Hinduja Hospitals®
The way to better health

MHP PRINT / 0075 / MRD

MRD CHECKLIST

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

Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/IPD/2022/002

Medway Heart Institute

Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Gnanavelu **Speciality:** Cardiologist

Advised Date & Time: 13/1/24 @ 10:39

Provisional Diagnosis:
USA 9/2017 / (N) LV function / Type II DM / TMT +ve / Gr I AR trivial / HBC positive / Hypothyroidism

Reason for Admission: ☐ Medical Management ☐ Surgical Management
☐ ~~Others~~ (please specify details) ______

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

Surgery / Procedure Name (if planned):
CAG

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

Expected Duration of Stay: Day Care

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

Payer: ☐ Self ☐ Insurance ☐ Others: ______

Instructions to Nurse (if any):
Admission in GR.

Any other Instructions (if any):
16000/-

Doctor's Signature	Name	Reg. No.	Date	Time
[signature]	Dr. G. Gnanavelu MD DM (cardio), FACC Advisor & Mentor Chief Cardiologist Reg. No: 39469		13/1/24	10:39

For admission desk staff only:

Room Category:

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

Admission intimation Receipt Details		Admission Time in HIS	
Date	**Time**	**Date**	**Time**
13-1-24	10:39	13-1-24	10:39

Source:

- ☑ OPD
- ☐ ER
- ☐ Direct

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

Is Blood Reservation and Blood Bank clearance completed as advised: ☐ Yes ☐ No

Front office Staff Signature	Name	Emp. No.	Date	Time
	Prathibha K	01922	13-1-24	10:39

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Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/HOSP/2022/129

Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	#, 141, Dr. Ambedkar Street Athipattu Pudhunagar Chennai - 600120	8148747064
Occupation		
RL		

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
Dr. G.G	13/1/24 10:39	18/1/24 @ 18:20	9 hours 59 minute

UNIT: RL

MLC ☐ Yes ☑ No If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
UNSTABLE ANGINA (09/2014)	I20.9
TNT (09/2014) - STRONGLY POSITIVE	
CAG - (10/2014) NIL IN LAD	I25.8
TYPE II DIABETES MELLITUS	E11.9
HYPOTHYROIDISM	E03.9
NORMAL LV FUNCTION.	I50.1

DATE	OPERATION / PROCEDURES	ICPM Code
15/1/24	CORONARY ANGIOGRAM.	88.50

DATE	TYPE OF ANESTHESIA	
13/1/24	☐ 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	

Signature of the Consultant

S. Alamelu 2538
Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

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

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date	Signature of the Patient / Relative / Gurdian
	13-1-24	

(Daughter) மகள்

உறவுமுறை

Nature of Relationship

Medway Hospitals®
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(A Unit of United Alliance Healthcare Pvt Ltd)

Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/IP/2022/008

Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

I, Ranjini. P 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	P. Rajesh	P. రాజేష్	13-1-24	10:39
Surrogate/Guardian (if applicable #)	S. Gayathri	S. GAYATHRI *(Write name and relationship with patient)*	13-1-24	10:39
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	S. Gayathri	S. GAYATHRI	13-1-24	10:39
Interpreter (if applicable)				

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

DAY CARE DISCHARGE SUMMARY

IP No.	IPH2024000114	**D.O.A**	: 13/01/2024
UHID	MHI202481809	**D.O.P**	: 13/01/2024
Name	Mrs. RANJINI. P	**Room No.**	: RL
Age / Gender	47 Years /FEMALE		
Consultant	: **Dr. G. Gnanavelu.** MD., DM., (cardio) FACC Chief Cardiologist	**D.O.D**	: 13/01/2024

DIAGNOSIS:

UNSTABLE ANGINA (09/2017)
TMT (09/2017)- STRONGLY POSITIVE
CAG – (10/2017) NFL IN LAD
TYPE II DIABETES MELLITUS
HYPOTHYROIDISM
NORMAL LV FUNCTION

PROCEDURE: CORONARY ANGIOGRAM DONE ON 13.01.2024 – MINIMAL CORONARY ARTERY DISEASE.

BRIEF HISTORY:

Mrs. Ranjini. P, 47 years old Female, presented with complaints of back pain for 1 week associated with breathlessness. She was advised Coronary angiogram and referred to Medway Heart Institute on 13.01.2024 for which she has been admitted.

ON EXAMINATION:

HR: 94bpm ; BP: 116/76mmHg ; SPO_2 : 99% in room air
CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: SGPT – 56 U/L, FBS – 165 mg/dl, PPBS – 260 mg/dl, SGOT – 29 U/L.

ECG: sinus rhythm HR-94 bpm

ECHO: Concentric LVH. No wall motion abnormality. Normal LV systolic function. EF – 62%. Grade I LV diastolic dysfunction. Trivial AR. Normal pulmonary artery pressures. No clot / pericardial effusion.

CORONARY ANGIOGRAM FINDINGS:

Right -dominant system; **MINIMAL CORONARY ARTERY DISEASE.**(reports enclosed)

ADVICE : Medical management.

ADVICE MEDICATIONS:

SI. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	**TAB. ECOSPRIN AV** (ASPIRIN & ATORVASTATIN)	10/75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	**TAB. ALDACTONE** (SPIRONOLACTONE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	**TAB. TAZLOC** (TELMISARTAN)	20 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	**TAB. THYROX** (THYROXINE)	12.5 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
5	**TAB. PANTOCID D** (PANTOPRAZOLE & DOMPERIDONE)	20/10 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
6	**TAB. ISTAVEL D** (SITAGLIPTIN & DAPAGLIFLOZIN)	100/10 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
7	**TAB. GLYCOMET GP** (METFORMIN & GLIMEPIRIDE)	2/850 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
8	**TAB. FOURTS B**	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH **DR. G. GNANAVELU AFTER 1 MONTH**

To report: If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations.
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
Dr. G. Gnanavelu M.D, DM (cardio), FACC
Chief Cardiologist
Reg. No. 39469

Typed by: Ezhilarasi.

MHI/NUR/2022/203

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Mrs.RANJINI P
Pt 47/Female/MHI202481809
N 13/01/2024/IPH2024000114
Dr.G. GNANAVELU

Medway Heart Institute
Every heart beat counts

DAY CARE INITIAL ASSESSMENT FORM

Date: 13/1/24 **Time of arrival :** 10.45

Part A *(to be filled by Nurses)*

Vital Signs: Temp 98.4 (°F) | Pulse / HR: 94 (beats/min) | BP: 116/76 (mmHg)
Respiration: 24 (breaths/min) | SpO_2 99% | Height: 150 (cms) | Weight: 72.3 (kgs) | BMI: 32.1 kg/m²

Any Language Barrier: ☐ Yes ☑ No If yes, please call Language Coordinator / Translator

Allergies : ☐ Yes ☑ No *If Yes, specify* : _____

Psychosocial Assessment:

Alcohol Intake: ☐ Yes ☑ No **Substance Abuse:** ☐ Yes ☑ No **Smoking:** ☐ Yes ☑ No

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

If Yes, specify details: _____

Pain Screening

Pain: ☐ Yes ☑ No. If Yes, Score: 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 (Age more than 12 years)

Duration: _____ Location: _____

Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:
Last 3 months Appetite ☐ Increased. ☐ Decreased ☑ No Change
Last 3 months Weight ☐ Increased ☐ Decreased ☑ No Change

Fall Risk Screening for adults: ☑ No Risk
☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem
In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

Fall Risk Screening *(for pediatrics)*
☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ☑ No Risk
In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

	Signature	Name	Emp. No.	Date	Time
Nurse	ANB DNB	Aarthi	0282	13/1/24	10-50

Part B *(to be filled by Physicians)*

Chief Complaints

C/o back pain 1 week
associated to breathlessness

Past Medical History

T2DM.

Hypothyroid.

Personal History

Married

Significant Family History

Current Medication

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	T. ECOSPRIN GOLD	20g	PO	0-1-0	12/1/24 at 8pm	☒ Yes ☐ No
2	T. ALDOACTONE	25g	PO	1-0-0	13/1/24 at 8am	☒ Yes ☐ No
3	T. ATENOL	20g	PO.	0-0-1	12/1/24 at 8pm	☒ Yes ☐ No
4	T. GLYCOMET GP	1/850	PO	1-0-1	13/1/24 at 8AM	☒ Yes ☐ No
5	T. Thyronorm	12.5g	PO	1-0-0	13/1/24 at 8am	☒ Yes ☐ No
6	T. PANTOCID D	1/0	PO	1-0-1	13/1/24 at 8am	☒ Yes ☐ No
7	T. PONTO-D		PO.	1-0-0	12/1/24 at 8am	☒ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

CBG - 177 mg/dL

Clinical Examination / Investigation

CVS: S1 S2 (+)

RS: BAE (+).

Echo
No RWMA
(N) LV

Provisional Diagnosis

T2DM
HBL positive
Hypothyroid,
TMT-positive

Plan of Care (including Investigations Ordered)

CAG

Doctor's Signature [signature]	Name [signature]	Reg. No. 2585	Date 13/1/24.	Time 11 : 00

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Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/IP/2022/041

Medway Heart Institute
...t beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
	CAG
13/1/24 13.40	App (R) ulnar artery
	[illegible]
	[illegible]
	10/24
	S/B Dr. Keerthi
13/1/24 14.30	Pt. received from cath lab.
	CVS: S1S2 (+)
	RS: B/L AE (+)
	Vitals stable
	Adv: Observation
	Analgesics.
	[signature]

DATE	NOTES
16:10pm	pt reviewed
	vitals stable.
	Adv Discharge.
	review in OPD
	[illegible]

MHI/DIET/2022/147

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NABH ACCREDITED

Medway Heart Institute
Every heart beat counts

Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAG / T2DM / HTN / Hypothyroidism / BF-62				
Height: 150 cms	Weight: 42.5 Kgs	Food allergies: Yes/No; if yes, specify.....		
Religious Beliefs:	☐ Vegetarian	☐ Non Vegetarian	☑ Eggetarian	☐ Jain
Diet Prescription: 1600 calories; low fat, low 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	Typid - caloric feeds	Starvation
3)	Gastrointestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anoredia
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity (Disease and its relationship to nutrition requirements)					
		☐ 1	☐ 2	☑ 3	☐ 4	☐ 5
		Healthy	Mild co - morbidity	Moderate co - morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
B)	Physical examination					
1)	Decreased fat stores or loss of subcutaneous fat					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
2)	Sign of muscle wasting					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
Total Score = Sum f above 7 components						

Nutritional Status : Based on this patient is	
Well Nourished	☑ (7 to 14)
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: 10380 13/1/24 11:30

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
13/1/24 17:30	A 43 years old Female came c/o Breathlessness was assessed to be well-nourished as evident by SGA. K/C/O - T2DM patient shifted to cathlab for procedure (CAG). kept on NBM. patient received RL. NBM over. patient Tolerated Diabetic liquid diet. can. Soft Solid diet.	0286
13/1/24. 16:00	Educated the patient & family on 1600 calories, low fat, low salt, Diabetic diet on discharge. Emphasized on small frequent meals. Diet modificated & clarifications done. Diet chart given on discharge.	0286

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Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/NUR/2022/111

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PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: T2DM/ HBc POSITIVE/ hypothyroidism **Allergies if any:** NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
RL	Cathlab	13/1/24	13:10	CAG.

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
98.4	24 b/m.	98 b/m	99%.	116/76	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: —

Any critical information: —

Any specific recommendation: —

	Signature	Name	Emp. No.	Date	Time
Handover by		Nathiya.	0240	13/1/24	13.10
Handed over to		Punya.S	0233	13/1/24	13.15

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°F	20 brlmt	95 bt/mt	98%.	110/70mmHg	1/10

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		Punya.S	0233	13/1/24	14.10
Handed over to		Nathiya.	0240	13/1/24	14.10

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Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH20240001114
Dr.G. GNANAVELU

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

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 have been explained that some reprocessed items might be used once its sterility and integrity is confirmed. 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	P. Rajani	MRS. RANJINI	13/1/24	10.50
witness	T. Dinesh	T. Dinesh	13/1/24	10.50
Doctor	Gnanavelu	Gnanavelu	13/1/24	10.50
Interpreter				

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

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

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. செயல்முறையினுள்ள 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. அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. 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				

JCI ACCREDITED NABH ACCREDITED

MRD

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TRANSULNAR CORONARY ANGIOGRAM REPORT

Patient Name:	**Mrs. RANJINI.P**	**ID:**	**MHI202481809**
Age/Gender :	**47 F**	**IPH:**	**IPH2024000114**
Cath No. :	**3611**	**DOP:**	**13.01.2024**
Done by	Assisted by	Technician	
Dr.Gnanavelu	Ms. Abinaya	Mr. Sathish	

DIAGNOSIS: USA (09/17); TMT STRONGLY +VE (09/17); CAG- NFL IN LAD (10/17); T2DM; DLP; HYPOTHYROID; NORMAL LV FUNCTION

Access: Right ulnar artery — Total exposure time: 1'37"

Hardware used: 5F sheath, 5F TIG — DAP : 7.13 Gy.cm2

Contrast used: CONTRAPAQUE 40 ml — Total RAK: 75.6 mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Ao Pressure– 106/70(87) mmHg, HR – 100/min, Spo2 – 99%

Selective coronary angiogram done in multiple angulated views :

ARTERY	FINDINGS
LEFT MAIN	Normal, Bifurcates into LAD & LCX
LAD	Type 3 vessel. Proximal and Mid LAD have luminal irregularities with maximum 30% stenosis. Distal LAD appears normal. Gives 2 diagonals which appear normal.
LCx	Nondominant. Proximal and Distal LCX appear normal. Gives 2 OMs. OM2 is major which appears normal.
RCA	Dominant. Proximal RCA has luminal irregularities. Mid and Distal RCA appear normal. Gives PDA and PLV which appears normal.

FINDINGS: RIGHT DOMINANT SYSTEM; MINIMAL CORONARY ARTERY DISEASE

ADVICE: MEDICAL MANAGEMENT

Dr. G. GNANAVELU, MD, DM

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

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Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

3/2022/048

DATE & TIME	Observation / Action	Signature with Emp.No
13/1/24	Patient Received from RL Came for CAG, Pt-IS Consious & Oriented, Vitals are monitoring. Groin preparation was done Pt shifted to cathlab @ 13:10.	
13/1/24	~~CATH LAB~~	
13.15	⇒ patient received From RL to cath lab. Pt concious and oriented	
13.15	⇒ vitals stable. IV line left side patent.	
13.30	⇒ sterile dropping done. procedure CAG Started	
13.40	⇒ Rt ~~Radial~~ ulnar artery approach. under local anesthesia.	
13.40	⇒ INJ: NTG 200 mcg + INJ: Heparin 2500 IV IA given O/B Dr. GG (Sir)	
13.30	⇒ INJ: Fentanyl 25 mcg + INJ: Emeset 4mg IV given O/B Dr. GG (Sir)	
13.55	⇒ HR: 99 bt/mt BP: 110/70 (86) mm Hg SpO2: 100% vitals stable	
14.00	⇒ procedure CAG done Rt ulnar artery sheath removed, Tight Plaster bandage applied. no oozing no hematoma	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Sathuja	0016	13/1/24	14.00

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MHI/NUR/2022/048

DATE & TIME	Observation / Action	Signature with Emp.No
13/11/24		
14.10	⇒ patient shifted to RL. all reports handover to RL staff	
14:20	⇒ Pt received from RL Pt conscious & oriented Pt Rt ulnar approach, No oozing & hematoma. No oozing & hematoma.	0240
	⇒ Pt had juice voided urine	0240
18:20	⇒ Pt got discharged @ , Pt conscious & oriented pt vitals Bp hemodinamically stable, pt Rt Radial appn No oozing & hematoma	0240
	⇒ Pt IV line Removed, Pt all Reports handEngaved to pt & Pt attendor.	0240

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jayl	JAYADRI.)	0004	13/11/24	19.00

Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/OT/2022/086

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SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

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Name of the Procedure : CAG Location : cath lab II Date & Time : 13/1/24

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☑ Yes ☐ No

SIGN IN 13.30 Before Induction of Procedural Sedation		TIME OUT 13.40 After procedural Sedation and before procedure		SIGN OUT 14.00 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 CAG
Procedure	☑ Yes	Procedures CAG	☑ Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA confirms labeling and sent to lab
Side	☑ Rt ☐ Lt ☐ NA	Side Rt ulnar artery 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 : R/N Abinaya 0202	Technician : Mr. Sathish 2547	Others Please Specify :
Date : 13/1/24	Date : 13/1/24	Date : 13/1/24	Date : 13/1/24	Date :
Time : 14.10	Time : 14.10	Time : 14.10	Time : 14.10	Time :

MHI/CATH/2022/085

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Procedure Monitoring Sheet (Cath Lab)

Mrs.RANJINI P
47/Female/MHI202481809
13/01/2024/IPH2024000114
Dr.G. GNANAVELU

Patient Name :
UHID / IP :
Consultant :

Age / Sex : 47y/F
Ward Unit : RL
Diagnosis : Unstable Angina

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 116/76 Temp: 98.4 Pulse: 98 RR: 24 SPO2: 99 %			
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered		✓	
Procedure site marked	✓		
Skin preparation done	✓		
NPO 8-00			
Loose Tooth removed		✓	
Contact lenses / Eye glasses removed		✓	
Prosthesis present		✓	
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food)	✓		
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse	Date & Time : 13-1-24 @ 10.50		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
13/1/24 13.40	100 bt/mt	20 brt/mt	106/70 (87)	100 %	—	
13.50	99 bt/mt	20 brt/mt	110/70 (86)	98 %	—	
			procedure	got over		

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

Time : 14.05 Route : Rt ~~Radial~~ ulnar artery approach

Complication : Nil

BP : 110/70 (86) mmHg, HR : 99 b/min, RR : 20 b/min SpO2 : 100%

~~Distal~~ Brachial Pulse: Felt, Puncture Site: No oozing no hematoma

Advise:

- Shift To: Ward / ICU/PL
- Bed rest up to 4 hours
- Observe puncture site for bleeding
- Watch for Pulse in Rt Radial artery.
- Diet DM Diet

- 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 Radial arterial dressing on 14/1/24 at 13.40 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

Nurses Notes :

procedure CAG done. Rt ulnar artery sheath removed. Tight plaster bandage applied. no oozing no hematoma.

Condition at the end of procedure : ☑ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time : 13/1/24 @ 14.10

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13/01/2024/IPH2024000114
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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 13/1/24		
					Time: 14	2	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 oyer most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY *degree of* physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. *Cannot bear own weight and / or* must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very *short distances, with or without* assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least *twice a day and inside room* at least once every two hours during waking hours	1	1	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	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	
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
				TOTAL SCORE	19	19	
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

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

S.No. : 22

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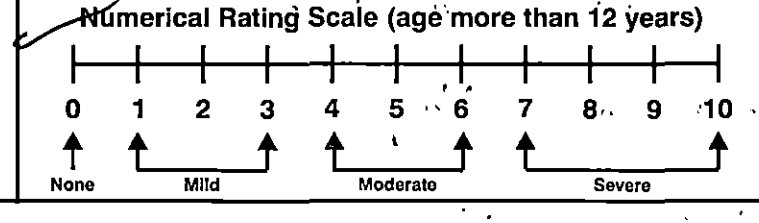
PAIN RE-ASSESSMENT & MONITORING CHART

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.
13/1/24 10:50	0/10	No pain	—	—	—	0282	
		Pt Received from RL @ 14:10					
14:10	0/10	No pain	—	—	—		
15:10	0/10	No pain	—	—	—		
16:10	0/10	No pain	—	—	—		
17:10	0/10	No pain	—	—	—		
18:10	0/10	No pain	—	—	—		
					D/C		

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.

PAIN SCALES

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

Pharmacological Interventions as per doctor's prescription

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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

	Date	13/1/24						
	Time	10-50						
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0						
5	Entire leg swollen (Assess for both legs)	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0						
9	Previously documented DVT (Assess for both legs)	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						
	FINAL SCORE	0						
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8							
	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							

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

Mrs.RANJINI P
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13/01/2024/IPH2024000114
Dr.G. GNANAVELU

MHI/NUR/2022/046

Medway Heart Institute
Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	13/1/24	13/1/24							
	Time	10:30	12:00							
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		50	50							
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)		✓	✓							
Signature & Emp. No. of RN		[signature]	[signature]							
Signature & Emp. No. of Sr. RN		[signature]	[signature]							

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

INTERVENTIONS *Tick as per the Risk Score*	Date	3/12/24	3/12/24							
	Time	10:50	11:00							
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surroundings		✓	✓							
Remind the patient to use call bell before getting out of bed		✓	✓							
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓							
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓							
Remove excess equipment or furniture to make a clear path		✓	✓							
Keep the patient's bed in the low position at all times except during procedure		✓	✓							
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓							
Bed wheels should be locked		✓	✓							
Encourage family participation in the patient's care		✓	✓							
Ensure that floor of the bathroom is dry and not slippery		✓	✓							
Review medications for potential side effects that can promote falls		✓	✓							
Use safety belts during movement in wheelchair		✓	✓							
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓							
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓	✓							
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓							
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓							
Use restraints and bed monitors as ordered by the doctor		✓	✓							
Allow the patient to ambulate only with assistance		✓	✓							
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓							
Do not leave patients unattended in diagnostic or treatment areas		✓	✓							
Accompany the patient while going to bathroom		✓	✓							
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓							
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓							
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions			✓							
Tie red fall risk tag in the bed, wheel chair and stretcher		✓	✓							
Locate the high-risk patients in a room close to the nurses' station		✓	✓							
Answer these patients call bells as quickly as possible		✓	✓							
Provide a commode at bedside (if appropriate)		✓	✓							
Urinal/bedpan should be within easy reach (if appropriate)		✓	✓							
Encourage family members or other visitors to stay with them		N/A	N/A							
If appropriate, consider using protection devices: safety belts		✓	✓							
Signature & Emp. No. of RN		[signature] 0820	[signature] 0820							
Signature & Emp. No. of Sr. RN		[signature] 0002	[signature] 0002							