense, Rigid	vernent , 1 - Coughing	but tolerati		Fighting v	rentilator (o	or)		
	harmacol iterventic		Cutaneous Stimulation a Thermal Therapies (no lo	and massage: onger than 15	: E - Positioning; F - F to 20 minutes); G - C	C - Music; D - Physical and me Rubbing / Massage the skin old application; H - Hot applic terferntial therapy Psycho-	cation; I - Shortwave d	iathermy selling: K -	Individu	al Couns	eling; L - Fa	amily	counse	eling
Pharma	cològical	Intervention	s as per doctor's prescrip	tion					• 1		1		,	







Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

dr.K.Jaishankar

MHI/NUR/2022/052



Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

	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.
W,00	olio	No push		•		Aus.	Nac
12,00	9/10		ì	J		BU	Nacas 2024
2200	o lu	ro pain	<u>.</u>	-		Ore Ore	Nad
0.00	123 Olia	no pain	-			Ö	Naa 024
D, OO	olic	no pain	_	-		Ord	Neca.
		<u>'</u>					
,						_	

Date &	" Pain Score	dull, achy	ain Character , sharp, stabbing, shooting, ,, referred / radiant pain)	Duration	Location / Site	Intervention	ons	Staff Initial & Emp. No.	Senior Staff Initlal & Emp. No.
	e/	v	lo mil		r 4	+		A STATE OF THE STA	Dory
100	र्वार्		No dri	7	<i>F</i>	1 -/		Po	Nag
1	,	, •					:		
1	,	٠.					·, ,		
	1	,	· —		<u> </u>	IN SCALES			
(28 weel	PIPPS ks to ≤ 36	3 weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me		n			
(38 [°] we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is po esic administration is indicated for a sco		,	-
	ACC Sca		0: Relaxed & comfortabl	e, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort	/ pain / both		
Pain	g-Baker F. I Rating S ars - 12 y	icale	O 2 No Hurts Little Bit	60 Hurts Little	6 Hurts Even More	8 10 Hurts hole Lot Num Num Num Num Num Num Num Nu	erical Rating Scale (age m	ore than 12 7 8	9 10
Observa	ical care lation Tool ation / con	(CPOT)	COMPLIANCE WITH VEI	Absence of m NTILATION (In ubated patler Relaxed, 1 - Te	novements or normal p ntubated patlents): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Ag - Tolerating Ventilator or Movement , 1 - Cot mal tone or no sound, 1 - Sighing, Moaning nse, Rigid	ighing but tolerating, 2 - Fighting	ventilator (or)	
	harmaco		Cutaneous Stimulation a Thermal Theraples (no lo	and massage: onger than 15	: E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mental exercisers abbing / Massage the skin Id application; H - Hot application; I - Short orferntial therapy Psycho-social therapy	wave diathermy /counselling: K - Individual Couns	seling; L - Family	counseling

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Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638 Dr.K.JAISHANKAR



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

			- 	_+-			iterei iio	. 10
1			31/12/23		0/1/23			
	Time	12:05	0019	<u>7.00</u>	7.00			
S. No.	PARAMETERS	_			·			
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	Ø	0	ව	D			
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	Ø			
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	Ø	0	Þ			
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0	Þ			
5	Entire leg swollen (Assess for both legs)	O	Ø	0	Ø			
6	Localized tenderness along the deep venous system (Assess for both legs)	0	Ø_	۵	D			
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	6	Ø	ଡ	P			
8_	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	۵	Ø			
9	Previously documented DVT (Assess for both legs)	<i>∂</i>		0	p		_	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	Q	0			
	FINAL SCORE	<i>D</i> _	0	Q	D			
Low F	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	1000	Lace	100	مرمز			
	DVT prophylaxis started	☐ Yes ☑ No	☐ Yes ☐ No	Yes	□ Yes No	□ Yes □ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	(B)	Han	(A)	2000			
	Signature & Emp. No. of Sr. RN	والمحالية	No.	مرعوبا	Par			



Medway Hospitals

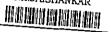
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR







MODIFIED MORSE FALL RISK ASSESSMENT CHART

						, 				
Variables		30/12/25	530/13/33	3/1/2/23	6)/14	3/12/2	01010	11124	1/1/24	2/1/24
	Time	2.05	20:00	8:00	14.00	200	8100	ر د ر 60	70 ⁻⁵⁰	8.01
History of falling	No	(o)	0	a	(B)	-0/	رو	و	10	-
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No		0	0	2	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	(15)	(15)	157	(65)	45	15~	15	J15	\15_
Intravenous Therapy /	No	0	0	0	(20)	0	_ 0	۰0	0	0
Heparin Lock / Tubes Insitu	Yes	(20)	2 0	26)	(20)	20	30	20 7.	20	(20-
AMBULATORY AID .)				_			
None / Bed Rest / Nurse Assist		/ 0	(o)	(9)	(C)	0	0	10/	\sigma_{\rightar}^{\rightar}	0
Crutches / Cane / Walker		45	15	15	15	15	`15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT ·			A							
Normal / Bed Rest / Wheel Chair		/0)	(o)	©	(a)	0	ر م	0	, o	0
Weak		46	10	10	40	10	10	10	10	10
Impaired .		20	20	20	20	20	·20	20	20	20
MENTAL STATUS		10								
Oriented to own stability		(0)	(0)	(97)	(g)	.0_	0	Ve/	ره,	10
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	. 6	(o)	<u></u>	0	0	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	48	15	15~	/15	_15,
Total Score		Y	35	35	3	35	50	50	50	20
Low Risk (0 - 24)		/	·							
Medium Risk (25 - 44)		9	/	7	1/	2				
High Risk (45 or above)		<u>a</u>						X	1	
Signature & Emp. No. of RN		D G	A Sylven	Por	3110	1542	Food	Alu	Diffee.	Palate
Signature & Emp. No. of Sr. RN	•	1994	Por	Mark	Negr	124	100	100	750	سعوا
		0 - 2	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	ı Risk

								i	,	- 1
	Date	100	3d12/23	1 1.2	01/12	112	2 , ,	1 100] ;	111
INTERVENTIONS	Date	3,01	300	Q1/12/23	31/1	3/17	61/01/64	III V.	# }	211/2/
Tick as per the Risk Score	Time	2.5	20:00	8,00	1400	2000	9.00	40	20.00	80 b
Low Risk Interventions (0 - 24)		*		_						
Familiarize the patient with the immediate surround	ings	17			•					
Remind the patient to use call bell before getting ou								7	7	
Keep the two side rails in the raised position at all t	imes for									
all patients regardless of age				V				7		
Keep the call bell, bedside table, water, glasses w	ithin the		_ر_ ا	<i>-</i>		l ./				
patient's easy reach				ļ. —		<u> </u>			1.2/	
Remove excess equipment or furniture to make	a clear				_		ł.,	12		-
path Keep the patient's bed in the low position at all times		-		-			ļ - -	-/	 -/-	<u> </u>
during procedure	sexcept			ارن ا					$ \wedge $	<u></u>
Teach fall-prevention techniques, such as sitting	un for a		-	}	-	-		- /	 	
moment before rising from the bed	ор юга			ر ب		V			$ \langle \rangle $	
Bed wheels should be locked				9				7		
Encourage family participation in the patient's care				1					1/2	
Ensure that floor of the bathroom is dry and not slip	pery				-2			7	1	-
Review medications for potential side effects t	hat can			_				7	5	
promote falls					4	_/			7/	
Use safety belts during movement in wheelchair			<u> </u>	√		/		-)		
The patients are not ambulated by themselves. The	ey are to			_	`			5	′	_
be ambulated only with assistance						<i>\</i>	1	′	$ \gamma \rangle$	
Medium risk interventions (25 - 44)				<u> </u>	2			7	15	
Apply all the low risk interventions				<u> </u>		· · ·			1/2	<u> </u>
Tie yellow fall risk tag in the bed and Wheel chair / S		-		<u>~</u>	-	- V	,	1	12/	
Make sure that proper transfer precautions are in for heavy or debilitated patients in a bed or wheel					_	_	·	1		
on a toilet seat	Criaii Oi							′	//	'
Use restraints and bed monitors as ordered by the	doctor			5/1	7			5	1	
Allow the patient to ambulate only with assistance						/		 	1	-
Consider peak effects of the medications that effe	cts level					<u> </u>		7	<u> </u>	 / -
of consciousness, gait and elimination when p	lanning	1		2		🗸		′	0	
patient's care								1	,	
Do not leave patients unattended in diagno	stic or								1	9
treatment areas				~	1			1	<u> </u>	<u> </u>
Accompany the patient while going to bathroom		<u> </u>		<u> </u>					12	
Advice the patient to use grab bars near the toilet, I	oathtub,				//	/				
and shower				<u> </u>			,	-	 /-	- /
Make sure the family and other visitors understrestrictions mentioned above	and the			ا . ا				5	17	
High-risk interventions (45 or above)				<i>\(\)</i>					1	
Apply all the low and medium risk interventions							/	4	1	
Tie red fall risk tag in the bed, wheel chair and stretc	her						1	- /-	1	
Locate the high-risk patients in a room close to the		-							 	
station	·	L	٦		<u> </u>				1	
Answer these patients call bells as quickly as possi	ole						<u></u>	L	1	
Provide a commode at bedside (if appropriate)							N	\overline{C}	5	
Urinal/bedpan should be within easy reach (if appro								0		
Encourage family members or other visitors to s	tay with						-	5		
them		<u> </u>				<u> </u>	<u> </u>		 	
If appropriate, consider using protection devices	safety							\	1	اہر ا
belts			(A) -		Stant .	A		0410	Da) //	1 × 101 ,
Signature & Emp. No.	of RN	\mathbb{Z}_{λ}	80%	85H 1		XX	20		800/66	
Signature & Emp. No. of S	Sr. RN	100	Paras	105	المول	100	100	Mes	مخگا	سقوا
		نگیا ا	V	12×	200	- D8	70	' ')/	· • • • • • • • • • • • • • • • • • • •	-162





MIS.RAJAMMAL C
73/Female/MHM66291
30/12/2023/PH2023002638
Dr.K.JAISHANKAR



PATIENT AND FAMILY EDUCATION RECORD

Assessment To be fi						olines. U						שא					
Barriers to	Lear	ning								Plan t	o A	ddr	es	s Factors			
None] Use	of l	nterp	rete	er										
Limited Reading Abilities		Physic	al b	arrie	rs] Edu	cate	fam	ily				
Religious / Cultural Factors	<u></u>	Langu	age	barri	ers				Simple Language								
Congnitive Limitations - unable to	ı	Low m	otiv	ation	/ de	esire to	learı	1		Writ	ten	Instu	ctio	ens			
understand and follow directions			_		_	=	-		1	ሻ _		_		·			
Completed By : Date 30/12/23 Tim	1e	2 : 0	り	_ N	urs	e Signa	ture	:		16	9						
								-		<u> </u>				<u>.</u>			
Learning Record										ſ	T						
Need		Date	ľ	/isit	1	Date		/isit	2	Date		Visit	3	Signature			
	2	dz^{22}	4	Р	0	3/13/23	L	P	0	1/1	F	Р	0				
Disease				_										<u>Doctor</u>			
Information on			0	p77	v									Dcv4nish Nelson			
Disease / Diagnostics			ľ	"			p	οĐ	v		ıρ	OD		*Reg. No: 8843			
Treatment			Ω	6P	ン						<u>'</u>						
Medications														Doctor / Nurse			
Information on Safe and		•	n	bp	υ		_										
Effective use of medicines	,			<u> </u>			P	e ()	V		P	0Đ	√	7/5/h1			
☐ Information on drug / drug and	′		. 0		.)						[
drug / food interactions				017	<u> </u>		p	go.	V		12	00	√	1609			
☐ Discharge Medications									L		Ľ	╙	L	,			
Surgical Instructions									<u> </u>	_	L	<u> </u>	L	Nurse			
Pre - Operative Instructions									L			_		,			
Post - Operative Instructions	1				'			\	1								
(Wound / Dressing Care)					$oxed{oxed}$				L			<u> </u>					
Pain Management	_		Ļ		_		Ļ		<u> </u>			<u> </u>	L	Nurse			
Reporting of pain	_		P	5	7		9	191	DV Fine Or					5000r			
Pain Management			P	ξ) ,	\forall		Ρ'	<u>ئ</u>									
Safe and effective use of medical	'								Doctor / Nurse								
Equipment (if required)	+	<u>-</u>		_	_			<u> </u>		 	_	 	-				
Name of Equipment														}			
Rehabilitation Techniques	- 1			l		1	1	ı	l	Ì	I		[

Need	Date	\ \	/isit	1	Date	\ 	/isit	2	Date	\	/isit	3	Signature - ,
-		L	Р	0		L	Р	0		L	Р	0	
Nutritional Guidance				П								П	Dietician
Diet Instruction for patients at Nutritional risk		D	ø	J		P	9	\$		4			Senior Vicine John
☐ Diet advice for home					_	ييد		ľ		V			-Nurse
Discharge Planning													
Self care				П									
Follow up		_		L	_	<u> </u>		Ш			_		
Reporting Concerns Immunizations						,							
Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation					•	•						$oxedsymbol{oxed}$	Doctor
☐ Weight Control				Щ								\Box	
☐ Exercise				Щ							<u> </u>	$oxed{oxed}$	
Hypertension		_		Ц									
Other Risks	٠.												
Written Material given and explained	d (if any)		:				٠						
Reports Given :	· 										_		
Given Pendi	ing)	NA.	_			,	•		Giver	1	Per	ndir	ng NA
Discharge Summary			_ [Diet	Advice								
ECG Report			_ (CT S	can Re	port					•		
Doppler Report			-		Scan Fil		•	•					
X-Ray Report			$\overline{}$		O Repo								
X-Ray Film			١.		sound		ort	•					
Compact Disk			١.		Other F			•		_		_	
				/,,	<u> </u>	.ope				_			
Name of Attendant / Patient :		2.				>	Sig	nati	ıre.		•		, ,
Name of Discharge Nurse				~			Sigi	natı	ire:				•







Mis.Rajammal C

73/Female/MHM66291 U 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





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Assessment To be f	illed by con									UR	עו		
Barriers to	Learning								Plan t	o A	ddr	ess	s Factors
None	☐ Vision	/ He	arin	g lin	nitations	;			Use	of Ir	iterp	rete	:r
imited Reading Abilities	Physic	cal b	arrie	rs					Edu	cate	fam	ily	
Religious / Cultural Factors	Langu	age	barr	ers					Sim	ple L	ang	uag	e
Congnitive Limitations - unable to Low motivation / desire to learn Written Instuctions											ns		
understand and follow directions										١			
Completed By : Date 2 12-2 Tim	ie_ 28 -0	0	1	lurs	e Signa	ture	:_		0	0	Ņσ		
Learning Record				_									
Need	Date	Į ,	Visit	1	Date	\	/isit	2	Date	١	/isit	3	Signature
	3/1/8		Р	0		L	P	0		ᆚ	Р	0	
Disease													Doctor
Information on													Jac W
/ Disease / Diagnostics		P	0	У									dae
Treatment													
Medications		P	a	M									Doctor / Nurse
Information on Safe and				7									-
Effective use of medicines		P	OD	У	,						•		Dal
☐ Information on drug / drug and													024
drug / food interactions		P	OF	Y									,
☐ Discharge Medications													
Surgical Instructions													Nurse
Pre - Operative Instructions									l				Mari
Post - Operative Instructions													0)4
(Wound / Dressing Care)		$\mid \mathcal{P} \mid$	OD	y									
Pain Management													Nurse
Reporting of pain	Reporting of pain POPV									L. 2-			
Pain Management		P	08	Ų	}								24
Safe and effective use of medical												П	Doctor / Nurse
Equipment (if required)													
Name of Equipment													
Rehabilitation Techniques													

leed	Date	١	Visit	1	Date	١	/isit	2	Date	١	∕isit	3	Signature ,
	2010	ī	Р	o	शाध	L	Р	0		L	P	0	,
Nutritional Guidance								\vdash					Dietician
Diet Instruction for patients at Nutritional risk		P	op	V		P	**	V				ļ.	aria Cath John Senior Dietham
Diet advice for home		17	مو	Ų		V	~		,				Nurse
Discharge Planning													
Self care	·												
Follow up `		<u> </u>		Ш						<u> </u>	<u> </u>		,
Reporting Concerns Immunizations													
Parenting education				П					_	Г	Γ		
Others											Ŀ		
Risk Factor Reduction													
Smoking Cessation									•	,			Doctor
Weight Control				·						·			
Exercise			<u> </u>	Ц						L	<u> </u>		
Hypertension													
7			ı							1	l		
PROCESS (P)- OD - Oral Discussion	, D- Dem	ons	trati	on,	W- Wri	itter			•		(;	Sta	te Relationshi
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EARNER (L) - PzPatient, M - Mother PROCESS (P)- OD - Øral Discussion DUTCOME (O) - RD - Return Demonstrates Material given and explaine Printed Printe	ing	ons	Verb	Diet CT S	Advice Sçan Re Scan Fil	port m ert Repo	tane	ding	Give	 	Per	ndii	ng NA





Mrs.RAJAMMAL C 73/Fcmalc/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 20 (12 23	Time:	12/10	15				
Checklist	Yes	No	NA	A	ction / Remarks		
MEDICAL							
Daily Consultant Visit	/						
Plan of care discussed							
Discharge Planning	\						
Others if any							
NURSING							
Safety Precautions Ensured	5						
Care of Lines and Tubes	بسه	,			_		
Infection Control Measures	7						
Skin Care	7						·
Response to assistance	<u> </u>						
Others if any					_		
DIETICIAN			,				*
Diet Adequate							
Special Request			_				
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living							
Others if any							
PATIENT CARE SERVICES							
Room Cleaning satisfactory				•	_		
Room Amenities Adequate							
Billing Update available					-		
Non-Availability of any service						-	
Spiritual Needs (if yes specify)				•			
Others if any							1
		In	iter Dis	sciplinary Team Members	<u>-</u>		
	Sigratur			Name Dr. Anish Nelson	Reg. / Emp. No.	Date	Time
Doctor	Afril	1)/		Reg. No: 88434	Dr. Anish Nelson Reg. No: 88431	8012-23	
Nursing Staff	7	D~		Q. Nalin Waria Catherine John	2084	20 12 52	0/20
Dietician Physiotherapist		MKIII	<u>.</u>	Senior Dictition	lapse	30/mh	Contract
Patient Care Service Staff					,	 	
ratient Care Service Staff			_		<u> </u>		





Mis.Rajammal C

73/Female/MHM66291 30/12/2023/IPH2023002638

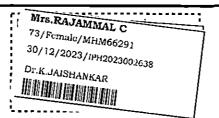
Dr.K.JAISHANKAR





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PHONE	/ VERBAL ORI	DER FORM / C	CRITICA	L VALUE	REPOR	TING F	ORM
	☐ Telephone ord	ler	der 🗗 🤇	ntical value	reporting f	orm	
Name of the	e Drug N/A		Dose	Route	Additiona	ıl informatio	on if any
						·	
Lab / Radio	logy Critical result repo	orting (if any): N	/A Inform	ed to Dr.:	ANIESI	4	
	TROP	I Court &	958.	8			
		I Caut >	425				
		,	,,,				
Non Medica	ition Order (if any):	N/A		_			
					-		
Order Recir	pient Response: Please	Tick		=			
	Yes No	Read Back Yes	No	Confirm	Yes 🗌 No		
Received	by		Ordering	g Physiciar	n / Informi	ng Staff	
Signature:		Date: 30/12/23	Signature		1 <i>J</i>	Data: 4	ا در ما درا
Name: ⊅ _/ ฟ Emp. No.:	0159 0159	Time: 14.90	Emp. No.:	NDUNDAH+	,	Date: 30	4.36
Action Take	n (only in Cases Of Critic	cal Value):	•				ļ.
	•						
	ona ±	PCI					
	SIGNATURE	NAME		REG. NO.		DATE	TIME
Doctor	Am	Dr. Anish Nels Reg. No: 884		Dr. Anish N Reg. No: 8	elson 8434	20/12/28	14.36







IN-HOUSE TRANSFER FORM

Part	t A (to be filled by Nu	rses)									
Date of Transfer: 811/2/25 Time: 12-10 Transferred from: CW To: 205											
Diag	gnosis: CAD//	ACS / I	LMI	-/ L70	ed ETN	x/ mar/cops	9				
Vital	I Signs: Tempet) (°F	F) Pulse / HR:	म्हा	(beats/n	nin) BP: 190	(mmHg) Resp	oiration: 2/ (breaths/min)				
Part	B (to be filled by Ph	ysicians) /	Any Critic	al Investig	gations:		•				
	Check for				nsferring Docto	or	Receiving Doctor				
· ·	piratory (Breath sounds)	-	Crepitat	tion F		thers:	Yes No				
	omen	Soft _	Tender			thers:	Yes No				
Hearl	t Sound	Normal [Feeble		d Others:		Yes No				
CNS		Consciou	us U Or	riented	GCS Scor	re:	YesNo				
	Surgical Patients plicable)	Surgical Site:	Heal	lthy S	Soakage	thers: NU	Yes No				
		Prese	nt Medic	ation (for	Medication Re	econciliation)					
S. No.	Current Medic	cation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay				
1	T. ECOSPIRIN	J	75 mg	plo	070.	3/10/27/20 9.00	∐ Yes □ No				
2_	1. CLOPILE		1 2		010.	ķ	☑ Yes ☐ No				
4	7.210000		80 2	00	001.	0	☐ Yes ☐ No				
	7. PLANEDON	womn	B 350	16	201.		∃Yes □ No				
آ ج	1. Numocory	710	20,	Plo	107.	(☐Yes ☐ No				
ا ط	1. PAN			P6.	(20).	.,	☐ Yes ☐ No				
7	R. ALPRAY	7	0.25.4		027.	<i>f</i> .	☐ Yes ☐ No				
D	1. Ameorie	L .	2.53	No	100.	7	⊒Yés □ No				
9	1. Ameoria		207	مہ	2-007.	1/3	□-Yes □ No				
10	Syp. CREMA,	FFIN ISK	25	PLO.	D-27.	4,	☐ Yes ☐ No				
γ	C. PLDACTE	2N2	259	Mo.	100.	"/ 	□Yes □ No				
						/	☐ Yes ☐ No				
			<u> </u>	<u> </u>			☐ Yes ☐ No				
			<u>'</u>		<u> </u>		☐ Yes ☐ No				
i I		'	1 '	1 '	1 !	1	. □ Ves □ No				

Additional Det						_		
	1	copiet o	ver (1) eyelir.	3-6	i Fines aday			- 1
	1							1
								l
Patient Condi	tion:	Stable	Sick-need urgent care	Oth	 ers:			
	Sign		Name		Reg. No.	Date	 -	Time
Transferring Doctor	2	~	Dr. K. Anusu		25851.	31/	(2/2)	\$ 0.00 PM
Receiving Doctor	/L	·80	Dr. K. Arusai	19	134559	31/	12/83	12/10
Part C (to be t	illed I	by Nurses)						
Check for			Transferring 1	lurse				ng Nurse
Drains		Chest A	bdominal Others:				∐ Yes	No
Respiratory	Air Way Type: Patent Tracheostomy Others: Bate: Ii/min							□ _{No}
NG Tube / Oral		☐ Yes ☑ Ńo	For Feeding Gastric S	uction	Fluid Restriction		Yes	No
Foley's Catheter	r	Yes No		Yes	□ No-			
Intravenous Acc	ess	Peripheral Li	ine Central Venous Line Others:					☐ No
Pressure Injury	-	Yes \	If Yes, give details:				Yes	□ No
Score		Fall Risk: 50	WELLS: NEWS/P	EWS:			Ves	- No
Patient Belongir	ngs	Yes /No	If Yes, give details:				☐ Yes	No
Handover Detail	s		inistration Record explained⊱ c Reports handed over: ☐ 🔀				. Yes	No I
Patient Attendar Informed	ıt ,	Yes No	If No, give details:				Yes	No No
Additional De	tails (if any): NIL		-				
		1/11/						1
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<u> </u>	Sign		Name		Emp. No.	Date	, 	Time
Transferring Nurse		- Cyr		<u> </u>	0189			40
Receiving Nurse	E	·Cot	Derrig . I		020 म		2/23	01.8)





Patient Details (Affix Label hore) Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR





FAMILY COUNSELLING FORM

CONSU	LTANT- DK	- Jaisha	DIAGNOSIS- CAP &-ACS / Da	te mi		
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
, 50/m/23	poct4	Gnardson .	barren consinon exempsons to accusion		Par.	Dr. Anish Ne sa Reg. No: 8843
	DECTOR		pt conduction acptained 9 ward shifted			184022)







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME 73/Female/MHM66291

Mrs.RAJAMMAL C

30/12/2023/IPH2023002638

AGE / SEX:

Dr.K.JAISHANKAR

IP No. / UHID No

Ward / Bed No. CCC /o2

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.
20/12/23	13:00	Anesthern	0/5	Inserted	Alisto	bluwed	20159
5	20:00	Arnstrosja	015	<u>Patout</u>	Flushod	Fallowad	A 7071.
81/12/23	8-00	Anesthogo	0/10	purport	Flushed	followed	(Red)
İ	0	LT A.	05	patent	Planshel	Lall busel	
0	70·00 20·00	id-vestheti	1/	Patient Po	hasva	Jollowel	
4.3							•
		1.6					\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	oo oo	Brachal		patent	flushed	followed	1530×
128/10/10	lu"	Boaling (F)	012	parena	fueld	follows	Keys
	20.00	brackia	6/5	patent	Pittinee		a la
2/1/24	\$ 20	Bracha		Patent I line Per	flushod		79.77
				10 wise feet	138V C		
			;				
	_		<u> </u>				



Drug Chart:__



Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Height (cms): <u>1</u>4기

Dr.K.JAISHANKAR



MHI/PHARM/2022/028



Every heart beat counts

Weight (kg): <u>59.1</u>

MEDICATION ADMINISTRATION RECORD

		KNOWN MEDICINE AL	LERGIE	S (if NO	ONE is c	onfirmed,	write NKDA ii	1 box 1)	_		
Drug D	etaíls		Descri	ption of a	Allergy	<u> </u>		Doct	or's Sign:		
		- " -		N K	DA				Name: Dr. Anish Nel Reg. No: 884		
	<u>. </u>					•		<u> </u>			
L T	ОСТО	R INSTRUCTIONS	4.051				TAFF INSTRUC	CTIONS			
2. Write i 3. Sign a 4. No pre	n BLOCK nd enter escription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	3. For ne follow 4. Stand Q8hrly	 Nurse in-charge should verify drug chart on daily basis For new prescription, follow the timings of doctor's prescription on Day 1 only, and ther 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, 10:00hrs, 14:00hrs, 14:00hrs, 18:00hrs, 22:00hrs, 10:00hrs, 14:00hrs, 14:00hrs, 18:00hrs, 22:00hrs, 14:00hrs, 14:00hrs, 14:00hrs, 18:00hrs, 22:00hrs, 14:00hrs, 14:00hrs, 14:00hrs, 18:00hrs, 22:00hrs, 14:00hrs, 14:00hrs, 14:00hrs, 18:00hrs, 14:00hrs, 14:00hrs, 18:00hrs, 14:00hrs, 14:							
		Stat / C	nce O	nly / P	remed	ication	Drugs				
Date	Time	Drug		Dose	Route		Doctor		Administered		
30 leb3	5.00	T. Min		650mg	oval	Sign.	Reg. No. Dr. Anish Nels Reg. No: 884:	Sign.	Emp. No.	Time 15:00	
CANADA	8/39	TAVE! LASKS		2011	18			SA	9(39).	8.50	
A	6.40	T. ALBAKIPNEL		+	oral	•		A	01597	5.40	
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2/1/14	9.25	JNT: DILZEM	١	D-21203	ДA	am	0 721	Que	0176	9.20	
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7

To be filled by Nursing Staff only. Sign and time given Date → **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time 1 **DRUG NAME** 7. EWSPRIN Clinical Pharmacist Medway Heart Institute 14.00 Dose Route Frequency 0-1-0 P1-Start Date & Time 30 12 00 Dr. Sign & Reg. No. / Seal Stop Date & Time 0 Additional Info: **DRUG NAME** 7. cupum Dose Route Frequency Clinical Pharmacist Medway Hearl Institute 14.00 0-1-0 Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** 7, ADMAS Route Frequency Dose Clinical Pharmacist Wedway Heart Institute 80 m 0-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time @ 90 CO Additional Info: **DRUG NAME** 7. FURNESON -MR Route Frequency Dose Clinical Pharmacist Medway Heart Institute 8.00 1-0-1 Start Date & Time 20/12-12-30-12-10 Dr. Sign & Reg. No. / Seal Stop Date & Time Ø 20.00 Additional Info: **DRUG NAME** 8.00 してしていいいから Clinical Pharmacist Medway Heart Williamte Dose Route Frequency 1-0-1 (0 Start Date & Time Dr. Sign & Reg. No. / Seal 20/12/2012.10 16.00 Stop Date & Time 0 Additional info: Area In-charge **Nurse Signature:**

• ,	REGUI	LAR PRESCRIP	PTIONS I	Date →			y Nurs	ing Sta	ff only.	Sign a	nd time	given
		filled in by Doctor		Time ↓	DC 100	31/12	dili	Hi				
•	DRUG NAME	<u>·</u>	· ·		6	6.10	-1.0°	5.30				
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	Dose 407	Route D>-	Frequency	•							} <u></u> ,	
acist liture	Dr. Sign & Reg. N	lo. / Seal	Start Date & Time		<u> </u>							
Aclinical Pharmacist Medway Heart Institute	And		Stop Date & Time									
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Q ₹	DRUG NAME											
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oy Heart Institute	Dr. Sign & Reg. N	lo. / Seal	Spart Date & Time 2:10									
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cist ilute	DRUG NAME	3		8.00	(3.00	-1073 -	8.40 PS:	5.30 (2)	1			
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i		gneu	Stop Date & Time	 		100	<u>-</u>					
Q	Additional Info:											
	Area In-charge Nurse Signature	o:				130 IA	55°4	00211		•		

REGUI	AR PRESCRIF	PTIONS I	Date →	To be	filled b	y Nurs	ing Sta	ff only.	Sign ar	nd time	given	
	filled in by Doctor		Time ↓	West of the second	11/	3/1				, -		
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Area In-charge Nurse Signature	:			(00 tr	00 N (396						

		P	PARENTE	RAL INFU	JSION P	RESCRIPTION AND ADM	/INISTR	ATION I	RECO	RD			
Date	Time	Intravenous	Volume	Rate /		Additive Drug			Do	ctor	Adı	ninistratio	
	Inne	Fluid	VOLUME	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
21/24	9.00	QVF; NS	900ml	30mu/hv	<u> </u>	0.9%		-	1/2	9724	9.00	9.50	JH SH
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Where heart beat never stops...

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

REQUISITION FOR ALEDICINE

MIS.RAJAMMAL C 73/Female/MHM66291 Name of Patient

30/12/2023/IPH2023002638 Ane / Sex

dr.K.jaishankar

__nsultant Name .

IP No.

DOA

UHID No. :

Room No.: (11)

					
S.No.	Date	Medicine	Qty.		
1	31/12/23	Cylone blade	2		
Ż	11	linder tool			
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Ц	\1	Nazr			
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		<u></u>	<u> </u>		

Pharm Bill & Name









Where heart beat never stops...

REQUISITION FOR MEDICINE

(A Unit of United Alliance Healthcare Pvt Ltd)

IP No.

Name of Patient

DOA

Age / Sex

C

UHID No.:

ultant Name :

Room No.:

C u	llani Name	Moom No. :							
S.No.	Date	Medicine Name	Qty.						
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11		molih wash							
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Pharm Bill & Name









Where heart beat never stops...

REQUISITION FOR MEDICINE

IP No.

Name of Patient

DOA

Age / Sex

isultant Name :

UHID No.:

Room No.:

	itani ivanic		
S.No.	Date	Medicine Name	Qty.
17	30/12/08	T. ECCSPPIN 15mg	15
?	ķ	1. CLOPILET TEMP	5
3	•.	T. A110003 80 mg	10
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Ty	,	10 m 1/2	⁽
13	_	5 ml syr	67

Nurse Name

Pharm Bill & Name

Mrs.RAJAMMAL C

73/Female/MHM66291

30/12/2023/IPH2023002638

Dr.K.JAISHANKAR



SUMMARY

MRS PAJAMMAE 7241 Female, LeIclo S.HTN - not on any now since last 2 months, brought by family members with complaints of sudden ondet left sidea chest pain - radialing to heft jan left shoulder seince today morning 01:20AM, Complaints of mild breating difficulty. Econ taken in Ele growed STT in Reads Ug. Nb. patient given loading dose in El & shipled to I'm. patient stanted on oxygen support & face mesh. Politant lysed whing Try Tenecheplase Aong. Post lysis. patient had Bp fall with Bp 90170 you which policy structured on motoropic Support. Now partient is being referred

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@medway-hospitals @medwayhospitals

(br.a)



Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodambakkam Mogappair

Kumbakonam 044-26530011 | 044-2473 4455 | 044-27426829 | 04146-242000 |

Chengalpattu

Villupuram

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

GICS ENUSM6 15/18 patient hutor via Face Mask

HP 56 bpm

Bolo (on Novad 4 millim)

Spor 99.1. (4 lito2)

PP 20/min

EWERGENCY DESPRIMENTAN INAM .TD ВЕЗІДЕИТ MEDICAL OFFI§€2581-ЭWИТ RESIDENT MEDICAL OFFIGE PS 1-OWNL EWELGENCA DEBY MAN THTAR INAM JO

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Date	Time	Intravenous Fluid	Volume	Rate / Duration	Route		Additive Drug	Dose	Range		Reg. No.	Start Time	ninistratio	
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						Dr. Kagar Mokkur Rugaran Edara,							ļ	
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Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
<u> આ પ્રકા</u>	12.1D	SOFT DIET	Aus	Dr. Anish Nels Reg. No: 884	on 3#				
31/12/2	8.00	Mpo	Kr	85851					
	9:00	softdielt	4.80	13455	3				
41124	2:00	Soft diet	k.82	13455	,				,
		سر							

NURSE IDENTIFICATION RECORD

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

		<u></u>				 			-
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
30/66	Evening	Down R	0159	2		Evening			
30/12/23		S. Phemalatha	021	\$		Night			
8//12/23	laa . i	Laya	0187	9	· .	Morning			
31/12/22	Evening	F. Cathrine	0807	E-C		Evening			
	ළ Night	1. Nardhini	0170	A.		Night			
01/1/04	Morning	F-Cathrine	OQUA	E-C	·	Morning			
eliloy	Evening	Agastya	014	8		Evening			
1/1/24	Night	·B. Manish	Olar	Con		Night			
osbila	Morning	E. lathrine	70207	EC		Morning			
211/24	Evening	M-Devila	00	Sp.	l	Evening			
	Night					Night	,		

DRUG CHART

Name of the Patient : MR	l Ra	Tarre	284				Age 7	2.	+ ,	Sex	£	E	Bed N	lo											
			جينر																						
Primary Consultant Name:																									
Name of the Medicine	Dose	Route	Frequency	ఇం	NY	4														_			\mp		
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INT TENECREPASE	400	48N	کر م																			\perp			
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TAR ATORNATIONS	Sign	Plo	Smor		\perp	\perp													<u> </u>		\dashv	\bot		<u> </u>	
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												_													
Administered by (Nurse Signature)	:																								
Verified by (DMO Signature) :			Dr. N	η Δ ΝΙ	LRA	TH	NAN	/ /	J.G																
Nurse Signature: Nurse Name: 1. Nurse Name: 30 12 23			MO Signatu	re (TME	135	7960 A260	<i>-ነ</i> ነ የ'FI(CEF	ł	P	rimar rimar	у Со у Со	nsu nsu	ltani Itani	t Sig t Na	natu ne	re	eg: 1	s a In	<u></u>) 	~~ <u></u>	130	- V
Nurse Name : 1, 1007 13	<i>a.</i> .	_ D	MO Name	ERGE	NØY	PE	ፈታሪነት አትሪንዝ _በ	(KU)	かん ろごべ	JAM 90	D	ate &	Tim						:	,	21x	ינטיי גרעו	ימטי רמים	150	- · 59 120
Date & Time : 30/12/83	9:	(= D	MO NameM ate & Time	:	<u> 2011</u>	N	13 .	<u>e_</u>	ଠ୍ୟ	2201	R	eg No	D .						:		ノ ^ー				
Allergic to	***************************************																					<u></u>			



SOS MEDICATIONS

DATE	TIME TO BE	DRUG	DOSE	ROUTE / OTHER	DR. SIGN.	GIVEN BY NURSE					
	GIVEN	(APPROVED NAME)	DOSE	DIRECTIONS	Dh. Sidiv.	TIME / INITIALS					

SOS MEDICATIONS

DATE	TIME TO BE	DRUG	DOSE	ROUTE / OTHER	DR. SIGN.	<u> </u>	GIVI	EN BY NU	RSE	-
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Mrs.RAJAMMAL C

73/Female/MHM66291 30/12/2023/IPH2023002638

Dr.K.JAISHANKAR

ERMEDIATE CARE FLOWCHART

UHID NO: m4m66291 AGE:

SEX:

734

SURGICAL PROCEDURE:

POSTOP DAY: -

NAME

30

FLUID REQUIREMENT: __

DATE	UR	INE	CH	IEST D	RAIN	AGE	TOTAL		I.V. FI	V. FLUIDS		ORAI	L/ R.T.	TOTAL	TOTAL
TIME	н.т.	G.T.		AIR LEAK	н.т.	G.T.	OUTPUT				H.T.	H.T.	G.T.	INTEKE	BALANCE
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13:05	30	30					30					_	_	-	w'
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02:05	100	795					795					j	450	450	- 345
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SPEC	IFIC O	BSERVA	TIONS/I	REMAR	KS			MEDI	CATION	/ DRUG	S				
			•												





Mrs.RAJAMMAL C 73/Female/MHM66291 30/12/2023/IPH2023002638 Dr.K.JAJSHANKAR



INTERMEDIATE CARE FLOWCHART

Α

NAME: MRS. PAJAMMAL. C

UHID NO: MHM 66291 AGE: 73 yrd. SEX: Formula.

SURGICAL PROCEDURE:

POSTOP DAY:

FLUID REQUIREMENT:

DATE	IIR	INE		HEST D	DRAIN.	AGF	<u> </u>		I.V. F	LUIDS		T	<u> </u>		<u>(3)</u>
& TIME	н.т.	G.T.	<u> </u>	AIR LEAK	н.т.	G.T.	TOTAL OUTPUT				H.T.	н.т.	G.T.	TOTAL INTEKE	TOTAL BALANCE
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SPEC	IFIC OF	BSERVA	TIONS/	REMAR	KS			MEDI	CATION	I / DRUG	SS	1	1		
	,														





Mrs.RAJAMMAL C 73/Fernale/MHM66291 30/12/2023/IPH2023002638 Dr.K.JAISHANKAR



INTERMEDIATE CARE FLOWCHART

A

NAME: MRS. PAJRAMMAL.C

UHID NO: NATURE: 73 year SEX: Formals.

SURGICAL PROCEDURE: -

POSTO	P DA	Y: ~					FLUII	D REQ	UIREM	IENT :	~		31/1	alas	<u> </u>
DATE	UR	INE	CH	 HEST D	RAIN	AGE	TOTAL		I.V. F	LUIDS		ORA	<u></u>	I	TOTAL
& TIME	н.т.	G.T.		AIR LEAK	н.т.	G.T.	TOTAL OUTPUT	-			H.T.	н.т.	G.T.	TOTAL	BALANCI
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SPEC	IFIC O	BSERVATI	ONS	REMAR	KS			MEDI	CATION	I / DRUG	9S	1	l		
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ASIS. CAD ACE (WMI) LYSED WITH THE COSTSIDE) SHTN !? COPD.







INTERMEDIATE CARE FLOWCHART

В

NAME: NIRS. Rayon Mas . C

UHID NO MHM66291 AGE: 73 yers. SEX: Female.

BLOOD GROUP:

HEIGHT: FMF (M)

WEIGHT: + 59.kg

B.S.A: 1.9 m2

HAEMODYNAMICS **RESP. PARAMETERS** INVESTIGATIONS / OTHER DATA TEMP H.R. RHY. ST. B.P. R.A.P. PERI. BREATH SPO₂ Br/U ON POOM AIR 8-00 99 E-FPRINGL 99 wash ++ p Sinus 97-9 DYlV 98 **9**,00 19 1000 S FP WILL 20 99 11 97.3 100 96 12.00 81 eres 19#1 a ware(

PREVIOUS DAY - HOURS 20 NOULL -

DRAINAGE ~

URINE 1050 M1.

TOTAL INTAKE TROM!

BALANCE 270M1.

. ASIS LAD ACS/IMMI LYGED WITH TAK (OUTSIDE) SHTA? CORD





Mrs.RAJAMMAL C
73/Female/MHM66291
30/12/2023/IPH2023002638
Dr.K.JAISHANKAR



INTERMEDIATE CARE FLOWCHART

В

NAME: MIRC. Rajammal. C

UHID NO: MHM66291 AGE: 73-yes- SEX: Forole

BLOOD GROUP:

HEIGHT: ZINFUM.

WEIGHT: 759. Kg

B.S.A: 1.9 m2

HAEMODYNAMICS RESP. PARAMETERS INVESTIGATIONS / OTHER DATA R.A.P. PERI. TEMP H.R. RHY. ST. B.P. P.P. RR **BREATH** SPO₂ 44 MOUN 79 d81. ging do BrCcl Pt ON ROOM AIR 989 91 linie 82 moon 22 471 By (c) Pt DN ROOMAIR 00,0d B Ding 988 21 J&1. Byld 1000M ++ deb Byld dd^{1} ++ 00F meean lol

PREVIOUS DAY - HOURS

DRAINAGE

TOTAL INTAKE

URINE

TOTAL OUTPUT

BALANCE







Mrs.RAJAMMAL C

73/Female/MHM66291

30/12/2023/IPH2023002638

Dr.K.JAISHANKAR

RMEDIATE CARE FLOWCHART

В

UHID NO:

mit m 66291 734 F

BLOOD GROUP:

NAME:

HEIGHT: 5147 Cm. WEIGHT: 19.119 B.S.A: 1.910

	НА	EMOE	YNAM	IICS	•		RES	P. PARAMET	ERS	INVESTIGATIONS /			
H.R.	RHY.	ST.	l	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA			
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69	jimis	明-3	138	192	woor	ी नेस	19	Brld	97	4			
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64	Spring	<i>98</i> €	13/19	84	rahar	44	20	erlu	984.	11			
62	Siring	CIPE	13/45	85	ww	1++	QY	Bulci	97+	11			
65	રિપાપી	985	152		nveev	++	90	Bylcl	981-	Ν			
64	linil	98F.	五节	कु	www	++	93	Brlc	991.	11			
61	8VIII				mucu	tt	21	B1(c)	981.	L1			
K	Eurus	984	121	85	needs	144	%	Bulci	991	<i>(</i> /			
	59 11 80 81 69 69 69 69 64 65 64 65	H.R. RHY. 59 STOWN 68 STOWN 80 STOWN 69	H.R. RHY. ST. 59 SIMM 98 68 SIMM 975 71 SIMM 975 80 SIMM 975 81 SIMM 975 69 SIMM 975 69 SIMM 975 69 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985 64 SIMM 985	H.R. RHY. ST. B.P. 159 String 94 5 12 12 12 12 12 12 12 12 12 12 12 12 12	59 SINU 98 178 120 TI SINU 97 120 130 TI SINU 97 120 110 80 SINU 97 120 110 81 SINU 97 120 110 69 SINU 97 2 120 69 SINU 98 120 69 SINU 98 120 69 SINU 98 120 69 SINU 98 120 69 SINU 98 120 60 SINU 98 120	H.R. RHY ST. B.P. R.A.P. PERI. 59 SINU 98 98 126 2000 2000 2000 2000 2000 2000 2000	H.R. RHY. ST. B.P. R.A.P. PERI. 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DRAINAGE URINE

PREVIOUS DAY - HOURS

TOTAL INTAKE

TOTAL OUTPUT

BALANCE