Madurai Hospitals®
The way to better health

MRD CHECKLIST

MH/PRINT / 0075 / MRD

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		
	✓	

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/IPD/2022/002

Medway Heart Institute
Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Gnanavelu. G **Speciality:** Cardiology

Advised Date & Time: 19-1-24

Provisional Diagnosis:

CAG - DVD.

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

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

Surgery / Procedure Name (if planned):

PTCA

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

Expected Duration of Stay: 3 Days

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

Payer: ☐ Self ☐ Insurance ☑ Others: ESI

Instructions to Nurse (if any):

- Investigations
- vitals monitoring

Any other Instructions (if any):

—

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr. Gnanavelu	39469	19/1/24	11:08

For admission desk staff only:

Room Category:

- [x] General Ward
- [ ] Single Room
- [ ] Twin Sharing
- [ ] Deluxe Room
- [ ] Suite Room
- [ ] Others ESI

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
19-1-24	11:08AM	19-1-24	11:08.AM

Source:

- [x] OPD
- [ ] ER
- [ ] Direct

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

Is Blood Reservation and Blood Bank clearance completed as advised: [ ] Yes [x] No

Front office Staff Signature	Name	Emp. No.	Date	Time
Ruj	Sandhya	M110285	19/1/24	11:08

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Dr.G. GNANAVELU

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	NO: E5, MPT QUARTERS, KAMARAJAR SALAI, CHENNAI - 600009	9566170605
Occupation Retired		

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
DR. GTG	19/1/2024 11:08 AM	21/1/24	3 days.

UNIT: Cardiology — MLC ☐ Yes ☑ No — If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
ATYPICAL ANGINA, CAD-NSTEMI, CALCIFIED DVD OF LAD LCX - (30.12.23, STANLEY HOSPITAL)	R07.4
NORMAL LV FUNCTION, SYSTEMIC HYPERTENSION.	I25.1, I21.4
ABSAN - POSITIVE, S/P RIGHT BELOW ELBOW AMPUTATION.	I10
	B19.1

DATE	OPERATION / PROCEDURES	ICPM Code
19.1.24.	SUCCESSFUL PTCA + STENT TO LAD, DONE USING 2.5 X 18 MM ONYX TROUGH & PTCA + STENT TO LCX DONE USING 2.5 X 18 MM ULTIMASTER DES DONE ON 19.1.2024.	00.66

DATE	TYPE OF ANESTHESIA				
19.1.24	☑ GENERAL	☐ SPINAL	☐ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

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

FOR Signature of the Consultant

S. Alem 2833
Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்
Signature of Admitting Nurse

தேதி 04/11/2024
Date 11:08AM

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

உறவுமுறை Daughter
Nature of Relationship

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/IP/2022/008

Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

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

☐ Read

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

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	J. RAVI KUMAR	J RAVI KUMAR	19/1/24	11:08
Surrogate/Guardian (if applicable #)	R. TRISHA	R. Trisha *(Write name and relationship with patient)*	19/1/24	11:08
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	R. MALATHY	R Malathy	19/1/24	11:08
Interpreter (if applicable)				

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

DISCHARGE SUMMARY

IP No.	IPH2024000143	**D.O.A**	: 19/01/2024
UHID	MHI202481736	**D.O.P**	: 19/01/2024
Name	Mr. RAVI KUMAR. J	**Room No.**	: GN
Age / Gender	47 Years /MALE		
Consultant	: **Dr. G. Gnanavelu.** MD., DM., (cardio) FACC Chief Cardiologist	**D.O.D**	: 21/01/2024

DIAGNOSIS:

ATYPICAL ANGINA
CAD- NSTEMI
CAG – SIGNIFICANT DVD OF LAD / LCX – (30.12.2023 ,STANLEY HOSPITAL)
NORMAL LV FUNCTION
SYSTEMIC HYPERTENSION
HBSAg – POSITIVE
S/P RIGHT BELOW ELBOW AMPUTATION

PROCEDURE:

SUCCESSFUL PTCA + STENT TO LAD DONE USING 2.5 X 18 MM ONYX TRUCOR & PTCA + STENT TO LCX DONE USING 2.5 X 18 MM ULTIMASTER DES DES DONE ON 19.01.2024.

BRIEF HISTORY:

Mr. Ravi Kumar.J, 47years old male, presented with complaints of chest pain left sided and chest heaviness since 6 months . He initially went to Stanley hospital and underwent Coronary angiogram which revealed **SIGNIFICANT DOUBLE VESSEL DISEASE of LAD/LCX** on 30.12.2023. He came to Medway heart institute and advised for PTCA to LAD & LCX for which he has been admitted.

No H/O fever, vomiting, diarrhea.

Known case of systemic hypertension on medication.

N/K/C/O Type II Diabetes mellitus, Dyslipidemia, and hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

P I C C L E	-	NIL
HR	-	70bpm
BP	-	164/70 mmHg
SPO_2	-	97% in room air

CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft
CNS	-	NFND

INVESTIGATIONS :

BLOOD(05.01.2024): Hb- 15.8gm/dl, TWBC – 9220cells/cumm, PLT – 406000cells/cumm, Urea – 14.91mg/dl, Creatinine – 0.67mg/dl, Sodium – 139mg/dl, Potassium – 5.10mg/dl, PT / INR – 11.3/1.0.

ECG: sinus rhythm HR @ 93bpm.

ECHO: No RWMA . Normal LV systolic function. EF – 60%. No MR/ TR.

POST PCI INVESTIGATIONS:

BLOOD(13.01.2024) :

Test Name	Result	Reference Value	Units
UREA	13	14 - 40	mg/dl
CREATININE	0.74	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mg/dl

ECG : sinus rhythm, HR – 68 bpm., No fresh ischemic changes.

SCREENING ECHO(20.01.2024) : S/P PTCA. Mild concentric LVH. All chambers normal sized. No RWMA. Normal LV systolic function. EF – 62%. Grade I diastolic dysfunction. Normal RV systolic function. All valves structurally normal. Trivial MR. Trivial TR. No PAH. No clot / vegetation / effusion.

COURSE IN THE HOSPITAL:

Mr. Ravi Kumar.J, 47years old male, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, he underwent **SUCCESSFUL PTCA + STENT TO LAD DONE USING 2.5 X 18 MM ONYX TRUCOR DES & SUCCESSFUL PTCA + STENT TO LCX DONE USING 2.5 X 18 MM ULTIMASTER DES DONE ON 19.01.2024** by Right femoral artery approach. Post procedure was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. He was treated with dual anti-platelets, statin, nitrates and other supportive measures. His general condition improved. He got shifted to ward, RFT within normal limits, maintained adequate fluid balance. His medications are optimized and he is being discharged in a stable clinical condition.

JCI ACCREDITED NABH ACCREDITED

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CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS	-	15/15			
Temp	-	98.6°F	BP	-	176/86mmHg
PR	-	76/min	SPO2	-	98% in room air

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1	TAB. PRAX – A	10/75 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. ATORVASTATIN	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ENVAS	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. MET XL	25 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	TAB. NIKORAN	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. PAN	40 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE
7.	TAB. FLAVEDON MR	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
8	TAB. ALPRAX	0.25 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT & SALT DIET.
PHYSICAL ACTIVITIES	AS TOLERATED & AVOID STRENUOUS ACTIVITIES
REVIEW	REVIEW WITH **DR. GNANAVELU AFTER 1 WEEK WITH RFT & ECG REPORTS.**

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

"I understood the content of the discharge summary."

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

CONSULTANT SIGNATURE

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

Typed by: Ezhilarasi.

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47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU
Consultant:

MHI/IP/2022/107

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INPATIENT INITIAL ASSESSMENT

Date: 19/1/24 **Time of arrival in ward:** 11:30

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others NIL.

HbsAg -ve

Vital Signs: Temp: 98 °F | Pulse / HR: 74 (beats/min) | BP: 130/90 (mmHg)
Respiration: 20 (breaths/min) | SpO_2: 96 (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m²

Pain: ☐ Yes ☑ No. If Yes, Score: 0/10
Pain Scale Used: ☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)
Duration: — Location: —
Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

This 47/M presented with complaints on & off sharp chest pain radiating to (R) shoulder since 6 months. He was initially evaluated in Omandur and started on conservative management. Further underwent Angio in Stanley revealing DVD of LAD/LCX & was suggested CABG. Patient further consulted in FSLC & now came here for further management

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☐ Yes ☑ No. If Yes, duration: — Hypertension: ☑ Yes ☐ No. If Yes, duration: 6 months

Others:

Past Surgical History:

Press Machine - injury - prosthetic hand (R)
20 yrs back.

Present Medication *(for Medication Reconciliation)*:

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. ASPIRIN	150 mg	P/O	0-1-0		☐ Yes ☐ No
2	T. CLOPIDOGREL	75mg	P/O	0-1-0		☐ Yes ☐ No
3	T. ATORVASTATIN	10mg	P/O	0-0-1		☐ Yes ☐ No
	~~T. METOPROLOL XL~~	~~25mg~~	~~P/O~~	~~1-0-1~~	19/12/24	☐ Yes ☐ No
	~~T. ISDN~~	~~5mg~~	~~P/O~~	~~SOS~~		☐ Yes ☐ No
4	T. ENVAS	2.5 mg	P/O	0-0-1		☐ Yes ☐ No
5	T. NITROCONTIN	2.6mg	P/O	1-0-1		☐ Yes ☐ No
6	T. MET XL	25mg	P/O	1-0-1		☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Family History:

NIL SIGNIFICANT

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

Lifestyle: ☐ Sedentary ☑ Active **Occupation:** Petrol bunk keeper

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

Others: _____

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

NIL SIGNIFICANT

General Physical Examination:

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

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

SYSTEMIC EXAMINATION

CVS: S1S2+

Respiratory System: BAE +, Chest Clear

Gastrointestinal System: Soft, non tender

Central Nervous System: NAD

Urinary / Reproductive / Locomotor System: (N)

Skin / Opthalmic / ENT (N)

Suspected of contagious disease: ☑ Yes ☐ No Immuno compromised status: ☐ Yes ☑ No

Isolation required: ☐ Yes ☑ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☐ Normal ☑ Anxious ☐ Depressed ☐ Others: _____

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

Weight loss within the last 3 months? ☐ Yes ☑ No Is the patient severely ill? *(e.g. in Intensive Therapy)* ☐ Yes ☑ No

Reduced dietary intake in the last week? ☐ Yes ☑ No Is the BMI < 20.5? ☐ Yes ☑ No

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

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

Provisional Diagnosis: UNSTABLE ANGINA - DVD.
SHTN.
(N) LV function.
CAG - DVD of LAD/LCx.

Plan of Care: PTCA to LAD & LCx
NPO from 10 AM
Shift On call...

Investigations Advised:

enclosed.

Diet Advice:

☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet

☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet

☐ Neutropenic liquid diet ☐ Others: low salt diet.

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

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

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor		Dr. G. Lakshmi	122608	19/1/24	11:50AM
Consultant		Dr. Gnanavelu	34864	19/1/24	18:00
Patient Attendant	R. Tanisha	Relationship Daughter		19/1/24	11:00am

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19/01/2024/IPH2024000143
Dr.G. GNANAVELU
Consultant.

MHI/ICU/2022/036

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Every heart beat counts

CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mr. Ravi Kumar the ☒ Patient or ☐ Representative of patient have *(please tick the correct option above and below):*

☒ Read

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

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

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

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

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

Intended benefits:

Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

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

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

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

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	RUDOVG	malathi / wife (Write name and relationship with patient)	19/1/24	16:30
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	N. [illegible]	[illegible] RANJANI	19/1/24	16:30
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	✓	Balaji	123115	19/1/24	16:30

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

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

MHI/ICU/2022/036

Medway Heart Institute
Every heart beat counts

உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

□ வாசித்திருக்கிறேன்
□ சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.
□ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

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

மைய சிரையில் கதீட்டர் உட்செருகல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

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

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

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

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

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

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/IP/2022/041
Medway Heart Institute
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DOCTOR'S PROGRESS NOTES

TERUMO
Ultimaster™
2.5-18
DE-RD2518KSM
LOT 230518

DATE	NOTES
19/1/24 14.45	PCI to LAD/Lcx
	App - (R) femoral artery / Inj Heparin 7500 IU
	6F sheath / 6F EBU guiding catheter / Inj Fentanyl 25mcg
LAD -	By using 6F EBU 3.5 guiding catheter, LCA engaged. Lesion crossed with BMW-J tip guidewire, predilation with Apollo 2x12mm at 10atm 15s. Lesion stented with Onyx Trucor 2.5x18mm DES @ 12atm 30s. Post dilation with Mozec NC 2.5x8mm at 12atm 10s. Check CAG revealed no flap, dissection
LCx -	Lesion crossed with BMW J tip guidewire, predilation with Apollo 2x12mm balloon at 8atm 10s. Lesion stented with Ultimaster 2.5x18mm DES at 9atm 30s. Post dilation with Mozec NC 2.5x8mm at 18atm 10s.
ACT - 261s	
	Drugs as per chart
	- TKR - 30cc/hr

Medtronic
Onyx TruCor™ RX DES
2.5 mm x 18 mm
REF TRCR25018X
LOT 0011919146
2026-08-21

[signature]

DATE	NOTES
	C/o / B: Dr. A. Alesh...
14/1/2? 4:45pm	Case Received from Cath lab.
	S/P PCI to LAD & Lcx
	HR = 98/min
	SpO_2 = 97% RA.
	BP = 140/100
	RR = 16/min
	S_1S_2 Heard: S_1S_2 (+)
	RS: BEAE (+)
	P/A: Soft
	CNS: NFND
	GCS = 15/15
	Rx:
	– Drugs as per chart
	– I/O chart
	– Vitals monitoring
	– W/F Bleeding / Haematoma
	– To Do ECG / B. urea / S. creat tomorrow Morning.
	[signature] 9480

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Patient Details
Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
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Date : 19/1/2023

ICU PROGRESS NOTES

Time : 8PM

Doctor's Name : Dr. Velmurugan P.

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

ICU Day — 1
Background

40 CAD - DVD s/p LAD/LCx

Issues last 24 hours

— Post PCI

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

Cardiovascular system
HR - 89/m Rhythm NSR Cardiac Output -
BP - 130/80mm CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation – RA
Saturation / PaO2-
Ventilator : Spontaneous / Controlled

Last C x R -
Drains -

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

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

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

Antimicrobials with days
1. —
2.
3.

Labs Awaited

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

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

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

Plan for the day

I/O charting

Urea / creatinine / [illegible] @ 6am

ECG at 6 am.

Doctor	Signature	Name	Reg. No.	Date	Time
	[signature]	Dr - vel	93468	9/1/24	9am.

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19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
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ICU PROGRESS NOTES

Date : 20/1
Time : 8:00
Doctor's Name : Dr. Balaji

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

ICU Day
Background

S/P PCI to LAD.

Issues last 24 hours

Post PCI stable

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

Cardiovascular system
HR - 94 Rhythm - Cardiac Output -
BP - 130/80. CVP -
Cardiac Medications:

Respiratory system
Oxygen supplementation –
Saturation / PaO2- SpO2 - 100
Ventilator : Spontaneous / Controlled

Last C x R -
Drains -

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

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

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

Antimicrobials with days
1.
2.
3.

Labs

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

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

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

Plan for the day

Rx

Plan work shift.

Doctor	Signature	Name	Reg. No.	Date	Time
	✓	DR. BALAJI	12415.	20/01/24	10:00

MHI/IP/2022/041

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

NABH ACCREDITED

Medway Heart Institute
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DOCTOR'S PROGRESS NOTES

DATE	NOTES
20/1/24 9AM	E/B Dr. Gnanavelu team
	– Pt reviewed
	– No fresh complaints
	No puncture site issues
	O/E : Conscious, oriented
	afebrile
I/1040 O/2100	PR – 84/min, BP – 124/86 (99).
	SpO2 95% RA
ECG sinus rhythm no fresh changes	– CVS: S1,S2 (+)
	RS: BAE (+)
CBG 120	
	Ur/Cr – 13/0.74 – Adv
	– Cont the same.
	– Screening Echo
	↑ Bisop 2.5 1–0–1 – Mobilise & shift to ward after rounds.
	Stop nitrocontin
	Add NIKORAN 5 1–0–1
	97211
	38411

DATE	NOTES
20/1/24.	S/B Dr. G. Lakshmi
11 AM	pt. reviewed
	POD-1 post PTCA No new complaints.
	O/E. Conscious
	Oriented
	afebrile BP. 120/80
	PR: 83
motion not passed	S/E. CVS-S1S2+ T - 96° F
	RS - BAE + SpO2 - 92% in RA.
flatus passed	PA soft.
	Adv
	- follow drug chart
	- Mobilise patient
	c/p/w Dr. Salai → plan d/c tomorrow
	S/O - monitor vitals Q4H
	[signature] 122068

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47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

041

DOCTOR'S PROGRESS NOTES

DATE	NOTES
	S/o Dr. Mohamed Cyclum
20/1/24 10pm	S/p PTCA to LAD.
	Patient Conscious Oriented Afebrile
Vitals Stable	CVS → S1S2 (+) RS → B/A (+) P/A → Soft, NT
	Adv - Monitor vitals - To follow drug chart - Mobilise the Patient - Plan: D/c tomorrow
	(Dr)

DATE	NOTES
21/1/24	S/B Dr. Salai Sudhan (cardio)
9.30	patient reviewed.
	c/o constipation x 2days.
	Advice
	continue the drugs as per chart
	- to give syp cremaffin 25ml stat
	c/D/W Dr. Gnanavel
for,	Patient looks comfortable, feeling better.
K.h (134559)	& patient can be discharged today.
21/1/24	S/B Dr. Anusuya
10.30	patient reviewed.
	Patient looks comfortable, feeling better -
	vitals stable
D.h (134559)	patient can be discharged today.

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PRE/POST OPERATIVE ECHO

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

Date & Time	Screening Echo Report	
20/01/2024	- S/P PTCA.	
10.03 am	- Mild concentric LVH. (IVS: 11 mm, PW: 11 mm).	
	- All chambers normal sized.	LVIDd: 43 mm
	- NO RWMA.	LVIDS: 29 mm
		EF: 62.1.
	- Normal LV systolic function.	SIMPSON'S METHOD
	- Grade I diastolic dysfunction.	EDV: 73 ml
		ESV: 29 ml
	- Normal RV systolic function.	EF: 59%.
		RV TDI: 15 cm/s.
	- All valves structurally normal.	TAPSE: 22.
	- Trivial MR.	E/A Ratio: 0.75
		Med E/e': 8.92.
	- Trivial TR. NO PAH.	Lat E/e': 6.68
	- NO clot / vegetation / effusion	TR Gdt: 28 mm Hg.
		RVSP: 38 mm Hg
	- HR: 73 bpm.	

Done by,
Ms. Rajani (Cardiac Tech)
MMC/2278/TGE.

MHI/IP/2022/065

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DIABETIC CHART

PNUD
Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

ACTUAL WEIGHT 70.6 kg HbA1c 6.1 %

PREVIOUS DIABETIC MEDICATIONS —

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
19/1/24	11:30	97 mg/dl	Npo	Nayoloo	Dr. Lakshmi
19/1/24	16:30	103 mg/dl	—		DR. AKilan
20/1/24	7:00	129 mg/dl	—		Dr VELMURUGAN

INSTRUCTIONS FOR INSULIN INFUSIONS

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

Urine Acetone

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

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47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

DATE	5/1/24		
COLOUR			
REACTION			
SPECIFIC GRAVITY	1.010		
APPEARANCE			
ALBUMIN			
SUGAR	NIL		
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN	Normal		
PUS CELLS			
EPITHELIAL CELLS			
RBC			
CASTS			
CRYSTALS			
OTHERS			

MICROBIOLOGY-CULTURE REPORTS

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

MHI/IP/2022/069

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47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

BLOOD GROUP

—

INVESTIGATION SHEET

Date	20/1/24					
HAEMATOLOGY						
Hb	15.8					
P.C.V	47.8					
Platelets	406000					
TLC	9220					
Polymorphs	68.5					
Lymphocytes	12.5					
Eosinophils	4.1 / 4.9					
Mono / Basophils	8.1 / 4.9					
E.S.R						
BIO-CHEMISTRY						
Urea	14.91	13				
Creatinine	0.67	0.74				
Sodium	139					
Potassium	5.10					
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	1.690					
D.Bilirubin	0.315					
I.Bilirubin	1.375					
S.G.O.T	27					
S.G.P.T	39					
ALP	120					
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Date	5/1/24					
COAGULATION PT / INR	11.3/1.5 1.0					
~~Fibrinogen~~ APTT	40.0/26.3					
D Dimer						
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						
THYROID FUNCTION T.S.H						
T.3						
T.4						
SEROLORY	6/1/24					
HIV	non reactive					
HBsAg	Reactive.					
V.D.R.L	non reactive					
COVID 19						
RT- PCR						
IgM Ig						
HBA1C	6.1					
FBS/PPBS	94					
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality **URINE**						
Osmolality						
Spot - Na						

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

HBSAg (+)

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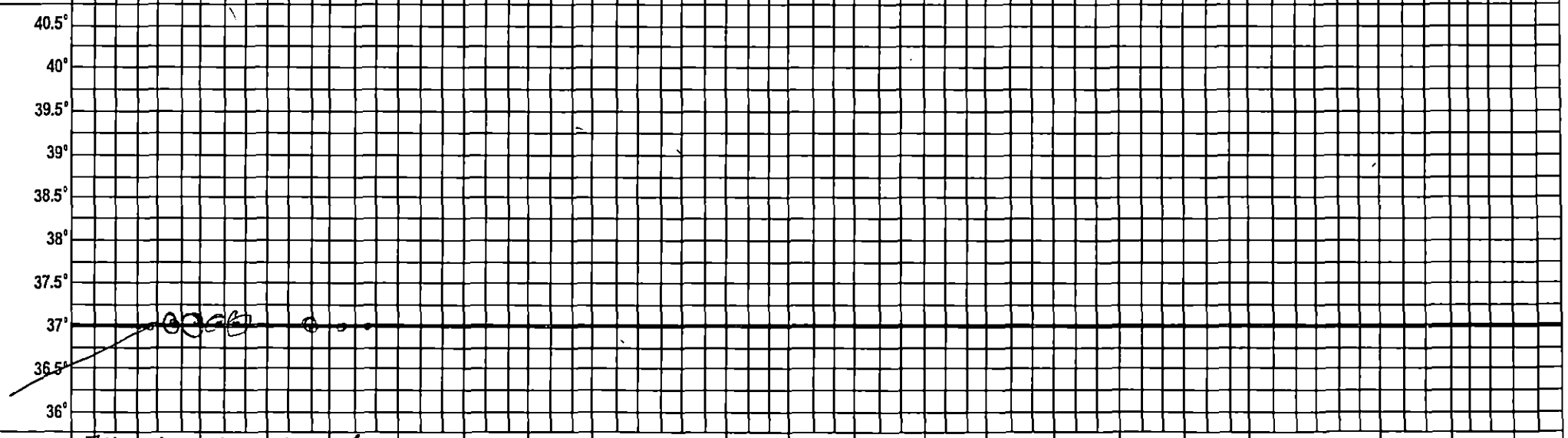
VITAL INFORMATION SHEET

BLOOD GROUP	
ON ADMISSION	
Height in CM	Weight in Kg.
162cm	70.6 kg

Diagnosis: CAD - DVR

Procedure : PTCA to CAD & LCX

NO. OF DAYS	POA				DAY-2				Day-3			
DATE	19/1/24				20/1/24				21/1/24			
HOUR	2	6	10	2	6	10	2	6	10	2	6	10
PULSE	74		77		74		74		68			
RESP	20		21		23		22		20			
B.P.	130/90		128/92		113/83		110/80		110/68			
SPO2	96		97%		96%		96		98%			
DAILY WEIGHT			70.6kg				70.6kg					
24 HRS INTAKE	1040ml				1500ml							
24HRS OUTPUT	2100ml				1300ml							
BALANCE	-1060ml				200ml							
MOTION	X				X				X			



4/12-3

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19/01/2024/IPH2024000143
Dr.G. GNANAVELU

EARLY WARNING SCORE MONITORING CHART

Name: ____________ **Age/Sex:** ________ **Patient Id No:** __________

Parameter																
Score key 0 1 2 3	DATE	19/1/24		20/1/24	20/1/24	20/1/24	20/1	21/1								DATE
	TIME	11:30		10:45	14:00	18:00	22:00	6:30								TIME
A+B Respirations breaths/min	>25															>25
	21-24							2								21-24
	18-20	•		•	•	•	•	•								18-20
	15-17															15-17
	12-14															12-14
	9-11							1								9-11
	<8															<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96	•		•	•	•	•	•								>96
	94-95							1								94-95
	92-93							2								92-93
	<91															<91
SpO2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % hypercapnic respiratory failure only scale 2 under the direction of qualified clinician	>96 on oxygen															>96 on oxygen
	95-96 on o2							2								95-96 on o2
	93-94 on O2							1								93-94 on O2
	>93 on air															>93 on air
	88-92															88-92
	86-87							1								86-87
	84-85							2								84-85
	<83%															<83%
Air or Oxygen ?	A= Air	•		•	•	•	•	•								A= Air
	O2litre/ min							2								O2litre/ min
	Device															Device
C Blood Pressure	>220															>220
	201-219															201-219
	181-200							2								181-200
	161-180															161-180
	141-160															141-160
	121-140															121-140
	111-120	•		•	•	•	•	•								111-120
	91-100							1								91-100
	81-90							2								81-90
	71-80															71-80
	61-70															61-70
	51-60															51-60
	<50															<50
Diastolic BP	mmHg					80	86	86								mmHg
Pulse beats / min	>131															>131
	121-130							2								121-130
	111-120							2								111-120
	101-110							1								101-110
	91-100							1								91-100
	81-90															81-90
	71-80	•		•	•	•	•	•								71-80
	61-70															61-70
	51-60															51-60
	41-50							1								41-50
	31-40															31-40
	<30															<30
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	•		•	•	•	•	•								Alert
	Confusion															Confusion
	V															V
	P															P
	U															U
E	>39.1 degree Celsius							2								>39.1 degree Celsius
Temperature Degree Celsius	38.1-39.0							1								38.1-39.0
	37.1-38.0															37.1-38.0
	36.1-37.0	•		•	•	•	•	•								36.1-37.0
	35.1-36.0							1								35.1-36.0
	<35.0															<35.0
NEWS Total		0		0	0	0	0	0								
Monitoring Frequency		[illegible]		[illegible]	4th	4th	[illegible]	[illegible]								
Escalation of Care Y/N		No		No	No	No	N	N								
Initials by RN		[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								
Initials by Sr. RN		[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								

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

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

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

-MHI/IP/2022/066

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Date	From: 19/1/24	To: 20/1/24	Bed No: CW (HE)
24 Hrs : Started Time : 11:30		Ended Time : 7:00	
NPO Started at :		NPO Over at :	

INTAKE & OUTPUT CHART

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE		400ml		
OUTPUT	300ml.	600ml.		

Total Intake: | Total Output: | Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
	Total intake cath lab				100ml	100ml
13.30	200					800ml
14:30	100					400ml
16.20	100					600ml

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
12:30	300					300		
13.30	300					300		
14.15	200					300		
15.30	100					100		

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MHI/IP/2022/066
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INTAKE & OUTPUT CHART

Date From: 20/1/24 To: 21/1/24			Bed No: CW (A)
24 Hrs : Started Time : 8:00		Ended Time : 7:00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	500ml			
OUTPUT	300ml			

Total Intake: 1800ml Total Output: 1300ml Difference: 200ml

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			[redacted]
			Type of Fluid	Additions	Amount	
8:00	CCV	Total	Intake		=	800
10:40	Milo 100					400
11:20	Soup 100					570
13:00	200					700
14:00	200					900
17:00	100					1000
19:30	100					1100
21:00	200					1300
21:30	50					1350
6:00	150					1500

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	[redacted]	R/N Sign	Endorsed by
8:00	Total	output			=	—		
12:80	300					300		
13:00	200					500		
18:00	300					800		
21:00	200					1000		
5:00	300					1300		
		Total intake	—		1800ml			
		Total output	—		1300ml			
		Balance	—		200ml			

MHI/DIET/2022/147

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NABH

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: DTCAI (HbA1c - 6.4%) - DM / HTN / EF - 60% / CAD - DVD				
Height: 162 cms	Weight: 70.1 Kgs	Food allergies: Yes/ No If yes, specify.....		
Religious Beliefs:	☐ Vegetarian	☑ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1600 calories, 60 fat, 60 salt, diabetic diet.				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

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

Dietitian Signature / Name / Date / Time: 19/1/24, 12:40

Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
19/11/24, 10:00	A 42year old male came c/o chest pain (on & off) was assessed to be well nourished as evident by SGA. Hlo- DOD / HTN. HbA1c = 6.4%. Patient shifted to Cathlab for procedure (PTCA) and kept on NBM. Patient moved to CCU. NBM apex. Patient started diabetic liquid diet. Can initiate on diabetic soft solid diet.	Maria Catherine John Senior Dietitian
20/11/24, 11:00	Patient moved to ward. Diet modification and clarification done. Motivated to eat well.	Maria Catherine John Senior Dietitian
21/11/24, 10:00	Oral intake is good. Educated the patient and family on 1600 calories, low fat, low salt, diabetic diet on discharge. Emphasized on small frequent meals c̄ low glycemic control. Diet modification and clarification done. Diet chart given on discharge.	Maria Catherine John Senior Dietitian

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU
Consultant:

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FAMILY COUNSELLING FORM

CONSULTANT- DR Gnanavelu. | DIAGNOSIS- unstable angina - DVD

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
19/1/24	DOCTOR	wife.	pt condition updated to attenders.		RLG	
20/1/24	DOCTOR		cath explained			

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/111

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PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD - DVD **Allergies if any:** NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
Ward 2nd floor	Cath Lab	19/1/24	13:50	PTCA

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

ASSESSMENT OF PATIENT:
General condition of Patient: ☑ Conscious ☐ Semi-conscious ☐ Un-conscious

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

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
97.8	20	82	98	110/70	0/10

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

Any pre-medication given: Given

Any critical information: -

Any specific recommendation: HbsAg Positive, Right Lower Limb Amputated

	Signature	Name	Emp. No.	Date	Time
Handover by		Hannah Grace	0105	19/1/24	13:50
Handed over to		Nagathaniy	0176	19/1/24	14:00

After Procedure:
Procedure completed: ☑ Yes ☐ Yes | Any critical information: Nil

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.6	22 brs/mt	90 bt/mt	100%	154/94(114)	0/10

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

	Signature	Name	Emp. No.	Date	Time
Handover by		Nagathaniy	0176	19/1/24	16:20
Handed over to		Ramya.J	0152	19/1/24	16:30

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Patient Na	Mr.RAVI KUMAR J 47/Male/MHI202481736 19/01/2024/IPH2024000143	ANGIOGRAM / CORONARY ANGIOPLASTY	
Consultan	Dr.G. GNANAVELU	No:	Sex: M/F UHID

CONDITION AND PROCEDURE

Dr Gnanavelu 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 Gnanavelu 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

	Signature	Name	Date	Time
Patient/Guardian with relationship	J.RAVI KUMAR	J.RAVI KUMAR	19/1/24	12:00
witness	R.Trisha	R.TRISHA (Daughter)	19/1/24	12:00
Doctor	(Gnanavelu)		19/1/24	12:00
Interpreter				

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இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்ஐடி (UHID) :

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் ..... அவர்கள் விளக்கினார்.

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

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம்

ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

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

நோயாளி ஒப்புதல்

மருத்துவர் ..... அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு இரத்தமேற்றுதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்டும் என்பதை எனக்கு விளக்கினார், இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்திரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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

MRD

TRANSFEMORAL PERCUTANEOUS CORONARY INTERVENTION REPORT

Patient name	**MR. RAVIKUMAR.J.**	**ID:**	**MHI202481736**
Age/Gender	**47 M**	**IPH:**	**IPH2024000143**
Cath No.	**3630**	**D.O.P.**	**19.1.2024**

Done by DR.G.GNANAVELU/DR.KARTHICK

Technician : Mr. Pandian

Scrub nurse : Ms. Sathya

DIAGNOSIS: ATYPICAL ANGINA; NSTEMI; NO RWMA; NORMAL LV FUNCTION; HBsAg POSITIVE; HBP; S/P RIGHT BELOW ELBOW AMPUTATION (OLD)

CAG: 12-2023 : RIGHT DOMINANT; TWO VESSEL DISEASE – SIGNIFICANT LAD & LCx DISEASE

PLAN: **PTCA X LAD & LCx**

APPROACH : Right Femoral Artery — Total exposure time: 1867"

HARDWARE : 6F sheath, 6F EBU 3.5 guide — Total RAK: 358 mGy

CONTRAST : OMNIPAQUE 200 ml — Total DAP: 178 Gy.cm2

MEDICATIONS: Inj. Heparin 7500 IU IA; Inj Fentanyl 25 mcg; Inj Emeset 4 mg IV

HEMODYNAMIC DATA: ABP 134/97 (121); HR 90 bpm; SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
MID LAD	80-90% TUBULAR STENOSIS	BMW	2 X 10 SC balloon	2.5 x 18 ONYX TRUCOR 10 atms 20s	2.5 X 8 NC BALLOON 18 atms	TIMI III FLOW; MPG III
DISTAL LCX	80-90% TUBULAR STENOSIS	BMW	2 X 10 SC balloon	2.5 x 18 ULTIMASTER 9 atms 15 sec	2.5 X 8 NC BALLOON 18 atms	TIMI III FLOW; MPG III

REMARKS: Uneventful. Inj Nikoran 2 mg given intracoronary after post dilatation. ACT was 261 sec. at the end of the procedure

Dr.G.GNANAVELU, MD, DM

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

Mr. Ravi Kumar
44 yrs/M
MH120248436

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
19/1/24	Cath lab	
13.45	⇒ Pt Received from 2nd floor to Cath lab. Conscious and oriented. ⇒ Vitals stable. IV line left side Patent. VIP score 0/5	0176
14.30	⇒ NVF NS 5cmt/hr IV started.	
14.30	⇒ Sterile draping done. PTCA to LAD and LCX started.	
14.45	⇒ Rt femoral arterial approach under Local anesthesia.	0176
14.45	⇒ Inj: Fentanyl 25 mcg + Inj: Emeset 4mg IV given O/D Dr. GG (Sir)	
14.50	⇒ Inj: Heparin 5000 IU IV given O/B Dr. GG (Sir)	0176
15.00	⇒ BP: 140/98 (114) mmHg, HR: 84 bpm SpO2: 100%. Vitals Stable.	
15.05	⇒ Inj: Heparin 2500 IU IV given O/B Dr. GG (Sir).	0176
15.30	⇒ BP: 148/90 (100) mmHg, HR: 90 bpm SpO2: 100%. Vital Stable.	
15.55	⇒ ACT - 261 secs checked O/B Dr. GG (SIR)	0176
16.00	⇒ Procedure PTCA to LAD and LCX done. Rt femoral arterial sheath suture applied. kept in Position. Pressure bandage applied no oozing & hematoma	0176
16.20	⇒ Pt shifted to CW all reports hand over to RN Remya	0176

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Sathiya	0014	19/1/24	16.20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.

Document endorsed by	Signature	Name	Emp. No.	Date	Time

Mr. Ravi Kumal, MHI/OT/2022/086
44 yrs /M
MH202981736
Dr. Gnanavely

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NABH ACCREDITED

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Medway Heart Institute
Every heart beat counts

Name of the Procedure : PTCA Location : Cathlab Date & Time : 19/1/24

PATIENT LABEL

SIGN IN 14:30 Before Induction of Procedural Sedation	TIME OUT 14:45 After procedural Sedation and before procedure	SIGN OUT 16:00 When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)	(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure	
Patient Confirmation	All team members introduce themselves by Name and Role	To be done for each procedure in case of multiple procedures
Identity by two identifiers ☑ Yes	Identity by two identifiers ☑ Yes	Name of the Procedure done written down ☑ Yes (PTCA)
Procedure ☑ Yes	Procedures PTCA ☑ Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA confirms labeling and sent to lab
Side ☑ Rt ☐ Lt ☐ NA	Side Rt femoral arterial approach ☑ Rt ☐ Lt ☐ NA	
	Expected Blood loss NA	
Consent ☑ Yes	Position Supine. ☑ Yes	Any recovery concerns : ☐ Yes ☑ None
Known Allergy ☐ Yes ☑ No If yes, plaese specify	Consent ☑ Yes	If Yes, Pls. specify :
	Required equipment and implants available ☑ Yes ☐ NA	
Difficult airway / aspiration risk / dentures ☑ No ☐ Yes, equipment and assistance available	Essential Imaging displayed ☑ Yes ☐ NA	
	Antibiotic prophylaxis within last 60 minutes ☐ Yes ☑ NA	
Possibility of hypothermia ☑ No ☐ Yes, warmer in place	Name of the Antibiotic given	Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☐ None
	Venous Thromboembolism Prophylaxis Provided ☐ Yes ☑ NA	If Yes, Pls. specify :
All concerned anesthesia equipment and medication check complete	Anticipated duration briefed ☑ Yes	
☑ Spo2 ☑ NIBP ☑ Others pls. specify ECG	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 procedure available ☐ Yes ☐ NA	For procedural sedation cases	
	Any patient specific concerns : ☐ Yes ☑ None	
	Intra procedure glycemic control ☐ Yes ☑ NA	
	Any concerns about sterility ☐ Yes ☑ None	

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : RN-Sathiya 0016	Technician : Mr - Pandiyan 2501	Others Please Specify :
Date : 19/1/24 Time : 16.15	Date : 19/1/24 Time : 16.15	Date : 19/1/24 Time : 16.15	Date : 19/1/24 Time : 16.15	Date : Time :

MHI/CATH/2022/085

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Procedure Monitoring Sheet (Cath Lab)

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

Patient Na
UHID / IP :
Consultant

Age / Sex :
Ward Unit : 2nd floor
Diagnosis : CAD - DVD

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 130/90 Temp: 97.6 Pulse: 74 RR: 20 SPO2: 96			
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered		✓	
Procedure site marked			
Skin preparation done	✓		
NPO (0 : 00)			✓
Loose Tooth removed			✓
Contact lenses / Eye glasses removed			✓
Prosthesis present			
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food) not known			
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse :		Date & Time : 19/1/24 at 12:00	

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

Time	HR / min	RR / min	BP mmHg	SpO_2%	Medication / Remarks	Sign. of Nurse
14.30	86 bt/mt	20 br/mt	143/103(115)	96%	-	
14.45	84 bt/mt	22 br/mt	140/98(114)	100%	-	
15.15	88 bt/mt	22 br/mt	130/92(104)	100%	-	
15.30	90 bt/mt	22 br/mt	148/90(109)	100%	-	
15.45	90 bt/mt	22 br/mt	158/95(116)	100%	-	
16.00	90 bt/mt	22 br/mt	154/94(114)	100%	-	
		Procedure got over.				

Post Procedure Follow Up Data (to be filled by the doctor)

Time : 16.15 Route : Rt femoral arterial approach

Complication : Nil

BP : 154/94(114) mmHg, HR : 90 b/min, RR : 22 b/min, SpO2 : 100%

Distal Pulse: felt., Puncture Site: no oozing & hematoma

Advise:

- Shift To: Ward / ICU
- Bed rest up to 6 hours
- Observe puncture site for bleeding
- Watch for Pulse in Rt femoral artery.
- Diet Normal

- Inform Duty Medical Officer SOS
  a) If patient complains of any Discomfort
  b) If dressing is Loose or Socked with Blood
  c) If limbs are Cold / Absent Pulse
- Remove Rt femoral arterial dressing on 20/1/24 at 16.00 AM /PM after informing to the consultant.
- Special instruction if any: Nil

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
16.15	140/82	90	22	100%	no oozing & hematoma	Good	-	

Nurses Notes :

Procedure PTCA LAD and LCx done Rt femoral arterial sheath suture applied, kept in position. plaster bandage applied. no oozing & hematoma

Condition at the end of procedure : ☑ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☑ CCU ☐ Other _____

Name & Signature of the Nurse :

Date & Time : 19/1/24 @ 16.20

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/053

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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 19/1/24 Time of Arrival: 11.30 Mode of Admission: ☑ Walking ☐ Wheelchair ☐ Stretcher
Accompanied by Relative: ☐ Yes ☐ No If Yes, Name of the Relative: Doughter. (trisha)
Relationship with Patient: Doughter Contact Person's Name: trisha. Relationship: Doughter.
Contact No.: 9566170605. Primary language spoken: ☑ Tamil ☑ English ☐ Indian ☐ International
Interpreter needed: ☐ Yes ☑ No | Patient status: ☑ Conscious ☐ Unconscious ☐ Disoriented
Menstrual History : LMP : — Menopause: _____ | Patient Vulnerable: ☐ Yes ☑ No
Medical History : DM / HTN / Co - Morbidity : _____ If Yes, specify _____
Drugs History : Antiplatelet — (Specify)

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

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than one half of the days	Nearly every day	Total
1. Little Interest or pleasure in doing things	0	1	2	3	0
2. Feeling down, depressed, or hopeless	0	1	2	3	

Scoring: A PHQ-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with Columbia-suicide Severity Rating Scale (C-SSRS)tool.
Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☑ No
If Yes, specify details: _____

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

Vital Signs: Temp: 98.6(°F) | Pulse / HR: 74 (beats/min) | BP: 130/80 (mmHg)
Respiration: 20 (breaths/min) | SpO_2: 96 (%) | CBG: 97 (mg/dl) | Height: 162 (cms) | Weight: 70.1 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☑ No ☐ Medication ☐ Blood Transfusion ☐ Food ☐ Not known
If Yes, specify: _____

Pain: ☑ Yes ☐ No. If Yes, Score: 1/10 **Pain Scale Used:** ☐ NRS (>12 years) ☐ CPOT (ventilator / comatose)
Duration: 6Months. Location: Abnormal Chest
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: Non Diabetic
Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: Ms. Catherin. Time: 12:00

Orient Patient if: ☑ Conscious **Orient Patient Attendant if:** ☐ Unconscious ☐ Disoriented
☑ Room ☐ Side Rails ☑ Toilet Bell ☑ Patient Information Board ☑ Bathroom ☐ Bed Controls
☐ Use of Footstool ☐ Grab Bars ☐ Nurses Call Bell ☑ Television ☐ Light Controls ☐ Telephone

Functional Assessment:

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

Daily Activity Of Living:

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

Pressure Injury Risk Assessment: Braden Scale

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

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

Total Score: 23 Action needed: ☐ Yes ☐ No Pressure injury present at the time of admission: ☐ Yes ☐ No

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

Witnessed by: _____ Signature: _____ Relationship: _____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

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

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

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

Medium risk interventions (25 - 44)

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

High-risk interventions (above 45)

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

Initial Assessment to Special Needs and Vulnerability of Patient:

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

DVT RISK ASSESSMENT

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

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

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

Tick the score obtained (✓)

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**	✓		19/1/24	
Moderate Risk	**1 to 2**				
High Risk	**3 to 8**				

Personal Belongings / Valuables:

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

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

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	R. Trisha	R. TRISHA	Relationship Daughter	19/1/24	11.30
Nurse	Jeni	Jenipriya.	0284	19/1/24	11.30
Unit In-Charge		S. Nalini	0024	19/1/24	12:00

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19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 19/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

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

B

BACKGROUND

Type of surgery: —
Date of surgery: —
Allergies if any: not known
On room air / oxygen: on RA
IV fluids on flow: —
Complaints / New Symptoms in last shift:

A

ASSESSMENT

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 71 (beats/min) | Respiration: 20 (breaths/min)

BP: 130/90 (mmHg) | SpO_2: 96 (%) | Height: 162 (cms) | Weight: 70 (kgs) | BMI: 26.9 kg/m²

Others :

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

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

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

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

Current diet: Normal diet
Drains: Nil

R

RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	A. Monisha	0121	19/1/24	12:30
Handover taken by	[signature]	Darshanaf	0176	19/1/24	12:30
Document endorsed	[signature]	P. Nalini	0024	19/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
19/1/24	Admission note	
	pt got Admitted on 2nd floor	
	e.w (A) c/o chest pain CAG done	
11:30	DVR. plan for PTCA Today	[illegible]
	NPO From 10:00	
	Vital are checked &	
	Recorded. HBsAg (-) 6/1/24	
	nurse Assessment done.	
	pt mobilized well	
	preparation done	[illegible]
12:00	consent was taken.	
	IV line secured	
13:00	Patient Shifted to Cath lab	
	on Call	[illegible]
	handed over to Cath lab Staff	

Document endorsed by.	Signature	Name	Emp. No.	Date	Time
	[signature]	S. Nalini	0024	19/1/24	13:00

MHI/NUR/2022/048

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NABH

Patient Details (Affix Label here)
Name: MR. Ravikumar
UHID: 2024817736
DOB: 47y Sex: male
DOA: 19/01/24
Consultant: DR. Anand

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 19/1/24 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - DVD

GCS: 15/15

NEWS / PEWS Score: —

POD: —

Ventilator day: —

Central line days: —

Peripheral line day: Right: Left: Brachial metacarpal

VIP Score: 0/5

Ryle's Tube: ☐ Yes ☑ No Day:

Urinary Catheter: ☐ Yes ☑ No Day:

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

B

BACKGROUND

Type of surgery: PTCA to LAD & LCX

Date of surgery: 19/1/24

Allergies if any: NKDA

On room air / oxygen: on room air

IV fluids on flow: IVF NS 30ml/hr.

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 67 (beats/min) | Respiration: 20 (breaths/min)

BP: 186/106 (mmHg) | SpO_2: 98% (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m2

Others : —

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

Fall Risk Score: 35 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High

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

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

Wound Dressing done: ☐ Yes ☐ No ☑ NA

Current diet:

Drains: —

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

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

Pending follow-up orders:

Special instructions if any: Tom urea, creatinine, S. echo to do.

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Ramya. J	0257	19/1/24	19:30
Handover taken by	[signature]	UMA MAHESWARI	0208	19/1/24	19:30
Document endorsed	[signature]	JAYASREE)	002	19/1/24	19:30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No:
19/1/24 16:30	patient received from cath lab in stable condition, vital parameter is normal. pt undergone to PTCA to LAD & LCX in (R) femoral Sheath (+) procedure site no oozing & no haematoma. IV line patent. IVF NS 30ml/hr on flow.	[signature]
17:00	ECG taken, CBG checked & recorded.	[signature]
[illegible]	pt passed urine	
17:30	S/B DR. Gnanavelu advised to continue the same.	[signature]
18:30	Sheath removed procedure site is healthy.	[signature]
19:00	No special complaints	[signature]
19:30	pt handed over to next duty Staff.	[signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	JAYADEV. S	00[illegible]	19/1/24	

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NABH ACCREDITED

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 19/1/24 Shift: ☐ Morning ☐ Evening ☑ Night

S — SITUATION

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

GCS: 15/15
POD: —
Central line days: —
VIP Score: 0/5

B — BACKGROUND

Type of surgery: PTCA to LAD & LCX
Date of surgery: 19/1/24
Allergies if any: NKDA
On room air / oxygen: On room air
IV fluids on flow: INF NS 30ml/hr
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 97.6 (°F) | Pulse / HR: 74 (beats/min) | Respiration: 22 (breaths/min)
BP: 140/97 (mmHg) | SpO_2: 97 (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m²
Others : —

Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: ~~55~~ **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: NORMAL DIET Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		S.UMA MAHESWARI	0208	19/1/24	7:30
Handover taken by		Nathiya.	0240	19/1/24	7:30
Document endorsed		S. UMA/RNP	0024	19/1/24	8:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
19/11/24 @ 19:30	⇒ Pt taken over from evening duty staff pt is conscious & oriented while taking the pt IV line present in Rt metacarpal & Brachial	0208
	⇒ today PTCA to LAD & LCX done in Rt femoral approach no oozing & haematoma.	0208
20:00	⇒ pt had diet medication given as per chart pt was stable under the cardiac monitoring IVF NS 30ml/hr IVF on flowing / Tab. Nitrocontin 2.6 mg. not given in 16:00 so I have informed to Dr. Akila sir. Sir advised to give as per chart I have given	0208
23:00	⇒ pt slept well under the cardiac monitoring	0208
00:00	⇒ pt was stable no fresh complaints	0208
02:00	⇒ Pt vitals hourly checked & recorded.	0208
03:00	⇒ pt I/O chart maintained	0208
04:00	⇒ pt was under the cardiac monitoring.	0208
4:30	⇒ Blood sample collected & sended to lab.	
06:00	⇒ Morning care done, ECG taken.	0208
07:00	⇒ CBG checked, Tab. Pan 40mg given, pt had coffee.	
7:30	⇒ pt handed over to the morning duty staff.	0208

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. VALPAI	0024	19/11/24	16:00

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19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/11/24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

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

GCS: 15/15
POD: —
Central line days: —
VIP Score: 0/5

B — BACKGROUND

Type of surgery: PTCA to LAD & LCX
Allergies if any: NKDA
On room air / oxygen: RA
Complaints / New Symptoms in last shift: —

Date of surgery: 19/11/24
IV fluids on flow: —

A — ASSESSMENT

Vital Signs: Temp: 98.6°F) | Pulse / HR: 73 (beats/min) | Respiration: 20 (breaths/min)
BP: 121/83 (mmHg) | SpO_2: 95 (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m²
Others : _____
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 00 **Fall Risk Protocol:** ☐ Low ☑ Medium ☑ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Drains:

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		Nathiya.	0240	20/11/24	12:30
Handover taken by	Hay	Hannah Grace	0005	20/11/24	12:30
Document endorsed		S. Gopal PNS	0024	20/11/24	18:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
20/1/24 @ 7:30	pt taken over from Night duty staff. pt conscious & oriented, pt vitals is HR-72/mt SpO2-95%, BP-121/83 mmHg checked & Recorted	0240
8:00	→ pt on RA, pt had (N) diet, medicine given as per drug chart	0240
	→ pt IV line present & patent.	
9:00	→ pt Pressure bandage removed. No oozing & hematoma	
10:20	→ pt shifted to ward @ 10:20	0240
	Recovery note	
10:30	pt Received from CCU. pt is stable & conscious. vital are checked & Recorded.	0111
	There is no complain issue	
	pt mobilised well	
	vital are checked & Recorded	0111
12:00	pt hand over to evening duty Staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature]	Srivalsan	0040	20/1/24	10:30

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NABH ACCREDITED

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/1/24 Shift: ☐ Morning ☑ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - DVD GCS: 15/15

NEWS / PEWS Score: 0 POD: —

Ventilator day: Central line days: —

Peripheral line day: Right: Left:

Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/5

Urinary Catheter: ☐ Yes ☑ No Day:

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

B

BACKGROUND

Type of ~~Surgery~~ Pro: PTCA → LAD x LCX Date of ~~Surgery~~ Pro: 19/1/24

Allergies if any: NKDA

On room air / oxygen: On room air IV fluids on flow: —

Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 97 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO_2: 98 (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m²

Others :

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

Fall Risk Score: 60 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ High

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

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

Current diet: Normal diet Drains: —

R

RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

(all above: Nil)

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

Pending follow-up orders: —

Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by	[signature]	Hannah Grace	0605	20/1/24	19.00
Handover taken by	[signature]	R. SUSHMA	0801	20/1/24	19.00
Document endorsed	[signature]	S. [illegible] PNP	0002	20/1/24	18.20

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
20/11/24	Evening duty notes	
12:30	Patient handing over taken from Morning duty staff in a hemodynamically Stable Condition	Hey 005
14.00	⇒ Pt due drugs are given as per drug chart.	Jeni
	⇒ Pt had normal diet.	
16.00	⇒ Pt mobilized well.	Jeni.
	⇒ Medication given.	
	⇒ Pressure bandage Removed.	
18.30	⇒ pt vitals checked and recorded.	
	⇒ Pt I/O chart Monitored.	Jeni on.
19.00	⇒ pt hand over given to night duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Neel	S. Neelima	00nf	20/11/24	16:30

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NABH ACCREDITED

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 20/1/24 Shift: ☐ Morning ☐ Evening ☐ Night

S — SITUATION

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

B — BACKGROUND

Type of surgery: DVR + PTVA + LAD PLEX Date of surgery: 19/1/24
Allergies if any: —
On room air / oxygen: RA IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 97.1 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/60 (mmHg) | SpO_2: 97 (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m²
Others: —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 50 **Fall Risk Protocol:** ☐ Low ☐ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☐ NA Wound Dressing done: ☐ Yes ☐ No ☐ NA
Current diet: Normal diet Drains: —

R — RECOMMENDATION

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

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0261	21/1/24	7:00
Handover taken by		Hannah Grace	0105	21/1/24	7:30
Document endorsed		A Vali PNP	0024	21/1/24	16:50

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
20/11/24 @	Night duty staff notes	
12.00	⇒ Pt handing over taken from night duty staff.	
12.00	⇒ Pt Conscious & Oriented	
20.00	⇒ Pt dose drugs are given.	
20.30	⇒ Pt had a diet.	
21.30	⇒ Pt well mobilized.	
22.30	⇒ Pt well sleeping	
2.30	⇒ Pt well sleeping.	
6.00	⇒ Pt Vs checked & Recorded.	
6.45	⇒ Pt I/O chart maintained	
7.00	⇒ Pt handing over given by morning duty staff.	

Document endorsed by	Signature	Name	Emp. No:	Date	Time

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Mr.RAVI KUMAR J
47/Male/MH1202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 21/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - DVD
GCS: 15/15
NEWS / PEWS Score: -
POD:
Ventilator day:
Central line days: -
Peripheral line day: Right: Left: D3
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of ~~surgery~~ Pro: PTCA → LAD + LCx
Date of ~~surgery~~ Pro: 19/1/24
Allergies if any: NKDA
On room air / oxygen: On roomair
IV fluids on flow: -
Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 97.8 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 21 (breaths/min)

BP: 110/70 (mmHg) | SpO_2: 98 (%) | Height: 162 (cms) | Weight: 70.1 (kgs) | BMI: 26.9 kg/m^2

Others :

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

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

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

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

Current diet: Normal diet
Drains: —

R

RECOMMENDATION

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

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

Pending follow-up orders:

Special instructions if any: Plan d/s today

	Signature	Name	Emp. No.	Date	Time
Handover given by	Hay	Hannah Grace	0105	21/1/24	12:30
Handover taken by		discharged			
Document endorsed	[illegible]	S. Vallapa	0004	21/1/24	1:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
21/1/24	Morning duty notes	
7:30	patient handing over taken from Night Duty Staff in a hemodynamically Stable Condition	Hay 0105
8:00	Vital Signs Checked & Recorded	Hay 0105
9:00	Due drugs are given as per drug chart	Hay 0105
11AM	Patient today Plan for discharge.	0271
13:30	IV line removed, prepaid discharge Summary, patient get after.	0271

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Neel	S. Neel PNP	0024	21/1/24	16:30

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ADULT NURSING CARE PLAN

P Mr.RAVI KUMAR J
N 47/Male/MHI202481736
U 19/01/2024/IPH2024000143
D Dr.G. GNANAVELU
D
C

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 19/1/24 **Time:** 11:30 **Modified Date:** **Time:**

Reason for Modification: **Diagnosis:** CAD - DeD

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M NPO From 0200 E pt had (N) diet N pt had @ diet	0200
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M SpO2 - 98% E Pt on room air SpO2 - 98%. N pt on room air SpO2 - 98%	0200
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O chart monitored E Inf NS 30 ml/hr. on flow N IVF NS 30 ml/hr on flowing	0200

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt mobilized well E pt mobilized in bed fully. N pt will mobilize in bed freely	0700 0700
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☑ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M @ 8pm Pt had elimination pattern (N) E pt had (N) elimination pattern N pt had @ elimination pattern	0700 0700
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M — E pt had (N) skin integrity N pt had @ skin integrity	0700 0700

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

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by		S. Nalini	0084	19/1/24	16:00

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 20/1/24	Time: 8.00am	Modified Date:	Time:
Reason for Modification:		Diagnosis: UNSTABLE ANGINA – DVD / SHTN / @ RV FUNCTION	

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
MOBILITY ☑ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M	pt will mobilize on bed.	0240
			E	Pt Mobilized well	Hay 0105
			N	pt mobilized well	0201
ELIMINATION ☐ Catheter, bedpan, urinal ☑ Nasogastric tube ☐ Bowel movement ☑ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistent / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M	pt on Ⓝ elimination pattern.	0240
			E	Patient had normal elimination pattern	Hay 0105
			N	pt Ⓝ pattern	[illegible]
SKIN INTEGRITY ☐ Maintain normal skin integrity ☑ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH,Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M	pt will maintained Ⓝ skin integrity	0240
			E	Patient had normal elimination Pattern	Hay 0105
			N	Pt Skin Ⓝ Integrity	06

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 stay clean & clean E Pt groomed well N pt groomed well	
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M pt ID Band present E ID band present N ID band present	
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M pt on comfortable position E — N —	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M pt vitals checked & recorded E Patient Vital Signs are Stable N Pt V/S checked	
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 psychological support given E — N —	

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

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nurse	S. Nel/PnP	00 Dec	20/1/Dec	1630

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ADULT NURSING CARE PLAN

Patient Details (Affix Label here)
Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 21/1/24. Time: 8:00	Modified Date: Time:
Reason for Modification:	Diagnosis: PTCA to LAD X Lex

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

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt groomed well E N	Hay 0105
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 IDband present E N	Hay 0105
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 Patient Vital Signs are Stable E N	Hay 0105
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M — E N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation		Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M	Pt communicated well	Hay 0100
			E		
			N		
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ *Others:*	☑ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ *Monitor DVT score and continue treatment as per doctors order*	M	Due drugs are Given	Hay 0100
			E		
			N		

	Signature	Name	Emp. ID	Date	Time
Endorsed by	[signature]	S. valiant	0024	19/1/24	16:00

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NABH ACCREDITED

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 19	1	20
					Time: M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	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	4	1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	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	4	3	3
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	23	17	14
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

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

S.No. : 22

MHI/NUR/2022/045

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NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

Patient Details (Affix Label here)
Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Date: 20 | 1 | 24
Time: ND | E | N

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

S.No. : 22

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Patient Details (Affix Label here)
Name: Mr.RAVI KUMAR J
UI: 47/Male/MHI202481736
D: 19/01/2024/IPH2024000143
D: Dr.G. GNANAVELU
C:

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 21 / 1 / 2024		
					Time: M	E	IV
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	3		
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3		
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4		
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3		
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3		
				TOTAL SCORE	20		
				Initial & Emp. No. of Staff Nurse:	Hay 208		
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:**	Nurse		

S.No. : 22

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PAIN RE-ASSESSMENT & MONITORING CHART

NABH ACCREDITED

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

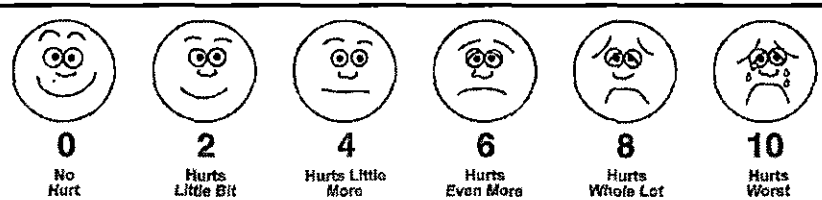
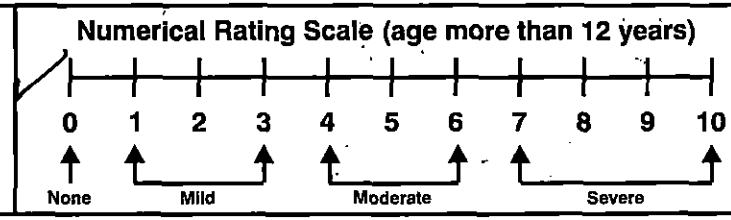
MHI/NUR/2022/052

Medway Heart Institute
Every heart beat counts

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
19/1/24 12:30	0/10	No pain	-	-	-	[signature]	[signature]
		Pt returned from cath lab @ 16:30					
16:30	0/10	No pain	-	-	-	[signature]	[signature]
17:30	0/10	No pain	-	-	-	[signature]	[signature]
18:30	0/10	No pain	-	-	-	[signature]	[signature]
19:30	0/10	No pain	-	-	-	[signature]	[signature]
20:30	0/10	No pain	-	-	-	[signature]	[signature]
21:30	0/10	No pain	-	-	-	[signature]	[signature]
22:30	0/10	No pain	-	-	-	[signature]	[signature]

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
23:30	0/10	No Pain	—	—	—	[illegible]	[illegible]
00:30	0/10	No Pain	—	—	—	[illegible]	[illegible]
01:30	0/10	No Pain	—	—	—	[illegible]	[illegible]
02:30	0/10	No Pain	—	—	—	[illegible]	[illegible]

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
***Wong-Baker* FACES Pain Rating Scale (7 years - 12 years)**	 
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Pharmacological Interventions as per doctor's prescription	

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MHI/NUR/2022/052

Mr.RAVI KUMAR J
47/Male/MHJ202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

Medway Heart Institute
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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
20/1/24 03:30	0/10	No pain	—	—	—	0203	
04:30	0/10	No pain	—	—	—	0203	
05:30	0/10	No pain	—	—	—	0203	
06:30	0/10	No pain	—	—	—	0200	
7:30	0/10	No pain	—	—	—	0208	
8:30	0/10	No pain	—	—	—	0200	
9:30	0/10	No pain	—	—	—	0240	
10:30	0/10	No pain	—	—	—	0240	
15:00	0/10	No pain	—	—	—	Hari 0100	

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
19:00	0/10	No pain	—	—	—	[illegible]	[illegible]
23:00	0/10	No pain	—	—	—	[illegible]	[illegible]
3:00	0/10	No pain	—	—	—	[illegible]	[illegible]
7:00	0/10	No pain	—	—	—	[illegible]	[illegible]

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
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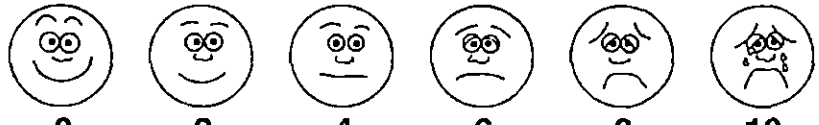
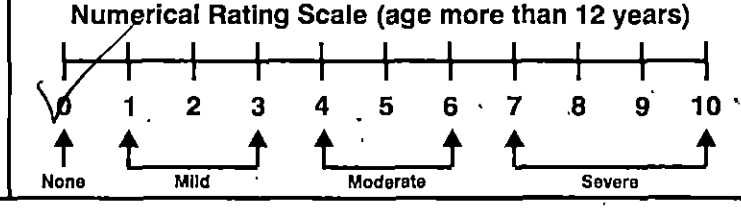
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
11:00	0/10	No pain	—	—	—	[illegible]	[illegible]

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

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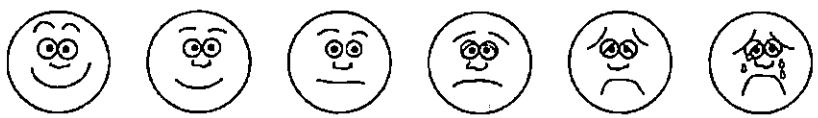
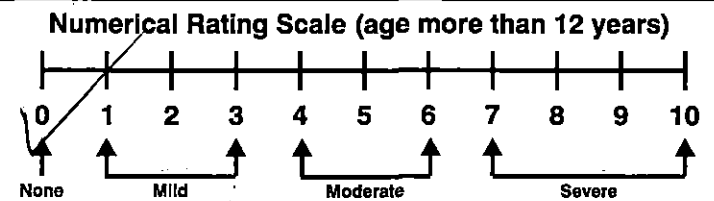
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
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Pharmacological Interventions as per doctor's prescription

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Dr.G. GNANAVELU

MHI/NUR/2022/047

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DVT RISK ASSESSMENT

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

S. No.	PARAMETERS							
	Date	19/1/24	20/1/24	21/1				
	Time	11:30	8:00	8:00				
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0				
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0				
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0				
5	Entire leg swollen (Assess for both legs)	0	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0				
9	Previously documented DVT (Assess for both legs)	0	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0				
	FINAL SCORE	0	0	0				
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low	Low	Low				
	DVT prophylaxis started	☐Yes ☑No	☐Yes ☑No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

24

MHI/NUR/2022/046

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Pi 47/Male/MHI202481736
N 19/01/2024/IPH2024000143
U Dr.G. GNANAVELU
D

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Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	19/1/24	19/1/24	19/1/24	20/1/24	20/1/24	20/1/24	21/1/24		
		Time	11:30	16:30	19:30	8:00	14:00	20:00	8:00		
History of falling (immediate or within 6 months)	No		0	0	0	0	0	0	0	0	0
	Yes		25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
AMBULATORY AID None / Bed Rest / Nurse Assist			0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker			15	15	15	15	15	15	15	15	15
Furniture			30	30	30	30	30	30	30	30	30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No		0	0	0	0	0	0	0	0	0
	Yes		20	20	20	20	20	20	20	20	20
GAIT Normal / Bed Rest / Wheel Chair			0	0	0	0	0	0	0	0	0
Weak			10	10	10	10	10	10	10	10	10
Impaired			20	20	20	20	20	20	20	20	20
MENTAL STATUS Oriented to own stability			0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations			15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Total Score			30	65	65	65	65	65	50		
Low Risk (0 - 24)											
Medium Risk (25 - 44)			✓	✓							
High Risk (above 45)				✓	✓	✓	✓	✓	✓		
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN											

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

INTERVENTIONS *Tick as per the Risk Score*	Date	19/1/24	20/1/24	19/1/24	20/1/24	20/1/24	20/1/24	21/1/24		
	Time	16:30	16:30	19:30	8:00	14:00	20:00	8:00		
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓	✓		
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓	✓		
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓	✓		
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓	✓		
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓	✓		
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓	✓		
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓	✓		
Bed wheels should be locked		✓	✓	✓	✓	✓	✓	✓		
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓			
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓	✓		✓	✓		
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓		✓		
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓	✓		
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓	✓		
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓		✓	✓			✓		
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓	✓	✓				
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓			✓		
Use restraints and bed monitors as ordered by the doctor		✓		✓	✓	✓	✓			
Allow the patient to ambulate only with assistance		✓	✓	✓	✓		✓	✓		
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓	✓		
Do not leave patients unattended in diagnostic or treatment areas		✓		✓	✓	✓	✓	✓		
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓			
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓	✓	✓	✓	✓		
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓	✓		
High-risk interventions (above 45)										
Apply all the low and medium risk interventions			✓	✓	✓	✓	✓	✓		
Tie red fall risk tag in the bed, wheel chair and stretcher			✓	✓	✓	✓	✓	✓		
Locate the high-risk patients in a room close to the nurses' station			✓	✓	✓	✓	✓	✓		
Answer these patients call bells as quickly as possible			✓	✓	✓	✓	✓	✓		
Provide a commode at bedside (if appropriate)			✓	✓	✓	✓	✓			
Urinal/bedpan should be within easy reach (if appropriate)			✓	✓	✓	✓	✓	✓		
Encourage family members or other visitors to stay with them			NA	NA	NA	✓	✓	✓		
If appropriate, consider using protection devices: safety belts			✓	✓	✓	✓	✓	✓		
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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MHI/IP/2022/055

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PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning			Plan to Address Factors
☑ None	☐ Vision / Hearing limitations		☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers		☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers		☐ Simple Language
☐ Congnitive Limitations - unable to	☐ Low motivation / desire to learn		☐ Written Instuctions
understand and follow directions			

Completed By : Date 19/11/24 Time 11:30 Nurse Signature :

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	19/11/24	L	P	O	20/11/24	L	P	O	21/11/24	L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics			P OD	✓			P OD	✓		P	OD	✓	
☑ Treatment			P OD	✓									
Medications						P	OD	✓		P	OD	✓	Doctor / Nurse
☐ Information on Safe and Effective use of medicines										P	OD	✓	
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse
☑ Pre - Operative Instructions			P OD	✓			P OD	✓		I			
☐ Post - Operative Instructions (Wound / Dressing Care)										P	OD	✓	
Pain Management													Nurse
☑ Reporting of pain		P	OD	✓		P	OD	✓		P	OD	✓	
☑ Pain Management		P	OD	✓		P	OD	✓					
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

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

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

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

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

Written Material given and explained (if any)

Reports Given :

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

Name of Attendant / Patient : R. TRISHA Signature : R. Trisha

Name of Discharge Nurse Sul monisha Signature :

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MHI/ICU/2022/056

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Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 19/1/24 Time: 11:30

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor	Dr. G. Gnanavelu		122068	19/1/24	12:00
Nursing Staff		A. Monisha	OP1	19/1/24	11:30
Dietician		Maria Catherine John, Senior Dietitian	2401	19/1/24	12:40
Physiotherapist					
Patient Care Service Staff					

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IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 20/1/24 Time: 16:20 Transferred from: CCU To: IInd FLOOR

Diagnosis:
CAD - DVD .

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 88 (beats/min) | BP: 123/64 (mmHg) | Respiration: 20 (breaths/min)

Part B *(to be filled by Physicians)* **Any Critical Investigations:** _____

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

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. Atorva	40mg	P/O	HS.	19/1/24/[illegible]	☑ Yes ☐ No
2	T. Envas	2.5	P/O	BBD	20/1/24	☑ Yes ☐ No
3	T. [illegible]	2.5	P/O	BD	"	☑ Yes ☐ No
4	T. Met XL	25	P/O	BD	"	☑ Yes ☐ No
5	T. Pan-A	40/75	P/O	1-0-0	"	☑ Yes ☐ No
6	T. Lan	40	P/O	1-0-0	"	☑ Yes ☐ No
7	T. Alp	0.25	P/O	BD	19/1/24	☑ Yes ☐ No
8.	T. Nikorandil	5mg	P/O	1-0-1	20/1/24	☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

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

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		BALAJI	123119	20/1/24	10:30
Receiving Doctor		Dr. Lakshmi	122068	20/1/24	10:30 AM

Part C ***(to be filled by Nurses)***

Check for	Transferring Nurse	Receiving Nurse
Drains	☐ Chest ☐ Abdominal ☐ Others: _____	☑ Yes ☐ No
Respiratory	Air Way Type: ☐ Patent ☐ Tracheostomy ☐ Others: _____ Oxygen Therapy: ☑ No ☐ Yes via: _____ Rate: _____ li/min	☑ Yes ☐ No
NG Tube / Oral	☐ Yes ☑ No ☐ For Feeding ☐ Gastric Suction ☐ Fluid Restriction	☑ Yes ☐ No
Foley's Catheter	☐ Yes ☑ No	☑ Yes ☐ No
Intravenous Access	☑ Peripheral Line ☐ Central Venous Line ☐ Others: _____	☑ Yes ☐ No
Pressure Injury	☐ Yes ☑ No If Yes, give details: _____	☑ Yes ☐ No
Score	Fall Risk: 65 WELLS: NEWS / PEWS:	☑ Yes ☐ No
Patient Belongings	☐ Yes ☑ No If Yes, give details: _____	☑ Yes ☐ No
Handover Details	Medication Administration Record explained: ☑ Yes ☐ No Lab & Diagnostic Reports handed over: ☐ Yes ☐ No	☑ Yes ☐ No
Patient Attendant Informed	☑ Yes ☐ No If No, give details: _____	☑ Yes ☐ No

Additional Details *(if any)*:

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		Nathiya.	12240	20/1/24	10:30
Receiving Nurse		A. Monisha	0121	20/1/24	10:30

MHI/IP/2022/116

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Medway Heart Institute
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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

IP No. / UHID No

AGE / SEX :

Ward / Bed No. CW(9)

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
19/1/24							
	19:30	Lt-Brachial Metacarpal	0/5	Patent	Flushed	Followed	
20/1/24	8:00	Lt- Brachial metacarpal	0/5	Patent	flushed	followed	0246
	[illegible]	IV	Lt brachial	Removed			
20/1/24	14:0	Lt Metacarpal	0/5	Patent	Flushed	-	
	20:00	Lt Metacarpal	0/5	patent	Flushed	-	
21/1/24	8:00	Lt Metacarpal	0/5	Patent	Flushed	-	
				IV line Removed			

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

MHI/PHARM/2022/028

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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1 Height (cms): 162 cm Weight (kg): 70.6 kg

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

Drug Details	Description of Allergy	Doctor's Sign:
NKDA	—	Name: Dr. G. Lakshmi Reg. No. 122068

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

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
19/1/24	14.45	INJ: FENTANYL	25mg	IV		102466		0176	14.45
19/1/24	14.45	INJ: EMESET	4mg	IV		102466		0176	14.45
19/1/24	14.45	INJ: HEPARIN	5000	IA		102466		0176	14.50
19/1/24	15.05	INJ: HEPARIN	2500	IV		102466		0176	15.05
21/1/24	10:00	SYP. CREMAFFIN	25ML	P/O		134555		0005	10:10

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given
Time ↓	19/11/24 20/11/24 9/11/24

DRUG NAME
T. ASPIRIN

Dose	Route	Frequency	Time
150 mg	PO	0-1-0	14:00

Dr. Sign & Reg. No. / Seal: 122068

Start Date & Time: 19/11/24 1:30pm

Stop Date & Time: 19/11/24 @ 15:00

Additional Info:

DRUG NAME
T. CLOPIDOGREL

Dose	Route	Frequency	Time
75 mg	PO	0-1-0	14:00

Dr. Sign & Reg. No. / Seal: 122068

Start Date & Time: 19/11/24 1:30pm

Stop Date & Time: 19/11/24 @ 15:00

Additional Info:

DRUG NAME
T. ATORVASTATIN

Dose	Route	Frequency	Time
40 mg	PO	0-0-1 1:30pm	20pm

Dr. Sign & Reg. No. / Seal: 122068

Start Date & Time: 19/11/24

Stop Date & Time:

Additional Info:

Clinical Pharmacist
Medway Heart Institute

DRUG NAME
T. ENVAS

Dose	Route	Frequency	Time
2.5 mg	PO	0-0-1	20:00

Dr. Sign & Reg. No. / Seal: 122068

Start Date & Time: 19/11/24 1:30 pm

Stop Date & Time:

Additional Info:

Clinical Pharmacist
Medway Heart Institute

DRUG NAME
T. NITROCONTIN

Dose	Route	Frequency	Time
2.6mg	PO	1-0-1	8:00 16:00

Dr. Sign & Reg. No. / Seal: 122068

Start Date & Time: 19/11/24 1:30pm

Stop Date & Time: 20/11/24 @ 10:00

Additional Info:

Clinical Pharmacist
Medway Heart Institute

Area In-charge Nurse Signature:

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date →	To be filled by Nursing Staff only. Sign and time given							
Time ↓	19/1/24	20/1/24	21/1/24					

DRUG NAME T-MET XL

Dose	Route	Frequency
	25mg	1-0-1

Dr. Sign & Reg. No. / Seal: 122008

Start Date & Time: 19/1/24 11.30PM

Stop Date & Time:

Additional Info:

8am → 8:30 Hay

DRUG NAME T-PRAX-A

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

Clinical Pharmacist Medway Heart Institute

Dr. Sign & Reg. No. / Seal: 10246

Start Date & Time: 19/1/24 @ 15:00

Stop Date & Time:

Additional Info:

8:00 → 8:30 Hay

DRUG NAME T-PAN

Dose	Route	Frequency
40mg	PO	1-0-0

Clinical Pharmacist Medway Heart Institute

Dr. Sign & Reg. No. / Seal: 10246

Start Date & Time: 19/1/24 @ 15:00

Stop Date & Time:

Additional Info:

7:00 → 7:30 Hay

DRUG NAME T-RIPRAY

Dose	Route	Frequency
0.25mg	PO	0-0-1

Clinical Pharmacist Medway Heart Institute

Dr. Sign & Reg. No. / Seal: 10246

Start Date & Time: 19/1/24 @ 15:00

Stop Date & Time:

Additional Info:

21:00 → 21:00

DRUG NAME T-RABEPRAZOLE MR

Dose	Route	Frequency
35mg	PO	1-0-0

Clinical Pharmacist Medway Heart Institute

Dr. Sign & Reg. No. / Seal: 10246

Start Date & Time: 20/1/24 @ 9:30

Stop Date & Time:

Additional Info:

8:00 → 8:30 Hay

20:00 → 20:30

Area In-charge Nurse Signature:

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

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

DRUG NAME			Time	20/1/24	21/1
T. Emras			8:00	→	9:00 Hay
Dose: 2.5 mg	Route: P/O	Frequency: 1—0—1			
Dr. Sign & Reg. No. / Seal: (12361)		Start Date & Time: 20/1/24@10:00 / Stop Date & Time:			
Additional Info:			20:00	20:30 [signature]	
DRUG NAME: T. Nikoran			8:00	→	8:30 Hay
Dose: 5 mg	Route: P/O	Frequency: 1—0—1			
Dr. Sign & Reg. No. / Seal: (12361)		Start Date & Time: 20/1/24@10:00 / Stop Date & Time:			
Additional Info:			20:00	20:30 [signature]	
DRUG NAME					
Dose	Route	Frequency			
Dr. Sign & Reg. No. / Seal		Start Date & Time / Stop Date & Time			
Additional Info:					
DRUG NAME					
Dose	Route	Frequency			
Dr. Sign & Reg. No. / Seal		Start Date & Time / Stop Date & Time			
Additional Info:					
DRUG NAME					
Dose	Route	Frequency			
Dr. Sign & Reg. No. / Seal		Start Date & Time / Stop Date & Time			
Additional Info:					
Area In-charge Nurse Signature:				[signature]	[signature]

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

AS REQUIRED PRESCRIPTIONS

			Date → / Time ↓	To be filled by Nursing Staff only. Sign and time given
DRUG NAME				
Dose	Route	Frequency		
Dr. Sign & Reg. No. / Seal		Start Date & Time		
		Stop Date & Time		
Additional Info:				
DRUG NAME				
Dose	Route	Frequency		
Dr. Sign & Reg. No. / Seal		Start Date & Time		
		Stop Date & Time		
Additional Info:				
DRUG NAME				
Dose	Route	Frequency		
Dr. Sign & Reg. No. / Seal		Start Date & Time		
		Stop Date & Time		
Additional Info:				
DRUG NAME				
Dose	Route	Frequency		
Dr. Sign & Reg. No. / Seal		Start Date & Time		
		Stop Date & Time		
Additional Info:				
DRUG NAME				
Dose	Route	Frequency		
Dr. Sign & Reg. No. / Seal		Start Date & Time		
		Stop Date & Time		
Additional Info:				
Area In-charge Nurse Signature:				

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
19/12/24	4.30	IVF: NS	500ml	30ml/hr	IV	0.9% NS	-	-	[signature]	10246	14.30	4.30	[signature] SIFE

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

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

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

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
19/1/24	10:00	NPO		1220608					
19/1/24	16:30	Low salt diet.		122619					
20/1/24	8:00	Salt dit.							

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
19/1/24	Evening	Ramya S	0057	J		Evening			
19/1/24	Night	S. UMA MAHESWARI	0205	S.		Night			
20/1/24	Morning	Vathiya.	0240			Morning			
20/1/24	Evening	Hannah Grace	0105	Hay		Evening			
20/1/24	Night	Ravi Shea	0072	Pak		Night			
21/1/24	Morning	Hannah Grace	0105	Hay		Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

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19/1/24.

CW

1) Bed wipes → (1)
2) Glove D/s → 10 pair
3) Ecg leads - - 10
4) T. Pan [illegible] → (5)
5) T. Alprax [illegible] (5)
6) Syringe [illegible] → Fault (4)

Dr.

AB - UNSTABLE ANGINA - DVD / STEMI / @ LV FUNCTION / CA

MHI/ICU/2022/064

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

:RMEDIATE CARE FLOWCHART

A

NAME :

UHID NO : MH-2024817136 AGE : 47Y SEX : M

SURGICAL PROCEDURE : PTCA to LAD & LCX

POSTOP DAY : D1 FLUID REQUIREMENT :

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.					H.T.	H.T.	G.T.		
20/1/24 8:00	-	-					-					50	50	50	50↑
9:00	-	-					-					200	250	250	250↑
10:00	-	-					-					50	300	300	300↑
		Pt		Shifted		to	Ward.								

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
-	-

→ Dis: unstable angina - DVD / SHTN / (N) CV FU

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INTERMEDIATE CARE FLOWCHART

A

NAME : MR. RAVI KUMAR. J UHID NO : MH12024081736 AGE : 49Y SEX : M

SURGICAL PROCEDURE : PTCA to CAD & LCX

POSTOP DAY : D0 FLUID REQUIREMENT : —

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT 300	I.V. FLUIDS				ORAL/ R.T.		TOTAL INTEKE 100	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.		D/F NS			H.T.	H.T.	G.T.		
16:30	—	—					300	30			30	100	100	230	-70
17:30	600	600					900	30			30	—	100	260	-640
18:30	—	600					900	30			30	50	150	340	-560
19:30	—	600					900	30			30	—	150	370	-530
20:30	—	600					900	30			30	150	300	550	-350
21:30	—	600					900	30			30	—	300	580	-320
22:30	700	1300					1300	30			30	50	350	660	-640
23:30	—	1300					1300	30			30	—	350	690	-610
00:30	—	1300					1300	30			30	100	450	720	-580
01:30	—	1300					1300	30			30	—	450	750	-550
02:30	—	1300					1300	30			30	—	450	780	-520
03:30	—	1300					1300	30			30	—	450	810	-490
04:30	—	1300					1300	30			30	100	550	940	-360
05:30	—	1300					1300	D/C				—	550	940	-360
06:30	—	1300					1300					—	550	940	-360
07:30	800	2100					2100					100	650	1040	-1060

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
—	—

IG - DVD OF LAD & LCX

MHI/ICU/2022/064

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Mr.RAVI KUMAR J
47/Male/MHI202481736
19/01/2024/IPH2024000143
Dr.G. GNANAVELU

ERMEDIATE CARE FLOWCHART

B

NAME

UHID NO : 202481736 AGE : 47Y SEX : M.

BLOOD GROUP : -

HEIGHT : 162 Cm WEIGHT : 70.6 kg B.S.A : 1.86 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8:00	71	Sinus	98.6	120/83	95	Warm	++	20	BRCL	95	O2 on RA
9:00	85	Sinus	98.6	123/81	95	Warm	++	20	BRCL	95	"
10.00	84	Sinus	98.6	123/84	97	warm	++	20	Br/cl	95%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE = 1040ml

TOTAL OUTPUT = 2100ml

BALANCE = -1060ml

chon / CAG – DVD of LAD / LCX

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MHI/ICU/2022/064

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INTERMEDIATE CARE FLOWCHART

B

NAME : MR. RAVI KUMAR. J UHID NO : MH12024817 36 AGE : 47Y SEX : M

BLOOD GROUP : +

HEIGHT : 162 cm WEIGHT : 70.6 Kg B.S.A : 1.86m2

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
16:30	67	Sinus	97.4	186/106	116	warm	++	20	BAL	98%	On room air
17:30	68	Sinus	97.4	153/104	116	warm	++	20	BAL	98%	"
18:30	77	Sinus	97.6	127/92	104	warm	++	21	BAL	97%	"
19:30	72	Sinus	97.8	137/94	109	warm	++	19	BAL	99%	"
20:30	76	Sinus	97.3	132/94	107	warm	++	21	BAL	96%	"
21:30	77	Sinus	97.4	138/97	111	warm	++	22	BAL	97%	"
22:30	80	Sinus	98.4	136/94	108	warm	++	23	BAL	96%	"
23:30	81	Sinus	97.7	114/84	94	warm	++	22	BAL	98%	"
00:30	75	Sinus	97.7	107/73	84	warm	++	23	BAL	98%	"
01:30	73	Sinus	97.4	123/84	97	warm	++	24	BAL	99%	"
02:30	74	Sinus	97.4	142/87	112	warm	++	22	BAL	98%	"
03:30	76	Sinus	98.3	122/85	98	warm	++	23	BAL	97%	"
04:30	72	Sinus	97.7	127/93	104	warm	++	24	BAL	96%	"
05:30	74	Sinus	97.6	134/95	109	warm	++	23	BAL	97%	"
06:30	71	Sinus	97.6	119/83	95	warm	++	24	BAL	97%	"
07:30	74	Sinus	97.6	128/88	101	warm	++	23	BAL	96%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE